From FDAP in association with WIRED

DDN
Drink and Drugs News

31 October 2005
www.drinkanddrugs.net

TOO MUCH TOO YOUNG
Alcohol and pregnancy: do not mix

DIVERSITY CHALLENGE
The new-look Federation agenda for change

HEPATITIS C AND ME
An ex-user's story and questions

VOICES FOR THE VOICELESS
Advocacy support and training through co-ordination

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Quality = Success
National Conference

Delivering better services and better outcomes for service users across the addiction field.

Monday 14th November, Hilton Hotel Conference Centre, Sheffield, S4 7YA

The National Treatment Agency launched its 'Drug Treatment Effectiveness Strategy 2005 - 2008' earlier this year in June. Building upon Models of Care, the plan stresses the importance of emerging new evidence, strongly highlighting that greater attention should be paid to service improvements that can, in turn, improve client outcomes.

Hearing from leading UK experts and practitioners in the field and distinguished international speakers, Quality = Success has been designed to provide an effective forum for critical debate and an examination of evidence-based work and best practice to help meet the challenge of delivering more effective and dynamic treatment services over the next 3 years.

Purpose of the Conference

This is an excellent opportunity for you to assess your service, treatment programme and working practices and discuss and reflect on best practice with speakers. The conference will provide a learning experience for all workers and commissioners within the substance misuse field.

Delegates will have the opportunity to:

- Hear from the NTA on Models of Care II and the implementation of the Treatment Effectiveness Strategy 2005 - 2008.
- Learn about new research evidence, focusing on the importance of high quality service delivery and impact on service user outcomes.
- Hear about future targets for the substance misuse field and the Government's backing and commitment.
- Learn about best practice and what "Quality" means for the substance misuse field - defining quality.
- Gain an understanding of your service's performance against other providers within the treatment field.
- Examine the gains for society and the contribution that high quality, effective drug treatment services make to the whole community.

Choose from 10 sub-plenaries and workshops on the day. Themes will focus on:

- Best practice, specifically concentrating on therapeutic effectiveness
- Models of Care II and government strategies to improve effectiveness
- Community integration and pathways out of addiction

Speakers include:

Rt Hon Caroline Flint,
Parliamentary Under Secretary of State for Public Health

Bill Puddicombe,
Chief Executive, Phoenix House

Kevin McEneaney,
Executive Vice President, Phoenix House, USA

Annette Dale-Perera,
Director of Quality, NTA

Gabor Kelemen,
Chief Executive, Leo Amici, Hungary

Ian Robinson,
Chief Executive, European Association for the Treatment of Addiction (EATA)

Simon Shepherd,
Chief Executive, Federation of Drug and Alcohol Professionals (FDAP)

Who Should Attend:

- Drug Treatment Managers and Workers
- Treatment Providers
- Social Work Managers, Heads and Workers
- Assistance Chief Officers of Probation
- Probation Managers and Workers
- DAT Chairs and Co-ordinators
- Joint Commissioning Managers
- Heads of Community Partnerships
- Crime Reduction Managers
- DIP/DRR Managers and Workers
- Head of Anti-Social Behaviour Teams
- Progress2Work Managers and Workers
- Training Providers
- Government Officials
- Policy Officers/Advisors
- Academics

Supported by:

EATA European Association for the Treatment of Addiction (UK)

For a copy of the full conference programme and to register online visit: www.pavpub.com or telephone: 0870 890 1080

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Drink and Drugs News

31 October 2005

Editor's letter

I can't resist saying it – we're a year old this week! A huge thank you for your support over an exciting year, which has certainly taught me a lot and brought me into contact with some of the most dedicated, inspiring and interesting people I have ever met. The letters page and invigorating feedback is a constant reminder that there's so much to investigate. Thank you also to our advertisers – without you we couldn't keep publishing the magazine free of charge for our circulation, which has already reached 10,000. If you're recruiting, please keep giving us a chance to quote for your (very reasonably priced!) advert.

User involvement has certainly grown in the past year. When David Griffin first started thinking about starting up UserActive (page 16) there was nothing much about to help service users influence the way they were treated. Now Daren Garratt is announcing that the Alliance is recruiting regional advocates to make sure services are meeting real needs (page 4). Visiting a service in Southwark gave a strong impression of how readily the user advocacy model is received – by both trainee advocates and the services who benefit from more open communication channels. St Giles' service is still in its infancy, so it will be interesting to check on progress further on, but the uptake by service users has been very encouraging indeed for Philroy and his colleagues (page 6).

You may remember David Wright's 'diary of a heroin addict' series a few months back, that drew response from many readers. This issue (page 14) David tells us how he realised he had joined the estimated half a million people in this country with Hepatitis C. Now an active volunteer helping others conquer drug use, he wants to know why more isn't being done to find and help people with the disease. Maybe you can offer suggestions.

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Notes from the Alliance – Methadone and beyond

The Alliance is recruiting regional advocates – a vital support for the national targets on improving standards for service users. Daren Garratt gives an update

After months of deliberation and vague promises, the Alliance is proud to report that we're finally in the process of recruiting our first three regional advocates in Yorkshire and Humberside, West Midlands and the East. It is anticipated that the North West, East Midlands and South East regions will have their advocates by April/May 2006, with the North East, South West and London having dedicated regional advocates in 2007/08.

However, if the national model is to prove successful, we need to ensure that the regional advocates act as an independent and objective support mechanism for local activity.

It is our firm belief that, as with the Southwark example highlighted in this issue of DDN, all local advocacy activity should be developed organically within existing partnership areas. Furthermore, any peer advocacy initiatives should be funded and supported by local partnerships in line with guidance currently being developed by the NTA on commissioning advocacy and the forthcoming best practice toolkit on advocacy.

This move from the NTA to provide specific direction to the development of local advocacy services reflects their desire to establish advocacy as a performance management target. This is emphasised in the 2006/07 treatment planning guidance, which places an expectation on partnerships to develop service level agreements requiring services to 'display a service user charter, include user consultation in service reviews, and promote access to advocacy for users'.

However, we need to ensure that services remain clear about the actual nature of the advocacy they are providing. The treatment effectiveness strategy will place a necessary focus on providing housing, employment and wider socio-economic support, but for the majority of users the initial priority will be stabilising on an optimal dose substitute prescription.

It is crucial, therefore, that local user advocacy services are appropriately trained in treatment issues, are clear about their remit and adhere to two core principles. Namely,

- Safeguarding individuals who are in situations where they are vulnerable, and
- Speaking up for, and with, people who are not being heard, helping them to express their views and make their own decisions and contributions

(From Independent Advocacy – A Guide for Commissioners: A Supplement, Scottish Executive, 2001)

It will be one of the roles of each regional advocate to support this process.

The Department of Health grant enables us to employ the regional advocates on a part time basis, so we are looking to use this current Treatment Planning period to specifically target local partnerships in these areas and ask them to identify resources that will support expanding these posts to whole time equivalents, and allow for the development of adequately trained, supported and mentored local user advocates.

It is now time for us all to work together and explore how local services can be effectively networked with ours to help us make this Department of Health, Home Office and NTA endorsed initiative an effective, sustainable reality.

Government and industry meet for strategy on underage drinking

New measures to crack down on underage drinking have been announced by government.

The Home Secretary, Charles Clarke, and Culture Secretary, Tessa Jowell, have agreed a 'co-ordinated approach' with six supermarket chains, the Wine and Spirit Trade Association and the British Retail Consortium.

Mr Clarke offered to provide adequate police resources to combat alcohol-related disorder, and expected retailers to use their 'unrivalled access to consumers' to get the message out about preventing underage sales and 'engender a culture change'.

Following a meeting last week, Mr Clarke commented he was confident that working with industry partners would promote sensible drinking and responsible retailing throughout the sector.

'What I have heard today convinces me that industry is fully committed to tackling this issue – from the boardroom to the checkout,' he said.

Kevin Hawkins, director general of the British Retail Consortium, said their members were forming an Alcohol Retailing Standards Group, representing major retailers and trade associations, to ensure a co-ordinated approach.

He also added that fundamental changes in the binge drinking culture would take longer to achieve and would 'require a comprehensive strategy involving government, schools, parents and other stakeholders'.

Ex-prisoners need better support to stay clean

Returning to the community without support or adequate accommodation is a major reason why people return to drug use when they come out of treatment, according to new research.

National drug and alcohol treatment charity, Addaction, carried out two major studies on aftercare, funded by the Department of Health. The reports were compiled from in-depth interviews with 350 drug users from all over the country, most of whom were prisoners or prison leavers; and service interviews in 25 drug action team areas.

Most users feared returning to drug use without appropriate support and aftercare to meet their needs, and were concerned at a lack of suitable housing. Others were anxious about getting employment and training to help them move on from their drug-using lifestyle.

From evidence in the reports, William Butler, Addaction's acting chief executive, concluded that the treatment sector needed to reach out to local authorities and work more closely with specialist housing services.

'We must persuade influence and persuade local authorities that success in reducing drug-related crime and true regeneration of communities means inclusion of ex-offending drug users in local strategic planning,' he said. 'It is in everyone's interest that we all work together for a common goal.'

Strengths that were revealed as making a positive difference to service users, included the effectiveness of having a single point of contact in the service, and flexibility and responsiveness of staff – such as meeting people at the prison gate on release and fitting into clients' needs. Good working partnerships with other agencies were also seen as key to client-focused services.

Both surveys, *Aftercare Users Survey* and *Year Two Aftercare*, are available online at www.addaction.org.uk

Keeping active offers relief to addicted homeless

Social and cultural activities offer homeless people distraction and relief from drug and alcohol problems, according to research commissioned by Westminster Primary Care Trust.

Carried out by London homeless charity, Broadway Lodge, the research found health benefits of taking part in activities included reducing anxiety, depression, and feelings of isolation, and promoting relaxation and better sleep patterns.

Feedback from 45 homeless people, clinicians, and workers with homeless people, contributed to recommendations that included a wider range of better-advertised activities, with the chance of independent access through discounted leisure facilities.

Westminster PCT's community health and regeneration manager, Anna Waterman, said the findings would influence allocation of project funding and be beneficial to other key areas of their Health Promotion Strategy.

The impact of social and cultural activities on the health and wellbeing of homeless people can be found online at www.westminster-pct.nhs.uk/keypriorities/reportsmisc.htm

Specialist nurses to prescribe wider range of drugs

Nurses will be able to prescribe a wider range of drugs from 14 November, including morphine and diamorphine.

The government's series of amendments to the Misuse of Drugs Regulations 2001 aim to increase efficiency in the NHS and ensure patients have quick access to the drugs they need.

Extended prescribing will only be extended to about 5,000 fully trained nurses out of a total of 440,000, who will have to demonstrate their competency. Five drugs – diamorphine, morphine, oxycodone, buprenorphine and fentanyl – will be prescribed, administered and supplied by nurses for pain relief or palliative care. Chlordiazepoxide hydrochloride and diazepam will also be prescribed by these specialist nurses, to ease acute withdrawal symptoms for those suffering from alcohol addiction.

The regulations will also soon be amended to allow ascorbic acid – used for safer injecting, to reduce the spread of blood borne viruses such as HIV and hepatitis C – to be supplied by practitioners, pharmacists and drug treatment services. Citric acid is already included on the list of allowable items; ascorbic acid will be added, as evidence to the ACMD showed it is more likely to be used by those who inject crack or freebase cocaine.

In-volve has launched a new series of drug information cards for young people, with distinctive illustrations by Basher and text written by young people.
Jonathan Akwue head of Rat Park, In-volve's communications agency that produced the cards, said: 'The thinking behind the pack was to create something of value that would have an iconic status. Too much information these days is designed to be read once and thrown away. By getting the author Irving Welsh to contribute text and commissioning a 'cult' artist to produce the illustrations, we hope the packs will be something that young people in particular will want to keep.'
For more information contact akwue@in-volve.org.uk'

Westminster diet and health forum: Engagement with young people

Government hopes to energise young people's strategy

Things are worsening, or at best static, for young people – one section of the population where there's more to do,' Geoff Dessent, deputy head of sexual health and substance misuse at the Department of Health, told last week's Westminster Diet and Health Forum.

