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DDN Drink and Drugs News

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DDN Drink and Drugs News

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Editorial – Claire Brown

Wars of words

How can you fight a war with nonsense?

There's some tough talk on the 'drug war' in this issue, and we make no apology for that. Danny Kushlick's piece (page 12) highlights how drug policy is governed by forces other those at the heart of drug work, ignoring many respected names who speak out against prohibition. Who controls received wisdom? Whatever our views, shouldn't drug workers be at the heart of policymaking, bringing much needed experience of clients' public health needs to the debate?

The national press often have a lot to answer for in making our jobs (or experiences of drug treatment) more difficult – but interestingly, we always land the blame on the tabloids. Chris Huhne, speaking at the Release conference (page 10) says 'we need to get the debate back to what works, rather than what titillates the tabloid newspapers'. But the broadsheets are equally capable of pulling us backwards. Only today, as we go to press, a *Times* columnist headlined her piece with 'Say no, no, no to the rehab industry' and proceeded to tell readers why the 150,000 people working in drug action teams are helping to rip off taxpayers by contributing to a 'pharmaceutical holding pen in which the UK's addicts can be corralled'. Furthermore, 'the industry doesn't care,' she says. Do their readers believe this? Unfortunately, judging by the remarks on the online version, many do. 'Two months is usually sufficient to get most people off drugs,' the columnist proclaims confidently, with no consideration of factors that might contribute to a drug-using background or exacerbate relapse. I know you've read many of these pieces before, but their frequency is a stark reminder of how difficult it is to engage in informed dialogue outside of this field.

Talking of changing culture, our cover story presents a huge challenge: are you prepared to treat smoking seriously in your drug service? It's an issue that you might not want to tackle – but will you be taking it on board?

This issue


Page 12


Page 10

Review entire classification system, not just ecstasy, government urged

Drugs organisations have been urging the government to overhaul the entire drugs classification system, not just the classification of ecstasy, as part of their submissions to the Advisory Council on the Misuse of Drugs' (ACMD) MDMA review.

Release is calling for an independent review of legislation and the national drugs strategy in order to find a 'more effective way forward'. This should look at all international evidence and potential methods of drug control 'including de-penalisation, decriminalisation and regulation,' it says. 'We would urge the ACMD to encourage the government to review the entirety of the Misuse of Drugs Act 1971, including the classification system,' says its written evidence. 'It is clear that any drug policy and strategy should be based on current up-to-date research.'

The UK Drug Policy Commission (UKDPC) also states that a wider review of the classification system is 'now overdue'. The purpose of the system needs to be clarified, says the UKDPC, as it is variously expected to deter use and supply, 'send a signal' to drug users and potential users and prioritise policy and resources, as well as setting criminal penalties. How drug classifications are made – especially in terms of assessment of harm – and the increased politicisation of drug classification also need to be seriously addressed, it says.

The fact that ecstasy has little risk of dependence and is mostly used by young people in nightclubs means its class A status dilutes the seriousness of becoming involved in more harmful class A drugs, says Release. Ecstasy is estimated to be responsible for less than 3 per cent of annual drug related deaths – most of these involve dehydration or water intoxication and many users will have taken other drugs as well. Transform calls ecstasy death statistics 'an epidemiological minefield'.

'Where classification is now being used as a tool for sending a message to the public, ecstasy's classification as a class A drug is wholly irresponsible,' says Release. 'Where relatively large numbers of people take ecstasy with little or no harmful effect despite it being classed in the highest category of harm, the logical conclusion would be that the harm associated with heroin for example is also grossly exaggerated. There can be no benefit with sending out this type of misleading message.'

Many organisations have also pointed out that, as was the case with cannabis, even if the ACMD committee recommends reclassification of ecstasy, there is no guarantee the government will do so, with other influences such as media pressure playing a decisive role.

'The ecstasy review will produce little more than posturing on all sides,' said a spokesperson for Transform. 'Given that the government overruled the council on cannabis classification, the entire exercise is doomed before it has begun. The council's time would be far better spent reviewing the harms caused by criminalising drugs in the first place. The prohibitionist regime is unique in the public health field in deploying criminal sanctions to reduce social and health harms. It is also uniquely ineffective.'

The ACMD will report to the government on its findings by the end of the year.

www.ukdpc.org.uk/resources/ACMD_Ecstasy_Submission_September_2008.pdf

www.tdpf.org.uk/Transform%20ACMD%20ecstasy%20submission.pdf

For full reports from this year's Release conference see pages 10 and 14.

Campaign challenges public perceptions

The first major awareness raising campaign for drug and alcohol treatment in the UK is launched by Addaction this week. The campaign aims to raise £10m through fundraising as well as challenge public perceptions of drug and alcohol treatment as an unpopular or unfashionable cause.

The campaign will feature real life stories – the toddler son of a recovering alcoholic, a drug misuser turned drugs worker, a young girl from an estate with high levels of drug use and youth drinking and an Addaction training and employment worker – accompanied by a strapline of 'unfashionable, not unimportant'.

The money raised will be used for projects to support young street drinkers, children living with parents with drug and alcohol problems and children at risk of exclusion from school among others.

'People don't think of charities when they think of drug and alcohol treatment and it's certainly not seen as a "sexy" cause,' says director of marketing and public affairs Alan Booth. 'We want to turn that on its head and show that our work may be difficult, gritty and unfashionable but it is deserving of people's support. Drug and alcohol addiction is at the root of many of our biggest social problems, from knife crime to family breakdown. If we want to ensure more young people don't grow up into a life of substance misuse then we have to act now – because we have a far better chance of supporting them to regain control of their lives at 16 than we do later in life.'

Welsh alcohol plan

A new ten-year strategy to reduce the harm caused by drug and alcohol misuse has been launched by the Welsh Assembly Government. The primary emphasis of *Working together to reduce harm* is on alcohol, but the strategy also covers prescription and over the counter drugs as well as illegal substances.

The strategy combines a focus on education with service improvement and support for families, and sets out how the government will work with partner organisations. It will be backed up by an extra £9.6m from the government's substance misuse action fund over the next three years, which will take the total amount of annual funding to more than £27m by 2010-11, along with a further £11m per year to local health boards to help tackle substance misuse.

'This strategy sets out a clear agenda for the next ten years,' said minister for social justice and local government Dr Brian Gibbons. 'It is a route map for all agencies in Wales to work together to make a real difference to reduce harm and improve lives. The harmful use of alcohol in Wales is far more widespread than that of illicit drugs or other substances... The Assembly Government will press for stricter rules on the promotion of alcohol, an increase in taxation, minimum pricing and a reduction in the drink drive limit.'

http://new.wales.gov.uk/consultations/closed/housandcomm/workingtogether/?lang=en

NTA announces 'watershed' figures

The number of people successfully completing drug treatment was more than 35,000 – 51 per cent of all those discharged – in 2007/08, up from 27,500 (42 per cent) in the previous year, according to new figures from the NTA. The figures represent a watershed in drug treatment in England, says the agency.

More than 202,000 people were recorded in drug treatment in 2007/08, exceeding government targets, and of the 82,000 people that started treatment in the year, 78 per cent remained in structured treatment for 12 weeks.

Heroin remains by far the most frequently reported main drug of misuse by adult clients, at 66 per cent, while for those under 18 it is cannabis, at 78 per cent. The average age of adult clients was 32 – 88 per cent were white, and 72 per cent were male. The NTA will publish a more detailed report of young people's treatment later in the year.

'Treatment services in England are continuing to achieve excellent results for individuals as well as communities,' said chief executive Paul Hayes. 'In the year ahead, all of us in the field face the challenge to focus our efforts on the outcome of treatment, to enable more addicts to become drug-free. The treatment sector as a whole, and the NTA as an organisation, must again raise our game, ensuring our staff are skilled enough, our resources are allocated appropriately, and that we better communicate what we are doing to the public.'

Differing interpretations to code the success of people completing and leaving the treatment system has led to the introduction of a new coding system from next April, which will ensure that all services return data to the National Drug Treatment Monitoring System (NDTMS) in the same way. This will define treatment completed 'drug free' as no longer using heroin, crack or any other drugs for which treatment is being received, says the NTA.

The agency has also published new guidance to help commissioners and service providers plan for and buy effective Tier 4 (residential) treatment. Based on close work with service users and their families, as well as providers and commissioners, the guidance states that Tier 4 services have not benefited from improvements in capacity and quality compared to community based treatment and that local partnerships need to review their arrangements to make sure they are commissioning Tier 4 services in the most efficient way possible.

NDTMS statistics available at www.nta.nhs.uk/areas/facts_and_figures/0708/docs/ndtms_annual_report_2007_08_011008.pdf

Guidance available at www.nta.nhs.uk/areas/tier_4/docs/nta_improving_the_quality_and_provision_of_tier_4_drug_treatment_interventions_2008.pdf

NTA 2008/09 business plan available at www.nta.nhs.uk/publications/documents/nta_bus_plan_0809.pdf

Essential new guide to young people

A new guide for professionals working with young people who misuse drugs or alcohol – or are at risk of doing so – has been launched by DrugScope. The essential guide to working with young people about drugs and alcohol is aimed at youth workers, teachers, Connexions advisors, youth offending teams and drug treatment staff.

The guide includes sections on education, the criminal justice system, working with families, evaluation methods, youth support services and government policies. Written by practitioners in the field, it is supported by the Department for Children, Schools and Families and the BRIT Trust.

'Although overall illegal drug use among young people has fallen we cannot be complacent,' said chief executive Martin Barnes. 'Our members are increasingly concerned about young people's alcohol misuse and some young people are putting themselves at greater risk of harm by using a number of drugs such as alcohol, ecstasy and cannabis.'

DrugScope is also looking for examples of good practice from practitioners in order to counter the often negative view of treatment in the mainstream media. It is particularly keen to hear about family based interventions, community engagement, measures to support reintegration such as jobs, housing and training, and providing help to drug misusing parents and their children. Anyone who would like to submit a case study should contact Harry Shapiro on harry@drugscope.org.uk

Available from HIT at £14.95. www.hit.org.uk

'Cannabis co-ordinator' to take on organised crime

A new post aimed at disrupting organised criminal gangs that supply cannabis has been announced by the Home Office and the Association of Chief Police Officers (ACPO).

