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Drink and Drugs News
10 March 2008
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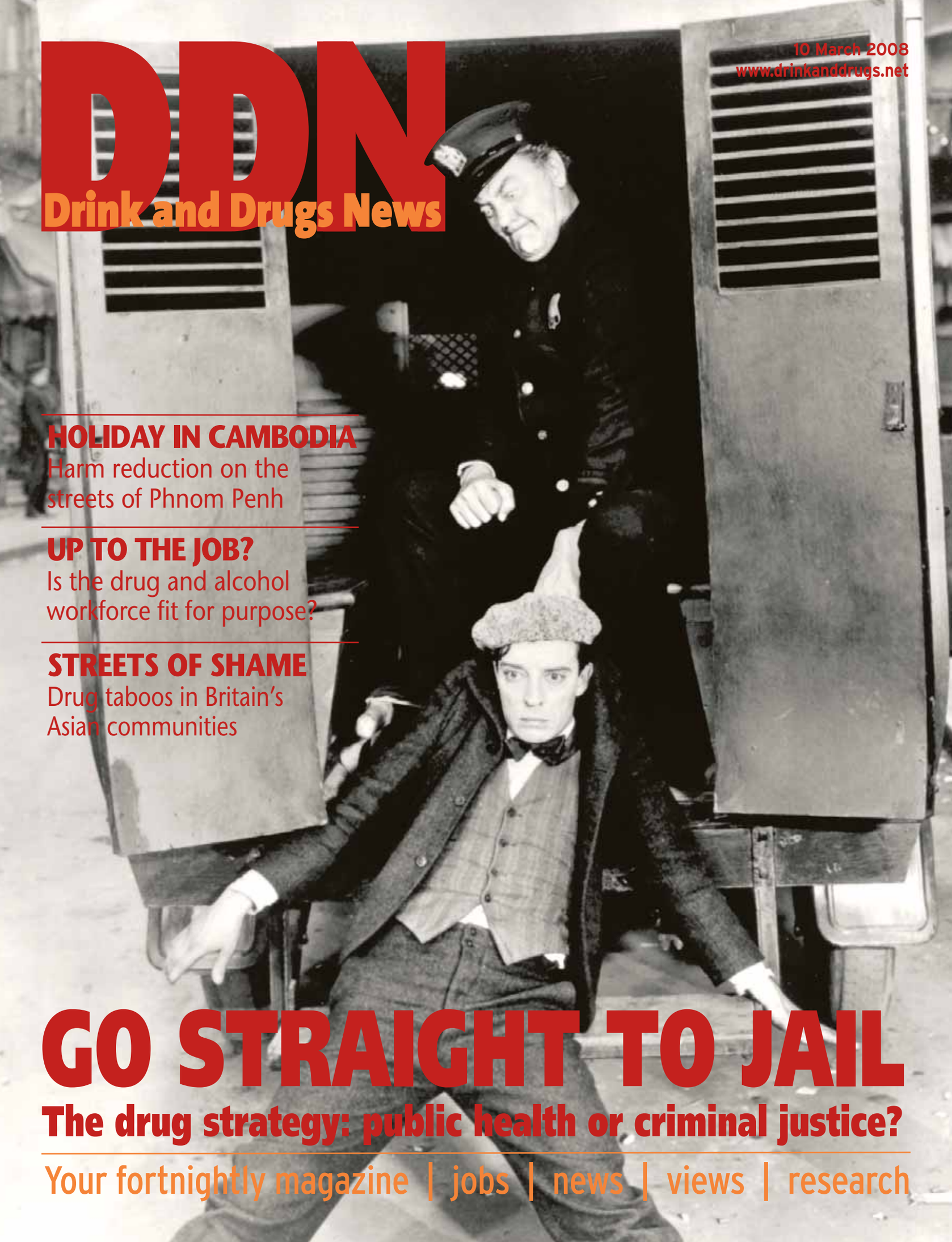

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Drink and Drugs News

10 March 2008

Editor's letter

The new ten-year drug strategy's out – and yes, it's a serious business. There's some essential paperwork to prove it: not just the detailed strategy itself, but also the report on the consultation which gives vital clues on whose comments and suggestions made it to the strategy document. The accompanying action plan gives the timescale for key actions (some on the horizon, and some way off in the no-man's land of beyond the next election) and says who – for the moment at least – is responsible for delivery.

It's a lot to take in, and initial reactions have tended to land squarely on the headline grabbing bits. Most people I've spoken to haven't had chance to read the strategy in detail yet, and have only had time to read press coverage of the bits that concern them – which is what gave us the idea of presenting key points from the strategy as a game, on page 6-7.

The issues are serious, but this will give you an at-a-glance round-up until you have time to read the full document. Everyone affected by the drug strategy needs to know what's in it sooner rather than later – how else will we keep abreast of the many timings in the action plan? 'Getting tough' seems to have won the headlines again, obscuring some gems of progress, particularly on family support.

The commitment to helping drug users get into treatment and reintegrate into society are among the strategy's most important elements, but they have been swept into the coercion bag. Everyone understands the need to get vulnerable people into treatment, but why – when launching a strategy with input from right across government, including the Department of Health – focus on the threat of removing financial support?

Of course public health does not grab headlines like removing 'bling' from drug dealers. But we have to make sure that the daily headlines for those working in the drug and alcohol field – the increase of bloodborne viruses; rocketing rates of liver disease – do not get lost in the noise of the crowd pleasers.

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In this issue

Next issue out on 7 April. Happy Easter!

'Support' and 'responsibility' the twin focus of new ten-year strategy

The government's new ten-year drug strategy offers support to substance misusers in return for responsibility on their part, according to prime minister Gordon Brown.

Among the key policies of *Drugs: protecting families and communities* are using the benefit system to 'reintegrate people into society' and examine how claimants can be 'incentivised' to engage with treatment services, making sure arrangements are in place to refer people from job centres to advocacy, treatment and housing advice, prioritising parents' access to treatment where children are thought to be at risk and more support for grandparents bringing up the children of substance misusers.

'It is based on the principle that with rights to state support comes responsibility – responsibility not just to look for work, not only to get the skills necessary to get into work, but now to rid yourself of drug addiction,' said the prime minister. 'And in return there will be targeted support to help you help yourself.'

In terms of criminal justice, powers to seize the assets of drug dealers are to be extended, prison treatment improved, use of community sentences with a drug rehabilitation requirement increased and efforts made to target drug-misusing offenders causing the most crime. Improved public information campaigns and community engagement are also promised. NTA chief executive Paul Hayes said the strategy demonstrated that 'treatment is at the heart of the government's approach to protecting families and communities from the damaging effects of drug misuse'.

The threat of benefit cuts, however, has been criticised by the field as ill-thought out and 'headline grabbing'. Addaction said it was difficult to see how it would work, while Turning Point warned of 'unforeseen consequences' on health and crime. 'We would want to see clear evidence from pilot programmes that such a policy would keep people in treatment and would not lead to problems becoming more intractable,' said spokesperson Harry Walker, while DrugScope said such announcements did nothing to tackle the problem of stigma. Transform branded the strategy 'a miserable regurgitation of past mistakes', and agencies also called for improvements in funding, joined-up working and closer integration with efforts to tackle alcohol-related harm.

The new drug strategy is online at http://drugs.homeoffice.gov.uk/drug-strategy
For a look at detail of the strategy, see page 6.

True cost of drugs more than £100bn, says Addaction

The cost of substance misuse-related crime over the ten-year period of the government's previous drug strategy (1998-2008) was £100bn, and the total health costs £10bn, according to a briefing compiled by charity Addaction to coincide with the launch of the new strategy.

The information in *Financial costs of addiction* is culled from official figures on primary, A&E and community care, criminal justice procedural and prison costs, acquisitive crime costs and state benefits among others and is, says Addaction, 'probably at the low end' of the true figures. While there have been high levels of investment in drug treatment, much of this is wasted because of the lack of employment, training and housing opportunities for those completing it, it says.

Estimating the number of problem drug users in the UK at 327,000, the briefing works out the cost of drug-related crime and medical treatment at around £44,000 per problem class A user. 'If just 100,000 problem drug misusers were able to break free from drug use and get back into the labour force this would generate £750m a year in additional taxes to the economy,' it says. 'We estimate that for every £1 spent on treatment £36 is spent on paying for the consequences of not treating problem drug users.'

'Many of the millions spent by the government on dealing with the consequences of the illegal drugs trade could be recovered if drug users were given a better route out of a life dependent on drugs,' said chief executive Deborah Cameron. 'We have to ensure drug users get help but also a roof over their head and the chance of a job or training.'