Mr Dessent was concerned about volatile substance abuse, as an area responsible for more deaths a year than drugs. Binge drinking was an obvious priority, and we should resist compartmentalising topics when looking at young people's issues relating to alcohol and sexual health, he said. Teenage drinking, lack of contraception and sexually transmitted diseases were issues that needed careful co-ordination to address risky behaviour.

The government was 'doing a great deal' to energise its strategies on young people, through *Choosing Health* and the *Youth Matters* green paper, said Mr Dessent. A youth development programme from the Departments of Health and Education was addressing risk-taking for 13 to 15-year-olds.

Asking young people what they wanted was a basic guiding principle in getting strategy right, according to Mr Dessent. The government had been working with the General Medical Council to make sure newly qualified doctors had the skills to communicate with young people; with universities to underpin research in this area, and schools to bring the Healthy Schools initiative to all schools.

Government was serious about taking forward an alcohol reduction programme to tackle underage and binge drinking, said Mr Dessent. Real change on drink and drugs needed to take place in communities, he said, where local primary care trusts were crucial to mainstreaming work and families had a 'huge role'.

Part of the government's 'exciting, challenging agenda' was finding a way to make children's transition from primary to secondary education easier, he said, the stress of which could contribute to getting involved in substance misuse.

Gain trust of young people through sustained contact

We need to give information to young people as adults, with access to confidential and quickly available services, Ann McPherson, a GP in Oxford, told the Forum .

Sustaining contact was equally important, said Rachel Egan, of Connexions Central London, who emphasised the vital role of youth workers in developing an ongoing relationship with young people and keeping track of any substance misuse problems.

Alex Hooper-Hodson, 'agony uncle' for teen magazine *Sugar*, received 2,000 letters a month from young girls, many who felt intense peer pressure to grow up faster. His postbag contained regular questions about drugs and in the course of responding he had discovered 'a strong and efficient network of support for parents'.

Getting messages across to young people also depended on using very clear messages, added Richard Forshaw from social marketing company, Dr Foster. 'Don't float messages in space and hope people will find them,' he advised.

What do we tell the kids..?

The government's *Youth Matters* is a huge radical platform for change, helping people make informed choices, according to Anne Weinstock, of the Department of Education and Skills.

In addressing priorities for public policy, we should not look at young people's drinking in isolation, added Srabani Sen, chief executive of Alcohol Concern. Positive drinking messages were everywhere in society – every six or seven minutes on television, as a result of the £800 million a year spent by the alcohol industry on marketing and promotion.

Binge drinking among 16-year-olds had doubled in the last 10 years and a culture change on this 'toxic substance' was overdue, Ms Sen emphasised. The alcohol industry had a strong responsibility to abide by the law, and needed to get its act together, she said.

Public policy on drug testing was addressed by Peter Walker, head teacher of the Abbey School in Kent, the first school to set up random drug-testing. While he was 'not telling anyone what to do', the drug-testing initiative had worked for his school, he believed, resulting in the best academic results in their history.

Mr Walker was keen to conduct further research to prove that drug testing improved the quality of life for everyone in the school and increased drug prevention levels.

Richard D North of the Institute of Economic Affairs added to debate that we can't take the glamour out of excess.

'You are stuck in this ghastly profession of manipulating people into virtuousness,' he told delegates. Society was shrouded in myths, and the least we could do was tell the truth, he said. Forget the doom and gloom scenario, he advised: 'Tell them, drugs are fun, smoke for a few years and it will do you no harm – the only problem you'll have is getting off it.'

Finding the user's voice

Southwark's peer advocacy project started this summer with the ambition of better co-ordination with service users. The benefits that have sprung from the scheme have already taken everyone by surprise, as DDN finds out

On a Saturday morning in summer, Philroy Forte, a peer advocacy co-ordinator, was pleasantly surprised to find his group of trainee advocates already waiting for him outside St Giles Trust, keen to get going ahead of their 10am class. His supervisor, Jane Bailey, on the train up to London from Brighton, was fretting that the newly formed group would not turn up, and it would be difficult to do the exercises they had set. She need not have worried. The trainee peer advocates not only showed for their first session, but maintained 100 per cent attendance throughout the training, every Saturday morning and Monday evening for two months.

The concept of peer advocacy has been around for a while, with the Alliance's pioneering advocacy training. The idea is to use the skills and experiences of ex and stable users to help people who need support in difficult or unfamiliar situations while they are receiving treatment. It might be to do with their treatment, or it might be relating to another aspect of their life – housing, social security, employment, or a court visit. The advocacy training supplements their knowledge and experience of drug and alcohol treatment with a range of professional skills, to enable them to take on case work.

For those organising Southwark's programme, the objective was straightforward from the outset. 'The idea was to train ex and stable users to advocate for other service users within Southwark,' says Forte, who leapt at the 'exciting challenge' of developing the programme. From distributing leaflets to local services, he quickly began receiving phone calls from people wanting to become peer advocates. 'In fact, after a couple of months we were swamped,' he says.

Application forms were sent out, followed by a round of interviews.

'Most of them were really suitable – enthusiastic and willing to speak up for their peers,' says Forte. Sixteen people were soon ready to be trained as peer advocates, with further names on file for the next recruitment round.

'There has been service user involvement in Southwark in various shapes forms for a while,' says Rebecca Walker, the team's area manager. 'So to some extent it was natural progression. But Philroy was very clear from the outset about what he wanted to do and this has really motivated participants. They were very clear about what they were signing up for.'

Advocacy can mean different things to different service users, depending on the level of support they need. So the first thing for trainees to learn is that they will be the voice of the service user, says Forte. They won't initiate anything without the service user actually giving them the go-ahead to do so, but will give them the options: 'would you like me to go with you and support you in taking the issue forward? Would you like me to be the voice for you, or just be there with you?'

Once the service user has decided the level of support and involvement they need, the advocate can move on to advising them about bringing issues forward in a clear and respectful manner. It may be that the service user just wants more information; whatever their need, the advocate can provide the right level of support.

Putting together the advocates' training programme was about choosing modules that would equip participants with the skills they would need to engage with clients, communicate, listen and counsel.

Course units were selected from Open College Network website, as the course leads to OCN accreditation – equivalent to NVQ level 2 in advocacy skills. The rest of the programme was informed by service user involvement from the start.

'We asked them 'what are your expectations?', 'what do you understand about user advocacy?', says Bailey. 'We got them to define for us what they thought the stable user would want. So they've had ownership of the programme.'

The induction programme over the summer explored different models of

advocacy, and drew on their experiences as a service user. The kind of issues they had come across became material for role-plays, and gave chance to examine how they resolved an issue, whether it worked at the time – or whether it could have been dealt with a different way. Situations where conflict was involved supplied interesting examples. 'We ask, what other route could you have taken? At what point could you have stopped, stepped back and looked at the alternatives?' Bailey explained.

Examining negative experiences can prove very illuminating in learning better negotiating skills, according to the team, as advocates learn to look at treatment services from the other side. 'They realise that emotional involvement often got in the way of getting what they needed,' says Bailey. For instance, 'If you're having trouble with your script, and you're physically suffering, you're not going to necessarily be presenting your case in a calm clear fashion.'

The unpicking process lets participants look at what they did to worsen their own situation – and learn how to play the situation better for someone else's benefit. 'When they look at some of the negative outcomes they have had, they conclude that if they had had an advocate they could have dealt with the situation a lot differently, and better,' says Forte.

The project not only has benefits for the trainee advocate. Local services have been quick to realise its value and have welcomed advocates' involvement. 'It has spin-offs,' says Walker. 'The client receives a better service, and it's also a lot easier for the workers, as they're not dealing with someone hysterical.'

Getting to this point involved a rigorous process behind the scenes. Forte writes to the manager of services they want to send peer advocates into, explaining to them what peer advocacy is about. He then arranges a meeting with the management and staff. After the training, he likes to visits the service with the peer advocate, and now has a strong relationship with local projects who have been 'very supportive and accommodating' to the advocates. The ongoing proposal is to have a slot at their team meetings, to address any anxieties staff members might have.

The training process is no less thorough for the advocates themselves. Each candidate compiles a portfolio of information for their accreditation, which has had them researching issues such as GP complaints, 'so there's plenty for them to be getting on with, even if they haven't had the opportunity to go out and deliver advocacy yet,' says Bailey. Their focus and commitment have had another positive side-effect, she adds: 'We were getting very positive feedback from those services we had advocates from, saying they had seen marked improvements in the advocate's participation as a service user.' Walker has noticed that 'the level of responsibility makes them behave in a slightly different way'.

'The idea was to train ex and stable users to advocate for other service users within Southwark. After a couple of months we were swamped... Most of them were really suitable – enthusiastic and willing to speak up for their peers.'

This is all part of helping the advocates move on to further training and work, says Forte. He encourages participants to get involved in Progress 2 Work courses, counselling and college courses. Some answer phones for Narcotics Anonymous. 'Part of the objective is that they themselves will begin to move on with their lives,' he says.

He enjoys seeing the transformation of those who gain new confidence with their advocacy role. 'I get peer advocates saying to me, "you know Philroy, it's amazing. I went into the doctor's surgery to get some information and I was actually invited in. I couldn't believe I was treated with such respect".'

Left to right: Rebecca Walker, area manager; Jane Bailey, supervisor; and Philroy Forte, peer advocacy co-ordinator, outside St Giles Trust.

The team spirit on the course also helps. 'It's very supportive, very much teamwork,' says Forte. Trainees are encouraged to swap telephone numbers and work together on their portfolios. 'We said at the beginning, you will be supporting each other throughout this, as much as we will,' adds Bailey. 'And that team spirit has been there from the start.'

Finding skills and adapting them for advocacy has been an interesting process. Bailey recalls how 'a few difficult moments' during training made her realise that it was having the effect it was supposed to. She noticed members of the class were starting to challenge issues instead of accepting them – 'why are we doing it this way?', and 'you don't want that like that'.

'I thought what's happening here? Then, ah! It's working! They're beginning to challenge.' It was part of learning to apply advocacy skills in a practical way.

Reaching this stage also meant the group was ready to consider procedures and policies – also a vital part of learning to work with services and seeing situations from the other side. The group had to learn to impose rules, to deliver services, so they were given a question that applied to their own group: 'how are we going to use the services of stable users in advocacy?'

Forte says they were surprised by the clear response: 'The group said they surely would not like to have an advocate who comes to see them and is using.' So a definition was drawn up by the group of a stable user, as 'someone who's had experience of substance misuse, who no longer uses street drugs or alcohol, but who is taking positive action to maintain stability and move forward in their lives.'

This definition reflects the personal determination that many user advocates have experienced in arriving at this point, and signifies an ambition to carry on and work in the field. They get involved for no more short-term benefit than 'a cup of tea and a sandwich'. The benefits are all long term, enhancing skills and training while recovery is still new. For services who still hang on to the 'two-year rule', volunteering for different schemes gives a chance to develop skills within a tight support network until they are ready for permanent employment.

The contract for Southwark's peer advocacy programme is managed by Crime Reduction Initiatives (CRI), but this is kept necessarily low key, the team explains. It's about making it possible for advocates, who are not employees of CRI, to go into services. As Forte says, 'advocacy in its essence needs to have an aura of independence.'

The project has been met with such enthusiasm, and interest from neighbouring boroughs, that CRI are considering making peer advocacy an element of all their substance misuse services. Three months down the line the service is only in its infancy, but Walker, the area manager has already realised that it is 'incredibly cost effective and can have a massive impact because of the ripple effect it has'.

The others are equally convinced. 'It's a win-win all round,' adds Bailey. 'Everybody gains. It's logical.' **DDN**

Fit to drive?

In response to Ian Dickinson's letter 'Should services inform DVLA about users' fitness to drive?' (*DDN*, 17 October) I have spent a great deal of time considering this very same question. Many services across the country seem to take very different approaches to answering this question, however, most reach the same answer. Ultimately it is the decision of the multi-disciplinary team.

In my experience this has always given a variety of responses based more upon the emotional response of the individual clinicians than on a clinical decision based upon actual known risk. In addition the geographical area in which the service is delivered can have a paradoxical effect upon the decision making process; rural areas where service users regularly continue to drive against advice of the substance misuse services appear less likely to inform the DVLA than urban services where the vast majority of service users access public transport.

I feel that a response must be demanded from the NTA from which best practice can be drawn.