Former chief superintendent Mark Matthews has been appointed as cannabis co-ordinator, with a remit to research cannabis cultivation trends across England and Wales, liaise with enforcement agencies to help detect cannabis farms, and co-ordinate cross-border investigations to identify trends such as gangs growing the drug in rented accommodation.

The government's intention is to step up action against organised crime networks involved in the cannabis trade, said Mr Matthews. 'Traditionally law enforcement has focused upon drug issues at the point of importation. Here we are seeing criminals producing drugs within our local neighbourhoods. The same criminals are also very often engaged in other forms of illegal activity such as counterfeiting, tax evasion and people trafficking.'

'I want those criminal gangs who are involved in supplying illegal drugs to experience the fact that the UK is a hostile place in which to do business,' said Home Office minister Vernon Coaker. 'We will bring them to justice and seize their ill-gotten gains.'

The appointment however comes as the new Global Cannabis Commission Report states that a 'regulated market' would cause less harm than international prohibition. Regulation could also protect people from extremely potent forms of the drug, says the report, produced for the 2009 UNGASS review of global drug policy by the Beckley Foundation.

The Home Office minister stated that enforcement would continue to be backed by information campaigns such as FRANK, whose helpline recently received its two millionth call. Most calls to the service are now from 16- to 25-year-olds, says the Home Office, rather than the 26- to 35-year-olds that were in the majority when the service launched.

News in Brief

Consent consultation

The board of The International Network of People who Use Drugs (INPUD) is consulting on a new consensus position with the aim of ratifying it at their general meeting in Copenhagen at the end of the month, part of the organisation's ongoing restructuring and reform process. The document will shape the strategy for taking the organisation forward over the next 18 months with a clear mandate from the membership. Draft document available at *www.ihra.net/Assets/533/1/INPUDDraftConsensusPosition.pdf* To comment contact matthewsouthwell@mac.com; closing date 19 October.

Recovering clarity

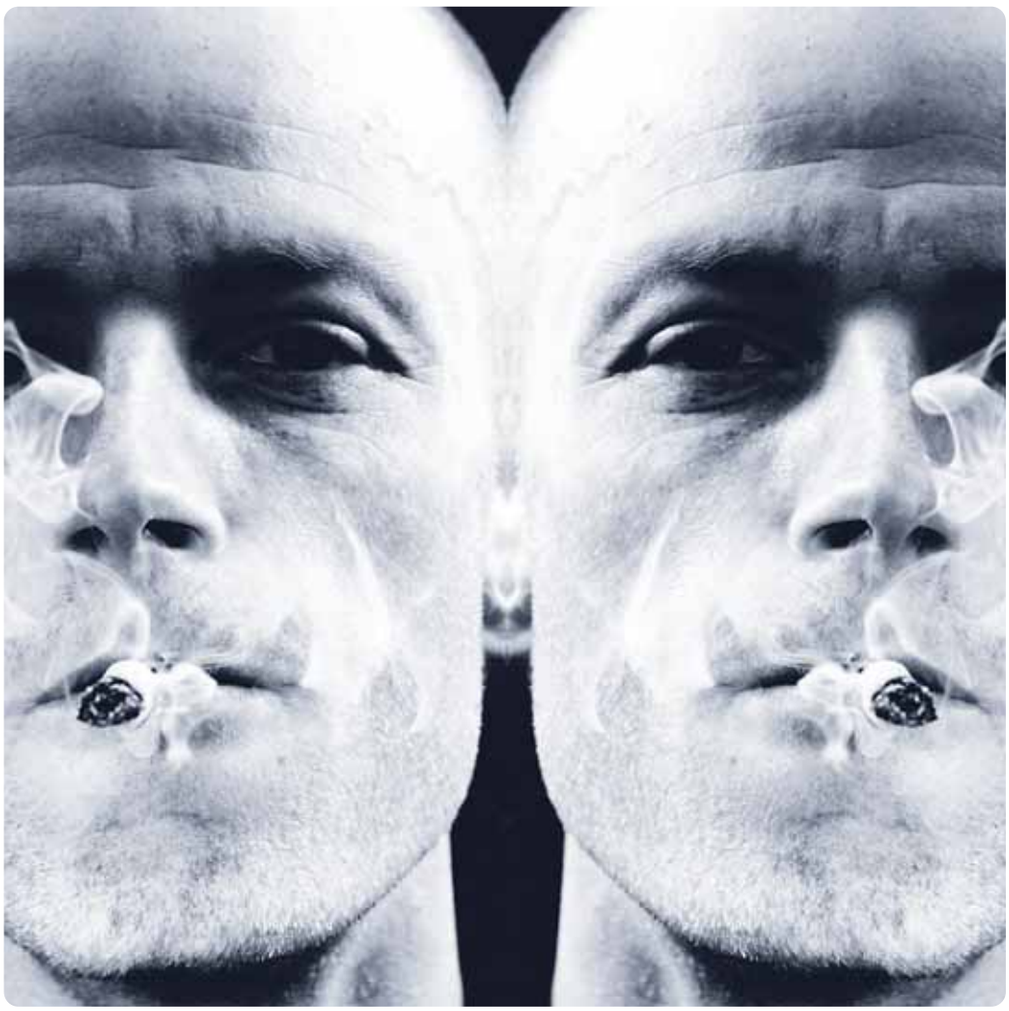
EATA is to consult its members on the UKDPC's consensus group recovery statement in the interests of greater clarity, looking at what characteristics services need in order to be recovery-orientated. EATA members' responses to the government's welfare green paper – especially the requirement for claimants to declare if they use certain drugs – were also heard by a departmental panel recently. 'While there are positive elements in this paper, particularly in identifying those drug dependent claimants who may benefit from access to treatment, there are also problems that concern EATA and our members,' said chief executive Sharon Carson. For the consultation contact Rachel Clarke on rachel.clarke@eata.org.uk

Short work

Alcohol Concern has produced a short form to make it easier to respond to the government's consultation on the marketing and promotion of alcohol and access to treatment. The form lays out the key elements of the consultation, which Alcohol Concern will then forward to the Department of Health. Available at www.surveymonkey.com/s.aspx?sm=qWR4yxus7XJTPt2h7JA1ng_3d_3d Closing date 14 October.

More Hope

Action on Addiction's women only service, Hope House, is to expand and relocate to Clapham Common from next February. The new premises will offer a temporary home and treatment for 22 women instead of the current eight. 'There is a great shortage of women only treatment services in the UK and as Hope House celebrates its 20th year in providing specialist support for women with addiction problems we are glad to be expanding our services to meet demand,' said head of service Susanne Hakimi.



Why do drug treatment services steer away from smoking cessation when tobacco use causes such clearly documented harm? DrugScope's **Dr Marcus Roberts** tackles the issue that many drug workers would rather ignore

Smoke and mirrors

In an article in the *Lancet* in March 2007, Professor David Nutt and colleagues set out to assess the harms of different drugs – both licit and illicit – using a 'rational scale' to capture 'physical harm', 'dependence' and 'social harm'. Response to this article from the media and commentators focused on the high placing of alcohol in the harm scale (above amphetamines, cannabis, LSD and ecstasy) and the low position of ecstasy (assessed as the third least harmful drug, with only alkyl nitrates and khat having lower mean harm scores).

Tobacco attracted much less comment. In the overall harm league table it rested in mid-table obscurity, at eighth out of 20 substances (still above cannabis, solvents, LSD and ecstasy). On key measures, however, tobacco scored higher than illicit drugs and alcohol. It was the most harmful drug for 'chronic physical harm', and the second most costly to health services after heroin. It had the third highest 'mean dependency' score, after heroin and cocaine. In short, tobacco is highly addictive and very bad for your health... not exactly news. But it is curious, therefore, that it figures so little in debates on drug policy, dependency and treatment.

DrugScope has considered these issues in depth in developing a response to the government's recent consultation on tobacco control. We convened an expert seminar to bring together drug treatment and smoking cessation specialists and conducted an online survey. Our key message is that the government should take a close look at the potential role of the drug treatment sector in reducing smoking-related harm.

The tobacco control Green Paper explains that there is a strong relationship between tobacco use, social inequality and health inequality. Poor and marginalised people tend to suffer more health problems and die earlier. Smoking-related disease is a major contributor to these most fundamental and shocking of inequalities. (Conversely, of course, smoking contributes to poverty as the price of tobacco products rises, largely as a result of tax rises intended to discourage use, but which appear to be having a limited impact on smoking rates among the people least able to afford them.)

The Green Paper states that 'the chances of being a smoker are substantially increased in people living in rented housing, receiving state benefits, without access to a car, who are unemployed or living in crowded accommodation... In groups with an extreme clustering of deprivation indicators (such as prisoners and homeless people sleeping rough), rates of smoking prevalence as high as 85 to 90 per cent have been observed'. These are precisely the socially excluded groups that are at most risk of problem drug use too. Yet there was a lack of explicit reference to problem drug users in the Green Paper, nor any serious consideration of the possible links between tobacco dependency and substance misuse.

Gay Sutherland, research psychologist and expert in smoking cessation, explained to her audience at the National Drug Treatment Conference 2007, that 'most people in drug treatment smoke – between 70 and 90 per cent – and they are more nicotine dependent that the general population of smokers.' A 2006 survey of the available research literature cites a UK study of

methadone outpatients that found that 93 per cent were smokers.

Most users of drug services smoke and are highly dependent on nicotine. Many suffer serious health consequences. But, as Gay Sutherland proceeded to argue, 'hardly any are offered help to stop smoking... in fact it is the only addiction not addressed when a client presents for substance misuse treatment.'

Around half of respondents to DrugScope's online survey (52 per cent) said that they provided smoking cessation advice and/or support to their service users. Forty eight per cent of respondents said they did not provide advice and support to clients with tobacco dependency. Asked whether they referred clients to smoking cessation services, 14 per cent said that they did 'regularly', 7 per cent 'frequently' and 54 per cent 'occasionally'. Twenty five per cent never did.

There are various reasons why drug treatment services may feel unable or unwilling to engage in smoking cessation work – some historical, some cultural, some practical... some better than others. For a start, it is not as if they are short of stuff to do. They don't get funded to look at tobacco dependency, and they don't have targets for it (yet).

As one respondent to our online survey explained 'I think this could add more pressure to workers as inevitably 'targets' will be introduced and they will have to be met. As workers we have other priorities... It would be another problem for services to cope with.' Another argued that 'service users consider tobacco as a bad habit rather than a problematic one, and a habit that they still enjoy, whilst tackling more significant dependency issues. All service users should be offered support should they want to stop smoking, but is this realistic in view of the time slots they are allocated and key performance indicators?'