Available at www.addaction.org.uk/Briefing-financialcostsofaddiction.pdf

'21 minute' drinking culture

The average opening hours of licensed premises since the advent of the '24 hour drinking culture' have increased by just 21 minutes, according the government's first review of the impact of the 2003 Licensing Act.

The overall volume of crime and disorder has remained stable and there has been no increase in alcohol consumption, according to the Department for Culture Media and Sport.

There are now 470 premises with a 24-hour licence but the review states that 'there is no evidence that more than a handful operate on that basis'. Alcohol-related violence has, however, increased in the hours between 3am and 6am and some communities have seen increases in disorder, it acknowledges.

The introduction of the Act had not led to the widespread problems that some had feared, said secretary of state for culture media and sport Andy Burnham, in a written ministerial statement. 'Our main conclusion is that people are using the freedoms but are not sufficiently using the considerable powers granted by the Act to tackle problems, and that there is a need to rebalance action towards enforcement and crack down on irresponsible behaviour.'

There would be more instant closures of problem premises, and the offence of 'persistently selling alcohol to a person under 18' would be changed from 'three strikes' to two in three months, he said. There would also be a 'yellow card and red card' system – the first putting the premises on immediate probation with sanctions, and the second withdrawing the licence. Legislation to increase the fine for not obeying an instruction to stop drinking in a designated public place to £2,500 would also be brought forward, he said.

Alcohol Concern responded by saying they wanted to see the Act amended so that licensing decisions are more informed by public health information like A&E and treatment data, allowing additional licences or extensions to be refused if alcohol-related harm was a concern. It also calls for measures to raise awareness of reviews and complaints procedures among residents.

'Alcohol Concern does not disagree with the extension of licensing hours *per se*, but we do have outstanding reservations about the lack of community safeguards and serious misgivings about the extent to which public health is being ignored as a licensing concern,' said director of policy and services, Don Shenker. 'Our review finds a policy dangerously tilted towards the needs of the drinks industry.'

Review available at www.culture.gov.uk/Reference_library/Publications/archive_2008/evaluation_licensing_act_impact.htm

Alcohol concern's analysis of the Act, Licensing 2003: a lopsided policy available at www.alcoholconcern.org.uk

Improve access to treatment and seize dealers' assets, says INCB

Governments of member states have been urged to widen access to drug treatment by the UN's International Narcotics Control Board's (INCB) annual report. They are also 'strongly' urged to implement legislation allowing for drug traffickers' assets to be seized and look at options of mandatory treatment as an alternative to imprisonment.

The report calls on governments to apply the law proportionately when prosecuting people for drug-related offences, criticising countries that expend 'disproportionate effort in targeting low level offenders and drug users' as opposed to large scale traffickers. But at the same time as stressing the need for alternatives to prison and improving access to treatment, it warns against being lenient with high profile celebrity drug users.

'Celebrity "endorsement" of drug-related lifestyles is particularly relevant when it comes to the issue of deterring drug use among youth, who are often most vulnerable to the cult of celebrity and its attendant glamour,' it says. 'Young people are quick to pick up on and react to perceived leniency in dealing with such offenders. This raises questions about the fairness of the justice system and could undermine wider social efforts at reducing the demand for drugs.'

The report also offers a regional breakdown across member state areas. West Africa is 'rapidly developing into a major smuggling route for cocaine from Latin America through and into Europe' it says, something that countries there are largely powerless to tackle. It also calls on Afghanistan to do more to address its growing heroin production, and for other governments in Asia to strengthen controls on the smuggling of acetic anhydride, the main chemical used to manufacture heroin. This is readily available in Afghanistan, which has 'no legitimate need' for it, it says.

'In looking at the world's drug problem, two areas are of particular concern,' said INCB president Dr Philip Emafo. 'First, criminal organisations are taking advantage of loopholes in the control systems in Africa and west Asia for chemicals used in illicit drug manufacture and are in the process of establishing trafficking hubs for chemicals in those regions. Also of concern is the establishment of trafficking routes for cocaine between countries in South America and Africa. Countries affected by these developments should introduce appropriate measures to prevent their territories from being exploited as centres for criminal activity, possibly with the assistance of richer countries in a spirit of shared responsibility,' he said.

Any suggestions that the world's drug problems would be resolved by legalisation 'ignore historical facts', he added. The INCB is made up of elected members and is independent of governments and of the UN, however it was recently criticised in a report by the International Harm Reduction Agency (IHRA) for being secretive and failing to modernise its processes (*DDN*, 25 February, page 4).

Report: www.incb.org/incb/en/annual_report.html

Focus on diversity and Tier 4 services

Diversity and Tier 4 service provision are the focus of the National Treatment Agency's (NTA) 2007/08 service review, the NTA and Healthcare Commission have announced.

The aim of the review is to deliver independent assessments of the quality of services in each DAT – or equivalent – area, and improve them where necessary. Previous reviews have focused on commissioning systems, harm reduction, community prescribing and care planning.

Among the review's specific aims are to determine whether commissioning partnerships carry out effective needs assessments and treatment planning which responds to the needs of diverse populations, and whether access to Tier 4 services – inpatient detoxification and rehabilitation interventions – is 'prompt and flexible.'

Details at: www.nta.nhs.uk/areas/standards_and_inspections/2007-08_review/docs/assessment_framework_0708_diversity_tier4.pdf

Community cash boost for Welsh strategy

An extra £9.35m for community safety partnerships has been promised as part of the Welsh Assembly Government's next substance misuse strategy.

The increase in funding aims to cut waiting lists and improve children and young people's services. The strategy, *Working together to reduce harm*, will address both drugs and alcohol.

'Community safety partnerships are in the best position to deliver local solutions and services to tackle substance misuse in their areas,' said minister for social justice and local government, Dr Brian Gibbons. 'The extra funding will mean that the partnerships will be able to focus on delivering the key priorities in the new substance misuse strategy which is out for consultation at the moment.'

Consultation closes on 13 May. Available online at www.wales.gov.uk/substancemisuse

News in Brief

Needle exchange news

The National Needle Exchange Forum (NNEF) holds its annual meeting on Friday 4 April at the Enterprise Conference Centre in Derby. The event is free for all NNEF members and a packed agenda will include presentations on latest harm reduction interventions and regional updates from across the country. The NTA will reveal new initiatives on needle exchange, and invite discussion. For more information on NNEF and the meeting, contact Ruth Goldsmith at DrugScope at 020 7940 7517 or email ruthg@drugscope.org.uk

Probation packs

A new alcohol information pack to help identify offenders on probation with alcohol-related needs, deliver brief interventions and offer support and referrals has been launched by the National Offender Management Service (NOMS). The Alcohol information pack for offenders under probation supervision, developed by NOMS' substance abuse unit in partnership with Alcohol Concern, includes sections on specific offender groups, routes into treatment and an alcohol screening tool. Available at http://noms.justice.gov.uk

Young booze busters

A new interactive online campaign to raise awareness of the dangers of alcohol misuse among young people has been launched by the Greater Easterhouse Alcohol Awareness Project (GEAAP). By completing online alcohol-related quizzes on the Young Booze Busters website, 9-17-year-olds can unlock games, compete against each other and enter a prize draw to win an iPod every month. 'Our intention with this site is to enable young people across the country to access clear, factual information about alcohol in a fun interactive way,' said GEAAP project manager Stewart McKay. www.youngboozebusters.co.uk

Cracks in the system

The 'largest police offensive against drug dealers ever seen in London' in 2000 and 2001 had no major impact on the availability of crack, according an article from issue 7 of Drug and Alcohol Findings magazine, now available online for the first time at http://findings.org.uk/issuesResults.php5?issueChoice=issue+7. Despite more than 1,600 arrests, there was also no indication that Operation Crackdown had any effect on robberies and burglaries in the areas targeted. To access a wealth of archived features visit: http://findings.org.uk/index.php

Last orders

More and more people in their 60s, 70s and 80s are accessing alcohol detox and ongoing treatment, according to The Linwood Group chain of treatment centres. It can be hard to spot of symptoms of dependent drinking in older people as they can be mistaken for general symptoms of aging, according to Linwood's director Sue Allchurch, who cites fragmented families and difficulties adjusting to retirement as primary causes for older people drinking more. 'Combine boredom, loneliness and the worry of getting older and you have the perfect formula for someone to turn to drink,' she says.

The Drug Strategy Game

HOW TO PLAY:
Choose which government character you would like to be, roll the dice and you're off!
The winning player is the first to get through the strategy objectives without too much consultation.