The NTA needs to decide if drug and alcohol services place engagement and retention of service users above the safety of the community.

Community charge nurse, name and address withheld

You can email Ian Dickinson direct, with further comments or suggestions in response to his letter in the 17 October issue, at ian.dickinson@awp.nhs.uk

Harm Reduction – Water, water everywhere but not a drop to dig?

It's another rainy autumn day and I've just tried to explain to a dripping wet client why we haven't got any water. As the co-ordinator of a busy city centre needle exchange I should know the answer, but I don't. Maybe I just don't understand the situation, maybe there is a reasonable, rational explanation why I can't give out 1.4 or 2mls of clean water for injection – I don't know. But I do know two things,

The customers want them.

I want to give them out.

Try explaining to a client why they can't have water amps, after you've just told them to make sure they don't share anything and keep all their tackle to themselves. Try explaining that three or four times a day, try explaining it to any number of colleagues on a regular basis. It's not just a pain in the arse, it's quite ridiculous telling someone they can't have a little bottle of water – I mean a water shortage in Manchester of all places?

The only answer I seem to be able to get is that there is some kind of problem at the Medical Licensing Authority. Its sod's law, the paraphernalia law is finally changed so that we can now (legally) give out water for injection, and then someone puts the kybosh on one of the essential bits of kit. If you don't believe me, try doing that exercise from the safer injecting course (the one where you leave out just one piece kit from your pack); you simply can't follow any of the advice you might get from a needle exchange worker if don't have the tools to do the job. Perhaps those people responsible for the shortage should go on a safer injecting course, or perhaps come and spend a day in a needle exchange and see what effect their bureaucratic dithering has in the real world.

I've not been an angry young man for a long time – cynical and jaded, yes – but not spitting feathers angry like I am now. I wonder if any of your readers would care to explain to me why the current situation came about and who is responsible.

Gary Beeny, needle exchange co-ordinator, Lifeline – Manchester

I have an academic and management background and find that drivel such as you publish lets us all down. Was he paid by the word for the article or were his feelings, having inflicted his 'self' on a public – and therefore I suppose having moved closer to attaining 'self actualisation', reward in itself?

Clients deserve evidence-based treatment

Simon Morton's letter (Is maintenance really an insane option? *DDN*, 17 October) suggests that a belief in abstinence services is based on having 'faith' in individual success stories, but methadone maintenance has a strong evidence base. Yes, it is inspiring to meet people in abstinence-based recovery and with 70 NA meetings in the North West there are more of them around than you might think. But there is also a strong body of empirical evidence and research: I suggest anyone who's interested studies the DATOS project that followed over 8,000 people through residential, in-patient and out-patient drug free treatment, as a starting point.

Simon also acknowledges that most clients, if asked, do select abstinence as a treatment goal, but he believes they are somehow naive and that we professionals know 'it is not as simple as that'. So just what does a client have to do to convince someone they want to come off drugs? Come on, let's give people a chance!

Jon Royle, ADS Area Director, Manchester

Alcohol and drugs inextricably entwined

Your correspondent Richard Phillips, formerly of Alcohol Concern, and now Director of Services at Phoenix House is right to challenge the practitioner who said that alcohol was not his concern as he worked solely with drug users, and that a priority in future strategy must be to enable existing drug workers to respond to the drinking of their clients. Addaction wishes to work with everyone in the field to make sure that this future comes sooner rather than later. Why?

Addaction's data from a client base of 23,000 shows that alcohol is the second drug of choice for drug users treated for drug misuse.

This data is submitted to the NDTMS database.

The NTA are aware of the numbers of clients presenting with alcohol problems where they have received data from clinical data management systems.

It is likely that an alcohol version of the NDTMS dataset may be developed but probably after Models of Care for alcohol is released.

Where Addaction provides drug-specific services we respond to people for whom alcohol is a component of other drug use, and would expect to respond in full to treat alcohol misuse with as much weight as any other drug misused by this client group.

Alcohol is a significant factor in compromising liver function particularly for those with Hepatitis C, which is widespread among the drug using population.

Identifying alcohol misuse is something we encourage in the training of our drug workers in delivery of our Core Competency Framework alcohol module, asking unlocking questions, looking for evidence of self-medication, particularly among those detoxing from drugs.

Alcohol Concern calculated from a recent UKATT cost effectiveness and programme research study that for every £1 spent on alcohol treatment £5 is saved in social and economic costs to society at large.

In our services commissioned to provide substance misuse, we will also respond to drinkers for whom alcohol is the primary problem with the same priority as drug users

However – in some areas we have been requested only to signpost primary alcohol misusers to other services and intervene only where we can demonstrate we are using excess capacity after all drug targets have been met.

The money allocated for services in these areas is in reality, ring-fenced drugs money, and DATs or even DAATs must meet these targets. Room for manoeuvre is extremely difficult for everyone – not least the client with the presenting problem.

There is an added complication in responding to clients with a dual problem of alcohol and drug misuse when clients do not see their drinking as a problem and choose not to attend treatment for that issue, even where we are able to find a supporting service or can offer the service ourselves.

There is currently an imbalance in focus. Responsible drinking messages for those who can enjoy alcohol and anti social behaviour crackdowns, although very important, can not be allowed to totally overshadow effective action matched by proper funding to address the enormous health and social consequences of harmful drinking.

There are many things we can do

to support DAATs, Government, our many services and the clients we have with innovative ideas for service delivery, much more alcohol awareness and education within our services – spreading the knowledge and expertise from specialists within our own organisation and using internal communications to reach the client. But that is not a substitute for treatment needs. To achieve that, we must continue along with other agencies, to raise the issue with the Department of Health and other key people in government, particularly within local government, and jointly, not separately. We must also be innovative in our thinking – perhaps thinking the unthinkable and ask why should not the Industry help government to fund more alcohol treatment sooner rather than later, if, as I am sure, that shortage of money is a major barrier to responding to treatment need.

Rosie Brocklehurst, director of communications, Addaction

'Letting go' was psychobabble

Having read Alan Rayner's article Letting Go (*DDN*, 17 October) I despair for those of us who work at the front line. How constructive was the deluge of psychobabble in the article? I personally thought the article was a piece of self-gratification typical of intellectual academics who have completely lost touch with the real world and those of us who live in it. If the tool of measurement is 'can the man on the Clapham omnibus understand it?', I can only think that it was written in the knowledge that the omnibus no longer runs.

I am sorry to be so negative. I have an academic and management background and find that drivel such as you publish lets us all down. Was he paid by the word for the article or were his feelings having inflicted his 'self' on a public – and therefore I suppose having moved closer to attaining 'self actualisation', reward in itself? I can only agree with Alan Rayner's article, stemming from 'unhooked thinking' can only be taken literally. Perhaps if I owned one of Ford Prefect's Babel Fish I might have understood the article with greater clarity.

These are my personal views and do not represent the views of my employers Aberdeenshire Council Housing and Social work.

Stewart Dickson, Team Manager, Criminal Justice Addictions Team

Comment

The Drugs Act and coercive treatment: misguided toughness

Dr David Neil challenges the updated drugs strategy and the 'hopeless project' of aggressive policing

The UN International Drug Control Programme's 1997 World Drug Report found that over the preceding decade global heroin production had trebled and global cocaine production had doubled.

Since the 1970s prohibitionist, supply side policies have addressed the drug problem primarily in terms of the suppression of criminal activity. These policies have, on any reasonable assessment, failed spectacularly and tragically. Nevertheless we still see national drug policy declarations announcing in strident and moralistic language that, some utterly unrealistic objective will be achieved in less than a decade. The measures proposed inevitably involve an escalation of the 'fight', and via a kind of Alice in Wonderland logic we are typically told that the only way to arrest the increasing damage is buy a bigger hammer.

The areas of real success in tackling drug related problems have come through harm reduction strategies and effective treatment programs. It is a particularly worrying trend in recent policy developments that, instead of seeing treatment as an alternative to criminalising addicts, treatment services are being subsumed into the justice system. In the UK the 2002 Updated Drug Strategy announced substantial increased funding for treatment programs, but nominates arrest, conviction and imprisonment as key gates at which offenders can be funneled into treatment. The new Drugs Act introduces a range of unprecedented police and judicial powers to identify drug users and coerce them into treatment programs.

Of course it is necessary to improve access to treatment services both inside and outside of prison. The real problem with the current strategy is that it frames treatment as something that should happen within the criminal justice system – not as a means of avoiding the criminalisation of addicts. The proper goal of treatment is to improve health. The aetiology of drug addiction is complex, and the kind of trusting therapeutic relationship necessary for effective treatment will be difficult to achieve where treatment is framed in a context of coercion and punishment.

Like its historical precursors, the Updated Drug Strategy sets absurd supply reduction objectives. For instance, through increased assistance to the Afghan government it aims to help eliminate opium production in Afghanistan by 2013. Since 2002 when the strategy was published the area under poppy cultivation in Afghanistan has increased from 80,000 hectares in 2003 to an unprecedented 131,000 hectares in 2004. The current global drug market is estimated to be worth over US$320 billion annually; greater than the GDP of 88 per cent of the world's nations. The profitability and growth of the drug trade shows no real signs of abating, and the aim of the current UK drug strategy of permanent supply reduction through aggressive policing is, frankly, a hopeless project.

The Updated Drug Strategy tells us that: 'Treatment works and is cost-effective: for every £1 spent on treatment, at least £9 is saved in terms of reduced victim costs of crime and demands on the Criminal Justice System. Treatment breaks the link between drug misuse and crime.' What is interesting about this statement is the idea that the effectiveness of treatment should be measured in terms of crime reduction. The drug strategy nowhere considers the fact that the link between drug misuse and crime – the link we want to break – is not a natural effect of drug use, but a link created by the criminalisation of drug use.

'The profitability and growth of the drug trade shows no real signs of abating, and the aim of the current UK drug strategy of permanent supply reduction through aggressive policing is, frankly, a hopeless project.'

The question then, is why other obvious strategies for breaking the link between drug misuse and crime remain politically unmentionable. The real obstacle to rational drug policy is the political necessity to appear tough on crime, and the fact that in the public imagination the figure of the drug addict still evokes fear and loathing. The economic evidence undeniably points to treatment services and harm reduction as the most cost-effective (not to mention humane) intervention strategies. Yet it is politically necessary to 'package' treatment for drug addiction as punishment. This threatens to undermine the effectiveness of treatment, and situates drug treatment workers in an ambiguous position between the health system and the criminal justice system.

If we really want to reduce the social and individual costs of drug addiction, the answer does not lie in trying to persuade poor third world farmers not to plant the crop that offers them the best income. The problem a national drug strategy needs to address is how to change popular misconceptions about addiction, so that the public can see the drug addict as a human being with a health problem.

Dr David Neil is at the University of Wollongong, NSW Australia. You can see him presenting 'The Ethics of Treatment to Reduce Crime' at the Release Drugs University V conference in London on 27 January 2006 – full details available at www.release.org.uk

I have just qualified as a mental health nurse and although I am working at a psychiatric unit I realise that this is not the area I want to pursue. I have begun working on a detox unit doing occasional shifts and this has finalised my goals of becoming a substance misuse worker or something similar. However, I am unsure what length of experience I require to start applying for posts. I have volunteered for Turning Point in Chester to gain experience and will be spending a day at Addaction next week. Any advice would be greatly accepted.

Lynze, Wrexham

Don't underestimate transferable skills

Lynze,
Hi, like you I decided that wanted to work within the drugs field. Unlike you I had no real relevant experience, or so I thought. I was working as a recruitment consultant interviewing people and sending them off to do what sounded like really exciting jobs, working in hostels, in outreach services, with substance users *etc*.

I contacted one of the companies that I was recruiting for, and asked the question 'what experience do I need to work for you'? They informed me that they take on people with no experience, but in a support role to the project workers, it meant a £5k paycut, but I was excited about a job for the first time in ages.

I had the interview... waited with baited breath... only to get the call. They had decided that because of my other work experience, my approachability, my non-judgemental attitude and my obvious willingness to learn that they would start me off as a project worker (only a £4k paycut!)

So I started work in a hostel for clients with a history of substance use. I knew from experience, as a recruitment consultant, that once I gained 12 months experience I would be a much more marketable proposition, so I set about attending as many training courses as I could, and spent lots of my own time researching drugs on the internet. After my 12 months I started to look for other opportunities, and landed a job as a Housing Assessment and Support Worker on the substance use team with the local authority. A brilliant job to say the least.

