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DDN

Drink and Drugs News

17 July 2006
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Scottish Drug Enforcement Agency

Jack Law,
Chief Executive,
Alcohol Focus Scotland

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CJ Wellings

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Editor's letter

Approaching the chief executive of the charity Compass to ask him about a seemingly successful youth project, he was charming but firm in diverting me away from talking to him.

'It was something driven by the young people themselves – something they wanted to do. I was pleased with the good idea,' said Steve Hamer. 'But when I saw the outcome, I was completely bowled over. It's a testament to the tenacity of these young people in making it happen. It was orchestrated in partnership with the education and youth service – so they're the ones to talk to.'

I soon realised I wasn't being fobbed off. Talking to the young people of Forest Fields Youth Club brought their project alive. The youth workers who have tackled this venture with such belief have pulled off that rare and difficult feat: transferring ownership of the project to young people who are keen not only to be involved, but to take it to the next stage.

Meanwhile the ripples of budget-related distress continue. A support worker wrote in, wanting to know if there's anything we can do: her dedicated team of four drug and alcohol workers have just been told that the funding for their posts will be stopped by March 2007. 'We are only a team of four which can't make that much difference to the budget,' she says. 'I have changed a lot of lives... we are only a small team but we do so much. It breaks my heart to think in nine months we won't be anymore... I will try anything to save our posts and to save the people we help.

Another drug worker called this week to say the DAAT had told him he was losing his job because of cuts to the pooled treatment budget. He's been given two months to find another job. What's going on here? Has the PTB really disrupted plans – or are some DAATS using it as an excuse?

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In this issue

News in Brief

Scare for injecting users

Health professionals have been alerted to a case of necrotising fasciitis and severe systemic sepsis in the Greater Glasgow and Clyde area. The condition affects injecting drug users and is related to soft tissue inflammation. Those who inject into muscle or subcutaneously are particularly at risk, and are being advised to smoke heroin instead of injecting – or if they must inject, to make sure they hit a vein, as blood is better than muscle at killing bacteria. The usual harm reduction precautions, such as using clean 'works' and not sharing, are more crucial than ever. Any redness, swelling or pain on injection sites should provoke an immediate medical check-up.

Tobacco age limit to rise

The legal age to buy tobacco could be raised to 17 or 18, as part of a government crack-down on teenage smoking. About 9 per cent of children aged 11-15 smoke, with nearly 70 per cent of these buying cigarettes from newsagents or corner shops. Public Health Minister Caroline Flint said the proposals demonstrated the government's determination to reduce preventable diseases and health inequalities. Consultation will run from 3 July to 9 October. Submit your views by emailing underagesales@dh.gsi.gov.uk

Cannabis and psychosis

New research is being carried out into cannabis and psychosis, funded by the Priory Group and the Medical Research Council. Dr Sagnik Bhattacharyya will look at whether certain genes increase vulnerability to the effects of cannabis, contributing to the medical profession's understanding of its effects on the brain. The study aims to help identify high-risk groups so interventions can be developed.

Education down with the kids

Hip hop and rap music are being used by a Birmingham charity to involve young people from BME backgrounds in drug education. Right Start Foundation International is teaming up with Birmingham DAT to run a Drugs Rap 'n' Mix evening on 21 July and has lined up young performers to demonstrate their views on drug culture through rap, beat box, poetry and comedy. For information and tickets, contact Rawaad Mahyub on 0121 631 1679 or 07791 072227.

New directors for public health

As part of the NHS shake-up, nine directors of public health have been announced by Chief Medical Officer, Liam Donaldson. Each director will replace the existing roles of regional director of public health, Strategic Health Authority director of public health and medical director. Names are listed on the Department of Health website at www.dh.gov.uk

Alcohol hospital admissions reach record levels as children's drinking doubles

Drink related illness is continuing to soar, according to figures published this week by The Information Centre for health and social care.

The special health authority's statistics show that hospital admissions from alcoholic liver disease have more than doubled over the past decade, with 35,400 admissions in 2004-05, compared to 14,400 in 1995-96. Twice as many men as women were hospitalised with the disease.

A similar picture is emerging for cases of alcohol poisoning, with hospital admissions at 21,700 for 2004-5, compared to 13,600 ten years earlier.

Surveys carried out by the IC during 2004-5 confirmed that young people were more likely to binge drink than any other age group. A third of men aged 16-24 who were interviewed, and a quarter of women the same age, had drunk more than double the recommended number of units on one day during the previous week.

Drinkers were likely to take up the habit early: nearly a quarter of the secondary schoolchildren aged 11 to 15 said they had drunk alcohol in the week before the interview, with cider, lager, beer and alcopops the favourite choices. The average amount consumed by this age group has doubled between 1990 and 2000, to 10.4 units a week, according to the IC.

Professor Denise Lievesley, the IC's chief executive, commented that the report showed we could not underestimate the effect of alcohol on health. She hoped the data would help health professionals 'to be better equipped to put their work in context and to raise awareness of the dangers of alcohol misuse.'

Statistics on Alcohol England 2006 is on the Information Centre's website at www.ic.nhs.uk/pubs/alcoholeng2006

Birmingham DAT celebrates staging the first drug treatment fayre supporting pregnant drug users. Professionals were brought together from the drugs, social care and health fields with the aim of encouraging more pregnant drug using women into treatment services. Tracey Parsons, care co-ordination review officer for the DAT, said 'it also highlighted the need for closer liaison and partnership working between all professional agencies, which is central to providing good quality treatment.' A new series of leaflets was launched to give practical advice to pregnant drug users, their partners and families. The information dispels unhelpful myths, as well as warning of the risks of continuing drug use.

New guidance to support youth offending teams

Young offenders will be given better access to substance misuse treatment, through new guidance developed by the Youth Justice Board and the National treatment Agency.

With YJB research confirming the high levels of substance misuse among those going through the youth justice system, the guidance support youth offending team managers, DATs, commissioner and substance misuse workers in improving substance misuse services for young offenders. From effective commissioning to delivery of services, it looks at effective management, appropriate clinical supervision, locally agreed protocol and care pathways.

Professor Rod Morgan, Chair of the YJB, said the board was working with the NTA, Home Office and DfES to address issues where youth justice and substance misuse overlap. He said the development of a targeted specialist substance misuse service aimed 'to ensure that all young people can reach potential', as well as preventing harm.

NTA chief executive Paul Hayes added: 'Appropriate early interventions can help young people establish control of their lives and their behaviour, shortening their offending and drug-using careers to the benefit of everyone.'

Scottish 'social contract' proposals fall on stony ground

Scottish minister Duncan McNeil has met with hostile media reaction for his suggestion that drug addicts should sign a 'social contract', agreeing that they will not start a family until they have ended their habit.

The bargain would involve methadone, benefits and housing – and a breach of contract could mean existing children being taken into care, as well as benefits being withheld.

Scottish papers reported immediate angry reaction from drug workers, alongside a cautious welcome to the proposals from the Labour leadership, which said it would consider the matter at their party conference in November.

The Scottish Drugs Forum condemned the proposals as vicious and unfair.

'What's proposed dehumanises people who are in need of help and support, simply because their problems are seen as too difficult and complex for society to deal with,' said an SDF spokeswoman.

Singling out drug users for hardline treatment was completely at odds with the patient-centred approach applying to other groups, she added.

The SDF also pointed out that double the number of children affected by parental drug use were affected by parental alcohol problems – as many as 100,000 lived in households with heavy drinking.

'Quite rightly, no-one is suggesting that we adopt such proposals for these parents, or those with obesity or mental health issues, or those with serious smoking problems,' she said. 'These proposals smack of cynical expediency and a depressing lack of vision.'

Trust pledges joint action on Britain's drinking culture

A new independent charitable trust aims to challenge the UK's drinking culture, by bringing together experts in the field, medical professionals, lobby groups, charities and the alcohol industry, to address alcohol misuse and promote sensible drinking.