START

1 New asset seizure powers would demonstrate that 'crime doesn't pay', says government, which wants to extend police powers so they can seize dealers' cash and assets – 'their "bling", plasma screens and other household goods' – at the point of arrest before they get chance to disperse them. But seizing anyone's assets before they are even charged, let alone convicted, marks a 'radical departure within the traditional principles of British justice, where one was innocent until proven guilty,' says Release. The government aims to be recovering £250m a year in criminal assets by 2010.

Go back to the start

12 Alcohol has again taken a back seat, despite consultation responses calling for a 'substance misuse strategy' that would support service providers in helping clients address their alcohol and tobacco use. The strategy declares a continued focus on heroin and crack use but does not prioritise alcohol – surprising considering the high proportion of drug users, particularly cocaine users, that are identified as problem drinkers. The consultation highlighted 'weak and inconsistent links' between drug and alcohol strategy.

Go back 2 spaces

13 Focusing on enforcement will increase stigma instead of removing it, many fear. The strategy will stigmatise users even more and penalise those in the worst situation, say contributors to the Alliance's online forum. 'How can you effectively tackle the stigma of addiction when the government sets out to alienate those people brave enough to try to sort there lives out?', asks one. 'The stick of coercion and threats to remove benefit will be counterproductive without tackling the reluctance of employers to recruit former drug users,' commented DrugScope chief executive Martin Barnes. Pointing out that stigma is a major barrier to drug users and their families getting access to services, housing and employment, he added: 'We can see nothing in the strategy document that will directly address this important issue.'

Roll a 1 to finish!

11 Demand for more and better evidence to underpin drugs strategy has led to the promise of a 'cross-government programme of research and pilot programmes' to determine what works. Roger Howard of the UK Drug Policy Commission is among those calling for solid evidence that using benefit sanctions to get people into treatment would not produce unintended consequences.

Move on 2 spaces

10 Drugs education will begin earlier in schools – 'from when they enter school at four or five' according to children and families minister Kevin Brennan. The Home Office's FRANK campaign (which received some strong criticism in the strategy consultation) will be adapted to complement wider drug education objectives and the website will become a portal for young people to access drug treatment or targeted support. Local partnerships will be encouraged to run local drug awareness campaigns and schools and parents will be offered help in preventing drug, alcohol and volatile substance use. Drug Education Forum chair, Eric Carlin, commented: 'It is going to be important for the government to get it right when talking to parents, schools, and others who deliver drug education about what evidence says is effective, and to tie this to the wider public health agenda.'

9 Workforce competence is highlighted as essential to the strategy's success. 'Developing a competent substance misuse workforce, including both generic and specialist practitioners is crucial to ensuring a high standard of service delivery,' it says, putting the onus on local areas to make sure they have adequate numbers of appropriately skilled staff that also reflect the diversity of the local population. FDAP's chief executive Simon Shepherd commented: 'I am delighted to see that the new strategy recognises the critical need for a highly skilled workforce.'

Move on 1 space

8 The wider public health agenda has been sidelined in favour of the emphasis on enforcement, despite calls from many organisations in the field – among them the Drugs and Health Alliance, formed last year by a group of organisations and individuals to call for public health and harm reduction to be put at the heart of UK drug policy. Despite worrying trends in the increase of bloodborne viruses such as HIV and hepatitis C (nearly half of injecting drug users in the UK are infected with hep C) the strategy fails to address the situation. Release called 'sinister' the 'idea that enforcement tactics leading to an increase in drug prices act as a form of harm reduction'.

Roll a 2 to continue

2 The drug treatment system will be better tailored to meet young people's needs – and this will involve families wherever appropriate, says the strategy. A new Parent's Partnership will bring together children's charities and parents' groups to support parents with information. The strategy emphasises early intervention: Drug-misusing parents will have rapid access to treatment to reduce risk to their children; at-risk families will be offered interventions and support; and kin carers such as grandparents will be eligible for local authority payments and information to help them with their role. Treatment charity Addaction welcomed the commitment to this vital work but added: 'We urge the government to match this important pledge to support families with the resources needed to back it up.' Adfam chief executive Vivienne Evans was pleased to see 'children at the heart of the strategy, and that many of the Hidden Harm recommendations have been embraced'.

3 The strategy declares a new focus on re-integration through treatment, training and employment – 'joint working across institutional boundaries' – and will use various funding streams alongside the Pooled Treatment Budget to support local partnerships. For instance, the Working Neighbourhoods Fund will support 87 local authority areas to tackle low levels of skills and enterprise over the next three years. Pilot projects will look at managing clients' journey through treatment into work and help them 'access the wider support they need to re-establish their lives'. The RSA Drugs Commission responded favourably to a strategy whose 'most promising features lie in helping users reintegrate into society, and making drugs a genuinely shared responsibility across government'.

Move on 2 spaces

14 Congratulations!!!!

You have won the war on drugs. Play the game again in 2018.

4 This strategy will ensure that treatment is more personalised and tailored to suit individual needs,' said Health Secretary Alan Johnson, acknowledging that 'every drug user is different'. Responding to concerns that too many drug users relapse, do not complete treatment programmes, or stay in treatment too long before re-establishing their lives, the Department of Health will look at barriers to treatment for those with mental health problems, clients from minority or under-represented groups, or those who have particular problems accessing services, such as drug users with children. An equality impact assessment attempts to address diverse needs as raised during the consultation and identifies the need for imaginative approaches in reaching all areas of the population.

Move on 1 space

5 Drug-misusing offenders will be given 'tough choices to change their behaviour or face the consequences', with more offenders brought in contact with the DIP programme and its powers of drug testing on arrest, a required assessment, and restrictions on bail. The Ministry of Justice aims to use more community sentences with Drug Rehabilitation Requirements (DRRs). Improvements have been promised to prison drug programmes, including a pledge to bring prison clinical drug treatment 'to at least a minimum evidence-based standard across all prisons' by 2011. The Ministry has also pledged to look at the potential for offering more community-based sentences for substance misusers as an alternative to prison.

Miss a turn

6 The benefits system will be used to tackle the 'formidable social problem of drugs' with a 'more personalised approach'. Drug users who claim benefits will be required to attend an assessment by a specialist treatment provider; if they don't, they could risk having benefits cut – 'the first steps to ensuring the benefits system gives people the access route off drugs while making sure taxpayers' money is well spent,' according to Work and Pensions Secretary James Purnell. The initiative has been dismissed by many as political posturing. Drug advocacy charity, the Alliance, were among those to say coercion would not address the barriers that prevent people from entering treatment and the workplace, and could drive more people to crime. Release added that the punitive approach simplified addiction and could seriously compromise the trust between drugs worker and client, if the worker was obliged to contact the Department of Work and Pensions about any failure to attend.

Go Back 4 spaces

7 Work with international partners will be stepped up to disrupt drug smuggling, 'dismantle serious and organised crime' and intercept drugs before they reach the UK, including drug screening at overseas airports. Dealers will be targeted at home through local campaigns such as 'Rat on a Rat', where communities can report dealers anonymously in their area. People are sick of drug dealers driving their flash cars around the estate, says minister Vernon Coaker. 'We're going to make sure our role models are decent hardworking people.' Dealers will be issued with ASBOs after conviction to stop them from re-establishing their businesses.

'I am constantly faced with... discrimination from people. I am determined to succeed and have a successful career. In response to Mr Hayes, I feel that he is the one who needs a reality check, as I am a prime example of someone who has turned their life around and battles on a regular basis against prejudice, due to past mistakes.'

Hayes reality check

I feel the need to respond to Paul Hayes' comments (*DDN*, 25 February, page 9): 'Reject the victim label, but also the fantasy that if everyone would stop stigmatising you everything would be alright. Get active, and with a hard-headed reality of the society you are operating in. Be an activist and a realist – then you have real opportunity.'

Firstly, I have been clean now for seven years, and off methadone for four years. I am a parent and have worked hard to gain a place at university, doing a social work degree. I am now finishing my final year, and due to having a criminal record from my using days, I am finding it very difficult to find employment.

I know that this is not me feeling sorry for myself; it is in fact facing the reality that many agencies (statutory) are not interested in employing ex-users. Recently I had an interview for my local authority regarding my final year practice placement. I was successful at interview and offered the placement. However, when I had to explain my criminal record and how I used to suffer with heroin dependency, I was told that I was no longer suitable. Apparently I had been assessed as being 'vulnerable'.

I am constantly faced with this type of discrimination from people. I am determined to succeed and have a successful career. In response to Mr Hayes, I feel that he is the one who needs a reality check, as I am a prime example of someone who has turned their life around and battles on a regular basis against prejudice, due to past mistakes.

I can indeed sometimes understand why some service users feel that there is no point in changing, as I thought I had won the battle by staying clean. However, the real battle begins when you have to constantly fight for your rights to be treated as an equal, especially when you work hard to achieve a career and are constantly faced with brick walls.