You already have many transferable skills, especially with your knowledge around mental health issues, I am guessing that you will be fantastic around issues relating to dual diagnosis.

You are going in the right direction, start looking on the web, getting job specs for posts you like the look off, see what experience you need to do them, and go out and get it. Good luck

Oh, by the way, I have just been promoted, my new job title is 'policy and development officer – substance use'.

Never forget those transferable skills!
Alyson Taylor

Get online

Dear Lynze
Check out this site which has all sorts of information on what it takes to become a drug worker – it's pretty good.

www.drugshelper.org

Cheers
Simon

'You already have many transferable skills, especially with your knowledge around mental health issues, I am guessing that you will be fantastic around issues relating to dual diagnosis.'

Dual diagnosis needs you

Hi Lynze
It sounds as though your experience would equip you very well for working in dual diagnosis. You would be using your skills and training and working in a vital and under-resourced part of the field. There's a desperate need for expertise such as yours. We have lots of enthusiastic staff at our service – myself included – but we recognise we are out of our depth with dual diagnosis and are quick to call on our colleagues in the mental health services to help out. If we had someone with your training, we might be able to keep people engaged with our support services for longer.
Good luck with finding your new role.
Helen, Portsmouth

Shameless plug

Dear Lynze
How about dual diagnosis? It sounds to me that you have the twin skills to work in this expanding field. There are dual diagnosis positions being advertised in this issue for Powys Council. If this doesn't appeal, lots of organisations out there will offer on the job training to someone with your background and your enthusiasm. Why not send them all your CV? And of course always keep your eyes on the job pages in DDN!
Good luck with your job search.
Ian Ralph, advertising manager, DDN.

Fancy a job with us?

Dear Lynze,
As a newly qualified mental health nurse you would be very welcome to apply for posts (substantive and bank work) at Kenyon House. Kenyon House is an NHS in-patient unit at Prestwich, Manchester providing detoxification and stabilisation to people from Greater Manchester and Lancashire. The unit is part of a substance misuse directorate within a mental health trust, which offers career opportunities in alcohol and drug treatment, including both in-patient and community work. The telephone number is 0161 773 9121.
regards
Louise Sell
Associate Clinical Director

Welcome to the field

Lynze,
Great news to hear that you want to join the drugs and alcohol field. It's actually quite difficult to give you firm advice on how to do so – but for someone with your qualifications it should be a fairly straightforward matter.

As you are probably aware our field has grown substantially in recent years, which makes it an employees' market to some extent, particularly for someone with a qualification and experience in the health care sector. You may well find that you could apply for some positions with what you already have – particularly those aimed at nurses. But certainly doing some voluntary work can only enhance your CV. You could also do some introductory training – the 'training' section of the DDN website has probably the most comprehensive list of courses, and you might also want to contact your local colleges to find out what they have on offer.
Good luck – and we look forward to you joining the field soon!
Simon Shepherd, FDAP

Reader's question

I work at a DAT and have responsibility for improving service user involvement. It's one thing to say it, but another thing to do it – I've found not all service users want to be engaged. Can anyone give me inspiration?

Jim, West Midlands

Email your suggested answers to the editor by Tuesday 8 November for inclusion in the 14 November issue of DDN.

New questions are welcome from readers.

Diversity challenge

The Federation has emerged with a new structure and a reinvigorated agenda of representing all aspects of diversity. DDN hears more.

Working with diversity is not necessarily about the race of your staff, says Abd Al-Rahman, Head of strategic development at the Federation.

Formerly known as the Federation of Black and Asian Drug and Alcohol Workers, the Federation is in the process of adjusting its image, and its focus, to reflect an updated agenda.

Over the last five years the Federation has been representing and supporting the development of Black and Minority Ethnic (BME) workers in the drug and alcohol field, and the demand for fair representation is still as high: 'We don't want anyone to get impression we're diluting work with BME communities,' says Al-Rahman. But with a new structure in place, the Federation is keen to demonstrate that it is extending its diversity framework to cover other areas of the workplace.

We need to stop putting people in boxes, giving them labels that are not particularly helpful, says Al-Rahman: 'A lot of people have a problem with the term BME and the sheer diversity that exists within it. It implies that there are a lot of white people – and the rest are BME. Apart from the vast array of nationalities that might cover, most of whom know little about each other to justify sharing the same bracket, it also takes no account of the fact that some communities might be fresh into Britain, while others will have been born here.'

The other reason for broadening the focus was the result of brainstorming with the new team. There was a realisation that a workplace's culture would be very unlikely to change by just dealing with one issue from a 'BME' worker's point of view, explains Al-Rahman. The message needed to penetrate colleagues' sensibilities – whatever their race – so that policies were accepted in a mutually supportive environment.

So the Federation's diversity agenda is now about making sure the organisation reaches out to everyone working within substance misuse, health and mental health, social care, criminal justice and related fields, whatever their ethnic background. Their new DANOS-based diversity training programme looks at developing a diversity friendly culture in any workplace, sensitive to any issues that might otherwise attract a 'minority' tag.

'A lot of people have a problem with the term BME and the sheer diversity that exists within it. It implies that there are a lot of white people – and the rest are BME.'

Harninder Athwal was recruited as marketing and membership officer last May. Her role contributes directly to giving the organisation a stronger voice and she is finding that members' concerns can relate to gender, sexuality, or a whole range of other issues that might or might not be linked to BME workers. Her job, and that of others at HQ, has become about finding common ground; linking with other organisations to share expertise and give mutual support. They hope these links will strengthen over time, to develop work on diversity in mental health and other areas.

While they are looking ahead to a broader agenda, the Federation is still seeking to inform policy as an advisor to government and key stakeholders on approaching the national drugs strategy from a culturally sensitive standpoint. Helping them comply with the requirements of the Race Relations (Amendment) Act 2000 is one aspect of consultancy. The other is to encourage a proactive approach to diversity.

The Federation receives funding from the Home Office's Drug Strategy Directorate, with other specific projects funded by the National Treatment Agency, and has worked closely with drug action teams reviewing the policies and procedures of commissioned services in relation to the Race Relations Amendment Act 2000. 'It's not just about whether organisations have an equal opportunities policy,' emphasises Al-Rahman. 'We ask, "are there evidences of guidelines beyond statements, timescales and is there a named person championing equalities?" as well as looking at what's contained in policies and procedures.' The Federation's Equality Health Check is a toolkit that not only allows DATs to check that their commissioned services have equitable policies and procedures in place – but it also allows DATs to review their commissioning practice.

Much of the Federation's agenda is about empowerment – not just for the individual, but also for organisations that are trying to establish a fair culture in the workplace. The organisation's own redefined structure reflects a similar determination to show 'strong leadership, able to work across boundaries', says Al-Rahman. Emerging from a membership consultation process to canvass opinion on the way forward, the Federation hopes to flourish through representing the real diversity agenda, whatever the issue. **DDN**

The Federation's diversity training will take place on the following dates:
London – 8 November 2005 and 7 February 2006.
Birmingham – 22 November 2005.
Manchester – 6 December 2005
East Midlands – 24 January 2006
Visit www.thefederation.org.uk for more details, or call 0208 692 2525

Too much, too young

Can a mother drink during pregnancy without harming her baby? Louise Gallagher assesses the risks.

Maternal alcohol consumption is not a new concern. Aristotle said in 343 BC: 'Foolish, drunken and hare-brained women most often bring forth children like unto themselves, morose and languid'. During the 1720s, the Royal College of Physicians reported that parental drinking was a cause of 'weak, feeble and distempered children'. A hundred years later, a House of Commons paper, Effects of Drunkenness on the Nation, reported on the effects of maternal alcohol consumption on the newborn, stating 'they tend to be born starved, shrivelled and imperfect in form'. During the 1960s and 1970s, findings led to a recognition of a distinct dimorphic condition associated with maternal gestational alcoholism named as Foetal Alcohol Syndrome (FAS), which has since become an established clinical entity.

Alcohol is a teratogen, which means that it can induce foetal malformations both at the earliest, as well as at the lowest level of intake, its effectiveness spreading differentially over the whole spectrum of reproduction. It can affect the developing foetus in varying degrees, in both extent and severity, depending on the dosage and timing – from very mildly affected, to full blown Foetal Alcohol Syndrome (FAS).

As well as FAS, there is evidence to suggest a number of other adverse conditions connected to maternal alcohol consumption, including Foetal Alcohol Effect (FAE) or Alcohol-Related Birth Defects (ARBD), which may not have all the features of full-blown FAS, but some of the problems can be just as severe. Researchers estimate ARBD exceed cases of FAS by a ratio of 2:1 to 3:1.

Alcohol can cause increased complications during pregnancy and delivery such as bleeding, miscarriage, stillbirth and premature birth. Babies of women who are heavily dependent on alcohol can even suffer withdrawal after birth. Symptoms can include tremors, irritability, fits and bloated abdomen. Evidence shows that the development of the foetus can be affected, because during the period of gestation, almost any substance entering the mother's bloodstream can also enter the foetal blood circulation. Maternal alcohol consumption has also been shown to generally decrease foetal movement.

All trimesters have been associated with abnormalities and no lower limit of alcohol dose is known. It is not known what levels of pre-natal alcohol exposure produce what intensity of developmental problems, and evidence from different studies is conflicting as to what level of alcohol is safe for a pregnant woman to consume. It seems best to advise not to drink at all. A vast amount of research has been carried out on Foetal Alcohol Syndrome, which affects the foetus in such a way that will have a lasting effect throughout its whole life after birth. Evidence suggests the most common characteristics of children born with FAS are: prenatal and postnatal growth abnormalities; craniofacial abnormalities; musculoskeletal abnormalities; variable musculoskeletal and limb defects; cardiac abnormalities; congenital heart disease; nervous system abnormalities; neurodevelopmental delay or mental deficiency. According to studies, foetal alcohol syndrome is the third leading cause of mental retardation due to birth defects, and the only one that is preventable. The natural history of FAS has now been traced into adulthood and the average academic functioning of these adolescents and adults does not seem to develop beyond early school grade level. The most noticeable behaviour problems were found to be with comprehension, judgement and attention skills, causing these adults born with FAS to experience major psychosocial and adjustment problems for the rest of their lives.

Two maternal alcohol use patterns have been identified as being detrimental to the offspring: two or more drinks on average per day during pregnancy;

and 'binge-pattern' of alcohol consumption (five or more drinks on any occasion) as both can lead to marked behaviour and learning disabilities in school-age children.

For years, the French have believed wine to be no more harmful than a soft beverage. A recent report in the *Guardian* stated that France is now reassessing its attitude, as legislation is being debated that bottle labels are to warn pregnant women of the dangers of drinking. If this goes ahead, all brands of alcohol will have to carry a health warning advising pregnant women of the risks of FAS and recommending total abstinence. About 7,000 babies born in France each year are thought to be mentally or physically damaged by passive consumption of alcohol in the womb. Philippe Douste-Blazy, the French Health Minister, stated that FAS was 'aside from genetic factors, the prime cause of mental retardation in children'. This shows that cultural norms are even being re-evaluated due to the potential health risks of alcohol to pregnant women.

Even though there seems to be a direct connection between alcohol intake and birth defects, other factors associated with maternal drinking must also be considered as contributing to adverse pregnancy outcome. Foetal Alcohol Syndrome is not simply an issue of alcohol misuse, but a complex issue rooted in the underlying social and economic conditions which influence all aspects of maternal and child health. Some alcohol misusers produce children who are apparently normal, so the relationship between consumption and harm is not that simple. Researchers find it extremely difficult to control the effects of other factors that influence perinatal and developmental outcomes.

Although a lot of attention in research has been placed on maternal exposure to alcohol, some of the factors contributing to FAS may be male-mediated. This may occur biologically through damage to the sperm, or physically and psychologically through violence or other abuse to the mother. The father's drinking can lower testosterone levels, decrease healthy sperm, and increase the risk of disorders in offspring, often resulting in low birth rate.