Then there is 'the question of whether someone who smokes can deliver smoking cessation?'. Let's face it, lots of people working in drug treatment are smokers themselves – we don't know how many – and smoking is interwoven into the cultures and rituals of some services. As participants in the DrugScope expert seminar explained, 'in drug treatment services, smoking breaks, rituals and routines are built into the day' and 'many initial short assertive outreach type interventions are dependent on developing trust quickly... one route into this is for workers to bond over a shared cigarette.'

DrugScope's consultation work has convinced us that it is time to surmount these barriers and to get serious about the smoking-related harm experienced by drug service users. We recognise that drug services are more than busy enough already. Service users with, say, heroin dependency, homelessness and mental health problems to address, may place smoking cessation low on their list of priorities too.

The evidence suggests, however, that addressing tobacco dependency is not a distraction from these other problems, but can contribute to addressing them. The 2007 Clinical Guidelines on Drug Misuse and Dependence say smoking cessation may be associated with better treatment outcomes and less risk of relapse. In her presentation to the 2007 National Drug Treatment Conference, Gay Sutherland reassured delegates that there was little evidence that efforts to stop smoking impaired drug treatment outcomes. On the contrary, she confirmed that the research suggests that smoking cessation is associated with improved outcomes. We should be building that evidence-base – at present, perhaps more suggestive than conclusive.

Nor need this work involve a large investment of resource. For example, NTA Guidance on Reducing Drug Related Deaths (2004) says that 'good practice' could consist simply of building working links with local smoking cessation services and advising clients (as and when appropriate) of the potential health benefits of giving up smoking. Not a big ask.

Indeed, some potentially effective harm reduction initiatives – as first steps – are really easy to do. A good example is action to encourage drug treatment clients who smoke hand rolled cigarettes to use filters. Research suggests that people who smoke hand rolled cigarettes without filters (*ie* many drug treatment service users) are at much greater risk of lung cancer than smokers of 'tailor made' cigarettes.

The place of smoking in the cultures of some services does need to be addressed. There is a certain irony in the notion that outreach workers may bond with drug users by sharing a drug that is (roughly) as addictive as heroin and cocaine and is strongly linked to chronic health harms. Sharing a fag outside the doors of the treatment service is exclusive of non-smokers, and hardly consistent with minimal standards of health promotion within the drug treatment sector. It is time to move on – and that means developing a strategy for healthy drug services which addresses smoking by managers, workers and clients.

'There is a certain irony in the notion that outreach workers may bond with drug users by sharing a drug that is (roughly) as addictive as heroin and cocaine and is strongly linked to chronic health harms.'

All this requires national policy leadership and funding – which is why DrugScope is pushing the Department of Health and the National Treatment Agency to raise the profile of smoking cessation and to work pro-actively with the sector to develop a more effective and consistent response to service users who smoke. And, yes, this may require some monitoring too...

Despite the sorts of concerns discussed in this article, there is support for this agenda among drug service providers. Forty five per cent of respondents to our online survey 'strongly agreed' that drug services should support clients to stop smoking, and a further 35 per cent 'agreed'. Only 7 per cent disagreed.

This is how one respondent to our online survey put it: 'Drug services are clearly well positioned to help clients, many of whom smoke, to stop smoking. The issue should be addressed in an integrated way with clients asked about whether they smoke during an initial assessment – something that doesn't currently happen consistently – and then that becoming part of their care plan. The priority attached to it would depend on the client and the level and nature of their dependency. But as a minimum, all drug services should have smoking cessation advice information available and be able to refer clients to smoking cessation clinics'. Sounds about right... and surely achievable too.

To receive a copy of DrugScope's full response to the tobacco control consultation or send comments, e-mail Marcus Roberts at marcusr@drugscope.org.uk. You can also email Dr Roberts for a fully referenced version of his article.

What's the attitude to smoking in your workplace? Write to our letters page by emailing claire@cjwellings.com or use the address on page 3.

'The good reputation and trust engendered by the helpline could well be damaged by the wider association with FRANK; the campaign machine lacks the same honesty, integrity or accuracy. And young people can see through it.'

Huge questions for FRANK

The article 'Who's Listening to Frank' (*DDN*, 22 September, page 10) asked important questions as to whether FRANK was gaining credibility, and earning its keep. In the uncritical piece that followed, neither question was really addressed, leaving me with huge questions about FRANK.

The article cited a huge figure of £26.8m having been spent on FRANK in the past five years but in practice a small fraction of the spend has gone on 'support services for young people'. The lion's share has been spent on advertising, TV slots, literature, PR and marketing.

In the past it's not been possible to ascertain how much of the FRANK spend has gone on the helpline. In a written answer in 2007 Dawn Primarolo said 'it is impossible to give completely accurate costs for the Talk to FRANK helpline alone. But… we estimate that the Talk to FRANK helpline service would cost roughly £800,000 of the £1.5 million [allocated to the pooled service that provides Know the Score, Drinkline, Sexual Health Line, and Hep C information Line in 2006-07.]'

It's also worth mentioning that in allocating this budget to FRANK (the helpline) other services lost out. Adfam, who had a well-respected helpline for families, had its funding pulled, and Home Office funding for the Release helpline was withdrawn at the same time, even though its primary client group of older drug users experiencing problems was poorly served by the youth-oriented FRANK.

If there is confusion about how much has been spent on FRANK, this is nothing compared to the confusion as to how many people have contacted FRANK (the helpline) for guidance.

In a written answer to Norman Lamb MP, Ivan Lewis, in May 2007, said that in the two years to April 2006, FRANK received 1.6 million calls, and answered 107,000 emails.

This was curious, as in the FRANK Action Update for Autumn Winter 2006, a sample press release stated that 'over the first three years of the campaign there have been over 1.4 million calls made to the helpline, and they had responded to 82,888 emails.'

The 'quality' of these calls is not clear. A report on FRANK covering 2004-2006 talks about the helpline receiving 495,000 in 2005 but then says, 'although calls categorised as "fully interactive" did not increase – 70,000 calls were fully interactive.'

Fully interactive means a complete conversation was made with the caller and so of the 1,350 calls per day in 2005, only some 190 per 24-hour period were fully interactive.

However, it is in Dawn Primarolo's written answer in July 2007, two months after Norman Lamb's question, where some real discrepancies appear in the figures. She gave figures as follows:

	Under 16yrs	**16-25yrs**
2004/05	4,237	11,629
2005/06	5,917	14,136
2006/07	4,444	14,974
Total	**14,598**	**40,739**

Based on these figures a total of 55,337 people under the age of 25 called the helpline since 2004 – a tiny fraction compared to the 1.6 or 1.4 million callers claimed by Ivor Lewis and the FRANK action update. Granted, Primarolo's figures only related to under-25s but then as this is FRANK's target demographic to take under 5,000 calls from under-16s is frankly astonishing. And it scarcely seems credible that 95 per cent of FRANK's calls came from people over the age of 25. Something seems fishy with the call figures.

Either way, assuming that the FRANK helpline budget was something in the region of £800,000 per year for the three years, this means that some £2.4 million was spent directly on the helpline, to speak to some 55,000 under 25s, not including the additional spend on advertising and marketing.

While phone-calls to the helpline do not lead to an official in the Home Office, any questions about publications and website content are unerringly redirected to the 'man from the Ministry' – often Matthew Mitchell, from the FRANK team at the Home Office.

Much of the content is written by the Department of Health or the Home Office with additional content sourced from elsewhere.

Feedback from stakeholders suggests an almost naïve trust for FRANK, with one respondent in the 2004-2006 report saying, 'We know we can trust it if the information comes through FRANK. We don't need to think twice or question it.'

This trust is somewhat misplaced as, ever since the website's launch, there has been concern about the accuracy and balance of some of the website content. It is primarily about drug risk, and for most drugs there is little or no real harm reduction information. And like everyone else, FRANK sometimes gets things wrong. Last year, FRANK's Action Update on cannabis was withdrawn because of significant mistakes (such as misrepresenting the law on cannabis for young people, and suggesting that smoking cannabis in spliffs was the safest option). The errors were highlighted by ourselves, and others such as the UKCIA and LCC. FRANK didn't notify its many stakeholders who had already been sent the Cannabis Action Update that it was erroneous.

While stakeholders appear to love FRANK, what of young people? Again, there's a mixed picture and little up-to-date information.

Between 2004 and 2006 the number of young people who agreed with the statement, 'The people who work there [FRANK] really know what they are talking about' dropped from 47 per cent to 40 per cent.

Most of the research about FRANK has been commissioned by FRANK. One of the few other pieces of research that features FRANK is the annual report *Smoking Drinking and Drug Taking amongst young people in England and Wales in 2007*, which asked which, of a range of services, 11 to 15-year-olds had received helpful information from. Less than a third cited FRANK, below the police, and way below parents and teachers.

FRANK is all about trying to manufacture trust. But rather than doing this through a track record of honesty, openness and accuracy, it has taken a short-cut. FRANK is trying to do it through branding, marketing, and image; it is spending a fortune on image, working with consultants, market researchers and PR companies to sell FRANK to young people.

FRANK has a plan, and it's one that would put Big Brother to shame. The plan is outlined in the 2004-2006 report: *Know FRANK – Like FRANK – Trust FRANK – Experience FRANK*. 2006-07 was the year of experiencing FRANK. The report doesn't say what 2007-08 would be, but the research seems to

suggest that it's Reject FRANK.

Ironically the highest quality feedback relating to FRANK comes from those people who actually phone up and speak to advisors – user feedback is very high here, showing what a good job John McCulloch and his colleagues do. But unfortunately for him, and for young people, is that the good reputation and trust engendered by the helpline could well be damaged by the wider association with FRANK; the campaign machine lacks the same honesty, integrity or accuracy. And young people can see through it.

Kevin Flemen, KFx (www.ixion.demon.co.uk)

Last word

I find myself totally at a loss to understand Michael Linnell's allusion to so-called promotion of my 'business entity' (*DDN*, 22 September, page 8).

What on earth is he talking about? As an 81-year-old disabled volunteer charity worker, over the last 19 years I have never received a penny of fees, salary or even out-of-pocket expenses for my self-chosen work in promoting 'a drug-free society'.