Hayley Brooks, by email

Change benefit to support work

Northern regional social inclusion and drugs charity Developing Initiatives Supporting Communities (DISC) welcomes the focus on community education, awareness and integration in the government's new ten-year drug strategy.

This is essential if drug users are to have a chance to build on the successes they gain through completing treatment programmes. They need support and understanding from communities and employers, and opportunities to realise their potential – something DISC has always felt passionate about.

If the government really wants to get people into employment, the single most effective thing they could do is to allow people to make a transition to working one, then two, then three days a week, as their confidence and ability grows. The current benefits situation makes this impossible.

DISC also welcomes the strategy's recognition of the need for a wide range of support for families and children in difficult situations. The damage done to young people who live with daily substance misuse is phenomenal.

Now resources are needed to develop innovative services and deliver drug education that is flexible enough to engage with the most at risk groups, who often miss out because of their poor school attendance. We must make sure the opportunities to commission through Children's Partnerships are not missed, and that this issue is recognised as a joint responsibility.

Thirdly the piloting of individual budgets could provide a key way of giving people choice and control over their treatment package in the future, and we await developments with interest.

Avril Tully, DISC drug service operations director, Co Durham

The real culprits

Peter O'Loughlin is right to draw attention to the bias in the IHRA report on human rights and the death penalty. Adults who, for money, traffic in toxic drugs – in the full knowledge that the substances from which they are profiting can addict, bankrupt, criminalise, poison and even kill more than the end users – deserve little pity, with one exception.

Many of those used as 'mules' by the 'barons' are also victims, and the legal systems of the countries which retain the death penalty must – in the name of human rights – be sure to very very carefully differentiate between the real traffickers and their hapless carriers.

Peter is also right to have noted, amongst the myths of Methadone Maintenance 'Treatment', that it is not much more than the swapping of one addiction for another – to psycho-pharmaceutical industry profit and at taxpayer cost, and he is supported by two other important national news items.

In 'drug-free' terms, MMT is clearly a failed policy, and it is significant that the psycho-pharms who 'sold' methadone to our governments as a habit management harm reduction policy should now be exposed in banner headlines on front pages of our national press as equally failures in the expensive 'treatment' of depression.

Then we also have the release of the government's new drug strategy, which makes a lot of good and positive comment about continuing to destroy illicit supply lines, but which makes little mention of handling the more important and controlling demand factors, which are apparently to continue solely in the hands of the same psycho-pharmaceutical fraternity which gave us the failed methadone and failed anti-depressant 'treatments'.

And while the wider provision of more effective treatment is mooted, no definition of 'effective' is given – even though, if government wants the drug-free society it outlines, the only logical treatment goal possible is comfortable abstinence for life. This goal is regularly achieved in over 42 countries – but is not mentioned in policy because it is something the psycho-pharms cannot and do not want to achieve.

Kenneth Eckersley, CEO of Addiction Recovery Training Services (ARTS)

Covert agenda confusion

I would like to congratulate you for the 'Deadly Serious' cover story (*DDN*, 11 February, page 6). I feel it was brave to include it given the animosity many feel towards its subject matter; it was an excellent read and shone light on a subject that rarely receives attention.

With this in mind, I was surprised by the 'Irresponsible and distorted' reader's letter (*DDN*, 25 February, page 7). Try as I might, I can't find any sign

in the article of a 'covert attempt to advance the agenda for the global legitimate peddling of addictive substances'.

Opposing the death penalty for murderers does not mean we approve of murder; I am astonished that a *DDN* reader would equate ending the death penalty for drug offences with total impunity for traffickers.

Nine Davidson, project worker, Scottish Prostitutes Education Project (Scot-PEP)

THC retention reply

In response to Cliff Chapman's letter (*DDN*, 25 February, page 6): After 20 years of smoking cannabis I took regular voluntary urine tests for three months before THC was cleared from my system.

I am a very physically fit person who has a fast metabolism. The rehab staff would be wrong to ignore the disparity between timescales, as three months should be seen as the end date for THC retention.

For some it may be quicker – who knows the reason. But I do not take many, if any, pharmaceutical products. (Get a new doctor/psychiatrist as reported recently on *The Times*' front Page – 'Depression drugs don't work').

The whole life/attitude change (and please don't just think of Cognition and Cognitive Behaviour Therapy) is a path of will, perseverance and exploration. But trust in the professionals is earned by their trust in the patient, and should they advise, they should be honest and present choices whose beneficiaries are not GlaxoKlineSmith *etc*. I refer you to the (oh I hate suggesting the NHS but it does have some good to it) 'Self-management of long-term health conditions' (NHS Experts Patient Programme 2002, Bull Publishing Company).

Reduce your anti-depressant to the point of being abstinent from all pharmaceutical products, except where absolutely necessary. Strengthen your will, strengthen your mind and tell those at rehab that here is someone with 20 years of cannabis use who knows how long it took to give a clean specimen – three months.

I am a 'compensated depressive' and also suffer from 'reactive depression' and emotional cognitive dysfunction (not in the DSM IV – the Diagnostic and Statistical Manual of Mental Disorders) and it is as much if not entirely due to life events and only really exacerbated by skunk, which really is the nasty substance.

Get clean, stay clean – find your new way.

Name and address withheld

We welcome your letters

Please email letters to the editor, claire@cjwellings.com or post them to the DDN address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.

Notes from the Alliance

keeping it real

Why undermine the real highs of the drug strategy with some headline-grabbing lows? asks Peter McDermott.

So the new ten-year drug strategy is upon us, and for the most part it's more of the same.

While we might want to quibble about some of the details, the last strategy was about as successful a government strategy as we could realistically hope. The focus on expanding treatment, and on an enforcement strategy that prioritises dealers over users, and antisocial behaviour over recreational drug use, is having a real impact on communities across the UK.

In my home borough of Sefton 20 years ago, you couldn't walk into some neighbourhoods without being accosted by packs of youthful dealers, each touting the superior weight or quality of their five-pound bag. A survey of residents of that area this year indicated that concerns about drug use and dealing are no longer on their radar.

Similarly, just five years ago in the same borough, if you were seeking treatment, you would be put on a waiting list two years long. Today, you'll be seen within a fortnight.

Unfortunately though, there's a continuous tension between the need for a rational, evidence-driven approach to social problems, and the need to respond to political attacks, to retain a power base. It's hard to see the recent re-referral of the cannabis classification back to the ACMD as anything besides an example of this process in action.

The decision to link access to benefits to enrolment in treatment is one of those decisions that seem to be driven by political imperatives rather than rational analysis. Our experience at The Alliance is that there is no shortage of desire to enter treatment, and the overwhelming majority of people who are receiving benefits as a consequence of their drug problem will inevitably already be receiving treatment.

Through the National Treatment Agency, and its insistence that service user involvement is a critical part of the treatment process, the last ten-year strategy has been responsible for very real and significant advances in the struggle against discrimination and prejudice. Sadly, this component of the strategy appears rooted in those same old regressive attitudes and impulses.

If the government is serious about improving take-up and increasing the efficacy of the treatment system, it would be much more helpful to start looking at some of the barriers that stop people from accessing drug treatment and returning to meaningful work.

Despite its reputation as the home of the drug war, people accessing drug treatment in the United States benefit from the Americans with Disabilities Act, which protects them against discrimination when they attempt to re-enter the workplace. It's an act that act seeks to reduce stigma, rather than simply pandering to it.

The decision to enter treatment has consequences that will be ongoing for the rest of someone's life. Insurers generally either deny cover, or make it so costly as to be effectively impossible to justify. No insurance cover might effectively mean no job, no mortgage, no ability to legally drive a car. If our aim is to successfully reintegrate people with drug problems into productive society, we have to address these problems before seeking to compel people to act against their interests.

Then there is the issue of increased offending by those who may actually have benefits denied. In the main, we're talking about a population that doesn't have large reserves of savings to draw on. For most, 26 weeks without benefits will mean 26 weeks of fairly intensive acquisitive crime, accompanied by a strong possibility of homelessness, prison, or both.

Finally, one wonders what impact this is likely to have on the needs of the estimated 250,000 to 300,000 children of parents who are living with a drug problem. Does the government plan on going the whole hog and stopping Child Benefit and Child Tax Credit for these families as well?

On balance, as a drug user, I consider the last ten-year drug strategy to have been a real success, both for people with drug problems, and for the wider community. This is the first time I've been able to say that about any of the government's responses to drugs and drug policy since the Thatcher support for needle exchange in the late 80s.

It would be a real tragedy if aspects of the next ten years undermined those successes, rather than continuing to build on them, and silly initiatives like this one are a step in that direction.