Many factors in addition to alcohol consumption contribute to an increased risk of preterm and small-for-gestational-age (SGA) births. These include stress, low weight, age, inadequate prenatal care, hypertension, poor nutrition and smoking. The 1980s saw an increase in these risks, as the percentage of women who received no prenatal care increased by half and the number of infants born to unmarried women rose by 40 per cent. The National Commission to Prevent Infant Mortality concluded in 1990 that the concentration of extreme poverty, drug use, inadequate health care, and other factors have turned some communities into 'infant mortality disaster areas'. It is also important to remember that many of the obstetric problems commonly associated with alcohol are also associated with social deprivation and poor health and nutrition. Another relevant factor is that cigarette smoking has been linked to many of the perinatal and developmental effects also attributed to alcohol.

Prenatal care can reduce the risks of preterm or SGA birth even in the presence of these risk factors and neonatal care can alleviate many of the effects of prenatal alcohol exposure. Studies in the US 1969-1974 showed that illness in babies born to drug and alcohol-dependent women could be directly related to the amount of antenatal care received.

Infants born too soon or too small can face serious and fatal threats, including elevated risks of Respiratory Distress Syndrome, intrauterine hypoxia, birth asphyxia, perinatal infections, and Sudden Infant Death Syndrome (SIDS).

The quality of the care-giving environment, reflected in family, stability and status, has been related to children's development in study after study. Emerging research on resiliency suggests that neither prenatal exposure to alcohol nor poverty can, in itself, predict the developmental outcomes. The effects of poor childrearing skills can produce and amplify the types of developmental consequences associated with prenatal drug exposure. Prenatal alcohol exposure many indicate that a child is at risk, but exposure cannot be taken as a definitive sign that the child will not develop normally.

'Two maternal alcohol use patterns have been identified as being detrimental to the offspring: two or more drinks on average per day during pregnancy; and 'binge-pattern' of alcohol consumption (five or more drinks on any occasion) as both can lead to marked behaviour and learning disabilities in school-age children.

Studies indicate differential susceptibility to Foetal Alcohol Syndrome occurring on both a racial and genetic basis. We do not know whether certain ethnic groups have a genetic susceptibility to FAS, even though we do know that there are ethnic differences in the metabolism of alcohol. The worldwide incidence of FAS is 1.9 per 1000 live births, but within the Southwest Plains Indians it is 9.8 per 1,000 live births. The reason for the large difference could be because of genetics. The result of the latest research indicate that many more members of some populations, in this case the Southwest Plains Indians, are lacking or have a reduced amount of an enzyme necessary in the breakdown of alcohol. The amount of enzyme produced by the body is genetically coded. Therefore some populations must be more careful with regard to FAS, just as some other populations are at a much higher risk of developing high blood pressure or having an infant with spina bifida.

Some scientists believe that the development of FAS, following excessive alcohol exposure, is likely to be influenced by genetic factors in both the mother and child. Mixed-ancestry children in the Western Cape Province of South Africa have the highest frequency of FAS in the world. In the case of black people, the risk of FAS remains about sevenfold higher than for white people, even after adjustment for the frequency of maternal alcohol intake, occurrence of chronic alcohol problems, and parity. This raises the question of some kind of genetic susceptibility, the nature of which is unknown.

There is evidence to suggest that there are many risks of harm to the baby if a woman drinks during pregnancy and she does not necessarily have to 'misuse' alcohol, as there is no known safe level. There is evidence to support the fact that alcohol affects the foetus in every trimester during pregnancy; there is an elevated risk of preterm and SGA births, the development of the child is affected and in some cases the child will have problems for the rest of its life due to maternal alcohol consumption. However, alcohol is not the only factor that causes risks to the baby. Other contributing factors are male-mediated effects, inadequate prenatal care, poor nutrition, obstetric problems, self-neglect, smoking, the environment and genetics. There was no research found to support the idea that drinking alcohol while pregnant has no risks of harm at all.

Research on a woman's consumption of alcohol once she knows she is pregnant, is inconclusive and there are problems gathering statistics as women are not completely honest about their alcohol use. This can be for various reasons, which include the risk of having their children taken away from them or the children being put on the 'at risk' register.

Further research needs to be established, to get a clearer picture of the effects of maternal alcohol consumption. Some ways of doing this could be: establishing a set of agreed-upon criteria for diagnosis of FAS at all age levels; more accurately determining the incidence of FAS and other alcohol-related birth defects in all populations; looking at the relationship between alcohol consumption levels and patterns of use and birth defects; determining the relationships between alcohol use and other factors affecting foetal and child health; establishing the most effective programs for the prevention of FAS and other alcohol-related birth defects; and working out the most effective treatment and support for those diagnosed as having FAS and their families.

Louise Gallagher is an NHS CARAT manager, based at HMP Bronzefield. She works for Inclusion Drug and Alcohol Services, part of the South Staffordshire NHS Trust. This article is a much abridged version of her fully referenced essay for the Postgraduate Diploma in Addictive Behaviour at St George's Hospital Medical School, Tooting.

I know I was a drug-user, but do I really **deserve** Hepatitis C?

David Wright never imagined that his youthful experiments with injecting drugs would blight his life with Hepatitis C. Here he tells his story and asks, is prejudice getting in the way of identifying and treating sufferers?

Looking back now, I am pretty sure in my mind when the Hepatitis C virus was injected into my blood stream. I only shared with strangers twice in the days before needle exchanges, which is not bad considering the charade we had to play to get a bag of ten 1ml syringes from the chemist.

First you had to pick a chemist that you had not been in for a week or two. Then you would walk in, buy a bar of diabetic chocolate, and as the change was given back to you, almost as an afterthought you would say, 'oh I better take a bag of 1ml insulin syringes'. Never forget to say the word insulin. Even then sometimes the pharmacist saw through it and would refuse you, but I am talking early 80s and HIV was unheard of then.

I reckon that the fix that got me infected with Hep C was my first. A dealer had promised me if I paid him a fiver to help fill his hired minibus, which was going to take us to a Northern Soul all-nighter, I would get a free fix of speed. I must admit I was dying to try the needle, so the minibus could not get us there quick enough. However when we got there, the dealer gave me a wrap of speed and a syringe but it did not have a needle on the end. He reassured me all I had to do was ask for a 'spike'.

So there I was in a queue of about 30 people waiting to get into a cubicle in the gents to have a hit. I was totally out of my league and my heart was in my mouth. I felt too timid to shout out 'has anyone got a spike?' But as luck would have it, as I got into the toilets someone from behind one of the cubicles shouted, 'has anyone got a clean barrel?' Well I thought, that's what I have got, so I shouted 'yes but I need a spike'. The door opened and I was ushered in.

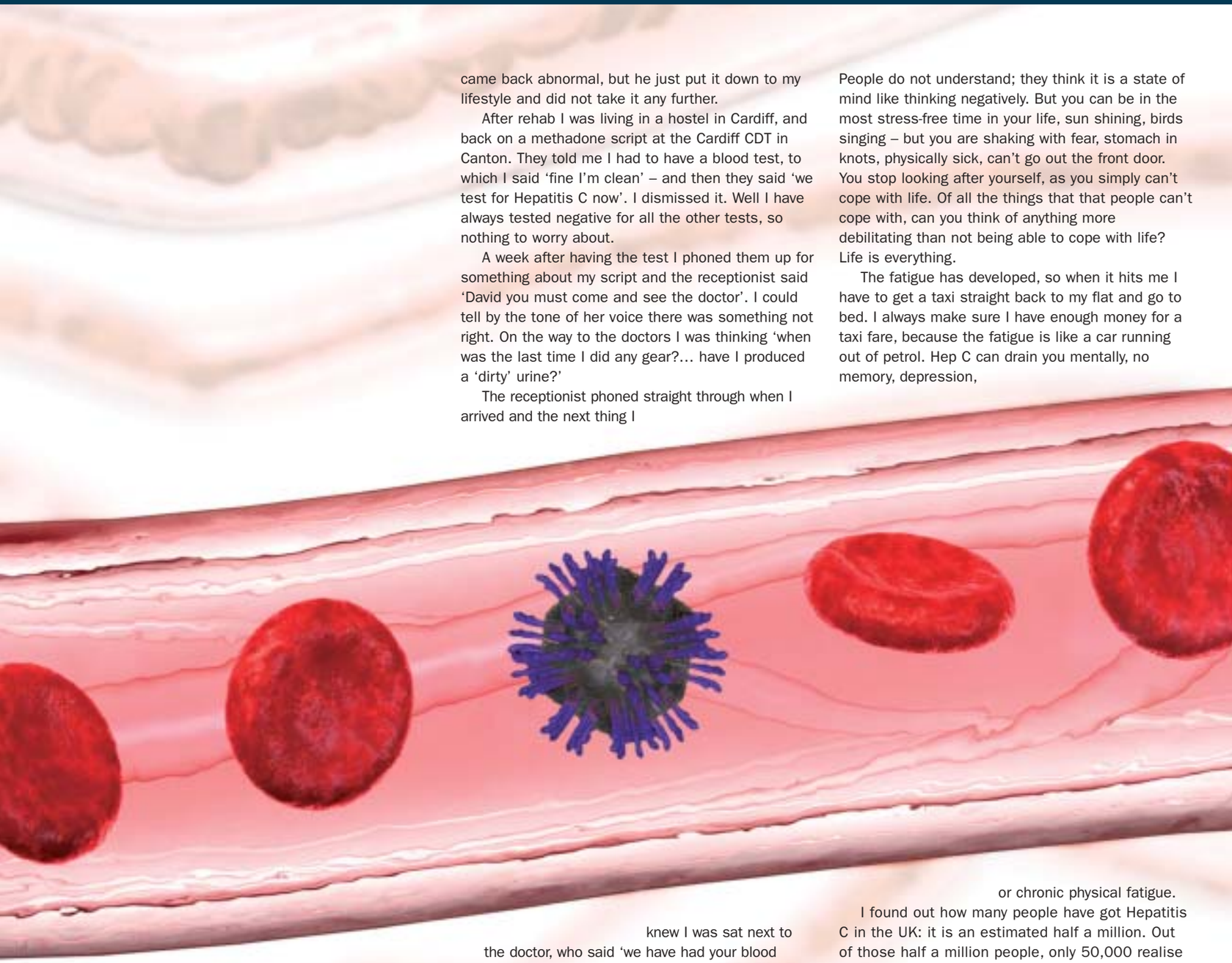
I remember the guy had blonde hair and his arm was a line of track marks. He took charge of the situation, as I was just a young kid. I watched him cook up his speed and shoot up. Then it was my turn. I was shaking that much that he sussed it was my first time, so he cooked up my hit, found a vein straight away, and at that exact moment someone ran in and shouted 'drug squad!' Lucky for me, one it was a false alarm, and two the guy who was giving me the hit kept his cool, told me not to move and the plunger went in.

So that was the start of a 20-year IV drug career, starting with speed and ending up on smack. In the meantime a bombshell was dropped, which had all us IV users shitting ourselves – AIDS. It was headline news, it was Armageddon to some people, and to us junkies it was total fear. We were all called in one by one to the hospital to have the initial test, then you had to wait three months if the first one was negative to have the second and final test. The reason was that once HIV was contracted, it could lie undetected for three months. The weeks waiting for the results were the longest weeks of our lives, and when it came back negative, it brought tearful relief.

So in my mind I was clean. I had been tested for Hepatitis B and that was negative. Also we could now get clean needles – which could have saved my life, I will never know.

Timed passed and I was sick and tired of waking up tired and sick. The hospitals were fed up with me after numerous detoxes, so my drug counsellor suggested rehab – and I jumped at the chance.

I had been in the rehab for five months without a drug or drink passing my lips, I felt better than ever but I found myself feeling very tired in the afternoon group. I had a job staying awake and as soon as the groups were finished I dragged myself up the stairs and slept on my bed for two hours. After the kip I felt fine, but the staff were concerned so they told me to see a GP. He did the liver function tests, which



came back abnormal, but he just put it down to my lifestyle and did not take it any further.

After rehab I was living in a hostel in Cardiff, and back on a methadone script at the Cardiff CDT in Canton. They told me I had to have a blood test, to which I said 'fine I'm clean' – and then they said 'we test for Hepatitis C now'. I dismissed it. Well I have always tested negative for all the other tests, so nothing to worry about.