The Drinkaware Trust is an initiative stemming from the government's Choosing Health white paper, and the Alcohol Harm Reduction Strategy. While funded by the alcohol industry, it will involve all parties in campaigning together for the first time. Educational campaigns are planned to promote sensible drinking and pilot projects will be evaluated to tackle alcohol related harm. There is help promised for local and national initiatives, through making project aid available.

Public Health Minister Caroline Flint called the project an 'international first' and a 'significant milestone' that would help achieve the goal of encouraging people to drink in moderation.

'Alcohol is a normal part of society and we're not trying to stop that,' she said. 'What we are saying is that people need to be sensible and not drink excess amounts that can lead to serious conditions such as liver cirrhosis or result in disorderly behaviour.'

Home Office Minister Vernon Coaker said the trust went beyond tough government measures on dealing with alcohol related disorder, and marked 'an important step forward in our efforts to encourage responsibility for their own behaviour'.

Alcohol Concern's chief executive, Srabani Sen, welcomed the chance to work with the drinks industry to 'really make a difference in changing the way we drink alcohol in the UK'. Chris Searle, chairman of drinks' industry body The Portman Group, said the approach demonstrated the benefits of working in partnership around a shared agenda.

The trust also has the signed support of the Scottish Executive, the Welsh Assembly and the Northern Ireland Office.

Kenward Trust greets new phase of growth

Kenward Trust opened the doors to its new purpose-built annex last week, providing 18 more bedrooms for its residential rehab near Maidstone, Kent.

Lord Clive Brooke of Alverthorpe, patron of FDAP, congratulated the charity on raising three-quarters of the £900,000 funds needed for the project. He also thanked them for their work over the past 38 years in turning lives around by using their own charitable investment: clients at Kenwood are asked to pay just 15 per cent of the cost of services, 'which compare in quality and expertise with any around the world', said Lord Brooke.

Back in 1968 Kenwood was bought by Ray and Violet Sinden, who sold their farm and possessions to buy it from Barnardo's, then opened it to the homeless. Now the Christian charity hopes to become a centre of European excellence for the welfare and recovery of those suffering from alcohol and drug misuse.

FRANK has been given a new image, following consultation with DrugScope, Barnardo's, Adfam and Young Minds. New leaflets and postcards aimed at young people, and a separate set for parents, give comprehensive information on how to identify different drugs, the effects and health risks of taking them, their legal status – and what to do if drug use becomes problematic.
The draft materials were tested on young people and parents to check that they were accessible to both audiences.
To get copies of the leaflets, register at www.drugs.gov.uk/frank or call Prolog on 08701 555455.

Notes from the Alliance

The Scottish Minister's proposal for a 'social contract' to prevent drug users from having families should be recognised as a chilling endorsement of social programming and rebutted at all costs, says Daren Garratt.

On Monday 10 July 2006, the Alliance's Alan Joyce alerted me to a story that had appeared on the BBC News website the previous day that reported that 'Labour MSP Duncan McNeil has proposed that addicts sign a "social contract", obliging them not to have children until they have beaten their habit.'

Mr McNeil, by the way, was also the MP who suggested that users could have some form of contraception put into their methadone earlier this year.

He felt we should follow the work of the North Carolina-based Project Prevention, which offers a cash incentive of $300 to users and/or problematic drinkers to receive long-term or permanent birth control.

I knew this insidious form of social programming went on over the Atlantic, but had missed out on it being discussed over here. It's really quite chilling, and is worryingly in keeping with a number of high profile anti-drug user proposals that have been put forward by a minority of Scottish policy makers and commentators lately, despite all the continued sterling work and best efforts of bodies like the Scottish Drugs Forum.

The problem is how to respond effectively. One strong argument is to not give these people any more publicity. Hit them where it hurts by ignoring them and hoping that balanced, reasonable people will see these policies for what they are and discredit these self-declared experts with common sense.

Unfortunately, these outpourings are coming with such regularity and increased ferocity lately that I have trouble ignoring them.

Take an article in a recent edition of the *Scottish Sunday Times* where a drug expert declared:

'We might have to create drug-free communities using drug testing or restrict addicts from retail areas between certain hours. It would effectively create ghettos. But if we can't control the addiction, all we can do is control the movement of people.'

I wrote a response to this in which I somewhat spookily called on the readers to read through the statement again, add two other solutions such as mandatory sterilisation or involuntary terminations and replace the words 'drugs' and 'addicts' with asylum seekers, hoodies, Islamic fundamentalists, happy-slappers, single-mothers, binge drinkers or any other highly visible group of folk devils that we are told are a threat to the very fabric of civilised, western society and tell me how it reads.

Now to be honest, I don't know if my response was even published, but I hoped that anyone reading it out would see that this proposal was not less a move of maverick radicalism we should embrace as social policy, but something rather more sinister.

But what if Mr McNeil did read it, completed the exercise and had some sort of 'Eureka' moment? You never know, do you? Maybe I should keep my mouth shut from now on.

Daren Garratt is development manager at The Alliance

'Sadly some of the reemergent abstentionist and anti-harm reductionists have lately found it safe to crawl out from the mass burial pits they have been hiding in, and now happily proselytise their creed of 'cleanliness is a hell of a lot closer to godliness'. Certainly a corpse cannot sin and is no longer a burden on family, community nor state.'

The right to choose

As an advocate and service user I welcome Chris Ford's latest Post-its from Practice column (*DDN*, 3 July, page 13) that acknowledges the positive role the 12 step movements, NA, MA, AA, and associated user led and founded organisations have played in helping a number of my less fortunate peers.

That respect afforded, I also recognise that some aspects of the 12-step movement have undeniably been associated with harm and cult like activities – at best reprehensible nonsense, at worst abuse on par with that of the Synanon movement and fellow travellers.

This may extend to the children of users who entered some of these establishments and suffered the most appalling abuse at the hands of unskilled, untrained mavericks – who precipitated harm I still see perpetuated among the children and grandchildren of some of my peers. If planning to enter into a family or child centred service, check it out. Make sure staff working with kids are qualified, competent and understand the whole complex range of issue kids have to deal with, if they share the rehab experience with Mum, Dad, or either. The harm untrained workers can do to your child is incalculable.

That said, it is important that we recognise and celebrate what works for some – even if not all – of us, whilst retaining our right to criticise and change that which we perceive to weaken or harm the more vulnerable of our community: our children, those who are mentally ill, and those who have suffered irreparable damage.

To be told it is your own recidivist conduct and it is all beyond your control anyway, is like Catholic absolution – forgiveness now, but I would not count on escaping hell fire later.

There are many users, in and out of treatment, who have profound philosophical problems with aspects of the 12-step system; the acceptance of the 'disease' model for example, the recognition of a 'higher power' being another. There are many others, again such as myself, who are unable to cease their drug use, abstinence being neither possible nor desirable. A number of these will find the 'medical model' more relevant to their personal experience of addiction and dependence than that embraced by 12-steppers and related abstinence orientated treatment modalities.

And yet again, there are many who do not see themselves currently fitting into any of the above. They are just getting on with it, just trying to survive. They will take what is offered until they are sufficiently knowledgeable and empowered to begin to take what they need here and now.

Certain parties may criticise maintenance treatment and long-term prescribing all they like, but I would answer with a quote from Bill Nelles, founder of the Alliance: 'Come what may, we must at the very least agree on this; you cannot rehabilitate a corpse.' Sadly some of the reemergent abstentionist and anti-harm reductionists have lately found it safe to crawl out from the mass burial pits they have been hiding in, and now happily proselytise their creed of 'cleanliness is a hell of a lot closer to godliness'. Certainly a corpse cannot sin and is no longer a burden on family, community nor state.

To put it bluntly, for any of us users who managed to survive, for now, the excesses of the anti methadone maintenance treatment, 'abstention is all', lobby in the 70s and 80s, I will fight to my dying breath for the right of my peers to choose, or seek abstinence. But by golly, I hope they will show the same dedication and support for me when it comes to defending my right to agonist maintenance of choice.