Peter McDermott is policy officer at The Alliance

Holiday in Cambodia

London drug worker **Lee Sugden** reveals how his unforgettable trip to the drug-littered streets of Phnom Penh took him to the front line of harm reduction.

My five-month odyssey had taken me to Singapore, Malaysia, Australia and Thailand, but the final month proved to be an action packed highlight of the whole trip as I found myself in the beautifully chaotic Kingdom of Cambodia.

Shortly after arriving in the capital city, Phnom Penh, I was put in contact with a harm reduction team called 'Korsang' which was founded as a Non Government Organisation (NGO) in 2004 by an American drug worker called Holly Bradford. Holly began by implementing a HIV prevention program principally by distributing clean needles to drug users on the streets of Phnom Penh. Since being founded, Korsang has rapidly expanded and is now Cambodia's leading drug project.

The modern history of Cambodia is by any standards bloody and has endured the tyrannical leadership of Pol Pot and his Khmer Rouge regime along with civil war and periods of severe famine. More than a million people were slaughtered by the Khmer Rouge and in order to escape this madness huge swathes of the population fled the country and were forced to live as refugees, many of whom arrived in America.

In the aftermath of 9/11, George Bush changed the law in America so that refugees could be deported from the country if they committed felony offences. To date, 170 young American-Cambodian men, or returnees as they are known, have been deported back to Cambodia, a country most of them knew by name only.

Many of the returnees were born in the refugee camps on the Thai/Cambodia border and were accepted into the States as young children, so many of them speak in broad American accents and have little if any knowledge of Khmer (Cambodian) language and culture. Utterly unprepared, these returnees suddenly find themselves homeless on the streets of Phnom Penh, a third world city with no social assistance or welfare.

The city is awash with high purity white Burmese heroin and yamma (methamphetamine) and some people turn to drugs and alcohol as a way of escaping the hideous reality of their plight, seemingly powerless to escape the poverty trap. There are success stories though, and a number of the former users who are now employed by Korsang are living proof of this.

When founding Korsang, Holly had the foresight to employ some of these returnees and now they are an essential part of the organisation's workforce. They are contributing to their Khmer community, while being empowered by career prospects they would otherwise be unlikely to have had.

Korsang is currently based in a sturdy three-storey building in a downtown part of Phnom Penh, with a team of about 60 people. They provide food twice a day, a drop-in facility five days a week, harm reduction programs, needle exchange, first aid, medical assistance and outreach work.

Their full-time doctor has delivered babies, removed broken needles from limbs, stitched up serious wounds and treated clients who have been brought to the centre after overdosing, sometimes fatally. In these cases and in the absence of any family, Korsang takes care of the funeral arrangements.

I was fortunate enough to go out with the outreach team one afternoon and my eyes were truly opened to the harsh realities of frontline harm reduction work. The team of five, led by a returnee called Shy, climbed into the tuk-tuk and headed out to one of the neighbouring districts which is renowned for its drug use. Slightly apprehensive, but excited all the same, I hopped on and shadowed them. After a few minutes of driving through the dusty streets of Phnom Penh we stopped at a derelict house, which has been turned into a squat where users stay and inject themselves with heroin.

As my eyes adjusted to the darkness in the building, I began to comprehend the conditions that these people are dwelling in. Slowly, bodies began to rise from the mounds of rubbish covering the floor and I realised that there were in fact several people in a room that I at first thought was empty.

Taking great care we collected used needles from the floor and placed them in the collection bucket. This building is visited almost daily by the outreach team and sometimes hundreds of needles at a time are collected from there alone. The drug workers then chatted to the users for a while and handed out packets of clean needles, giving encouragement to attend the project along the way. The people we spoke to were wearing tattered rags and had not bathed for weeks judging by the dirt-encrusted nature of their skin. Few had any teeth and almost all had open wounds and infected tracking marks clearly visible.

We then drove a few blocks to another notorious road and just the feel of the place made the hair on my neck stand up. It oozed menace and shady-looking characters, who I would guess were dealers, eyed us up from their motorbikes. I was assured that the dealers and Korsang agreed to leave each other alone and that we would not encounter any problems, but the sight of men openly brandishing knives did nothing to calm my nerves.

Clockwise from above: Drug litter in the shanty town; the outreach team; neck injecting with the needle exchange in the background; gouched out; and at the railway community.

The dusty dirt track of a street was buzzing with people, and among the obvious drug-related activity ordinary people were going about their business. I was shocked to see unconscious users lining the roadside and passers-by were forced to step over them as they lay there in their heroin-induced slumber. We checked them to see that they were still alive, before moving over to two young lads that were midway through injecting each other in the neck.

As the heroin in Phnom Penh is said to be very pure, it is standard practice to simply dissolve the powder straight into a syringe full of blood drawn from a vein before re-injecting the blood back into the body, and that is exactly what these men were doing there openly in the street. Next to this spectacle, another user was gouched out in the gutter with his trousers still pulled down from where he had just injected into his groin. A hideous abscess was visible at the injection site and I couldn't help wondering what he would lose first, his leg or his life.

Cambodia has clearly got a huge problem with HIV and hepatitis C, but people in the drug using community rarely die from either of these conditions. 'Why?,' you may ask. Because they do not live long enough for the viruses to kill them. Usually they fall prey to the multitude of other infections that thrive in the festering conditions they are forced to endure – conditions that I cannot adequately describe in words and far worse than anything I have ever seen before. Conditions that, as a drug worker, either break you or make you even more committed to delivering quality harm reduction.

We ended the day by visiting a shantytown that has grown along the tracks of a disused railway line on the banks of a large lake. Groups of friends and family gathered outside makeshift cafés and houses and people seemed genuinely pleased to see us. Grubby little children played and chased each other and old ladies gave us toothless smiles. Here we gave out condoms and kit bags containing soap, toothpaste, toothbrushes and written advice about basic healthcare.

In neighbourhoods such as this one, the team tries to engage with local youngsters to educate them about the risks attached to drug taking, as these slums are fertile breeding ground for future drug users. After my earlier experience, this work felt easy and relaxed and it was wonderful to see ordinary Khmer people smiling and enjoying life!

The drive back through the humming streets of Phnom Penh was fun and as we weaved in and out of traffic, elephants and people alike I felt plugged into the high energy of this frenetic city. By the time we had returned to the project building I was exhausted and my head was spinning with graphic images that had been burnt onto my memory.

I believe that these images will always remain with me.

Lee Sugden was a drug worker for Westminster Drug Project (WDP) at the Walthamstow Open Access, before taking a few months out to travel around Australia and SE Asia.

Streets of shame

While many BME communities have serious and growing problems with drugs, issues of shame and stigmatisation can act as a barrier to stop people from accessing – and remaining in – treatment. **David Gilliver** spoke to a Lancashire-based drug worker who's trying to make a difference.

'We recently got to know about some people who everyone thought had gone back to Pakistan for two years. Actually they were here, in prison. That's how far people will go to hide drug problems'.

Norman Raishbrooke is talking about the extent to which the stigma around drugs issues in some BME communities remains many people's biggest obstacle to accessing services, or even acknowledging there is a problem in the first place. It was this that has led him to go beyond his work as a substance misuse practitioner at Lancashire Care Foundation Trust's Burnley House to set up the Access for all communities confidential drop in service eight months ago.

'I was brought up a Muslim and I know what drugs have done to this community,' he says. 'There are families here in Burnley where generation after generation has been affected by drugs and alcohol. There are problems with crack, heroin, cannabis and alcohol but everything is taboo here. Drugs are taboo, alcohol is taboo – anything stronger than paracetamol unless it's been prescribed. There's still this "Asians don't take drugs" thing, but in the past few months we've had loads of Asian lads coming to us – not coming because of a court order or anything like that, but because they need help. We had someone recently who'd been taking drugs for 15 years. I asked him why he came through the door and he just said "desperation".'

Young Asian men are often drawn to the drug and gang culture because they think it makes them more adult, he believes, and boys as young as 13 have presented at his service with a heroin problem. Once they have substance misuse issues, however, tight-knit communities and extended families can make getting any kind of help a minefield.

'In Burnley there are a lot of Asian doctors and nine times out of ten the doctor will know members of your family, because it's such a close community,' he says. 'I know of people who've gone to their doctor and said "I've got a drug issue – what shall I do?" and then gone home and got a battering from their dad, because he's already been told. People have been kidnapped by uncles and taken back to Pakistan rather than be allowed to go through drug treatment. So it's about changing that culture.'