A week after having the test I phoned them up for something about my script and the receptionist said 'David you must come and see the doctor'. I could tell by the tone of her voice there was something not right. On the way to the doctors I was thinking 'when was the last time I did any gear?… have I produced a 'dirty' urine?'

The receptionist phoned straight through when I arrived and the next thing I knew I was sat next to the doctor, who said 'we have had your blood results back', pointing to something in my file. There it was in black and white: 'Hepatitis C Positive'. My response was a confused, not really understanding, as I said 'what is Hepatitis C?' She was telling me what they knew about the virus, which was going in one ear and out of the other. Then the alarm bells started to ring as I blurted out, 'am I going to die?' Doctors have a good way of talking a lot and not saying a direct yes or no. I realise now it was because she did not know. I might, I might not. This is still the same today, but the symptoms have developed into a really debilitating illness.

'I was shaking that much that he sussed it was my first time, so he cooked up my hit found a vein straight away, and at that exact moment someone ran in and shouted 'drug squad!' Lucky for me… the guy who was giving me the hit kept his cool told me not to move and the plunger went in.'

As the virus has progressed I have found my mental health deteriorating. For instance, when I am in town people come up and start talking to me like they have known me well for years. I know their face but I don't know where from and in the end I have to stop the conversation and tell them about my illness, and that I can't remember where I know them from. This really freaks them out because it may be someone I went to university with for four years.

Then there is the dreaded depression. I am so scared of that, because I have no control over it. People do not understand; they think it is a state of mind like thinking negatively. But you can be in the most stress-free time in your life, sun shining, birds singing – but you are shaking with fear, stomach in knots, physically sick, can't go out the front door. You stop looking after yourself, as you simply can't cope with life. Of all the things that that people can't cope with, can you think of anything more debilitating than not being able to cope with life? Life is everything.

The fatigue has developed, so when it hits me I have to get a taxi straight back to my flat and go to bed. I always make sure I have enough money for a taxi fare, because the fatigue is like a car running out of petrol. Hep C can drain you mentally, no memory, depression, or chronic physical fatigue.

I found out how many people have got Hepatitis C in the UK: it is an estimated half a million. Out of those half a million people, only 50,000 realise they have it. That's nine out of ten people who do not realise they have Hepatitis C. Let me ask a question to whoever is reading this – are you sure you have not got it? Have you ever used someone else's toothbrush, or used one of their razors? Had a tattoo?

Hepatitis C is a pandemic – that means it has gone past epidemic levels – and so why is the government keeping quiet about it? Remember the HIV adverts in the late 80s? Is it because Hepatitis C affects mainly IV drug users or ex-users? HIV spread through to white, middle class, productive families. The treatment, depending on what genotype you have, can cost up to £18,000 per patient. Why waste it on a drug user – even if the drug user is on just prescribed methadone?

A lot of questions and I think it is about time we got some answers.

Has being an IV or ex IV drug user stopped you getting treatment? Can you offer a medical viewpoint? Please email responses to the editor.

David Wright is a service user and Alliance volunteer.

Media watch

Police seized £100,000 worth of cocaine hidden in a tank full of deadly piranhas. The razor-teethed fish were guards for the drugs wrapped in cling film and buried in gravel at the bottom of their tank. A police spokesman said: 'It has to be the oddest hiding place for cocaine we have come across.'
Sunday Mirror, 23 October

Hours after he was confirmed as the overwhelming favourite for Tory leadership, David Cameron tried to end the drugs controversy which has been the only blot on his campaign. He declared that he had never taken cocaine since he was elected to Parliament. Mr Cameron stated: 'I have always said that lawmakers cannot be lawbreakers. All I have said about my past, though, is that what is private in the past should remain private.' But since he did not become an MP until June 2001, this could revive speculation that he experimented with drugs as a younger man.
Daily Mail, 21 October

A town hall has been criticised for applying to itself for a 5am drinking licence. The Unity Centre is run by the Peckham Programme, part of Southwark council's regeneration department, has a bar and social club – the subject of the application. But Lane ward councillor Andy Simmons said the council should think again because the area had a history of troublesome licence applications. He said: 'For the council to apply for a 5am licence sends out completely the wrong message and sets the pace for anyone else who wants a late licence.'
South London Press, 21 October

Lanarkshire's alcohol services have received an £814,000 cash boost from the Scottish Executive, to improve and extend alcohol services around Lanarkshire. The money will be used by Lanarkshire Alcohol and Drug Action Team to fund support services for parents and their families, young people, training, the development of counselling services for alcohol in north and south Lanarkshire, community detoxification and the extension of alcohol and drug liaison nursing services.
Airdrie and Coatbridge Advertiser, 27 October

Health Secretary Patricia Hewitt was forced to defend the government's controversial plans for a partial smoking ban as she faced a grilling from MPs. The partial ban, which exempts private members' clubs and pubs that do not serve food, was seen as a defeat for Ms Hewitt who pushed for tougher measures and had publicly described the proposals as 'unworkable'.
The Independent, 27 October

Fact file

Service User Groups

This issue: David Griffin from
UserActive – Peterborough, Cambridgeshire

When and why did you start your group?
I'd been heavily involved in the late 80s/early 90s D.I.Y. rave or free-party culture in the north of England, so I guess I thought that sort of model could be transferred to the addiction treatment scene in some way. I'd kept an eye on drugs policy generally, including the work of the harm reduction movement in the UK, and it was this that got me placed on an NTA/user initiative called 'Experts by Experience' just before this recent swelling of national and local user involvement began. Also, having got tired of moving to various cities in the UK in vague attempts at throwing off my own addictions, I wanted to just see what would happen. This area has a fairly large user population for its size and for the last couple of years it's had a heavy police crackdown followed by major Home Office investment into the criminal justice side of the equation.

How many members do you have?
We have a core of around ten reliable people, although as with most self-run groups of this nature, a couple of us do a fair volume of the work. The point isn't always about numbers, it's how well you communicate to the ex/user community. There are many groups run by one person and their dog around the UK, but they still act as representation where there would otherwise be none, or a watered-down version run by someone with little experience of root level drug issues.

How did you obtain funding?
We have a system where bigger items like training and conferences are resourced by application to the DAT. In addition we have pushed for our own budget which, although we keep tight records, is essentially directed by group consensus.

Where, and how regularly, do you hold meetings?
This has been the hardest area for UserActive. Although over two years back we had support from both CDT type agencies in the area, issues surfaced about one agency getting an unfair amount of influence, so it was hard to remain at one venue linking to the wider treatment scene. We have been told that we will be supported in locating a small office, but things have moved slower than we wished. People often forget that turning up to a prospective landlord and telling them ex or stable users require a workspace doesn't always go down well – addiction is one of the last taboos of our age. Despite this, some of us meet up weekly, if not more often.

What do you hope members get from attending?
I know for a fact that merely telling people they have a say in their treatment can do great things on an individual level. If as a group you can then work to a wider agenda, really useful things can come of U.I. In addition to working locally, we've opened avenues to the regional (via the NTA) and national movements and this has contributed to a large number of people becoming aware of something other than scoring or collecting a script each day. The state treatment scene has been historically so caught up in an idea of a 'beginning' and 'end' to treatment when addiction just doesn't fit into that model, that we need to create functioning structures that help people become productive and hopeful for the future.

How do you keep it going?
With regular group hugs(!) Seriously though, this is a hard community in many ways to encourage, so those driving involvement structures have to adjust to this – many of us have a decade or more of chaos behind us. User involvement isn't easy – it's often a thankless task. If your DAT or commissioners are supportive, that's a bonus. But there are many issues that make this aspect of things a bit of a lottery at the moment.

What have been your highlights so far?
Getting two members through the Royal Collage of General Practitioners course on Substance Misuse, getting the DAT to finally listen, doing our own research into complaints of syringe dumping in a local area and finding it was highly exaggerated. Nationally, I was pleased when Lifeline ran a campaign to bury the myth of the 'two year rule'; one thing (still) that's lacking in the wider drugs field is workers who have been though things first hand.

How do you communicate with your members?
Meetings, mail-outs, minutes and newsletters. We are also equipping with PCs and net access where possible, as I firmly believe the net offers good peer support locally and globally. We are working with Peterborough DAT/DIP on a user and carer website linked to their own resources, and have begun work on a content management system at www.useractive.net which should allow anyone with the most minimal of IT skills to add content.

Have you any tips for others starting a service user group?
Get your DAT onside and if necessary bully your NTA regional user rep or manager into helping you with this. In addition you'll need to find a way of working with local agencies – although most professional drugs workers are into user involvement, a minority still haven't taken in just what this means and assume it's something to do with a suggestions box in reception! Most of all link up with other areas for support – it helps when you hit those low points when it seems situations are conspiring against you.

Hidden heroin users

Professor David Clark describes an important research study conducted by Roy Egginton and Professor Howard Parker at the end of the 1990s that illustrated the life experiences of a group of young heroin users, and offered a practice and policy framework for intervening in their drug journeys to social exclusion.

The 1990s saw a large increase in the 'recreational' use of drugs such as cannabis, amphetamine and ecstasy among young people. While the vast majority rejected use of heroin because of its addictive properties and association with 'junkies', the number of young people starting to use the drug increased significantly in the latter part of the 1990s.

A study by Roy Egginton and Howard Parker provided important insights into the life experiences of a group of young heroin users they termed 'hidden heroin users'. The researchers pointed out that local officials often ignored local problems with heroin, due to the stigma associated with the drug. Failing to address heroin use among young people leads to difficulties at a later time when they present for treatment with a more serious problem.

The study involved interviews with 86 young heroin users (aged 15 to 20 years) from four different areas in England.

While the participants' childhoods were far from ideal, only a minority could be described as developmentally damaging. However, from age 13 years, the interviewees were routinely out and about with peers, unsupervised and doing things to which most parents would object. The parents did not know where they were.

They were early smokers and drinkers and entered a phase of 'florid drugs experimentation'. On average, they started to take heroin aged 15 years.

The educational performance of most of the interviewees deteriorated during secondary school. They truanted regularly and many became disruptive at school, and were repeatedly temporarily or permanently excluded.

A few obtained some educational qualifications but most were still underqualified at the time of the interview. Few had been successfully employed. Most were receiving state benefits.

The first time a person tried heroin was usually with drug using peers and involved smoking (91 per cent). Over half described the experience as 'good'. Retrying followed rapidly (60 per cent within a week) and most moved to weekly and then daily use.

Experimental injecting was widespread and 46 per cent were injectors. A poly-drug repertoire became common with more regular heroin use, involving cannabis (80 per cent tried in last month), tranquillisers (45 per cent), methadone (45 per cent) and crack cocaine (33 per cent). Although interviewees had been early drinkers, current regular alcohol use was not high. Over 50 per cent had not drunk in the past week.

Members of the sample gradually became stigmatised as smackheads. They were dislocated from parts of their family, 'straighter' friends and conventional activities. They gravitated into poly-drug using networks and cohabitations which provided support.

Seventy-three per cent of interviewees said that their health had been affected by their drug/heroin use. Most showed clear signs of physical and psychological dependency on heroin and other drugs. This dependency and associated anxiety increased with the length of use and the switch to injecting.

Average drug bills were over £160 per week. Most interviewees utilised benefits and acquisitive crime (especially shoplifting) to pay for their drugs.

Drug dealing, and to a lesser extent, begging and prostitution were also being used. Most had been convicted, but not imprisoned.

Approximately 50 per cent had delinquent careers prior to heroin use, but their drug habit amplified their offending. For most others, heroin use led to offending.

'The sample were initially very naïve and ill-informed about heroin. They did not understand its subtle potency and addictiveness, and had little idea where a heroin career might take them.'

The sample were initially very naïve and ill-informed about heroin. They did not understand its subtle potency and addictiveness, and had little idea where a heroin career might take them. They claimed to regret having ever taken heroin.

The drug knowledge of this sample was obtained by their own experiences and those in the local heroin networks, far more than from public health or drugs educational sources. They were basically too insecure and immature to visualise the benefits of 'presenting' to a treatment agency and simultaneously distrusted adult authority.

The researchers emphasised the need for early interventions to be developed, including provision of accurate targeted information: how dependency develops and its consequences; how to avoid and respond to accidents and overdosing; the dangers of injecting an sharing equipment; the additional 'price' of tackling crack cocaine; and the knowledge and skills required to detox/come off heroin.