I am sad to say that many of those who have been most vocal in supporting abstinence have also been the most active in seeking to deny the validity of my experience, my needs, and my maintenance treatment.

I embrace mutual respect, but sadly find little afforded me by those who claim a monopoly of the right – plus a God given mission to 'convert' me from my experience.

Maintenance and abstinence are not, need not and should never be placed at diametrically, polarised opposite ends of some eternal conflict but should rather be seen as different facets and representations of related conditions and states of being. Users may become abstinent, they may use, relapse, detox, use again. They may go onto buprenorphine, stabilise, relapse, withdraw themselves with community support. They may become abstinent, abstain for several years, then relapse. Then they may say maintenance for life – take the pathway, scramble the order, and set out again.

It is not for us to judge, punish nor control. Leave the drug war warriors to get their rocks off on that particular power trip.

Rather, let's facilitate, support, advise, educate, help, collaborate, guide, enable and empower each of our drug using patients to determine a pathway that will keep them alive and healthy, alleviate suffering, give them a decent quality of life – and then allow them to become active participants in creating their own personal pathway in life.

Alan Joyce, advocate, The Alliance

Budgetary lip-service

In common with many other readers, I am sceptical that the announced budget increases will convert to increased availability of services for substance misusers who are seeking treatment.

In my area I have been notified of a 60 per cent cut in residential care funding at a time when local drug agencies are struggling to meet demand. Danie Strydom is concerned in last issue's comment, 'Sane in an insane place' (*DDN*, 3 July, page 7) that waiting three months for a detox could present a fatal delay to client X's ambitions to undertake treatment.

In my area it is not unusual to wait six to 12 months. What I do see is increased management, increased monitoring, increased bureaucracy. Public service workers in health, education and social services will recognise a familiar theme.

There is no doubt that the criminal justice system as a whole has increased the number of people it refers to treatment, as well as increasing its own capacity for level 2–3 interventions. However, I am surely not the only person to conclude that many of the numbers produced to justify claims of achieving targets derive from a plethora of forms regarding the same people.

My experience suggests that there are a variety of needs regarding which substance misusers face active discrimination, including accommodation, mental and physical health care, education, social care, social benefits, as well as access to treatment for substance misuse.

It is also my experience, especially regarding women, that the entirety of the defects in these systems makes it so difficult to access treatment that people are deterred and their problems escalate. Treatment that could have been provided effectively at level 2–3 does not get delivered, especially for those with alcohol problems, and the presenting symptoms become very serious, disruptive, expensive and difficult to treat with corresponding reduction in favourable outcomes.

There are still too many organisations involved and access to budgets for treatment does not match responsibilities on the individuals and organisations who have the task of holding these people safely. The lack of ring-fencing for the alcohol treatment budget, and the shenanigans about drug budgets, coupled with announcements that targets have been met two years early, makes me suspect that the whole policy is about to slide into the fifth and sixth stages of project management (excusing and rewarding the guilty, blaming and punishing the innocent) before fading into ignominy.

Eleanor Levy,
Surrey Probation Service

Religion vs the spirit

I fear I can't have made my points well enough in my piece, Caged Recovery (*DDN*, 19 June, Page 8), for Tam Jordon to have come away with the opinions he has (*DDN*, 3 July, page 7).

I do not have any clients, as he suggests, to give a choice to. I am a writer, film-maker and entrepreneur who, like him, got straight through a 12-step programme. My understanding of 'spiritual' is that it is to do with inner experience and, as such, is beyond language, whereas 'religious' describes any practice, ritual or organised belief system that attempts to organise and experience the spiritual from and on the outside.

In these terms, the 12-step system is religious. I am not condemning it, but I am saying there are many other ways of rediscovering one's humanity after an addiction.

Yours in humanity

William Pryor

Branded for life

I was interested in the little snippet about drinking coffee as a shield against alcohol induced liver disease (*DDN*, 19 June, page 4), though I hope this is viewed sensibly and not as a cure-all for over-indulgence. Indeed, some of my colleagues would avoid coffee as much as they avoid alcohol because caffeine itself is also a drug that could have adverse effects.

However, what prompts this letter is cirrhosis of the liver – now, I am pleased to observe, properly classified alcoholic cirrhosis when that is the cause, because in around 10 per cent of liver cirrhosis cases it is most definitely not. Hopefully, if this is properly understood, it will save innocent people being branded for life – or death.

I say this with feeling. Nearly 33 years ago my mother died in Warwick Hospital of, according to the death certificate, 'Ai cirrhosis of the liver'. When asked by the hospital if she drank, my father said rightly, 'No,' but did not think to qualify this by saying that she was teetotal, and had been for nearly 20 years. Before that she had only kept brandy or whisky for medicinal purposes, but when I became teetotal at the age of 17, she firmly joined me (I am now nearly 65). Only when he saw the death certificate did my father realise the implications – and why he had perceived the hospital's attitude towards her change. She had been branded a secret drinker!

At the time of her death I was in hospital 300 miles away, having undergone major surgery the previous day. I wrote to the hospital to explain but received no reply. Within a matter of weeks we had discovered the potential cause – as far removed from alcohol as you could imagine – and I wrote to *The Lancet* to draw their attention to it. Their response was adamant – alcohol had to be the major cause and they were not prepared to consider anything else. Ironically, ten years later, I read a further report warning against the effects of the very substance I was querying!

What a danger there is in making assumptions – and, as you can see, how distressing for those who have to live with the fruit of those assumptions.

Perhaps by now a lot has been done to create more understanding, but as I read you pages, how I wish that more effort could be put into prevention – not least into promoting the really healthy and safe option – alcohol free. Somehow, as a valid alternative, it does seem to be played down. Why?

Dr P Batstone, administrator,
An Association of Teetotallers in Methodism

Email your letters to claire@cjwellings.com or write to: Claire Brown, Editor, DDN, Southbank House, Black Prince Road, London SE1 7SJ. ***Letters may be edited for reasons of clarity or space.***

Research and guidance

Documents below are the most recent additions to the research and guidance section of our website, www.drinkanddrugs.net
A full listing on all subject areas can be found at the website, with links to documents.

Integrated care:
Models of Care for Alcohol Misusers
Guidance on range of services to meet needs for alcohol misusers.
DH, June 2006.

Models of Care for treatment of adult drug misusers: Update 2006
Update to original Models of Care for drug misusers.
NTA, June 2006.

DIP and prolific and other priority offender programmes – emerging practice and lessons learnt
Guidance from experience on effective case management of drug using offenders.
Home Office, April 2006.

Throughcare & aftercare:
Evaluation of Scottish Prison Service Transitional Care Initiative
Research report on SPS transitional care initiative.
Scottish Exec, SMRT, February 2006.

Detox & prescribing:
Best practice guidance for commissioners and providers of pharmaceutical services for drug users
Guidance from NTA, Royal Pharmaceutical Society and others.
NTA, February 2006.

The Drugs Intervention Programme:
Information on the Drug Intervention Programme.
Home Office DSD, January 2006.

Families:
Hidden Harm: Next Steps
Details on strategy for addressing effects of parental substance misuse in Scotland.
Scottish Exec, April 2006.

Diversity:
Diversity Assessment Package
CD-Rom available from NTA to assist effective practice in relation to issues of diversity.
NTA, March 2006.

Substance specific publications:
Report on khat from Advisory Council on Misuse of Drugs.
ACMD, January 2006.

Further consideration of the classification of cannabis under the Misuse of Drugs Act
Addendum to report on classification of cannabis from Advisory Council on Misuse of Drugs.
ACMD, Jan 2006.

Speaking their minds

It's not just what you say on drug education, it's the way that you say it. Youth leaders in Nottingham went a step further, inviting their young people to take to the microphone against drug-related gun crime and violence. DDN reports.