The answer, he believes, lies in education and proactive outreach work – which corresponds with the findings of research carried out by the London Drug and Alcohol Network (*DDN*, 3 December 2007, page 10) and he recently extended Access for all communities to include a series of education sessions with Bangladeshi parents. He has had the full support of his colleagues at Burnley House and has recently linked up with Early Break's Drugs Action For Asian Youth (DAFAY) project to take the work further. So is there any optimism that the culture of stigmatisation can slowly be overcome?

'It is being acknowledged, and that's a start' he says. 'I worked with an Imam recently and was eventually invited to give a talk to 1,800 people at Friday prayer. I talked about the stigma and the fact that addiction can get hold of anybody, and because the Imam said listen, every one of them listened. But it took a lot of leg work – arranging a meeting took ten months. You can't just turn up at a mosque and say you want to talk about drugs because you'll get a brick wall. But things are slowly starting to change.'

He is far less adamant than many people, however, that fundamental changes are necessary in the way services are structured to serve BME communities – for instance that more staff need to be recruited from the communities themselves. 'I don't think that's the main issue,' he says. 'I'm not saying it shouldn't happen, but it's just not the case that one person form the Asian community will talk to someone else from their community about their drug issues. It may work, it may not. I don't think setting targets or things like that is necessarily worthwhile.'

But many in the sector feel that mainstream services are failing BME communities through a fundamental lack of cultural competency. 'Lots of people believe that drug services basically need to be dismantled and built again from scratch to address these issues,' he says. 'I don't think that's true – they just need some adjustments. Some people say that all Bangladeshi people should be treated in one place, for example, because substance misuse services can't cater for their needs. But when you take heroin, you're taking your culture away from yourself anyway.

'Things do need to change, but some people definitely do hide behind the culture – it becomes a means to an end. We have all kinds of people coming through our doors – not just from the Asian community, but Poles, Lithuanians and there's real desperation there. But if people come to us we can open the door to all kinds of support, education, therapy and opportunity.'

Norman Raishbrooke: 'There are problems with crack, heroin, cannabis and alcohol but everything is taboo here. Drugs are taboo, alcohol is taboo – anything stronger than paracetamol unless it's been prescribed. There's still this "Asians don't take drugs" thing.'

Up to the job?

Is the drug and alcohol workforce fit for purpose or fit for change? asks **Professor Neil McKeganey**.

If you need to visit a doctor in the UK you can rest assured that the person you will be seeing has had a medical education lasting many years.

If you want to buy a house you know that the solicitor you will be dealing with has been educated at least to degree level, and if you need to contact a social worker you know that the person you will be seeing will have had a university education. If you need to take your much loved cat or dog to a vet you know you that the person you will be seeing is one of the most highly trained professionals around. And if you did not know that at the outset, you surely will when you receive the bill!

If by contrast you need to contact a drug worker, you will in all probability be seen by someone who has not been to university, who may not have a professional or a post graduate qualification, and who may have only entered the field within the last few years. None of this is to suggest that they will not be good at their job, but if the same standards applied in each of the other areas of professional work mentioned above you could be forgiven for sleeping a little less comfortably in your bed at night.

The reason why social workers, lawyers, doctors and teachers take so long to train is because the knowledge base in their area of work is so large and the consequences of poor practice so serious. But much the same could be said of work within the addictions field. In terms of the knowledge base, for example, there are university libraries sinking under the tonnage of information on the genetics of addiction, the biology of addiction, the psychology of addiction, the economics of addiction, and the sociology of addiction. For the most part however, the knowledge contained within that list of 'ologies' passes the average drug and alcohol worker by with only the briefest of engagement. Indeed, one of the rare examples of this occurring can be found in the welcome *DDN* briefings from Professor David Clark who virtually single-handedly has taken on the role of increasing the drug and alcohol workers' knowledge of the results of that massive body of addictions research.

Working with addicts in recovery is by no means a straightforward process. Addiction workers need to understand the nature of drug dependency and the opportunities for recovery; they need to know when to confront and when to offer supportive encouragement. Increasingly they need to assess the impact of parental drug use on children; balancing the needs of the child and the needs of the adult in a way which does not do more harm than good for either the adult or the child. These are complex matters on which individuals' lives can hang by a thread. And in that sense the consequences of poor professional practice in the drug and alcohol field are no less serious than in other areas of medicine or the law. And yet when you look at the drug and alcohol workforce you can't help but wonder how those and other complex judgements are being made with such scant understanding of the knowledge contained within the various ologies of addiction.

'We spend more than £600m a year on drug abuse treatment. With that sort of money we should be ensuring that the workforce we are employing is every bit as well educated, well paid, well trained and well supported as... other areas of professional work'

There will be those who say that there is no need for the effective drug and alcohol worker to have received a university education or to have access to specialist knowledge and that it is sufficient for the individual to be enthused and committed to their work. But why, you might ask, should one assume that such commitment and enthusiasm would stand as a counterweight to accessing the accumulated knowledge in the addictions field? And would it not be better to have a committed and well educated workforce?

There is a further downside to the view that the drug and alcohol worker does not really require any specialist knowledge, which is the consequent lack of anything approximating a clear career structure. If you are an effective drug and alcohol worker seeking to acquire as much education and training as you can, you may be congratulated on your commitment – but that does not mean you will be paid any more money for the effort you have expended. In time you may move from working at the street level in your agency, to managing the agency. But that, in all probability, is your career prospects summed up in a nutshell. The result of this is that while some people stay in the drug and alcohol field for many years, others leave the field after a relatively short time, either burnt out or seeking something approximating a normal career.

Within the UK we spend more than £600m a year on drug abuse treatment. With that sort of money we should be ensuring that the workforce we are employing is every bit as well educated, well paid, well trained and well supported as the various other areas of professional work mentioned at the start of this article. Indeed until that happens we will continue to think of the drug and alcohol treatment field as involving a low status workforce – and we will think that, in part, because of the continuing view that those with a drug and alcohol problem are themselves of low status.

If we are to effectively tackle our substance abuse problems we had better start to realise that effective treatment and care requires no less a complex set of professional skills and knowledge as are displayed by our social workers, our doctors, our lawyers and our vets. We need to ensure that there is a proper university education for the drug and alcohol worker and that there is an appropriate career structure with a reasonable level of payment for those working in the field. If we fail in this then no matter how many occupational standards we come up with to try to improve the quality of drug and alcohol services, the reality will remain that those services will fall short of what they can achieve and of what their clients might rightfully expect.

Neil McKeganey is professor of drug misuse research at the University of Glasgow.

Treatment of substance use problems: Reflections part 2

Professor Clark continues his reflections on treatment of substance use problems.

Only a small proportion of people who use substances recreationally go on to develop problematic use. Many factors moderate the development of an addiction to substances, and help create exits from initial engagement and problematic use.

In general, people are less likely to become addicted to substances if they have few life problems, and good personal and social resources, such as healthy self-esteem, strong family relationships, and non-drug using friends. In addition, if a person can find satisfaction and happiness in other activities, they are less likely to become addicted.

In general, people are more likely to become addicted to substances if they have complicated personal problems (*eg* depression), few personal resources (*eg* low self-esteem), and live in a deprived social environment offering few alternative pleasurable activities. Serious substance use problems often occur as part of a larger cluster of psychological, physical, family and social problems.

A variety of factors can change problematic substance use once it has developed. For some people, the problems are transitional in nature and they mature out of them as their setting changes, *eg* other life events become more significant, such as setting up a home with a loved one.

Other people spend years misusing substances and suffering negative consequences and losses, before dying without overcoming their problems.

For most people, however, their substance misuse involves multiple attempts either to stop using or to bring their use under better control. The majority of people eventually resolve their substance use problems, often on their own without formal treatment.

In general, it is easier to resolve substance use problems at earlier and less severe stages of problem development. For some people, reduced use or abstinence can be triggered by relatively brief interventions, the impact of which is thought to be on the person's motivation for, and commitment to, change.

A common obstacle to early help-seeking is ambivalence and the perception that one does not have a 'problem' serious enough to warrant change or treatment. Once this ambivalence is resolved and a commitment made, change may proceed without much additional support.

For other people, their substance misuse is part of a larger cluster of life problems that can become very resistant to change. Family factors and social networks may be central in establishing and maintaining the substance misuse. It is important to understand what maintains substance use in these individuals and, more importantly, establish which components need to be addressed to produce stable change.

'There are many different ways that people overcome addiction, and no two people take identical pathways to recovery.'

Recovery is a word used to describe the process through which individuals with serious substance use problems resolve these problems and establish a meaningful and fulfilled life. Recovery involves the development and use of coping strategies and techniques that reduce a person's vulnerability to relapsing back into problematic use.