Obviously, the essence of a drug-free society is that no-one is threatened by the behaviour of addicts, because no-one is using drugs, and no one intends to use them. Which of course is probably unattainable.

But that should never be allowed to stop us from having a worthwhile goal and trying to reach it. Especially when the ability to get closer and closer to such a goal is also in itself a valued result, because it has the vital effect of benefiting a majority of our society.

So the definition of an 'effective' drugs policy is therefore one which continuously moves a society or community in the direction of total abstinence, *ie* towards a drug-free society.

Clearly, such a policy must result in less and less overall production, sale and distribution of all types of addictive substance – Illicit, licensed and prescription drugs – plus a continuing reduction in the number of citizens using all such substances.

Part of this is effective prevention and part is effective recovery – which is why Rob Thorburn indicated that any Narconon recovery centre offers inspection by honestly interested drug rehabilitation professionals. However, Linnell has preferred to further attack rather than taking up that offer.

I can provide several dozen testimonials from graduates of the Narconon programme to anyone interested [and can be contacted through the editor], which I trust would provide an answer to Linnell's unsupportable denigration of Narconon's 42 years of improving results.

Kenneth Eckersley,
CEO Addiction Recovery Training Services (ARTS)

(Editor: This correspondence is now closed.)

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

Post-its from Practice

Get screening!

Brief interventions for alcohol can work, says Dr Chris Ford

Peter came to have his blood pressure measured yesterday, and for the first time in four years of being on treatment, his blood pressure was within the normal range. He and I were both very excited! Peter is 48 years old, married with three children and works full-time in his own human resources business.

His only risk factor for blood pressure was alcohol. He is an ex-smoker, not overweight and has no family history of blood pressure, but he has been drinking above safe alcohol levels for years. Until five months ago he had refused to see this as a problem, in spite of what I had told him or what he had read. So what was the catalyst for change? He had scored positive on the SIPS (Screening and Intervention Programme for Sensible Drinking).

SIPS was designed to support the National Alcohol Harm Reduction Strategy for England. This called for 'more information... on the most effective methods of targeted screening and brief interventions' and aimed to find out 'whether the successes shown in research studies can be replicated within the health system in England.'

We had signed up to be a pilot site in the Primary Health Care (PHC) section of the study. The study is testing three models of implementation: a control group receiving a patient information leaflet (PIL); brief advice provided by PHC staff plus PIL; and brief lifestyle counselling provided by PHC staff plus PIL. Two screening approaches (targeted versus universal) and two screening tools of different complexity are being compared through 744 patients who drink to a hazardous or harmful level and are being recruited for the study (31 per PHC). The PHC study is designed to answer key policy questions concerning the implementation of screening and brief intervention.

We were randomly allocated to the brief advice plus PIL arm of the study. Peter was the first patient of our 31 on the first morning of the study and he agreed to take part. I'd thought that I had given him several varied brief intervention sessions, but perhaps because of my recent training or due to where he was in his cycle of motivation, he was much more receptive on this occasion.

The single screening question asked how often you drink eight standard (one unit) drinks as a man or six as a woman. If the answer is more than monthly, weekly or daily then you go on to the rest of the questionnaire. You then receive your brief intervention from your friendly PHC staff member. Even Peter was shocked when he realised he drank over eight units most days.

Until answering that simple question he had not really seen himself to have a problem. He didn't wake up in the morning and need a drink. He 'could' have a day without if he really wanted to, and the only people who complained about his drinking were his wife and his doctor! Or perhaps, as Malla said, '...unlike other disorders (alcohol misuse), is a disease many primary care physicians do not want to detect. In addition most alcoholics do not want their disease detected.'

People drinking hazardously make up over a quarter of the UK population. They do not present directly for treatment yet are at higher risk of accident, crime, health problems and social problems. The physical health problems such as gastritis, obesity, heart problems, stroke and cancer are numerous, as are the psychological problems such as depression (65 per cent suicide attempts), anxiety and brain damage. Social and family problems should not be forgotten, such as the involvement of alcohol in child abuse and in 40 per cent of domestic violence.

After we measured Peter's blood pressure and found it to be within the normal range, he also stated that he felt better. He was much less tired and stressed (his justification for drinking), he was taking more exercise and his concentration was improved. He hasn't stopped drinking alcohol but allows himself to share a bottle of wine twice a week which keep him well within safe levels. His wife came to see me today purely to say thank you and to explain that she was no longer embarrassed when putting the bottles out for recycling!

Don't forget to ask and record alcohol on all patients you see, especially if they use other drugs. Remember to undertake brief interventions on all heavy drinkers, offer support for behavioural change and refer on when necessary. Why not start with yourself – I did, scored positive and gave myself a brief intervention which seems to be working!

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

What's drugs got to do with it?

The 'war on drugs' is not only ineffectual, it's actually a misnomer for policies that are about far wider issues of race and discrimination, according to speakers at Release's 2008 conference. **David Gilliver** reports

Race and the 'war on drugs' were so inextricably linked as to be indistinguishable, US lawyer and executive director of Break the Chains, Deborah Peterson Small, told delegates at Release's Drugs, race and discrimination conference in London. 'You could even say "what's drugs got to do with it?"' she said. 'A lot of the conversation we have around drugs is not around drugs. It's around social control and maintaining the status quo – we're not having the real conversation.'

Drug policy was partly driven by public fear of crime, much of which was stoked by a media largely no longer there to keep the public informed, but to serve the interests of the large corporations that owned it, she said. This fear was then used as an excuse by governments to implement ineffectual drug policies. 'The "war on drugs" has become a proxy for dealing with other issues,' she said. 'Are we really engaged in a war on drugs, or are we using it as a way of addressing issues in society that we haven't figured out how to deal with yet?'

Even putting morality aside, US drug policy was clearly failing and made no practical sense, she said. 'If you're convicted of selling five grams of crack cocaine, which is worth way less than $1,000, you go to prison for five years, mandatory. But it costs $30,000 to keep someone in prison for a year.'

In poor, marginalised black districts, drugs were often the only way to make any money, she said – 'in my country, drug dealers are the only equal opportunities employers in many neighbourhoods' – and it was therefore time for policymakers to start redefining what constitutes a crime. 'The money that comes from the sale and manufacture of illegal drugs for the most part does not stay in the pockets of the people selling it, or even trafficking it,' she said. 'Most of it resides in large financial institutions. We're getting ripped off as long as we continue to think we can win the drug war that's being sold to us. The people selling it to us are the real thieves. If you view drug policy as a prism to maintain power and control, then it's incredibly effective.'

As misguided and flawed as US drug policy may be, we in the UK were ill placed to judge the country with a 'sense of patronising superiority,' said senior researcher at the European Institute of Social Services, University of Kent, Alex Stevens. African Americans were three times more likely than white Americans to be arrested for drug offences, and ten times more likely to be imprisoned for them. But a look at the data on the differential enforcement of drug laws in England and Wales revealed an even worse story throughout the criminal justice system here, he said.

Black Britons were six times more likely to be arrested and 11 times more likely to be imprisoned for drugs offences than whites. 'You're more likely to be cautioned if you're white, and you're more likely to be imprisoned if you're black,' said Stevens. 'Black people are likely to get harsher treatment at each stage of the criminal justice system.'

Senior research fellow at the Institute for Criminal Policy Research, Tiggey May told delegates about her work studying cannabis policing in the UK. 'There is considerable variation in who gets warned and who gets arrested,' she said. 'Cannabis accounts for 69 per cent of all drug policing, so you would hope there was some consistency, but BME offenders are heavily over-represented among cannabis offenders.'

So what was the reason for this? The 'innocent explanation' was simply that black people were more likely to use drugs, said Alex Stevens. 'But this is not the case,' he told the conference. 'According to the Home Office's Offending Crime and Justice Study (OCJS), the highest levels of drug use, class A drug use and class A drug dealing were reported among white people.'

So was it that the criminal justice system was just out and out racist? The reality was more complicated, he said. 'Statistical discrimination comes when you think you are likely to have better returns – if you think that it's more likely that black people are using drugs, then you're more likely to target them.' Another factor was that members of the public were probably more likely to report groups of young black males on the streets to the police on suspicion of dealing drugs than white youths.

Other inequalities in society could help explain the figures, he said – there was the argument that black people might be more 'available' to be stopped and searched on the street, as they were statistically more likely to be unemployed, excluded from school or homeless. And there was also the issue of the existing levels of resentment and anger in the black community towards the police, which could escalate levels of conflict and aggression – a vicious circle that could then lead to harsher treatment.

Racism in the criminal justice system was now far more underground than a few decades ago, and more likely to be represented by 'contextual' racism, he said – 'pockets of the system' in the police and prosecution services. Members of minority ethnic groups were also far less likely to have access to powerful friends and expensive lawyers to ensure leniency.

However, it was also felt that New Labour's 'target culture' could explain some of the statistics. 'Young BME males are being swept into the criminal justice system to meet Home Office targets,' said Tiggey May. There had been a 'huge and largely unremarked on' change to the youth justice and criminal justice systems in the UK over the last decade, former chair of the UK Youth Justice Board Rod Morgan told delegates, with the rise in 'summary, out of court justice'. The police were meeting the plethora of government targets placed on them by 'picking low hanging fruit,' he said. 'And the lowest hanging fruit are kids and young people.'

There was no real evidence to suggest youth crime was increasing, he said – in fact it was remaining fairly constant. But young people were being criminalised more and more, particularly those from minority ethnic groups. Black people were six times more likely to be stopped and searched by the police than whites, and Asians twice as likely. 'And in a proportion of these incidents, cannabis will be found. We have to put a serious question to the degree to which we are gratuitously criminalising a generation,' he told the conference, especially when it came to young people from minority ethnic groups.

'Drug law enforcement causes disproportionate harm to people of African and Caribbean heritage, and harms police effectiveness in reducing threats to community safety,' said Alex Stevens. From a policy point of view, it was essential that the capacity of the drug laws to criminalise black people be reduced, he said – by decriminalising possession, cutting the use of imprisonment and improving through care and after care in the criminal justice system for black people, as well as intensifying efforts to address the structural inequalities that penalised black people.

Treating the drugs problem as a 'public health issue' would save the Treasury a great deal of money, said Liberal Democrat Shadow Home Secretary Chris Huhne. 'We need to get the debate back to what works, rather than what titillates tabloid newspapers.'