It's Tuesday night at Forest Field Youth Club. Teenagers from 12 to 19 are waiting their turn to try out the new recording equipment. It's become the place to be since Nottingham DAT responded to what's been happening there recently, and helped to kit the place out.

Rebecca Wright and Fuzi Bradshaw, drug workers from Compass are there, talking to Devon Richards from the youth service. They're encouraging the young people to talk about their turn in the local spotlight – an event that began with the three drugs workers putting their heads together, and is promising to continue its positive momentum long term.

It all started with that familiar tricky question: how could the youth club involve its young clientele in thinking about positive messages relating to their community? Nottingham has had a flurry of bad press lately – statistics circulating that put the city at the top of a league table of England and Wales for gun crime, with an average of a shooting every week in 2004. Tragic incidents such as the shooting of 14-year-old Danielle Beccan have brought it home to these teenagers that gun crime is not just something that happens elsewhere.

As in any city, young people can lose their way, take up with the wrong crowd, start hanging out in the wrong places. The youth workers' job is to present positive activities as attractive and inclusive – and that's where the idea of making a music video jumped to life.

First things first, and they inevitably needed funding, explains Fuzi Bradshaw. Their vision was ambitious – because it had to be, for the young people to take the idea seriously. They needed enough money to engage a production company, Magicbox – who for their part would add an extra educational element to the whole process, explaining the stages of production, from transforming a storyboard with camera, sound and lights, to a complete five-minute film.

Wright and Bradshaw set about applying for funding from Change-makers. The detailed funding application also became educational: 'We got the young people involved in everything, told them what would happen, what it would cost, who gets paid what,' said Bradshaw. 'We consulted with them on every aspect of the project, from start to finish.'

Glimpses of talent that had fuelled the idea could now come to the fore. Teenage rappers Juga-Naut and 1st Class set to writing lyrics that became the song 'Speaking my mind'. Using workshops as a catalyst for ideas from all the youth club members, the storyboard was drawn up, and parts confirmed.

Fittingly, the two rappers take the lead. They swagger in confidently from left and right, followed by their peers. Some shots are dark, showing back allies and places where you wouldn't hang around alone at night. But despite this, and despite the uncompromising

nature of the lyrics – 'Drug fiends all over the streets, everybody getting stopped and searched by the police, it's like life's a stress, never knowing who's next to get stabbed in the chest…' – the underlying message is of hope and choice. The faces are glowing with optimism: don't choose that, choose this.

Talking to 16-year-old Juga-Naut reveals a keen involvement with the project, from hearing that it was a possibility, to staging a film premier in front of 150 people at the Empire Cinema in Nottingham. His interest in each stage is obvious, from making sure everyone had chance to contribute ideas, to the 'added value' he says he gained, through seeing how a film was made.

'We came down the youth club and did workshops to write lyrics, and started off making the track first,' he explains. 'As the process went on, we started storyboarding up the video – that was the main creative part. Then we started recording the video with the director.'

When he came to write the lyrics with fellow rapper 1st Class, 'it just came out really', he says. What inspired him was that he'd 'jump at any chance to do a music video'.

'I'm definitely going to be up for the next project,' he says. 'There's studio equipment now, and it's good that we've got the opportunity to use it.'

Youth worker Devon Richards, based at the Forest Fields, has seen the difference in interest, compared to the usual drug awareness workshops.

'This gave them the platform to express themselves in that positive way, through music,' he explains. It's all been education – but further to that, peer education, teaching them to teach others.

He reflects on why it's worked so well, why momentum increased – and concludes that much of it is do with the project workers' active encouragement. Richards and colleagues gave structure and boundaries to the project, but at the same time they were non-judgmental, deliberately empowering young people of all levels of confidence to have a go.

'Some of the critics were negative about how they were dressed,' he explains. (Think hiphop/gangsta – without the bling.) 'But that's not what we were looking at. We were looking at the message and putting it across, rather than pinpointing negative issues.'

The unforeseen bonus for Richards and colleagues, was the opportunities that came from working closely with other agencies, aiming for achievements that would have been too daunting without the support of a partnership.

But the most rewarding outcome has been that 'the end production seems to be the beginning', he says. Spurred on by the enthusiastic reaction to the premiere, and enquiries that followed, the organising partnership are now investigating taking their project into schools in the East Midlands, perhaps with workshops that fit in with the anti-drugs curriculum. From their local burst of fame, other areas of the city have been in touch, interested in chasing similar results – particularly other districts where there is gun crime related to drugs.

Whatever happens outside the youth club, Forest Fields has certainly found that elusive step beyond merely trying to stop their young people from getting into trouble. Their clientele now wants to know when the next project is going to be. As Bradshaw reflects, it's bringing new people into contact with drugs workers – and changing their perceptions of them 'as not just people who say don't do drugs…they realise that as drug workers we do creative projects'.

Seeing the participants' obvious enjoyment in making music, you can't help speculating how much of the anti-drugs message finds its way into the young peoples' consciousness. But encouraging signs come from two teenagers calling themselves Lala and Cheeks, who are now performing as 'the LC'. The two girls were inspired by seeing Juga-naut and First Class in the video, and as a result performed live on stage at its premiere.

'We did our performance after the video,' explains Lala. 'It was about street life, drugs teenage pregnancies.'

'My friends were there, and they realised what I was trying to say, adds Cheeks. 'I was talking about street life, wanting people to wake up.'

'I'm really proud of myself and I'm going to keep doing it,' she adds.

And from the sheer enthusiasm in these young people's voices, and the earnest enjoyment with which they play out the video sequences, you realise that it's not the 'don't' messages that matter, but the resounding 'do' messages that count, when communicating with young people about drugs and positive lifestyles. Giving them a way to say it themselves must surely increase the odds of them taking it on board. **DDN**

Speaking My Mind

by 1st Class and Juga-Naut

I'm just speaking my mind
Speaking about all the things
I've seen in my time

I'm just speaking my piece
Speaking about all the things I've seen
in the streets

It's time that we wake up
Because right now
I can see the whole system
Is starting to break up
Drug fiends all over the streets
Everybody getting
Stopped and searched
By the police
It's like life's a stress
Never knowing who's next
To get stabbed in the chest
Man don't wanna fight with fists
They would rather
Draw for the knife and slice the wrists
This is the life we live
A lot of youth
Can't get jobs
So everyday they're searching
For man to rob
Certain people shot for
A living
And certain people
That I know now
Are shotting of women
We all know only God can judge
So don't criticise
Just keep it shush
Although life might make me wonder
I'll never ever
Let life take me under

Hold up
Slow down
Wait one second
There's youth on the road
Carrying automatic weapons
Sons are dying
Mothers in depression
Forget preaching to you
I'm speaking to you
I've seen it
I've heard it
I've been on the corner
In my life
I've seen the kind of shit
That will haunt you
But I've got to
Keep out of it
And keep my head up
Because I don't wanna
Mess around
And get dead up

Boy I'm fed up
Life is depressing
Police circle
The wrong people they're arresting
Blud I'm stressing
The way that I feel

No more…
Innocent youths
Getting killed
Once more
I've got to say this
It's a statement
There's more crack being sold
Than the cracks
In the pavement
So…
Enough about the drugs
Enough about the guns
You got to look after yourself
Your fam
And
Your funds

It's daunting
All the gun talk flaunting
Your soul wakes up
But you're dead in the morning
Gunshots falling
Everyday
Toploaders trying to make change
Every way

I see them walking
Talking
Flashing in the whip
Then the gunshots
Stalk you
Dashing from the clip

I can't believe
Certain things
That I've seen
Top boys
Around my way
Turn into fiends

Blud (sigh)
We got to make a change
If the hood
Turned good
Boy…
That will be the day

I'll look on the bright side
Stick to the right side
Hopefully…
I'll end up with a nice life

I'm trying to put it into context
Say
It
In
A
Way
That
Ain't
Yo
Complex

I'm filled with anxiety
Hoping that this tune
Will make a change in society

The **ice** age is coming

As the media and the drugs field become increasingly preoccupied by methamphetamine (ice) it becomes harder to separate fact from fiction. In this article, 'Delia Venus Wynn' uses first hand experience of producers, suppliers and users to look beyond the hype at the reality of methamphetamine.