They emphasised the need to specifically target heroin using networks (where there is trust) with information in order to maximise the potential for reduced harm. Parents who knew about their child's heroin use were viewed as potential sources of influence if relationships were still intact or repairable.

Many of the interviewees had difficulties at school (truanting, exclusion) and may not have therefore benefited from drugs education in this environment.

The researchers pointed out that as young people's drug services develop they must pay full attention to understanding and monitoring their local drugs situation, reaching out to hidden adolescents developing problematic drug use, and providing user-friendly, flexible services.

The professionals (*eg* police, teachers, youth and community workers) who come into contact with young heroin users, must increase their knowledge about drug issues and experience of how to intervene and advocate help.

Egginton and Parker argued that a deterioration in the 'heavy-end' drugs scene was underway. While problem drug use remained correlated with socio-economic deprivation and difficult family life, there were signs that new waves of young users would also contain young people from more conventional, adequate family backgrounds.

They also pointed out that, 'in the current absence of effective routine monitoring systems, more immediate efforts should be made to better define what is happening in heavy-end drugs scenes across the UK'.

Hidden Heroin Users: Young people's unchallenged journeys to problematic drug use by Roy Egginton and Howard Parker (2000)
http://les1.man.ac.uk/SPARC/hiddenheroin.htm

Reducing re-offending in the Thames Valley

NOMS National Offender Management Service
Working together to reduce re-offending

NATIONAL PROBATION SERVICE
THAMES VALLEY

Substance Misuse Worker

Based: Oxford

Full-time *Ref: DDN966*

Salary: £21,020 - £28,251 per annum. A maximum relocation allowance of up to £6000 is payable (conditions apply).

You will contribute to the provision of Drug Treatment & Testing Orders and Drug Rehabilitation Requirements. Key duties will include providing substance misuse assessments, developing treatment plans and case management of offenders on Drug Treatment & Testing Orders and Drug Rehabilitation Requirements. The Substance Misuse Team is an integral part of the DIP in Oxfordshire.

Candidates will possess a professional qualification in criminal practice, substance misuse, health, social work or related field and a minimum of two years' experience of substance misuse work. You will need excellent communication, organisation and IT skills, alongside the ability to work with individuals who are substance misusers and enable them to understand and address their difficulties.

Applications from ex-users are welcome and previous convictions are not necessarily a barrier.

Closing date: 18 November 2005

Provisional interview date: 30 November 2005

For immediate access to an application pack, please visit our website **www.thamesvalleyprobation.gov.uk** Alternatively, e-mail tvl.personnel@thames-valley.probation.gsx.gov.uk or call 01869 255326 quoting the appropriate reference. Applications can only be accepted on official NPS Thames Valley application forms.

We are committed to developing individual potential and offer a range of professional development opportunities. Working to promote diversity and equality in the workplace.

BROMLEY

Bromley NHS
Primary Care Trust

Substance Misuse Services in Bromley

Bromley Drug Action Team (DAT) is inviting organisations to tender for the provision of drug and alcohol treatment services across the London Borough of Bromley. We are seeking organisations to provide Tiers 2, 3 and 4 services for drugs and alcohol, for adults and young people. Our specific requirements are outlined in our Tender Packs.

All Services must be provided within relevant national and local frameworks, e.g. Models of Care. Services may be provided in partnership with other service providers as part of an integrated substance misuse treatment system across Bromley.

Interested agencies should apply for a Tender Pack. This will contain specifications of what Bromley DAT requires and will detail how to submit Tenders. Speculative bids will not be considered.

Tenders must be received by 14th December 2005.

To apply for a Tender Pack, please email: sue.verran@bromleypct.nhs.uk or phone 01689 880684.

If further clarification is required, please contact Daniel Richter or Graeme Burgess on 01689 880658.

Supply and Demand: Reducing Harm to Children and Families

Cedar Court Hotel, Huddersfield

28 November 2005

Lifeline Kirklees has a unique and effective integrated children, families and young people service addressing the issues of harm reduction through a diverse approach to partnership working. The Community Safety Partnership have also commissioned an innovative method of delivering the harm reduction message in schools Kirklees-wide.

Aimed at all professionals, practitioners and commissioners who want to learn more about the benefits of working holistically to reduce the harm of substance misuse to children, families and young people, the conference seeks to share this innovative practice by empowering delegates to take away practical tools which will enable them to set up this approach in their own areas.

The event includes keynote presentations on 'Young People and the Prevention Agenda' and 'An Evaluation of the Role of Family Support', a debate - 'Is Harm Reduction Dead?'- and a range of seminar options on the topics of:

- Every Child Matters
- Drugs in Schools
- Keeping the Family Together
- Dealing with Drugs Incidents in Care
- Working with BME Families
- Promoting Safer Communities.

For a full programme, or to book your place, please contact:

Gill Kennedy, Altura UK Ltd on 01759 388855,
Email: gill@altura-events.fsnet.co.uk
Web: www.drugsense.org

Lifeline Kirklees | Family Drugs Service | Drug Sense

Danny's Story

Based on the experiences of ex-drug users the acclaimed film "Danny's Story" is now available on DVD priced £30 (inc. p&p).

The story of a young man's release from prison, his relapse back into drug use and overdose, is the ideal educational tool to help stimulate debate during drug rehabilitation programmes.

For further information contact Jim Mooney 0161 737 3000 or jim@the-basement.tv

Wigan & Leigh

TACKLING DRUGS CHANGING LIVES

Expressions Of Interest for the Provision of Substance Misuse Services in the Borough of Wigan

Expressions of interest are invited from suitably experienced organisations to tender for a contract(s) to deliver a variety of services for drug users in the Borough of Wigan. The borough is co-terminus with Ashton, Leigh and Wigan Primary Care Trust.

The expected term of the contract(s) will be 1st May 2006 to 31st March 2008 with possible extension to 31st March 2010 subject to recurrent funding and satisfactory performance.

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

Lot 1 Low threshold prescribing service

Lot 2 Criminal Justice Treatment Service

Lot 3 Community Prescribing Service including some harm reduction services, plus a predetermined and established service for alcohol dependency.

Lot 4 General Practice Liaison Scheme, which provides supported prescribing sessions in community settings.

Lot 5 Community Detoxification and Abstinence Service

Lot 6 Single Point of Contact Assessment Service for the whole service system, to include targeted and enhanced arrest referral work.

We expect that those interested in providing any of Lots 2-4 would tender for all of those lots. Prospective tenders should take into account the implications of TUPE arrangements with the existing provider of elements in Lots 2-4 and 6.

Written expressions of interest and requests for tender documentation should be made to: Nicola Yates, Drugs Business Manager, Community Safety Partnership, Unity House, Westwood Park Drive, Wigan, WN3 4HE.

The closing date for expressions of interest is 12pm on Friday 18th November 2005.

Tender documentation will be issued on 24th November 2005 with the deadline for receipt of tender submissions being 12pm on Friday 6th January 2006. Interviews are expected to be held week commencing 16th January 2006.

HMP LINDHOLME >

TREATMENT MANAGER
Manager G - £25,000

A Treatment Manager is required at HMP Lindholme to oversee a Drug Rehabilitation programme. The role involves professional oversight of the programme, programme facilitation and supervision, as well as the management of other facilitators.

Applicants will need to have a proven experience of facilitating structured group work with offenders and at least one year's experience in carrying out interventions with problem drug users.

SUBSTANCE MISUSE WORKERS - Executive Officers
£18,539 - £20,583

The roles will involve carrying out assessments, providing interventions via individual work and facilitating structured group work programmes.

The roles call for individuals who possess one or more of the following:
A degree in Psychology • RMN • Drug and Alcohol Counselling Diploma • Degree/Diploma in Social Work Probation Studies, or 6 months experience of working with Substances Misusers or Offenders
• Experience of running Drug Rehabilitation Groups would be desirable.

Securing both posts permanently is contingent on passing Prison Service PASRO training. Candidates successful in the sift for these posts will be invited to attend an assessment centre.

Benefits include 25 days annual leave plus 10 days public and privilege holidays, flexible working practices. The Prison Service also offers the choice of a final salary and stakeholder pension scheme which gives you the flexibility to choose the pension that best suits your needs.

For further information and an application pack please contact Joanne Lodge, Personnel, HMP Lindholme, Bawtry Road, Hatfield Woodhouse, Doncaster, S Yorks DN7 6EE. Tel 01302 524830. Fax 01302 524760. Email: Joanne.lodge@hmps.gsi.gov.uk

Closing date for both posts: 18th November 2005.

Applications for part time and job share are welcome.

For further information, please visit the current recruitment section of our website on www.hmprisonservice.gov.uk where you can download an application pack.

Please note that Prison Service posts are open to part-time and job share applicants. Applicants will be required to declare whether they are a member of a group organisation, which the Prison Service considers to be racist.

We are an equal opportunities employer.

HM PRISON SERVICE

Birmingham and Solihull NHS
Mental Health NHS Trust

DETOX & STABILISATION SERVICES (DASS)

BAND 6 CHARGE NURSES OR EQUIVALENT

• 2 POSTS • £19,523 - £30,247 PA • REF: 00522

These posts are open to allied health care professionals as experience gained within a non SMS setting will be recognised.

The Addictive Behaviour Centre provides detoxification, stabilisation treatment interventions for drug and alcohol users within a tier four Unit and is part of the wider community Drugs and Alcohol Treatment Service fitting the Models of Care guidance.

The Centre offers inpatient treatment to service users from the diverse community of Birmingham and Solihull. This post will require an enthusiastic approach in the delivery and supervision of skilled nursing care to meet the physical and psychological needs of our service users. Being able to identify and implement good nursing practice is essential and in return we offer regular supervision and access to training and development in a service striving for excellence.

This is an opportunity to develop your understanding of substance misuse and where your professional approach to treatment and contribution to the team will be valued.

A minimum of twelve months' experience at E Grade/Band 5 is required, together with a demonstrable interest in working with our service users. A rotational shift pattern is in place.

Relocation can be negotiated.

For further information please contact Magdalena Roskell on 0121 685 6258.

You can apply on line at www.bsmht.nhs.uk, click on 'working for us' and follow the link to e-recruitment or alternatively call the vacancy line on 0121 678 3210 for a manual application quoting the appropriate reference.

Closing Date: 16 November 2005.

Successful applicants are subject to a criminal records bureau disclosure.
For hearing impaired/deaf applicants you can also request an application pack by accessing Type Talk on 18001 0121 678 2727.

The Alliance
Taking treatment forward

Regional Advocate (West Midlands)
Regional Advocate (Yorkshire and Humberside)

Salary: £24,708 pro rata (NJC scale SO2 32)
Part time: 28 hours (four days) per week

The Alliance is a user led organisation providing helpline and advocacy services to drug users. We are looking for two advocates to provide services to drug users in Yorkshire and Humberside and the West Midlands as part of a newly developed National Model of Advocacy funded by the Department of Health.

They will work from home and will be expected to travel within the region. They will be expected to work as part of a national team while successfully managing all aspects of regional advocacy delivery. Excellent interpersonal and communication skills are essential, as is an understanding of treatment options for drug users.

The successful candidate will have direct experience of drug treatment and a commitment to improving the quality and availability of treatment in the UK.

The Alliance operates an equal opportunities policy and welcomes applications from all sections of the community.

For a job description and application form (CVs not accepted) please contact the Alliance on 020 7713 6222 or by emailing malliance@btconnect.com.

Closing date for completed applications is 9th November 2005. Interviews to be held on Wednesday 23rd November 2005.

The Methadone Alliance is a Registered Charity (No. 1081554) and a Limited Company (No. 3934379)

OPPORTUNITIES ACROSS LONON

Drugs Referral Workers

£23,088 – £26,386 inc LW (subject to skills & experience)

We are looking for people who are able to communicate effectively with drug users and refer them into the treatment they need. You will be part of an experienced team that has built up excellent referral pathways right across London. The successful candidates will work with clients in the criminal justice system either in police stations or at court. In return you will be part of developing a treatment system that responds effectively to the needs of service users. We currently have vacancies in Kingston & Chelsea, Barking & Dagenham, Enfield and Tower Hamlets.

The successful candidate will be subject to a Criminal Records Bureau check and Metropolitan Police clearance.

WDP offers excellent terms and conditions and development opportunities.