The misguided drug policies of the UK and US were not just leading to severe injustice in their home countries but were actually exacerbating the problem across the globe, said professor of criminology and criminal justice at Kings College, Ben Bowling. The joint enforcement initiative between British and Caribbean authorities to reduce the supply of cocaine to the UK had simply exacerbated existing problems, he said.

There had been a 'significant degree' of tactical success in that substantial amounts of the drug had been seized, but that had had little real impact as street prices – the best measure of availability – had continued to fall, he told delegates. 'It's not that law enforcement has no effect,' he said. 'It simply displaces trafficking.' Cocaine trafficking had been displaced from Columbia to the Bahamas, Jamaica, Venezuela, Guyana, Trinidad and other places, he said, along with the violent crime that accompanies it.

It was now West Africa's turn to become part of the cocaine trafficking route, he said, and it was experiencing extremely high levels of drug-related armed violence as a result. 'In this way, the prohibition of drugs actively creates the problems it sets out to address. It creates a clandestine market that attracts economically marginal people, and conflicts are resolved through violence.' The arming of drug enforcement agencies simply served to 'weaponise' societies, he said.

Tactical successes amounted to little more than strategic failure – arresting high or mid-level operatives simply served to destabilise markets and provoke armed power struggles and consequent spikes in violent death statistics. 'Armed violence is the result of prohibition,' he said. 'The only reason the Caribbean islands have become a transit point for cocaine is because of prohibition. There's no other reason for it to go there.'

It was time to embark on a more 'humane and rational' approach to drugs, he said. 'The criminal justice system has failed to solve the problems of community safety and social exclusion, and has in fact made them worse' he said. 'The end point of the criminal justice process is a hugely disproportionate black prison population. It would be disappointing if drug enforcement policies had merely been ineffective. But they have been more than a waste of money – they have been a waste of human life.' **DDN**

In pursuit of truth

Danny Kushlick suggests that the drugs field needs to be more honest if we are together to bring an end to the drug war

'I think there's a good reason why the propaganda system works this way. It recognises that the public will not support the actual policies. Therefore it's important to prevent any knowledge or understanding of them. Correspondingly, the other side of the coin is that it's extremely important to try to bring out the truth about these matters, as best we can.'

Noam Chomsky, Interview in 'The Chomsky Reader'

Across the many policy responses to drugs in society, the war on drugs ethos, its legislative instruments, and their enforcement has become a significant driver of drug harms. Through its mass criminalisation of users, its abdication of market control to unregulated criminal profiteers, and creation of a vast anarchic and violent criminal economy, prohibition, whatever its original intentions, has become a policy of harm maximisation, in both public health and criminal justice spheres.

But here's the good news: 'The Drug War cannot stand the light of day. It will collapse as quickly as the Vietnam War, as soon as people find out what's really going on.' (Joseph McNamara, Former Police Chief, Kansas City and San Jose; Fellow, Hoover Institution.) The flip side of this is that the war on drugs will continue for as long as people are kept in the dark about what's going on. The key question then is this: Who is responsible for informing people about what is going on in the drug war? Should the harm reduction and treatment field be doing more to cast light on prohibition?

There is a growing consensus that the war on drugs is the single largest force for maximising drug harm currently in operation. So why has the vast majority of the drugs field chosen to be economical with this simple truth? Firstly though, they are not alone – criminologists, public health experts, international development NGOs and many drug policy NGOs have chosen to refrain from calling for a fundamental alternative to prohibition. However, the drugs field occupies a place of supreme importance in exposing the harm maximising effect of the drug war on their clients. First they are the government's first port of call (and place of last resort) to reduce drug war harms and second most represent the harm reduction paradigm, and if harm reductionists will not question the war on drugs, who will?

Successive UK governments have gone out of their way to make sure that the public is misinformed about how the government's commitment to a war on drugs creates much of what we call the drug problem. In 2003 the Prime Minister's Strategy Unit Drugs Report was presented to the Cabinet. Withheld for two years, despite numerous freedom of information requests, it was eventually published in the *Guardian* in 2005. It detailed precisely how supply side enforcement creates a vicious and lucrative drug market that destabilises producer and transit countries and creates the context for crime and public health problems in industrialised consumer countries.

That same year I asked Bob Ainsworth MP, the government's then drug spokesperson, if the government would support an audit of the efficacy of supply side enforcement. He replied: 'Why would we do that unless we were going to legalise drugs?' Duping the public doesn't get more transparent than this; especially when you take into account Julian Critchley's recent damning comments on his time at the UK Anti-Drug Co-ordinating Unit. While calling for legalisation and regulation recently, he said: 'I think what was truly depressing about my time in UKADCU was that the overwhelming majority of professionals I met, including those from the police, the health service, government and voluntary sectors held the same view: the illegality of drugs causes far more problems for society and the individual than it solves.'

If Critchley is right, why has the drugs field chosen reticence on this issue? Nowhere is the damage of the war on drugs more obvious than to those who work with heroin and crack users or manage services for them. No amount of counselling, clean needles or methadone make up for the fact that their drugs cost more than their equivalent weight in gold, that they are of unknown purity and that their possession is, in and of itself, a criminal offence. And sadly, safe injecting rooms and heroin prescribing will not help the plight of Afghan and Colombian opium and coca growers.

There are glimmers of light though. In 2001 the Home Affairs Select Committee reviewed UK drug policy. The Committee's final recommendation was: 'We recommend that the government initiates a discussion within the Commission on Narcotic Drugs of alternative ways – including the possibility of legalisation and regulation – to tackle the global drugs dilemma.' It is worthy of note that one of the members of the Committee who asked us questions that day was one David Cameron MP. Too much truth? Cameron has not repeated this call since then.

The RSA Commission was split in terms of how far it should go in exposing the drug war to serious criticism. While all of the recommendations supported the status quo, the 2007 report let slip that: 'Prohibition is no more a viable policy in Britain today than it proved to be in America during the 1920s and 1930s.' If it isn't viable, shouldn't it be terminated and replaced with a system that is viable?

The UK Drug Policy Commission may be moving in that direction too. Its latest report concluded with a quote from Tiggey May and Mike Hough: '[If] markets continue to prove highly resilient in the face of enforcement efforts, then over time, the pressure to re-examine the current legislative structure for controlling drugs will be overwhelming.'

Using similar code, the Advisory Council on the Misuse of Drugs' Report *Pathways to Problems* includes the following recommendation: 'The current arrangements to control the supply of drugs covered by the Misuse of Drugs Act (1971) should be reviewed to determine whether any further cost-effective and politically acceptable measures can be taken to reduce the availability of drugs to young people. Action: Home Office.' Not surprisingly the Home Office failed to take this recommendation on board, presumably working from the time-honoured criterion of what is 'politically acceptable' to populist politicians. More surprisingly the ACMD itself has failed to seriously engage in any wholesale review, despite its own clear remit to appraise the efficacy of the MDA (1971).

So to sum up there are three major tendencies in the debate: firstly, those who call for an end to the war on drugs and its replacement with a system of legal control; secondly the gradualists, who suggest reducing prohibition's harms, while leaving the edifice of prohibition in place; and thirdly, a group that lies in between who suggest that we need to explore (encoded) alternatives.

The gradualist position has been chosen by many as the only viable position to engage policymakers in the short term; as the Beckley Foundation Drug Policy Programme report *Facing the future: the challenge for national and international drug policy* suggests: 'One of the barriers that has delayed or prevented international bodies and national governments from confronting some of the policy challenges of the past 40 years has been a concern that any admission of failure will be interpreted as a concession to, or a step towards, drug legalisation.' The report adds that: 'It is inaccurate and unhelpful to represent the debate about the future of drug policy in simple, polarised terms.'

The reality is that policy based on drug war ideology is very vulnerable to criticism and it is a short step from critique to alternative. There is no fence upon which to sit. However, if the goal is to engage with policymakers now, it makes perfect sense to build a fence of 'reasonableness' and sideline those calling for wholesale reform. Taking this position comes at a price though; firstly, longer term reforms are continually pushed out of reach, and secondly it entrenches the idea that more substantive critique of prohibition is politically dangerous and an intellectual no-go zone, thereby leaving the drug war almost unimpeded in exerting its harm maximising force.

Which brings us back to my starting point: who is responsible for informing the public about the drug war? The answer has to be those who know that the war on drugs is the problem and that ending it would seriously reduce the damage that it inflicts; the likes of Julian Critchley, Sir Keith Morris, the late Mo Mowlam, Adair Turner and Paul Flynn MP. Even Antonio Maria Costa (executive director of the UN Office on Drugs and Crime) has identified the drug control system as having major unintended consequences: a huge criminal market, policy displacement (from public health to enforcement) and geographical displacement (the 'balloon effect'). Which begs the question, does a consequence remain unintended once it is identified? Shouldn't it now be admitted these are just further consequences of the war on drugs? And, if Costa can concede significant harms created by the war on drugs, doesn't this open the door to the drugs field to follow?

For too long the debate on prohibition and regulation has been ghettoised and marginalised. However, as Mark Easton (BBC Home Editor) said recently: 'The political mainstream still see no electoral advantage in even engaging with a debate on legalisation. When pressed, they predict disaster – more drug abusers and no drop in crime. But a view not so long ago dismissed as the province of weirdoes and wackoes, is slowly edging towards centre stage.' If Easton is correct, the drugs field will become increasingly important partners in both publicly critiquing prohibition's failings and presenting public health-based regulatory alternatives.

In truth we can only enable the wider public to see the war on drugs for what it is if the drugs field is willing to shine its own light. If we are not, in Chomsky's words, going to 'bring out the truth', we should consider very carefully indeed, in whose interest we are choosing the alternative.

Pride and prejudice

Access to healthcare for drug users is often riddled with prejudice, double standards and media-led moral panic, hear delegates at Release's Drugs, race and discrimination conference

'The medical profession is very good at making people feel guilty,' former GP and clinical lead for Turning Point, Somerset, Dr Gordon Morse told delegates in the *Access to health – unlocking the truth* session of the Release conference. 'Engendering guilt is a very useful device.'

The way the health service dealt with drug users was riven with prejudice, he said, and giving less importance and fewer resources to conditions deemed 'self inflicted' simply served to excuse inadequacies in services. 'The most dangerous prejudices are those which seem reasonable and fair,' he said.