Pic: David Hoffman Photo Library

Methamphetamine is not primarily derived from a plant source so unlike heroin or cocaine, it doesn't necessarily require long supply routes. This has in turn made it especially popular in less accessible markets, such as New Zealand, where homegrown methamphetamine production is an easier undertaking than importation of, for example cocaine.

Unlike many other forms of drug synthesis, methamphetamine is relatively straightforward. Precursor chemicals are more readily available than is the case with most street drugs. Using certain decongestants containing the precursor chemicals, a box of tablets is enough to make about three quarters of a gram of pure methamphetamine which could be sold for £50-£80.

The majority of the US market is supplied by large-scale labs, principally in Mexico, California and, to a lesser extent Texas, but a significant proportion comes from what the Drug Enforcement Administration term 'mom and pop' laboratories. These manufacturers make small batches (between 10 and 50 grams) on a three to four day cycle at home.

Plant-derived production does also take place. South East Asian suppliers obtain Ephedrine from Ephedra Sinica, a hardy shrub. Growers extract the ephedrine, which can be easily converted to methamphetamine using very basic chemicals.

The relative ease with which precursors can be obtained has been exacerbated by the growth of the Internet, which makes both recipes and sources of precursors easy to find. Key chemicals used in common production processes are available cheaply on-line.

As the chemicals in question are not on watch-lists for precursor chemicals, such companies will be able to act with impunity unless the licensing laws relating to these compounds is changed or it is possible to prove that they are being supplied with the intention of manufacturing a controlled drug.

UK methamphetamine is currently imported either from the Far East or from former ecstasy manufacturers (mainly based in The Netherlands or Belgium) who have switched from MDMA production to the more profitable methamphetamine.

However, police reports from London and the South East have suggested that UK-based meth-labs are starting to crop up now.

Methamphetamine can be smoked, snorted, swallowed or injected. This makes it a very versatile drug.

Its effects are similar to amphetamine (speed) but it is four times stronger, weight for weight, and with a significantly longer duration of action. In addition, methamphetamine can be smoked like crack and has a similar rush. The difference is that while a crack high lasts for ten minutes or so, the methamphetamine high lasts for eight hours and is qualitatively very similar. This makes it a more

economical drug for those looking for a powerful stimulant high.

The downside is a much bigger crash, so heavy users seek to repeat dosing to avoid this event, often for days. The crash from a single dose begins after around the eight hours mark, and can last for a further eight to 16 hours. With chronic usage, the crash can last a week or more – see www.sentencingproject.org/pdfs/methamphetamine_report.pdf

Meth trends

Recent reports from the US have shown that methamphetamine is not the national epidemic that the media suggests, but is very prevalent in certain urban areas. For example, in Phoenix, Arizona as many as 38.3 per cent of men tested positive for methamphetamine on arrest. This compared to a national average of 5 per cent for positive methamphetamine results. At the same time, 30 per cent tested positive for cocaine and 44 per cent for marijuana.

These figures seem to indicate that methamphetamine is nowhere as popular as say, crack, probably because of its long duration and horrible crash. Also, as users become tolerant, they are likely to take larger and larger doses to obtain the same high, so methamphetamine looks increasingly less like a 'cheap' drug.

Lessons learned

The experience of the US, Australia and elsewhere is certainly that methamphetamine can, and does, have a massively damaging physical and psychological effect on users, and causes huge collateral damage to them.

However, the US experience has not been that the drug became a widespread 'foundation' drug in the same way that heroin has. Instead, it springs up in concentrated, but highly damaging pockets.

Indeed, evidence (www.methresources.gov) suggests a significant decrease in methamphetamine use in the States, with estimates that use has diminished 30 per cent since 2001.

A number of factors may have contributed to this decline in methamphetamine use. Heavy ongoing use of methamphetamine is less feasible than with most other drugs, because of the serious physical and mental health problems that are likely to stem from it and the increase in tolerance. So use tends to be sporadic and bingeing (similar to a crack 'mission') rather than ongoing for sustained periods of time.

Many areas of the US are only supplied irregularly (mom and pop producers are frequently caught) so finding a steady supply remains difficult.

With a longer timeframe of problematic use, education and awareness messages in the US and elsewhere are more widespread. With families and friends of users having direct experience of the effects of the drug, and in turn with these being translated in to education, there is a higher level of awareness, and in turn resistance, than in the UK.

Efforts to clamp down on precursor chemicals, including decongestants, have had significant impact on areas where supply was reliant on local production rather than imports.

View from the UK Street

Currently, the market in Manchester, UK, is just starting to see the drug being sold in two specific markets. Firstly, the gay scene has a small but expanding market of recreational users who love the energy-giving, inhibition-losing effects, which also boost sexual drive – initially at least.

'Heavy ongoing use of methamphetamine is less feasible than with most other drugs, because of the serious physical and mental health problems that are likely to stem from it and the increase in tolerance. So use tends to be sporadic and bingeing (similar to a crack ''mission'') rather than ongoing for sustained periods of time.'

A key risk to these users is unprotected sex due to the lack of inhibitions and increased sex drive. If the US experience is any kind of indicator, the rate of STDs among these users will increase quite drastically.

The second group of users is likely to form the bulk of drug workers' caseload. We are beginning to see a marketing campaign strongly reminiscent of the introduction of crack. Dealers are offering two points of brown and one of methamphetamine for £20.

From a supply point of view, methamphetamine is a profitable drug: its addictiveness and need for escalating doses can generate large sales.

In addition, the high levels of stimulation and unpleasant crash are likely to be offset by use of depressant drugs, and this has resulted in escalating heroin sales, or, increasingly, sales of highly profitable imported benzodiazepines.

On a personal note, having tried the drug, it does seem like only hardened drug users would contemplate imbibing this compound regularly. Its extreme physical and mental effects mean that only people who find extremely potent stimulant use pleasurable would enjoy the effects.

Next steps

Uniquely, the UK is in a good position to respond proactively to methamphetamine, as we have had fair warning that the drug is likely to start entering the UK in significant quantities or start to be produced here.

The decision to move methamphetamine from class B to class A should provide the required impetus to develop effective responses. Given the rapidity with which crack cocaine achieved substantial market penetration, it seems likely that methamphetamine would follow the same route and achieve a wide market distribution quickly, following the same supply lines and getting in via the heroin market and sex-worker markets. So developing effective responses now is essential.

This will require responses from law-enforcement and drugs agencies and would ideally include the following:

- Prevention of UK-based production: this will require reformulation and greater control of OTC medicines containing precursor chemicals, and more robust licensing to prevent the sale of additional chemicals used in the production cycle.
- Effective monitoring of importation routes.
- Targeted education messages to high-risk populations, especially clubbers, the gay scene, and heroin or crack users being targeted by suppliers.
- Effective training of drugs workers to be aware of methamphetamine and the role of therapies such as CBT in working with methamphetamine users.
- Local monitoring of methamphetamine trends to provide early warning of increased use.
- Closer examination of the experience of other countries' models of control and treatment, especially those with extensive experience of responding to methamphetamine.

Methamphetamine represents a new and significant risk to drug users and the communities in which they live. Drugs agencies, mental health services and the criminal justice system are likely to see users presenting with a collection of drug and health related needs.

However, if the experience of other countries, especially the US holds true, methamphetamine is unlikely to become as uniformly widespread as heroin or crack, due to the deeply unpleasant side effects. In the short term, the levels of use are likely to expand rapidly. This expansion could be reduced through effective control and education strategies.

Without wishing to be complacent, it may well be that, after reaching a peak within the next five years or so, levels of use will drop off as older users move away from the drug and the next generation reject a drug which perhaps offers too much of a high and too much of a crash.