Recovery, or overcoming problematic substance use, is rarely an isolated event. A person may make a number of attempts to stop using a substance before they finally stop permanently. Each of the attempts at stopping involves events and processes that the person can learn from and that can ultimately contribute to recovery.

There are many different ways that people overcome addiction, and no two people take identical pathways to recovery.

However, there are four main types of help that facilitate recovery. These include the person using:

- their own strengths and resources;
- the help of family members and other loved ones;
- support groups in the community;
- and, formal treatment.

People may draw upon these different types of help at different times in their path to recovery. Some may find one type of help more beneficial than others, although this may change over time.

For example, treatment may play a large role at the beginning of the recovery process, whereas later on help may be sought from loved ones and friends during difficult periods.

While there are many routes to recovery, they all have two things in common. Firstly, they all come from within the person. Self-change is the foundation and the process underlying all recovery. Formal treatment is a time-limited, circumscribed experience or series of experiences that interacts with and hopefully enhances the self-change process on the way to recovery.

Secondly, all routes to recovery involve behavioural change – a change from a problematic behaviour to one that is healthier for the person concerned.

In general, people pass through a sequence of stages on the way to resolving substance use problems. In brief, they:

- become concerned about the need to change
- become convinced that the benefits of change outweigh the costs, and make the decision to change
- create and commit to a feasible and effective plan of action
- carry out the plan by taking the actions needed to make the change
- and consolidate the change into a lifestyle that can sustain the change.

A person may move forwards and backwards between the stages on many occasions, before they finally achieve a sustained recovery.

A variety of processes, occurring within the person and in their environment, combine to help them move through the stages of change. Achieving and maintaining change depends on using the right processes at the right time. This can help explain why it can often take a person numerous attempts to overcome their substance use problem.

The first part of this article was published in DDN, 11 February, page 15.

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ACT provides Open Access social inclusion support services to anybody whose life is affected by their own or someone else's drug or alcohol misuse. We are enhancing our services across Buckinghamshire and have the following exciting vacancies available.

Service manager
Youth@ACT, young peoples service covering Buckinghamshire, based in Aylesbury or High Wycombe. Full time. Salary Circa £30,000 + pension.
An exciting opportunity to take a lead in the development and growth of our young peoples service. Car user essential.

Substance misuse Team Leader
Based in Aylesbury. Full time.
Salary Circa £24,000.+ pension
As part of our adult services you will be responsible managing and developing a team of staff, providing Tier 2 and Tier 3 interventions. Car user essential. Some evening work may be necessary.

Substance misuse project worker
Criminal Justice Alcohol Project, High Wycombe.
Full time. Salary Circa £21, 000 + pension
An opportunity to provide fast track interventions for alcohol misusers coming from the criminal justice system. Providing assessment, keyworking, group work and onward referral to other interventions. Some evening work may be necessary.

Substance misuse project worker
Structured Day programme. High Wycombe.
37 hours per week – Circa £21,000 + pension
An exciting opportunity to join of our Structured Day Care team. Duties include assessments, facilitating groups, keyworking, and supporting substance misusers in our rolling community based structured day care programme. Some evening work may be required.

Substance misuse project worker
Young People, High Wycombe area. Full time.
Salary Circa £21, 000 + pension
An opportunity to work as part of our young peoples service, providing engagement activities, advice, support and information, assessment, keyworking, and onward referral to other interventions. Some evening work may be necessary. Car user desirable.

Counselling Supervisor
6 hours per month – salary negotiable
Person with experience of providing group clinical supervision. Required to provide 2 x 2 hour group supervision to our Counselling Team in High Wycombe and Aylesbury. Suitable applicants will have counselling and supervision qualifications and experience of working with drug/alcohol issues.

Support workers
We are aiming to develop a support workers role within ACT so that we can provide a training route into the substance misuse sector. Applications from ex service users will receive a guaranteed interview.

Part time opportunities for the above posts may be available for the right candidate. We also have opportunities for sessional workers, providing support for one off projects or innovative pilots for which we often receive small pots of funding for. We provide training and require a bank of qualified sessional workers who are able to provide ad hoc support.

For an application pack please contact Nicky or Justine on 01296 425329
or email Justine@addictioncounsellingtrust.com
Closing date for all positions Tuesday 1st April, interviews week beginning7th April.

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ACT is an Equal Opportunities Employer and an Investor in People

Auricular Acupuncture training with ACT enhances practice and delivers results

A.C.T. Acupuncture Consultancy & Training

ACT (Est 2000) is committed to providing quality ear acupuncture training at a competitive price. This enables those working in the field of substance misuse to enhance their practice and provide a consistent and effective treatment intervention.

'The 5 Point Protocol' that is commonly used in drug and alcohol treatment agencies is a simple treatment that involves the insertion of fine needles into specific points in the ears. It is used for detoxification and stress management and is effective across the range of substances that people misuse.

In 2006 the NTA published 'Treating Drug Misuse Problems – Evidence of Effectiveness'. In this, two studies showed that those who had received auricular acupuncture stayed in treatment longer. According to the NTA publication, "Treatment retention has been found to be related to favourable treatment outcomes. Patients who received longer periods of care improved more than those who had shorter episodes". In 'Models of Care 2002' it is acknowledged that there is anecdotal evidence that offering acupuncture helps to attract and retain clients in treatment.

In line with the NTA report our unique 2 day training programme, with formal assessment 2-4 weeks later, enables agencies to work towards improving their treatment outcomes.

ACT trainers:

Carole Bishop. Carole has a Diploma in Acupuncture and is a member of the British Acupuncture Council. Carole has worked in the substance misuse field for 10 years both as a manager and practitioner. Carole has recently completed a Graduate Diploma in Addiction Studies at Leeds University.

Janine Cousins. Janine has over 20 years experience in the fields of social-care and adult education. Janine has a Diploma in Acupuncture, Certificate of Qualification in Social Work and a Post Graduate Certificate in Education.

Training courses are mapped to DANOS. They are work-based, subject to suitable training venues and also located in our centre at York. Courses are held over two consecutive days. Weekend courses are available upon request. Those who successfully complete the training programme are placed upon the ACT Register and will benefit from membership of a professional body.

For a competitive quote and details of what ACT offers, please contact Carole or Janine on 07999 816326 or email at info@acupuncturetraining.co.uk or visit our website: www.acupuncturetraining.co.uk

"The course provides a super grounding and you're given a training manual which covers absolutely everything you need. Anyone thinking about doing the course, I recommend it thoroughly".

TRACEY BROOKS, SENIOR COUNSELLOR, STREETWISE

"The course, teaching and learning strategies were well explained and in-depth. I can recommend this training to any agency that requires this therpay, it has changed the clients' time on the Kevin White Unit".

ANDREW JOHNSON, KEVIN WHITE UNIT, MERSEYCARE NHS

"I enjoyed the course, felt it gave good background information and also had fun doing it too. Thanks."

ANDREW MORETON, LIFELINE, KIRKLEES

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Part time programme – September 2008 entry

Enhance you career prospects in Addiction Counselling. This programme, run in collaboration with leading addiction treatment and research centre, PROMIS, prepares students for work in a wide range of organisational and therapeutic environments.

Apply now to secure your place.

- Equal emphasis on addiction psychology and research, and professional counselling practice
- Units include models of working, professional development & ethics, strategies & techniques, treatment contexts, personal development & robustness, psychological concept of addiction, development of addictive behaviours, theories of addiction and research methods
- Part-time, 1 day per week – MSc 2.5 years, PgDip 2 years, PgCert 1 year
- Successful completion of the Diploma fulfils the formal training requirement for FDAP Counsellor accreditation (NCAC) leading to UKRC registration
- Fees support for accepted students may be available via the Alcohol Education and Research Council

For full information and application forms, please contact the Course Enquiries Office on 020 7815 7815 or enquiry@lsbu.ac.uk

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Dyfed Powys Police

Dyfed-Powys Drug Interventions Programme

Tender

The Dyfed-Powys Police Authority on behalf of the Dyfed-Powys Drug Intervention Programme Regional Management Board is seeking expressions of interest from suitably qualified organisations interested in bidding for one or both of the following services:

1. Criminal Justice Intervention Team (Dyfed-Powys wide) and Drug Rehabilitation Requirements (Powys only).
2. Rapid Access Prescribing (Carmarthenshire).

The contract will be for a period of four years commencing 1st October 2008 with an option to extend for two further periods of one year.

Interested organisations should register their interest via the "Bluelight" e-tendering website www.bluelight.gov.uk against reference DYP/PLN/7C2MYA and download the pre-qualification questionnaire.

Bluelight is an electronic tendering system adopted by the Authority. Applicants need only register once and the process is free of charge. Registered suppliers benefit from email alerts of contract opportunities with other participating police authorities and fire brigades. Registration is not a mandatory requirement but is preferred.