Prejudice enabled people to feel better about the gap between their good fortune and others' misfortune – there were still thousands of doctors who refused to treat drug misusing patients, he said, using a range of 'seemingly plausible' arguments to justify their position. One was that if they started to treat drug-using clients, they would be 'swamped' by them. This was often a self-fulfilling prophecy simply because there were so few doctors dealing with the client group in many areas, he said.

It was easy to recognise the 'standard set of excuses' that health professionals employed to avoid treating drug users, said bloodborne virus team manager at East London NHS Trust, Mandie Wilkinson. 'They'll say "drug users don't turn up for appointments". Well, all sorts of people don't turn up for appointments – so the question then is "what can we do to improve access?".'

Drug users were an extremely mobile population, she said, and many services failed to update their records sufficiently, with appointment letters often sent to the wrong address. Services should ensure they have flexibility around appointments, make reminder phone calls and leave messages with hostels, pharmacies and needle exchanges, she said. They should also ask themselves whether their services are drug user friendly – would service users feel comfortable there?

Professionals were also put off by the fact that their clients knew much more about illegal drugs, their effects and the lifestyle that goes with them than they did, she stressed. 'My advice to healthcare professionals is "don't be scared". The best person to learn about drug use from is the patient.' This knowledge imbalance reversed the traditional 'powerful and controlling' relationship that doctors were used to with their patients, said Morse – another reason many GPs were reluctant to treat drug users.

Much of the moral debate around illegal drugs and the health service was fuelled by the media, said doctor and 'Bad Science' columnist for the *Guardian* newspaper, Ben Goldacre. 'It's very easy to do harm when you intend to do good,' he said. 'You have to be clear that you are speaking in line with the evidence.'

Media coverage of drugs issues amounted to little more than a 'desperate hunt for frightening statistics', very few of which stood up to any kind of scrutiny, he said. One example was a recent story that cocaine use had 'doubled in the playground'. The doubling was from 1 per cent to 2 per cent, but even this had been rounded up, he said – the actual increase was from 1.1 per cent to 1.4 per cent, and this was from small clusters of children in 30 different schools. 'The data couldn't possibly have been significant,' he told the conference. 'The story was total fantasy, but there was never any correction – it just stood, fomenting in people's minds.'

This was the typical media trick of using 'atoms of fake data to justify a moral position' he said. 'It happens in all kinds of different areas of politics – we like to reduce things down to molecules, rather than the complex social and political issues that we're all desperately trying to avoid talking about.'

Prejudice was not confined to wider health services – it also had a damaging effect on the drug treatment sector itself, said Morse, with the abstinence versus harm reduction debate undermining people's perceptions of the field. 'It's a war of ideology based on prejudice and it's deeply damaging,' he said. 'It makes the outside world think we don't know what we're doing.' The two entrenched lobbies were far from mutually exclusive and needed each other far more than they realised, he said.

'We'll never put an end to prejudice and discrimination, but we should at least be aware of our own,' he told delegates. 'We live in a world of guidebooks and evidence, but that's not always helpful when dealing with human beings. Our knowledge can be a prejudice, because it blinds us to everything else.'

Prejudices were gradually being overcome and myths debunked, but the 'good guys' were still a minority, he said. 'Prejudice dictates the sort of treatment someone gets, or whether they get treatment at all. When someone comes to us asking for help we're saddled with all kinds of beliefs and prejudices – our actions are governed by our own beliefs in what is right. It's never easy to cast our prejudices aside but we must never tire of trying to do so if our help is to be meaningful.' **DDN**

Sharing support

Peer mentors at Westminster Drug Project are discovering that helping others to take their first tentative steps towards recovery is having useful side effects for their own development

'A win-win situation' is how the volunteers at Westminster Drug Project referred to their experience on the peer-mentoring project. Speaking at the end of a celebratory summer tea party at the end of September, Rebecca, a mentor with the project, described how by helping other people she had benefited herself: 'It's built my confidence and boosted my self-esteem'. Her colleague Larraine agreed, 'it's a really good feeling, and clients are grateful for the help and advice we are able to give them.'

The A-Team (A is for advocacy) is a group of ex-service users trained to provide short-term, focused support and interventions with WDP's current service users. Established in January, and initially commissioned by Westminster DAT who provided six months funding for a peer advocacy service, the scheme has been continued and is now funded by WDP. In practice, it has helped supplement existing services for their clients.

Joe Vincent, WDP's volunteer co-ordinator, was involved in creating the scheme. He approached Westminster services looking for clients who had completed treatment and were suitable to become peer advocates. It was a route that enabled him to get the services buy-in from the outset, and made sure they were prepared to use the programme once the mentors were trained.

Training the volunteers meant looking at communication skills and helping participants to develop motivational interview techniques. It was important that they were equipped to help clients with trickier issues like conflict resolution.

The training took place over four weeks, with two sessions a week. 'We started with 24 potential advocates, and ran a group interview' Joe explained, 'at the end of the course we ended up with 12 really passionate volunteers'.

It was an intense experience, according to Ismail, one of the volunteers. 'But the good thing about it was that every one on the course got something out of it. No one's dropped out, they have gone into different areas.'

The 12 trained volunteers now work with clients to provide practical help and support. Mentors support clients in all kinds of ways, from being available on the end of a phone to accompanying them to interviews with housing and social services. 'Trivial stuff can become almost demonic' explains Ismail, 'so we help with basic stuff like filling in forms and making telephone calls.' While doing this the advocates find they are able to encourage clients to remain in treatment. 'We can share our experiences and inspire clients with how far we have come,' says Rebecca. Ismail agrees: 'It's not patronising, because we have been there.'

Clients are shared across the whole team, with referrals being taken by whichever mentor is available – a system that helps prevent overdependence by clients on particular advocates. While supporting the clients, the mentors themselves receive ongoing support from WDP, through regular contact with Joe and the team, as well as monthly clinical supervision sessions. They are encouraged to keep developing their skills through ongoing training; Larraine is among those doing more volunteer training although she is adamant she will continue working with the A Team.

All of the volunteers at the garden party were proud of what they have achieved and fiercely loyal to the project. Rebecca has gone back to college to train to teach adult literacy, but she is certain she wouldn't have been able to do that without her new-found confidence from working with the A Team: 'It's been a big help coming out of aftercare,' she explained. 'People who saw me back then see me now and can't believe how far I have come.'

Looking forward to the future of the project, Joe is delighted with the progress so far and would love to roll it out wider to train four teams a year. The momentum is easy to explain, he says: 'These 12 people have really inspired me.' **DDN**

> **'At the end of the course we ended up with 12 really passionate volunteers.'**
> **Joe Vincent, WDP's volunteer co-ordinator**

My favourite reads (part 5)

Professor Clark discusses another of his favourite books relating to recovery from substance use problems.

'...the client is a creative, active being, capable of generating his or her own solutions to personal problems if given the proper learning climate.'

In my last Background Briefing, I focused on two William White books that are classics in the field. In this Briefing, I describe another classic. While this book focuses on mental health and psychotherapy, the ideas it contains are of direct relevance to recovery from addiction and the treatment process.

How Clients Make Therapy Work: The Process of Active Self-Healing by Arthur C. Bohart and Karen Tallman

The authors of this book argue that the most important factor in making psychotherapy work is the active, creative involvement of the client. Clients are viewed as possessing self-healing capacities and resources that are responsible for the resolution of problems and for change in everyday life – and in any form of psychotherapy.

Clients, like all people, have a built-in capacity for learning and creative problem solving, which can help them overcome problems in their lives. The capacity for creative problem solving can be enhanced or supported – or limited or distorted – by the person's internal resources, and interpersonal and physical environments.

Their capacity for creative problem solving can also be limited by low self-esteem, feelings of discouragement, and a lack of hope.

Most people cope, survive and grow with challenges in their everyday lives without the help of a therapist.

Clients come for help with their 'problems' when their self-healing capacities or resources are inaccessible or blocked. Therapy is most effective when it makes use of these self-healing capacities and resources.

The most important thing that the therapist can do to be helpful is to find ways of supporting, stimulating, and energising client investment and involvement in the therapeutic process. The second most important thing is to stimulate client learning and creative problem solving.

The authors of this book view the therapist as a coach, collaborator and teacher who frees up the client's innate tendency to heal.

The therapist may use one of the major theoretical frameworks (*eg* cognitive-behavioural or psycho-dynamic), but the way their help is used will ultimately be determined by the client.

Clients know the intimate details of their problems and the intimate ecological connections that are created by their problems, and they have a sense of the factors that create the problems.

They also have a much more intimate sense of what is possible in their life space than does the therapist.

Clients actively translate the lessons and experiences of therapy into their life contexts. Therapists cannot expect a one-to-one translation of their technique and 'teachings' into client behaviour. Clients use their own idiosyncratic uses and understandings of whatever they have learned in therapy to help them deal with their problems.

This model of the client as a self-healer is in contrast to the medical model, which still dominates psychotherapy. In the medical-like 'treatment' model, the therapist is analogous to a physician.

He or she is an expert on the nature of the client's problems and on how to help alleviate these problems. He or she forms a diagnosis and then prescribes treatment, which consists of applying interventions appropriate to that diagnosis. These interventions cause change to the client, thereby alleviating the symptoms.

In their book, Bohart and Tallman provide a wealth of research evidence supporting the idea that the active efforts of clients are responsible for making psychotherapy work. They contrast their views with the medical model.

They emphasise the fact that differences in effectiveness between different therapeutic approaches have only infrequently been found. The self-healing tendency of the client usually overrides differences in technique or theoretical approach.

The authors describe the assumptions about clients, problems and change that underlie the self-healing model, and why clients come to therapy. They view therapy as a form of education and describe different ways therapy promotes self-healing.

They particularly examine how the provision of a basic empathic relationship can be helpful. Therapy is also viewed as a meeting of minds.

This book is essential reading for anyone working in the substance use treatment field. If you have any doubts about the relevance of this book, I remind you of a quote from the excellent book by Tom Waller and Daphne Rumball, *Treating Drinkers and Drug Users in the Community* (2004):

'Other people, however skilled they may be, never make a drinker or drug user better. It is always the client who does the work. Helping professionals can make assessments, point the way, offer suggestions, provide interventions tailored to meet a client's needs, give appropriate counselling, and do what they can to improve the client's environment, but success, when it comes, always belongs to the client, never to the professional worker.'