'Delia Venus Wynn' is a pseudonym; the author is a former manufacturer and user of a large range of compounds. Delia is now working towards a professional career in the other side of the drugs field. Additional material by Kevin Flemen/KFx.

A longer version of this article is on the KFx website at www.ixion.demon.co.uk

Making the skills connection

Trying to meet the needs of dual diagnosis clients can all too often lead to neither of their needs being met. Val Dunhill shares her experience of a workshop that explored relating more effectively to mental health and substance misuse.

The double stigma of substance use and mental illness can leave clients struggling to have their needs met. Perceptions of this client group, within the professional and public domains, often leave them marginalised – which sets challenges for agencies working in the field.

A recent 'Tackling Drugs, Changing Lives' conference in Birmingham invited us, as representatives of CAN, to facilitate a workshop which explored good practice in supporting people with a dual diagnosis. CAN is a voluntary drug, alcohol and homelessness agency providing a range of services for Adults and Young People across Northamptonshire and Bedfordshire.

Within the workshop my colleague, Bedfordshire Area Manager Liam Pickford, and I considered good practice principles for both drug and alcohol agency workers and social workers. These included comprehensive assessments and risk assessments and an understanding and implementation of the care programme approach.

A recurrent theme was that close working relationships are essential between substance misuse workers and social workers, to provide a comprehensive service to all of our clients. There also needs to be clarity about who is taking responsibility for what, clear record keeping and regular reviews of the service being offered. Agencies also need to be clear about what information they can share, and have confidentiality protocols in place.

User consultation is fundamental to supporting people accessing services, and service users have keen insights to their issues and attendant support needs. Many service users are 'experts by experience', and as such, can offer the firmest foundations for a sound care plan. Where possible, care planning shouldn't just be user focused, but defined by users and led by their needs.

Staff training is also a primary need – and one that often leads to workers realising that they are already using many skills that can be transferred to other clients with differing needs.

To highlight some of the issues arising from joint working, we presented case studies to encourage conference delegates to consider ways they could support their clients. One of these featured a client we called John, who is in his early forties, has used heroin, crack and cannabis, and has a diagnosis of schizophrenia.

John has fortnightly injections from a community psychiatric nurse and lives in a supported hostel, where he has a key worker. He also has a mental health social worker and a substance misuse counsellor. He has a pattern of being able to abstain from drugs when he has a network of support, but has lapsed in the past when living on his own. There are plans for John to move to more independent living, which has raised fears of a new relapse. The task of the workers involved is to help him prepare for this move, and to focus on relapse prevention.

We set out a scenario in which John returned to the hostel in an agitated and disorientated state. We asked delegates to put themselves in the role of a duty social worker who gets a call from the hostel about John, and asked them to consider what their responses might be.

The delegates took a measured approach to this scenario, acknowledging that they needed to gather information from John and workers who knew him, before deciding what would be appropriate action for them to take. They also considered his safety, and that of the people around him.

They were aware that his presentation could be influenced by a number of factors, including drug use, his mental health, or something completely unconnected with either or these. It was clear from delegates' feedback that good working relationships between agencies provide the best opportunities to support clients, so that networks are already in place should challenging situations arise.

A sound knowledge of interventions offered by other agencies is critical and one of the ways in which CAN bridges this knowledge gap is by working closely with universities, training social workers by being part of their assessment panels, delivering training within social work courses and by offering student placements – giving them a perspective that might not be available within a social services department.

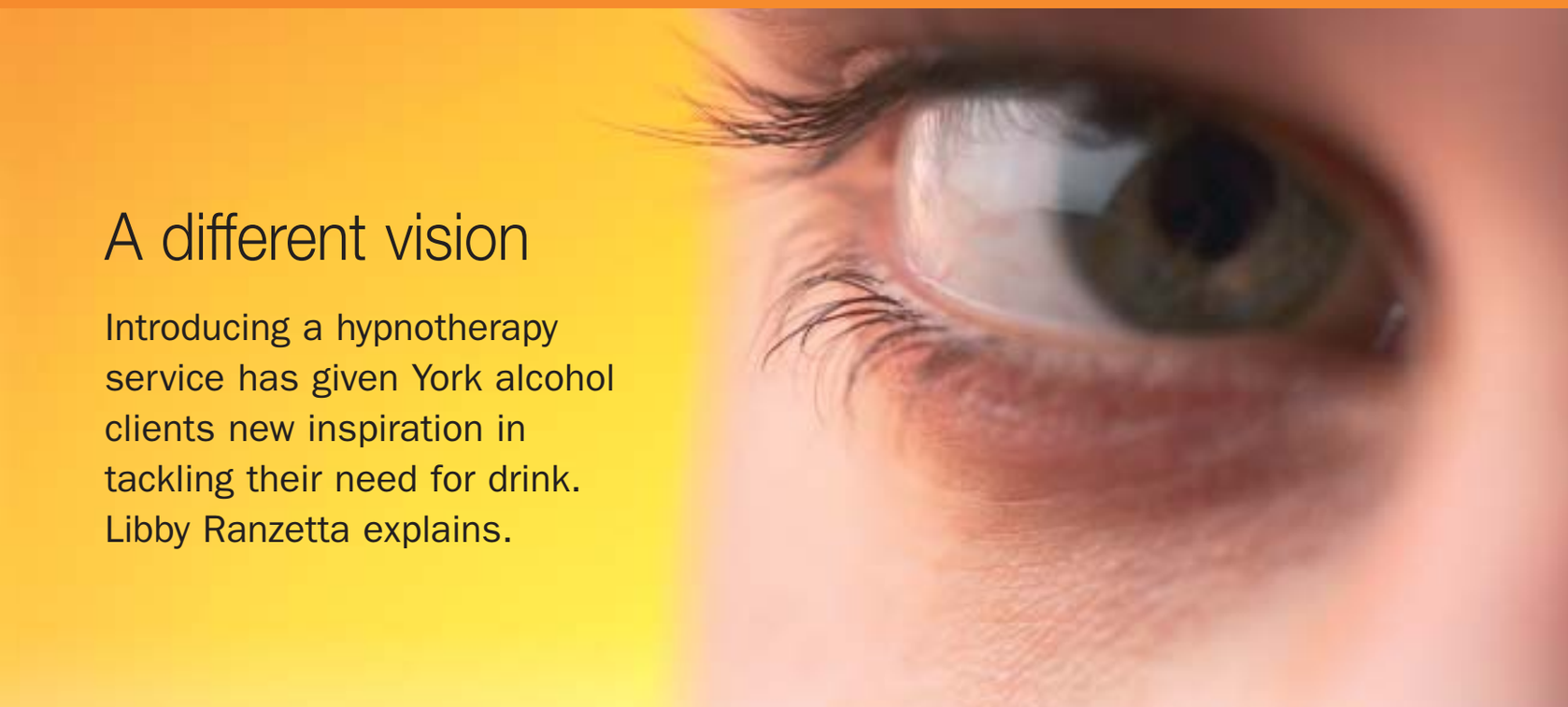
Students often go back to their universities with new understanding, which they cascade to other students and tutors. Their understanding of our client group and ways of working are passed on again when they qualify and go to work in social services teams, leading to a further cross-pollination of knowledge and skills in the care industry.

Sharing of skills and knowledge is a two-way process and CAN has benefited from learning different perspectives from students who have been on placement with the agency. This broadening of expertise is a clear benefit, which is in turn passed to clients – who know they are working with an agency that proactively embraces partnership as a matter of best practice.

'Sharing of skills and knowledge is a two-way process and CAN has benefited from learning different perspectives from students who have been on placement with the agency.'

Val Dunhill is substance misuse counsellor with CAN.

CAN offers training on ways of working with dual diagnosis clients. For details of a one-day course on substance use and mental illness in Northampton on 13 November, contact Jane Lawrence, learning and development manager on 01604 824777.



A different vision

Introducing a hypnotherapy service has given York alcohol clients new inspiration in tackling their need for drink. Libby Ranzetta explains.