For those organisations unable to access the Internet, expressions of interest should be made in writing to the following address: Ms E J Frizi, Procurement & Contracts Manager, Dyfed-Powys Police, Police HQ, PO Box 99, Llangunnor, Carmarthen SA31 2PF.

Completed pre-qualification questionnaires must be returned via Bluelight by 16:00 on Tuesday 1st April 2008. Those organisations that have advised that they are unable to submit documents electronically should post them to the above address to ensure receipt by the date and time stated.

www.dyfed-powys.police.uk

City of Westminster

Westminster Primary Care Trust NHS

An invitation to all drug and alcohol providers

Westminster Drug and Alcohol Action Team is planning to reconfigure treatment services in the City of Westminster over the next 18 months in order to better meet the needs of local residents. This is a significant undertaking and WDAAT is committed to ensuring that the new configuration is as effective as possible and is in line with the new national drug strategy, 'Drugs: protecting families and communities'.

WDAAT is keen to get input both from organisations currently providing services in Westminster and all organisations interested in doing so in the future.

WDAAT is holding a half day seminar with the purpose of informing provider organisations about the proposed model of service provision and consulting them on its likely effectiveness.

Places are limited and priority will be given to provider organisations. Each organisation will be allocated a maximum of two places.

The seminar will take place on 27th March from 9.30 – 1.00 in Broadway House, Tothill Street, SW1H 9NQ.

If you are interested in attending, please contact: Helena Quinn by e-mail: hquinn@westminster.gov.uk

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NOW REGISTERING AND SUPPLYING NURSES

Register online www.SamRecruitment.org.uk

Invitation to Tender – Tier 2 Alcohol Intervention Programme

Kent County Council wishes to invite expressions of interest from suitably experienced organisations to deliver a Tier 2 Alcohol Intervention Programme in the Dartford and Gravesham localities.

The aim of the service is to reduce the long term effects of alcohol including:

1 – reduction of alcohol related illness

2 – reduce alcohol related crime

3 – reduce alcohol related violent crime, including domestic violence

This opportunity is expected to run over a period of three years commencing in June 2008.

Parties wishing to receive a tender document should apply, stating reference number Y800213, in writing to Purchasing Services Group, Commercial Services, Gibson Drive, Kings Hill, West Malling, Kent ME19 4QG or via e-mail at purchasing@kent.gov.uk

Expressions of interested and final tenders must be received by 9th April 2008.

Kent County Council

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The Care Forum

JOB OPPORTUNITIES

Based in Fishponds, The Care Forum is the lead voluntary sector infrastructure organisation working in health and social care in Bristol, Bath & NE Somerset, North Somerset and South Gloucestershire. We also provide advocacy and information services. We now seek an

ADVOCATE

To lead on the development + delivery of our Drugs Advocacy Service. You will have experience of providing advocacy, excellent communication and organizational skills, and a good understanding of the drugs and alcohol sector and the issues that drug misusers face.

24.5hrs pw, £22,786 - £25,281 pa pro rata

We welcome applications for this post from ex substance misusers. Applicants will be assessed against relevant units from the Drug and Alcohol National Occupational Standards.

Applications must be received by midday 2 April – interviews will take place on 18 April. We welcome applications from all sectors of the community. Our offices in Fishponds are free from barriers and fully accessible for disabled people.

For a job pack, go to www.thecareforum.org email: admin@thecareforum.org.uk or tel: 0117 965 4444.

B.A.D.A.S
Drug & Alcohol Services

Adult Services Manager

Salary Scale: NJC Points 38 - 43 (£30,598 – £34,991)
Contributory Pension Scheme and Health Care Scheme
Annual Leave: 25 days (rising to 30)

Barnsley Alcohol and Drug Advisory Service is seeking to appoint an inspirational and dynamic individual to take on the exciting challenge of this role. We require someone who understands how to develop performance, manage systems and data and motivate people in order to deliver high quality treatment services. The successful applicant will be an exceptional manager with excellent strategic, operational and people management skills. You will champion the service users' rights to excellence in drug treatment services delivery within the role.

This is an excellent opportunity to join a third sector organisation that is proud to provide services for a local community and values the contribution of its people.

For an informal discussion please ring
Lynn Rogers, CEO on 01226 704094.

For an application pack please contact Louise Dack, BADAS, 9/10 Burleigh Court, Burleigh Street, Barnsley, S70 1XY. E-mail: recruitment@badas.org.uk; tel: 01226 779066 or download the pack from www.badas.org.uk. Closing date for applications: Friday 14th March 2008.

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Due to our unprecedented success, Trust The Process Counselling are accepting applications for:

- **Admissions Counsellors - Luton Branch**

Responsibilities will include supporting families and clients through the admissions process into private rehab. Developing and maintaining relationships with statutory and third party referrers. Completing triage and risk assessments. Managing the reception of clients and third party visitors. Answering email and telephone enquiries and reporting on admissions activity. If you are qualified or training as a counsellor and have personal or professional experience of the 12 step programmes we would like to hear from you.

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Telephone: Chris Simonite on 0845 241 3401 or Email: chris.simonite@ttpcc.org

Invitation for Expressions of interest to Tender for the provision of

(1) An Adult tier 2 open access gateway to drug treatment and assertive detached outreach service;

(2) A specialist Young People's tier 2 and 3 service

The London Borough of Barking and Dagenham's Drug and Alcohol Action Team (DAAT) invites expressions of interest from suitably experienced and qualified providers to tender for an Open Access tier 2 Drug Treatment and Assertive Detached Outreach Service and a Specialist Young Peoples (up to the age of 19) Substance Misuse Tier 2 and 3 service.

Organisations with a track record of creativity, innovation and the delivery of dynamic service provision and the ability to demonstrate that the organisation has the capacity to develop services in partnership and respond to change are sought.

(1) The tier 2 service will provide a comprehensive substance misuse service which will include the following;

A community focused harm reduction service that will include the following key elements;

- The service will be underpinned by a harm reduction philosophy, delivering harm reduction interventions, practices and approaches, such as the delivery of a centre based and detached outreach needle exchange
- Outreach facilities that will encourage engagement with local communities and re-engagement of those that drop out of treatment
- Interventions to reduce harm and risk due to blood-borne viruses (BBVs) and other infections, including dedicated needle exchanges
- Open access information, advice and support services to drug users, professionals and concerned others.

(2) The tier 2 and 3 Specialist Young People's service will provide a range comprehensive services which will include the following;

- Specialist Harm Reduction
- Family interventions
- Psychosocial Interventions
- Specialist Pharmacological interventions
- Clinical Supervision for DAAT commissioned substance misuse staff
- Information, advice and drop in services
- Satellite and outreach services.

Both services will integrate health and social care provision for drug users of all ages in the Borough and target hard to reach groups through the delivery of outreach and satellite services.

It is anticipated that the service will commence from October 2008 for a period of three years with an option to extend for a further one year dependent on performance review and availability of funding. Organisations should be aware that Transfer of Undertakings (Protection of Employment) Regulations 2006 may apply.

For further details on the Adult tier 2 service please contact Jenny Beasley, Joint Commissioning Manager on 020 8724 8110 or email: jenny.beasley@lbbd.gov.uk

For further details on the specialist young persons tier 2 and 3 service please contact Saleena Sreed-Haran, Young Persons Commissioning Manager on 020 8724 1288 or email: saleena.sreed-haran@lbbd.gov.uk

The London Borough of Barking and Dagenham will welcome expressions of interest for the provision of either of the above services, but providers wishing to tender for both services will also be welcomed.

Interested parties will be sent an application pack which will include brief details of the service, the tendering process and a pre qualifying questionnaire (PQQ) which must be completed and returned no later than by 12 Noon on Wednesday, 3rd April 2008.

Invitations To Tender (ITT) will be restricted to organisations with demonstrable experience and skills in delivering similar as those described above.

Application and Pre-Qualification Questionnaire packs can be requested by either:

1. Emailing your request to: jenny.beasley@lbbd.gov.uk
2. Sending a written request through royal mail post to: DAAT Tender 2008 (JB), Drug and Alcohol Action Team, London Borough of Barking and Dagenham, 3rd Floor Roycraft House, 15 Linton Road, Barking, Essex IG11 8HE.

All application requests MUST include 1. Full name of your organisation, 2. Full postal address, 3. Contact person, 4. Telephone number and 5. Email address (if available) and 6. Where you saw the advert, 7. State the tender(s) you wish to apply for.

Closing date for expressions of interest: 12 noon, Wednesday 26 March 2008.

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The London Borough of
Barking & Dagenham

www.barking-dagenham.gov.uk