For an application pack and further information visit: www.wdp-drugs.co.uk or email jobs@wdp-drugs.org.uk or for further information call 020 7421 3131. The closing date for applications is 17th November 2005.

For more info on WDP visit our website www.wdp-drugs.co.uk

WDP is committed to connecting with service users at all stages of the drug treatment system.
We have a track record of: • Maximising staff autonomy • Caring for staff and service users • Promoting a learning environment through training and career development • Valuing partnerships
Working at WDP you will be part of a diverse, inspiring and highly skilled team.
To maintain and enrich this diversity we warmly welcome applications from all ethnic communities.

WESTMINSTER DRUG PROJECT

Bridgend County Borough Council
Cyngor Bwrdeistref Sirol Pen-y-Bont ar Ogwr

www.bridgend.gov.uk

Senior Practitioner - Substance Misuse Services
(Fixed Term contract to March 2008)
£26,703 - £29,004 plus a £1,000 supplement

We are looking for an experienced and enthusiastic social worker for the role of Senior Practitioner (substance misuse).

Based within a multi-disciplinary Community Drug and Alcohol Team you will be responsible for the following key areas:-

- Developing a model of service to reduce the incidence of family breakdown related to substance misuse.
- Building upon existing links between Children's Services and Substance Misuse services.
- Providing professional leadership to social work staff within the team.

You will be a qualified social worker with at least 3 years' post-qualifying service, ideally in the fields of Children's Services or Substance Misuse with an interest in developing new services within an established and respected team.

This innovative post is funded by Bridgend Substance Misuse Action Team and has been developed in partnership between Bridgend County Borough Council and Bro Morgannwg NHS Trust.

An Enhanced Disclosure Check by the Criminal Records Bureau will be necessary for the successful applicant of this post.

For an informal discussion please contact Kelvin Barlow on 01656 754300.

To request a job pack please telephone 01656 642220 (24 hour recruitment line) or email perservstaffing@bridgend.gov.uk

Closing date: Monday 21 November 2005

Bridgend County Borough Council is aspiring to become a progressive employer with family friendly policies promoting a good work/life balance. All our employees enjoy a range of benefits including a final salary pension scheme. Find out more by requesting a Job Pack today.

All vacancy information is available in alternative formats on request.

We are committed to promoting equality and diversity and welcome applications from all sections of the community. Applications from Welsh speakers are welcome. Croesawir ceisiadau gan siaradwyr Cymraeg.

BRIDGEND

Positive about People

Are You Looking For Staff?

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

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

Consultancy, Permanent, Temporary

"The staff Solutions Action Management Ltd supplied to us in the form of a team of DiP consultants and Joint Commissioning manager, have proved invaluable in the preparation of the project plans to carry out needs assessments and development budgets and treatment plans/ documents for the NTA and Government Offices in consultation with the Swindon staff team. I would have no hesitation in recommending you and contacting you again in the future should we require staff to support our plans"

Drug and Alcohol Team Manager Swindon Community Safety Partnership

SAM Recruitment & Consultancy

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

www.SamRecruitment.org.uk

TV COMPANY LOOKING FOR ON-SCREEN EXPERT

betty, an award winning production company, is currently developing a documentary series inspired by the principles of family intervention as a way of tackling addictive behaviour. We want to talk to qualified professionals who support this approach and/or have experience of intervention.

betty has an ethical approach to programme-making. We have spoken at length to psychologists and former addicts to ensure this series offers the best on and off-screen support to any potential contributors.

For more information please contact rebecca@bettytv.co.uk or call 0207 290 0660 and ask to speak to Rebecca

Cyngor Sir **Powys** County Council

Powys

SOCIAL WORKERS
(Mental Health / Substance Misuse)
CSSC433 North Powys, CSSC432 South Powys

These posts are in response to the new expectations contained within the Welsh Assembly Governments 'Substance Misuse Treatment Framework - for co-occurring Substance Misuse and Mental Health Problems'. These dual diagnosis posts will be based within the Community Mental Health Teams (CMHTs) in North and South Powys.

You will carry out a wide range of assessment and care management tasks associated with the social care needs of people with substance misuse problems and / or mental health. You will work as the link between CMHTs and community based substance misuse services and be a key member of specialist planning and development groups.

To meet this challenge you'll need to be an enthusiastic and committed team player. You will have a relevant professional social work qualification and knowledge of issues relating to substance misuse and process and models of rehabilitation. You will need experience of working in the substance misuse and mental health fields, care management skills and the ability to work effectively in a multi agency/ partnership setting.

Powys County Council is a relatively small, friendly and supportive organisation. Powys is a great place to live with beautiful countryside, lively towns, good schools and reasonable property prices. A relocation package of up to £8000 is available plus new lease car, travel expenses and family friendly policies.

For information / applications please call the Workforce Planning Unit on 01597 826843 or 01597 826887 email maried@powys.gov.uk or allyson.boswell@powys.gov.uk. or apply on line at www.powys.gov.uk

Closing date: 11 November 2005

drugs, booze & edp

EDP is well recognized as THE leading non-statutory service provider of drugs work within the Devon and Torbay DAT areas. All staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

The Exeter, East and Mid Devon adult services are commissioned to deliver Tier 2 advice & information, needle exchange,

Tier 3 structured case work, street homeless outreach, criminal justice services and structured day programmes.

EDP currently has the following vacancies:

Tier 2 Substance Misuse Worker - Ref: 15/05

- Based: Exeter
- Hours: 21
- Salary: £20,295 - £24,808 (Pro-rata = £12,177 - £14,403)

The successful applicant will be a skilled communicator with knowledge and experience within the substance misuse field, including needle exchange services. You will be able to carry out triage assessments, offer advice and information, support and a range of interventions to those who approach the Tier 2 services. You will facilitate Service User entry into structured drug treatment programmes, provide advice and information to families, partners and other professionals involved with drug users, offer a Safer Injecting Service to injecting drug users and operate and develop the needle exchange.

Closing date for applications: Tuesday 22nd November 2005, 12noon.

Assertive Outreach Worker - Maternity Leave Cover - Ref: 16/05 (6 months, with potential for extension)

- Based: Exeter
- Hours: 35
- Salary: £20,295 - £24,808

Our multi-agency Street Homeless Outreach Team (SHOT) helps people sleeping rough in Exeter to find accommodation or relocate, and support those with substance misuse problems. As a key member of SHOT you will be right in the frontline of that service, identifying and making early contact with people sleeping rough and acting as keyworker. You will assess needs, sign-post to relevant services and develop written action plans, as well as helping clients access welfare benefits and helping manage the priority waiting list for hostel accommodation. You will have experience of delivering substance misuse treatment packages and will be able to be flexible in the hours you work.

Closing date for applications: Tuesday 22nd November 2005, 12noon.

For an informal discussion after receipt of application packs please contact Caroline Moore, Head of EDP Adult Services on 01392 666219.

We would welcome applications from general or specialist drugs practitioners as vacancies arise from time to time, please send your CV to the recruitment addresses below.

Application forms for all posts available from: Georgina Burford, Human Resources Officer, EDP Drug & Alcohol Services, Dove Clarke House, Southernhay East, Exeter, EX1 1PG. Or e-mail recruitment@edp.org.uk quoting the reference number.

MAKING A DIFFERENCE. THAT'S THE POINT.

We turn lives around every day, by putting the individual at the heart of what we do. Inspired by those we work with, together we help people build a better life. Turning Point is the UK's leading social care organisation. We provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

SOMERSET DRUG INTERVENTION PROGRAMME (DIP)

Somerset substance misuse services are expanding and this could now be an exciting time to make that move!

Turning Point, Avon and Somerset Probation Service and the local statutory NHS drug service successfully combine to form Somerset DIP. We are now expanding, aiming to further our innovative strategies by providing services at custody suites and courts based in Yeovil, Taunton and Bridgwater.

CRIMINAL JUSTICE DRUG WORKERS x 3 • £18,450 - £20,970

Yeovil, Taunton or Bridgwater • 37 hours per week You will be working with clients who have problematic substance misuse problems, and who come into contact with the Criminal Justice System. You will be responsible for engaging clients into the DIP, as well as working with those already in the programme. With relevant experience, you must possess good interpersonal, teamwork and communication skills. Working mainly in one of the locations above, you must be available to work some weekends, as well as work across Somerset if required. Closing date: 18 November. Interview date: 28 November.

For further information, please contact Janet Hucker on 01458 832225 or Galena Thackaberry on 01278 727140.

OUR BENEFITS In return you can look forward to a final salary pension scheme, generous annual leave allowance, a season ticket loan and employee assistance programme – and some flexibility in working hours including the opportunity to jobshare if appropriate.

HOW TO APPLY For more information and to apply online or download an application pack, please visit www.jobs-at-turning-point.co.uk/ddn You can also call 0845 055 0262 or email turning-point@peoplemedia.co.uk quoting the reference number L8630/3 and stating where you saw this advertisement.

We don't just talk about equality and diversity. We make it happen at every level of our organisation – promoting fairness, encouraging participation and challenging every barrier to individual growth and development.

TURNING POINT

To find out more and to apply, visit:
www.jobs-at-turning-point.co.uk/ddn

Registered Charity No. 324867

Addiction Counselling Trust

A Company Limited by Guarantee No. 3164431 &
a Registered Charity No. 1054524

Group/Project Worker

Sefton Project, High Wycombe, Bucks

37 Hours per week – £19,922 to £22,076 per annum

An exciting opportunity to join our Structured Day Care team. Duties include assessments, facilitating groups, keyworking, and supporting substance misusers in our 12 week rolling community based structured day care programme.

Closing date 16th November 2005.

To apply telephone Nicola on 01296 425329 or email nicola@addictioncounsellingtrust.com

addaction

Helping individuals and communities to manage the effects of drug and alcohol misuse

We all have a role to play in tackling drug addiction.

Could this be yours?

Chief Executive - c£85k — London EC1

Working solely in the field of drug and alcohol treatment, Addaction is a leading UK charity that provides services to clients from all backgrounds and ages. Addaction's work is underpinned by a belief that drug and alcohol abuse and dependency can happen to anyone, and that there are no easy answers. As a result, society needs to recognise the fact that drugs and alcohol abuse are a major social issue before we can all play our part in determining a lasting solution.

With responsibility for raising Addaction's profile within political and public arenas, you'll be dealing with high-level personnel across all of our stakeholders. A strong leader able to inspire and motivate staff and volunteers alike, you'll work with relevant external partners and strategic alliances to achieve maximum outcomes for clients, whilst also developing the organisation's strategy, aims and values.

Along with a successful track record of building corporate reputation, partnership working and maximising external funding streams, you'll have plenty of experience building the confidence and creativity of your team. You'll also have a comprehensive understanding of organisational structures, systems and processes, as well as the ability to manage budgets and people. Fully committed to the delivery of a high quality, needs-driven service, you'll be confident speaking on public platforms and will ideally have a keen awareness of substance misuse and other social inclusion issues.

To find out more about this life-changing opportunity, please contact our consultants Julia Oliver and Lexie Sims at Hodes Public Service on 020 7551 4773. For an information pack including details of how to apply, please email **Ltudball@hodes.co.uk**
Closing date: Monday, 21st November 2005.

HODES PUBLIC SERVICE

TACKLING DRUGS CHANGING LIVES

"I'VE HEARD THERE'S A WAY I CAN HELP PEOPLE LIKE MY BROTHER."

"He used to be a lovely bloke but now he steals to fund his drug habit. I've heard I can help people like him through the Drug Interventions Programme."

CRIMINAL JUSTICE DRUG WORKERS
DRUG INTERVENTIONS PROGRAMME

Throughout London
c£22,000 - £26,500

If you haven't already applied to be a Criminal Justice Drug Worker with the Drug Interventions Programme, there's still time. By joining us, you can help drug misusers who commit crime and all those adversely affected by it. It's vital work that could transform countless lives - including your own.
To apply online, visit our website at www.lifechanging.org.uk It's also the place to go if you want to check whether you're suitable for the role. The website has a wealth of information about breaking the link between drugs and crime by providing treatment and support to those who need it, as well as further details about our Programme.
If you are unable to access the internet, please call Barkers Candidate Management on 0845 300 0585 or 0845 450 3291. Closing date: 15th November 2005.
It could be a life-altering experience.