York Alcohol Advice Service (YAAS) is a voluntary sector alcohol counselling organisation, serving the City of York. Like many such organisations, YAAS has a number of small projects running alongside its core service, and one of these is a hypnotherapy service for clients. This is an unusual intervention to be found within mainstream alcohol treatment provision, but YAAS Service Manager Ali Tubbs is delighted with its success.

Hypnotherapy is the application of hypnosis – a relaxed state of consciousness – as a form of treatment for relieving pain or conditions related to state of mind.

In terms of treating addiction or substance misuse, hypnotherapy is widely promoted for smoking cessation, but the research literature barely mentions it as a treatment for alcohol misuse. Despite its apparent popularity for smoking cessation, its efficacy is contested. Researchers in a recent Cochrane Review of the evidence concluded: 'We have not shown that hypnotherapy has a greater effect on six month quit rates than other interventions or no treatment'.

Against this rather unpromising background, advanced hypnotherapist Robert Williams offered YAAS a free three-month trial in April 2004. The outcomes were so good that the Truemark Trust picked up funding for the project to continue for 2005, and York City Council have provided funding from 2005/06.

The project takes clients who have been with YAAS for some time, and who are not doing particularly well with alcohol counselling. After an initial session with a client, Williams prepares a personalised audiotape of relaxation and visualisation techniques that enable the client to reach a state of self-hypnosis.

There are suggestions at the end of the tape that work at the subconscious level on the client's belief structure; these suggestions help the client to perceive and respond to problems in a more constructive way. In the second session, Williams works on the underlying issues that are troubling the client. Often these do not include not drinking itself, but anxiety, guilt, grief, anger or depression instead.

Most of those using the service have anxiety problems; Williams uses psychotherapeutic techniques while the client is under hypnosis to find the cause of the anxiety, so that it can be addressed. About five sessions are sufficient for most clients, and the feedback has been overwhelmingly positive.

Williams says: 'The relaxation techniques are proving very useful to all clients to help deal with situations differently in their everyday life. Other benefits clients mention include being able to focus on certain emotions and learning how to manage them; feeling more positive about their ability to cope with stressful situations; and increased self-confidence. The main benefit however is resolving the emotional need for alcohol.'

Tony Ogden had been receiving counselling at YAAS for four months when it was suggested he try hypnotherapy. He was very sceptical initially but now says:

'I can't remember ever feeling like this. I started drinking at 13, have always drunk to cover feelings. It's different now – how come? I don't think I'll need to go back to hypnotherapy – I feel strong. I have tried many times to give up alcohol, now I don't even think about it. Somebody asked me the other day how long I had been stopped and I didn't know.'

'I have tried many times to give up alcohol, now I don't even think about it. Somebody asked me the other day how long I had been stopped and I didn't know.'

Another client, Pat Anderson, had been in counselling for two years but felt there was 'something missing' and jumped at the chance to try hypnotherapy. The six sessions she had in 2004 'broke the habit' of drinking and she has been dry since.

'I don't have cravings now – only the odd passing fancy. You don't have that fight; you know you can control it. He [Williams] was a godsend.'

Tony and Pat find it difficult to explain exactly how the hypnotherapy worked for them. Tony, who talks about hypnosis in terms of 'going under' explains:

'He [Williams] put me under… I wasn't under the first time. You go under and after two or three times you start to feel calmer, even going home. You feel in a daze. It didn't suddenly happen… over a period of weeks I felt better.

'He doesn't just put you under though; it's a therapy as well. He talks it all through before and after. I don't remember talking during [hypnosis] but I was going back to childhood. I didn't remember what I had said afterwards; Rob told me.

'I knew after the second session that it would work. Something was happening to me. I didn't understand how much was happening – I just knew.'

Williams would like to see hypnotherapy more widely used alongside traditional alcohol interventions. However, hypnotherapy is not currently a regulated industry and in theory anyone can practice. To work with this client group, practitioners should be suitably qualified.

For more details of the YAAS project, contact Alison Tubbs, Service Manager, York Alcohol Advice Service, 63 Bootham, York, YO30 7BT, telephone 01904 652104, email alison@yaas.info

The author, Libby Ranzetta, runs www.alcoholpolicy.net, a website with news and resources on problem drinking.

Events

FDAP events

8 November – London

Annual drug and alcohol professionals conference, 2006

Organised by the Federation of Drug and Alcohol Professionals (FDAP) in association with *DDN*. FDAP's annual conference aims to help support the development of front line workers, managers and commissioners, and tackles the important issues of the day. This year's event includes the future of alcohol services, residential rehab and harm reduction, and next steps on workforce development. Practical workshops and seminars cover services for steroid users; meeting the needs of young people; gambling problems; brief therapies for alcohol problems; and, managing child protection issues. Delegates will contribute to policy debates on: whether psychological therapies work with substance users; whether there's a role for coercive treatment; and whether practitioners should have to be qualified to work in this field.
w: www.fdap.org.uk.

Other events

20-21 July – Barlaston, Staffs

An audience with...

Organised by G.H.P. This two day event will cover current issues of concern in treatment and harm reduction, but will focus on establishing dialogue between enthusiastic and motivated individuals with the opportunity of discussions and debate with prominent professionals and practitioners.
e: g.h.p@hotmail.co.uk

3-8 September – Edinburgh

49th ICAA conference on dependencies

Organised by ICAA, Castle Craig Hospital and Addiction Recovery Foundation. This year's conference, 'What makes good practice', will provide a platform for dialogue and enlightenment for professionals in the fields of substance abuse prevention, treatment, research and policy-making.
w: www.icaa-uk.org.

21 September – Brighton

10th Sussex conference on drugs and alcohol

Organised by Brighton and Hove, West and East Sussex DAATs. Topics covered in this year's event include: cannabis and mental health, treatment of young people, sexual abuse and substance misuse, dual diagnosis, methamphetamine, user involvement and community prescribing.
e: nick.cole@eastbournedownspct.nhs.uk.

20-22 September – Piran, Slovenia

4th International conference on nightlife, substance use & related health issues.

Organised by Centre for Public Health, Liverpool John Moore's University and others. This three-day conference will bring together experts from around the world to exchange information on the latest research, policy and evidence on protecting and promoting health in nightlife settings.
w: www.clubhealth.org.uk/conference.

3 October – London

Adult drug problems; children's needs

Organised by the National Children's Bureau. Examining challenges posed by the 'Hidden Harm' of parental drug use, and improving the professional response from assessment to care planning.
w: www.ncb.org.uk/conferences

Our organisation currently provides a staff smoking room, but the new legislation coming into force next year will outlaw this. While I could just kick the smokers out into the cold I would like to offer them some help to quit. Has anybody offered any smoking cessation schemes to their employees, and if so how successful was it?
Mick, London

After the revolution...

Dear Mick
We had free 'quit smoking sessions' at our place, and agreed to turn the smoking room into a smoke-free zone. It went down OK with most people – until one by one we began to relapse. It will probably be an easier revolution to manage when there's no choice about whether a building is smoke-free or not.

One hint to you though: don't replace the fag machine with a chocolate machine... we all put on at least half a stone!

Cheryl, Staffordshire

You've got to want it

Dear Mick
We were offered a free session with a hypnotherapist at my last place of work. The woman in question came with a very good reputation and a string of recommendations as long as your arm. Her programme promised to help you quit in one hour and she claimed an over 90 per cent success rate. Her normal charge of £125 per hour was paid for by the company, with the sessions being held in a meeting room during the working day.

The uptake was huge (how many smokers do you know who don't want to quit?) and we duly attended our one-on-one sessions. But I am sad to say that within a week every single person was smoking again. This is not because the hypnotherapist was no good or some kind of fraud, she is still working in our local area and I know is still getting excellent results.

It is because giving up has to be a personal decision – the people who decide to give up £125 of their own money and their own time to travel to the clinic for a session are very committed to giving up and demonstrate their desire to do so, so she is able to help them. The people at my work did not have that commitment – they just saw it as an easy, no lose situation.