So think about this the next time you meet one of your clients. And think about the following excellent quote from Bohart and Tallman's seminal book:

'The client is a creative, active being, capable of generating his or her own solutions to personal problems if given the proper learning climate... therapy is the process of trying to create a better problem-solving climate rather than one of trying to fix the person.'

You can read 'the prof speaks out' blog at: www.davidclarkwired@blogspot.com

Concateno

Concateno is a global provider of drug, alcohol and blood borne virus testing and represents the combined expertise and product portfolios of Altrix Healthcare, Cozart, Euromed, Medscreen and TrichoTech.

Having expertise in all drug testing methodologies enables us to offer impartial, best fit solutions backed by unrivalled service and the highest levels of audited standards in the industry.

UK Drug Workers Forum

Meet us at the UKDWF conference in York on 14th & 15th October. This event provides an annual update for drug professionals and is aimed at all practitioners involved in drug service provision from drug agencies, drug action teams, youth offending teams, NHS workers, prison and probation services. Our team are supporting the exhibition and will be available on the Concateno stand to answer any questions.

drug testing

Your drug testing needs may vary dependant on the services you provide; we offer the widest best-in-class range of drug testing options available. Where a result is required immediately, we offer point-of-care solutions for both urine and oral fluid screening. Where accuracy and legal defensibility are more important than immediacy of results, our laboratory services provides UKAS accredited screening and confirmation.

blood borne virus screening

The NTA have set targets to establish viral infection amongst current or past injecting drug users. Concateno provides Blood Borne Virus screening via oral fluid (OraSure®) and dried blood spot testing, proven to make the screening of this hard to reach population an easier task. This service, which is provided in partnership with a CPA accredited laboratory, offers a screening service that is accurate, reliable and efficient.

Concateno provides the added benefits of free sample collection training, UK wide customer service and technical support, free awareness raising literature and a range of results delivery methods to suit your needs.

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C7150 Ed: 001

The Interventions and Substance Misuse Group, National Offender Management Service (NOMS), is holding a conference on best practice in tackling alcohol related offending. The focus will be on strengthening operational delivery across correctional services within the wider context of *Safe. Sensible. Social. The next steps in the National Alcohol Strategy.* Keynote speaker is the **Rt. Hon. David Hanson MP**, Minister of State, Ministry of Justice

ALCOHOL BEST PRACTICE CONFERENCE
TUESDAY 18th NOVEMBER 2008
Church House Conference Centre, Dean's Yard, Westminster, London, SW1P 3NZ

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

NATIONAL PROBATION SERVICE

ATTENDANCE IS FREE OF CHARGE. LUNCH AND REFRESHMENTS WILL BE PROVIDED. To apply for a place at the conference please contact Elaine Castle on 020 7217 8003 or email Elaine.castle3@justice.gsi.gov.uk. Closing date for applications is 31st October 2008

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We hope you found your Best Practice Bulletin enclosed in this issue of Drink Drug News, and that it was an interesting read.

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The 14th National Conference:
Working with Drug and Alcohol Users in Primary Care

Family medicine: from cradle to grave

Thursday 7 and Friday 8 May 2009 ACC, Liverpool

CALL FOR POSTERS, PAPERS, FILM AND OTHER MEDIA
For more information please contact Matt.
T: 020 8541 1399 E: matt@healthcare-events.co.uk

RCGP Royal College of General Practitioners

SMMGP

NCIDU08

National Conference on Injecting Drug Use

Monday 27th and Tuesday 28th October 2008

Novotel London West – Hotel and Convention Centre

A packed and varied programme with over 30 parallel sessions, meetings, poster presentations and films to inform practice, disseminate research, explore policy, and develop skills.

Conference highlights

The launch of the 2008 'Shooting Up' report
Vivian Hope, *Senior Lecturer, Centre for Research on Drugs and Health Behaviour and the London School of Hygiene and Tropical Medicine*

Speedball injecting
Neil Hunt, *Director of Research, KCA and Honorary Senior Research Associate at the European Institute of Social Services, University of Kent*

Hepatitis C risk and risk reduction – individuals and environments
Tim Rhodes, *Director, Centre for Research on Drugs and Health Behaviour, London*

Injecting injuries – problems and practicalities
Alison Coull, *Lecturer, University of Stirling and Specialist Nurse, Harm Reduction Team, NHS Lothian*

Contaminants and routes of drug administration – key points for harm reduction practitioners
Jenny Scott, *Lecturer in Pharmacy Practice, University of Bath*
John Ramsey, *Director, TICTAC Communications Ltd, St George's, University of London*

Teaching people to access veins – practical issues
Jacqueline Hough, *President, The National Association of Phlebotomists*

NICE guidance – what it said, how you responded
Mike Kelly, *Director, Centre for Public Health Excellence*

For full details, including online booking, see exchangesupplies.org

Mailing list
If you are not on our mailing list and would like to receive full details and a booking form, please click on the mailing list link on our website or call us on 01305 262244.

exchangesupplies.org
See the website for updates and programme details. We are committed to developing a permanent archive on our website of conference abstracts, reports, delegate lists, evaluations and powerpoint presentations from our conferences.

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FINDINGS

FRONTIER MEDICAL PRODUCTS
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Alcohol

The Debate

Liverpool, 6th November, 2008 The Liner Hotel, Liverpool
£225 plus VAT. Visit the HIT website for discounted prices

Confirmed speakers

Don Shenker
Director of Policy and Services Alcohol Concern

Professor Mark Bellis
Director of Public Health JMU

Councillor Warren Bradley
Leader of Liverpool City Council

Ernst Buning
Co-founder of IHRA

Bernard Hogan-Howe
Chief Constable Merseyside Police

Conference themes

Alcohol & Young people
Alcohol & Health
Alcohol & Public safety
Responsible Alcohol Industry
Role of Government
Alcohol and Housing

To register online or check on the latest speakers & news go to: www.hit.org.uk or call 0844 412 0972

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For more information on ALL our current vacancies or to apply online visit www.bournemouth.gov.uk

Bournemouth Borough Council

Community Care

DAAT Performance Officer - St Paul's Lane

Ref: SO0065, £24,545 - £27,594, 37 hours per week

Playing a central part within our successful Drug and Alcohol Action Team, you will help us deliver effective interventions every day. Experienced in managing and enhancing performance, you will be skilled in conducting needs assessments and analysing data, and capable of communicating productively at every level.

For an informal discussion contact Karen Wood on 01202 458740.

Apply online or an application pack may be obtained from Recruitment Team, 24-hour answerphone on (01202) 454775 or (01202) 458838. Alternatively, e-mail: recruitment@bournemouth.gov.uk

Closing date: 24th October 2008. This post is subject to a pay and grading review.

The Council is committed to achieving equal opportunities and a work life balance. Bournemouth Borough Council does not accept CVs without an application form.

Kent Drug and Alcohol Action Team (DAAT) and Kent Probation Area invite expressions of interest to tender for the Alcohol Treatment Requirement (ATR) Service.

Kent DAAT and Kent Probation Area are seeking expressions of interest from suitably experienced and qualified organisations to provide the ATR service across the West of Kent (within the geographical boundaries of the West Kent Primary Care Trust (PCT)). The service will be delivered from the 1st February 2009 until the 31st March 2011.

Expressions of interest are sought from providers who have previous experience in delivering this service as well as having a proven track record in working with the criminal justice sector including the Probation Service, the police and the courts.

Expressions of interest should be made **only** by visiting https://www.businessportal.sece.gov.uk and following the link to the South East Business Portal. The closing date for the expressions of interest is 19th October 2008 Tenders will be issued to applicants on 20th October 2008 and the closing date for receipt of tenders is 14th November 2008.

West Kent Primary Care Trust NHS

NATIONAL PROBATION SERVICE

Kent Drug & Alcohol Action Team

Kent County Council

Office Suite with therapy space available

Richmond, Surrey.
Call Ranjit on 020 8940 1160 or email
ranjit@addictionsupport.co.uk

www.addictionsupport.co.uk

Trevi

Trevi House set in the heart of Plymouth is a residential drug and alcohol rehabilitation centre for mothers aged 18+ with their young children.

Deputy Manager

£26,000 – 28,000pa

The Deputy Manager, reporting to the General Manager and working within the Trevi staff team, will provide inspirational leadership in the development, planning, delivery and monitoring of the therapeutic programme at Trevi House.

This post brings together responsibility for the training and development of staff in the therapeutic programme, as well as the monitoring and maintenance of service quality and standards of care. The post holder will work with the General Manager of to promote the achievement of the aims, objectives and values of Trevi. S/he will ensure that the provision of care is effective, relevant, and appropriate to the Trevi philosophy, the needs of staff and residents, and is of the highest quality. This post will make a significant contribution to the success of Trevi House, in terms of its service provision, its reputation (locally and nationally).

Candidates should have managerial experience, extensive knowledge from working with and counselling individuals experiencing substance misuse and related issues, an ability to network and collaborate closely with external agencies to move Trevi House forward professionally.

RMN, RGN or CQSW desirable, Counselling qualifications essential.
Email: claire@trevihouse.org for information and application pack.

Closing date: 21st October 2008. Website: www.treviproject.org

TORFAEN COUNTY BOROUGH | BWRDEISTREF SIROL TORFAEN

Invitation to Tender for the provision of an Adult Alcohol Treatment Service in Torfaen & Monmouthshire

Torfaen County Borough Council, acting on behalf of the Torfaen and Monmouthshire Community Safety Partnerships in Gwent, invites tenders for the provision of an adult alcohol treatment service.

The Service will deliver an adult alcohol integrated treatment system across the four tiers and around a stepped care model. This will consist of supporting providers at Tier 1 to screen target populations and facilitate treatment entry, providing a range of interventions of varying intensity according to client need across Tiers 2 and 3 including brief interventions, psychosocial interventions, case management, community detoxification and services for concerned others. In addition the Service will provide guidance, support and liaison for clients moving into Tier 4 services, where available.

The contracts are expected to be awarded for the period 1st April 2009 – 31st March 2012, subject to continued Welsh Assembly Government funding.

The indicative budget for the provision of the Service is approximately £400,000 (full year).

Organisations wishing to tender for this Service should apply in writing to Karen Jones, Substance Misuse Project Support Officer, Community Safety Team, Torfaen County Borough Council, Civic Centre, Pontypool, NP4 6YB. The closing date for the receipt of tenders is 12 noon on Wednesday 26th November 2008.

Sheffield City Council

Commissioning Manager

Vulnerable Children and Young People

Up to £40,101

Sheffield City Council is seeking a talented and motivated individual who can help deliver our objective to improve services for vulnerable children and young people.

Working under newly developed partnership arrangements with NHS Sheffield and other stakeholders, the successful applicant will be required to lead the development of commissioning strategies to support the Young People's Substance Misuse and Reducing Teenage Pregnancy Strategies.

If you understand the issues faced by vulnerable young people and their families, have a working knowledge of current policy direction, and are skilled in planning, initiating and evaluating service delivery, we would like to hear from you!

The successful candidate will be required to complete a Criminal Records Disclosure form in line with Section 115 of The Police Act 1997.

Sheffield City Council is currently undertaking a pay and grading review – as part of the review, the grade and salary for this post may be subject to change.

Closing date: 17th October 2008
Interviews: To be held week commencing 10th November 2008

Please quote relevant Post Ref: 1012CYSS

Please complete a form on-line at sheffield.gov.uk/jobs or Email hrfirstjobs@sheffield.gov.uk to request an application form or to submit a completed form. Alternatively telephone HR First on 0114 273 4677. Please quote the relevant post ref no. Can you please indicate on your application form where you saw the advertisement.

RBWM Drug & Alcohol Action Team

INVITATION TO TENDER – TIER 2/3 COMMUNITY SUBSTANCE MISUSE SERVICE

The Royal Borough of Windsor and Maidenhead Drug and Alcohol Action Team would like to invite expressions of interest from suitably experienced organisations to deliver a Tier 2/3 Community Substance Misuse Service. The service will include: Psychosocial Interventions, Drop-in, Needle Exchange, Support and Alternative therapies for stimulant users and Aftercare for adults and young people.

The contract will commence on 1 April 2009, or as soon as possible thereafter, and will be for a three-year term.

Applicants will, in the first instance, be required to complete a pre-qualification questionnaire, which will detail their financial status, resources, experience of similar work, Health and Safety Policies, Equal Opportunities Policies and Environmental Management Systems.

The deadline for receipt of expressions of interest is **3 November 2008**.

Applications should be made to:
Di Wright, DAAT Manager & Commissioner, 3rd Floor, St Mary's House, High Street, Maidenhead, Berkshire SL6 1PZ
Tel: 01628 796617
Email: di.wright@rbwm.gov.uk
Mobile: 07711 588058

The Royal Borough Windsor & Maidenhead

Aquarius – a great place to work

We pride ourselves in providing quality services for people affected by alcohol, drugs and gambling

AQUARIUS

Area Managers

Ref: HO/08/35

37 hours per week
Salary £37,543 to £40,099

We are looking for two highly motivated and committed people for our new Area Manager posts to be part of the Senior Management Team.

The post holders will be responsible for service delivery and development and contributing to the strategic vision of the organisation.

Closing date Friday 24 October 2008
Initial interviews will be held on either the 4 or 6 November 2008
Second stage interviews will be held on Tuesday 18 November 2008

Alcohol Practitioners

We are also looking for enthusiastic staff to fulfil a range of Alcohol Practitioner posts. Please see our website for full details.

An enhanced CRB check will be required for all posts.

Application packs can be downloaded from our website www.aquarius.org.uk or email human.resources@aquarius.org.uk quoting the appropriate reference code. Alternatively write to: Rachel Stubbs, Aquarius, 2nd Floor, 16 Kent Street, Birmingham, B5 6RD

Overcoming the harm caused by alcohol, drugs and gambling
Aquarius – actively working towards equality in employment and service delivery. Aquarius Action Projects is a Registered Charity No 1014305.

INVESTOR IN PEOPLE

Brighton and Hove City NHS
Teaching Primary Care Trust

Tender for Drug and Alcohol Misuse Services

Brighton and Hove City Teaching PCT invite expressions of interest from suitably qualified and experienced healthcare providers for the provision of drug and alcohol misuse services.

Contract duration is 2 years with an option for a 1 year extension. Planned date for service commencement is 1st April 2009.

The key elements of this contract are:

Tier 3 Drug Treatment Services

To include –

- Specialist Community Prescribing, GP Prescribing Support.
- This service will deliver the 'Vital Sign' target of increasing the number of drug misusers in effective treatment.

Community Alcohol Team

To include –

- Services for severely dependant drinkers, services for moderately dependant drinkers.
- The contract may also include liaison and brief intervention alcohol services for patients in the local acute trust.

These services will make a significant contribution to the vital sign target of reducing alcohol related hospital admissions, including the targeting of alcohol related domestic violence and prolific offending.

For further information about this contract and the procurement process see *www.brightonhovecitypct.nhs.uk/healthprofessionals/tenderscontracts/index.asp*

Those wishing to submit an Expression of Interest in tendering are required to do so by 10th October 2008

To register your interest and obtain a copy of the PQQ please contact: maryjayne.bosley@bhcpct.nhs.uk

Bristol City Council

Approved provider of Tier 2, 3, & 4 (excluding Residential Rehabilitation) Substance Misuse Services in Bristol

Ref: Drug Strategy/1643

The closing date for the completed submission is 12 Noon 11th December 2008.

For further information and to apply to be on the approved provider list, please visit the Bristol e-Procurement Systems (BEPS) web site at: https://procurement.bristol.gov.uk/suppliersselfservice/

BRISTOL CITY COUNCIL

Reducing harm caused by substance misuse

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

Project Co-ordinator Ref: PC01

£29,728 - £32,436 pa (SCP 37 - 40)
Kirkby CDT, Knowsley 35 hrs pw

This key role will manage the day to day running of an integrated Tier 2 and Tier 3 community drugs team. Working under the Knowsley Area Manager you will have responsibility for overseeing all day to day operations including the supervision of staff.

With an understanding of performance management you will oversee all data input relating to performance monitoring, supervise clinical sessions and be responsible for all health and safety issues paramount to the running of a stand alone service. With supervisory experience you will proactively facilitate and action plan weekly team meetings, manage staff and continuously improve service delivery. The ability to interact confidently with professionals and the client group, relevant experience within both Tier 2 and 3 services and a wide knowledge of the drug service provision is essential. You will also be expected to take part in the 'Out of Hours' duty rota.

In return Lighthouse Project offer 30 days annual leave rising to 35 after 5 years service, free Life Assurance and a commitment to your ongoing personal development.

Interviews will take place on the 23rd and 24th October 2008.

To apply please download an application form from www.lighthouseproject.co.uk

Alternatively, please email: recruitment@lighthouseproject.co.uk or send a large s.a.e (65p) quoting the job ref number to Lighthouse Project, Sefton House, Bridle Road, Bootle, Liverpool L30 4UG.

Application forms must be submitted to Human Resources before 12.00 noon on Monday 20th October 2008. CVs will not be accepted.

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

Lighthouse Project Registered Charity No: 519859

www.lighthouseproject.co.uk

Knowsley NHS Primary Care Trust

lighthouse project

NHS Cumbria Tel: 01228 814805 NHS

NHS CUMBRIA ON BEHALF OF THE CUMBRIA DRUG AND ALCOHOL ACTION TEAM PARTNERSHIP

TACKLING DRUGS CHANGING LIVES
Cumbria Drug and Alcohol Action Team

Cumbria Drug and Alcohol Action Team (DAAT) is the strategic partnership responsible for the delivery of the national drug and alcohol strategies in Cumbria. We are committed to working together to achieve a major reduction in the harm caused by alcohol and drug use in our County. We are recruiting to the following posts to help us to meet that commitment.

GENERAL MANAGER

- AfC Band 8a £37,106 - £44,527 p.a. • 37.5 hours per week
- Based at Penrith (to be agreed) • Permanent • Ref: 552-C245-08-PCT

This is a strategic leadership role which ensures effective partnership responses to substance misuse across Cumbria. It involves bringing together the work of a range of partner organisations and service providers, and the effective management of DAAT resources. A key responsibility is to drive the implementation of the new Cumbria Alcohol Strategy. You will be experienced in partnership working and commissioning at a strategic level.

SERVICE IMPROVEMENT MANAGER

- AfC Band 7 £29,091 - £38,352 p.a. • 37.5 hours per week • Based at Penrith (to be agreed)
- Permanent • Ref: 552-C246-08-PCT

You will be responsible for implementing improvements in the efficiency of the drug and alcohol treatment systems, placing users and carers at the heart of this, ensuring good value for money, and achieving high performance through the commissioning process. You will be experienced in service development, project management and service commissioning.

For informal enquiries on both posts please contact Vernon Watson on 01900 324237 or email vernon.watson@cumbriapct.nhs.uk

In order to improve efficiency, candidates applying via NHS Jobs will be called to interview by e-mail. Would you therefore please monitor your e-mails regularly following the closing date

Closing date for both posts: 24 October 2008.

APPLICATION INFORMATION

Apply online now at **www.jobs.nhs.uk**

Alternatively, application forms and job descriptions are available from The NHS Cumbria Recruitment Team, Cumbria Health Employment Services Bureau, 4 Wavell Drive, Rosehill, Carlisle, Cumbria, CA1 2SE, 24 hour recruitment line 01228 814805. Please quote the reference number.

We are committed to Equal Opportunities, Improving Working Lives and operate a No Smoking Policy.

For more details on these and other vacancies please visit:
www.cumbria.nhs.uk

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

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

Closing date: 20 October 2008.

Blenheim CDP: Registered Charity No. 293959.

Data and Performance Co-ordinator

£27,724 - £30,773 pa

Blenheim CDP is one of London's leading drug agencies, running over 15 different treatment services in the Greater London area. This is a new role that will work across all our services providing general data monitoring, analysis and systems compliance.

You should have excellent numerical skills underpinned by the ability to analyse complex data, report on your findings and present this in a clear and understandable way to a range of internal and external audiences. **REF: BCDP/22/DDN**

Project Worker (Temporary to 31/3/2009)

£25,301 - £28,499 pa **Novo - Lewisham SE8**

Novo is a partnership with Equinox Care, providing a multi-disciplinary stimulant service for the London Borough of Lewisham comprising direct access, outreach and structured interventions.

You should be able to engage effectively with service users dealing with their presenting needs, give harm reduction advice and work with them to address their drug using behaviour. You must demonstrate a proven ability in outreach, keyworking, assessment and care planning and groupwork. **REF: BCDP/23/DDN**

www.blenheimcdp.org.uk

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