I guess what I am trying to say is that you can't make someone give up, all you can do is make them aware that there is help available. But ultimately, it will be down to them if they decide to take it.

Eileen Belling, Surrey

It's all in your mind

Dear Mick
I have a book out on stopping smoking, it's called, *Stop Smoking – it's all in your mind and you can beat it*, published by Foulsham. I also have a diploma in addiction therapy and work with people who have addictions of all kinds, amongst other things running courses in prisons, and stop smoking training courses for the NHS. So, all in all I have pretty good credentials for offering smoking cessation schemes to groups!
Two years ago I spent many hours and quite a sum of money marketing the kind of scheme that you're interested in offering to your workforce. There was a huge amount of interest from management – but no eventual take up. Apparently the workers were simply not interested.

Times and legislation have moved on though. Presumably feelings on this subject will have done as well. I would still be very pleased to offer courses to any organisation that wanted to help its employees quit smoking, always assuming that they were up for it.

Please email me if you would be interested in talking it over, and the very best of luck in encouraging your workforce to quit.

Gillian Bridge, Bath
Email gillian.bridge@btinternet.com

No silver bullets

Dear Mick
I thoroughly applaud your willingness to help your staff break one of the hardest habits there is to break. Smoking is the largest single preventable cause of death in the UK, but one which is still legal and socially acceptable. There are many different ways of giving up the dreaded weed and all of them involve desire on the part of the smoker to quit and a degree of will power. Sadly it is not possible to pay for a 'silver bullet'.

The NHS offers free local smoking cessation services and by allowing your staff the time to attend these you will be offering practical assistance. Also why wait till the new legislation? Removing the smoking room now will have the immediate effect of reducing the amount of cigarettes that smokers in your organisation consume. It is too easy to sit and smoke two or three cigarettes on a break, whereas if you have to venture outside and face the elements they may have just the one or even not bother at all. So go on, kick them out into the cold, it's for their own good!

Isabelle Rolf, by email

Reader's question

Week after week I attend our regular team meetings – but frankly they're shambolic! There's no structure and people come away muttering that it's been a waste of time. The process demoralises me every week. My manager is good in other ways – but can anyone suggest a simple format for effective meetings that works?
Carrie, by email

Email your suggested answers to the editor by Tuesday 25 July for inclusion in the 31 July issue of DDN.

New questions are welcome from readers.

The drug experience: heroin, part 10

In his latest Background Briefing, Professor David Clark concludes his look at seminal research from the 1980s, which involved interviews with people who had recovered from heroin addiction without treatment.

The research conducted by Patrick Biernacki, with 101 former heroin addicts, showed some of the courses that people take in their lives when they give up using the drug without the aid of treatment.

When people resolve to stop using heroin, they face a variety of problems that go beyond the cravings for the drug and the temptation to use again. These additional problems are related to their attempts to fashion new identities and social involvements in worlds that are not associated with drug use.

As Biernacki pointed out: 'The manner of termination and the course [or courses] that follow withdrawal from opiates are closely related to the degree that the addicts were involved in the world of addiction, to the exclusion of activities in other, more ordinary worlds, and to the extent that they had ruined conventional social relationships and spoiled the identities situated in them.'

Former users of heroin may be reluctant to engage with ordinary people because they feel socially incompetent and stigmatised, and they may feel shame and guilt for past actions. Society has a very low opinion of drug addicts, which creates a formidable barrier for those wishing to move on from their heroin addiction.

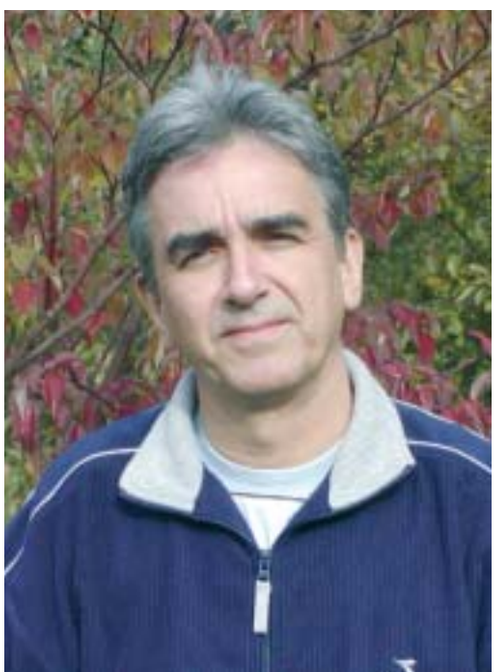
For some people, the transformation from being a problem heroin user to being a non-user can appear to happen abruptly and be quite simple. However, for many others the process is prolonged and very complex.

Biernacki described three major courses through which the interviewees naturally recovered from their addiction, involving different forms of identity transformation.

Some interviewees reverted to an old identity that had not been damaged too badly by the period of problematic heroin use. They had not ruined all their conventional relationships and therefore did not spoil the social identities situated in them. When they resolved to quit drug use, they attempted to re-establish an old relationship and revert to the identity rooted in it.

Other interviewees extended an identity that was present during the period of problematic heroin use and had somehow remained intact.

This course of transformation was typically taken by someone who managed to maintain other identities during their addiction – examples given were jazz musician and poet – that were not spoiled as knowledge of their addiction became widespread. Alternatively, the person may have compartmentalised different parts of their lives and maintained roles in social worlds unconnected to their drug use.



'Ultimately, the self-identity and perspective as an addict can become so de-emphasised and distant that cravings for the addictive drug become virtually non-existent. For all practical purposes, the addict can be said to have recovered.'

A third course of recovery involved the engagement of an emergent identity that was not present during or before the period of problematic heroin use.

Biernacki pointed out that a successful transformation of identity requires the availability of identity materials with which the non-addict identity can be fashioned. These identity materials are aspects of social settings and relationships (*eg* social roles, vocabularies) that can facilitate the construction of a non-addict identity and a positive sense of self. He emphasised that the availability of these materials is in part related to the stigma associated with the addiction.

It is worth quoting the full last paragraph of this chapter of Biernacki's book, although I have broken it up into smaller paragraphs:

'Those addicts wishing to change their identities may first have to overcome the fear and suspicions of non-addicts before they will accepted and responded to in ways that will confirm their new status. Gaining the recognition and acceptance of the non-addict world often is a long and arduous process.

'Eventually, acceptance may be gained by the ex-addicts behaving in conventionally expected ways. Following "normal" pursuits, remaining gainfully employed, meeting social obligations, and possessing some material things will often enable non-addicts to trust the abstainer and, over time, to accept him and respond to him in "ordinary" ways.

'At the same time, the addict's feelings of uncertainty and doubt will lessen as he comes more fully to accept the new, non-addict life.

'Ultimately, the self-identity and perspective as an addict can become so de-emphasised and distant that cravings for the addictive drug become virtually non-existent. For all practical purposes, the addict can be said to have recovered.'

Biernacki described several implications of his research in relation to therapeutic interventions. Firstly, addiction is not a uniform phenomenon, but rather, 'a variable condition reflecting different levels with the world of addiction and different courses of recovery'.

Secondly, addiction is not necessarily an irrevocable and everlasting affliction. Some people stop using heroin and do so through their own resolve and initiative.

Contrary to what might be expected, people who recovered on their own were relatively easy to locate and interview. Biernacki pointed out that natural recovery may be more common than often thought. Most of the people who recover on their own may not be socially visible because the stigma associated with heroin use prevents them from revealing this aspect of their lives.

Since these recovered addicts are not available as role models, people who currently have a heroin use problem rarely believe that they can successfully stop using drugs on their own.

Recommended Reading: Patrick Biernacki (1986) Pathways from heroin addiction: Recovery without treatment. Temple University Press, US.

NHS

National Treatment Agency for Substance Misuse

A chance for users to have their say!

The 2nd NTA annual user satisfaction survey

The annual service user satisfaction survey enables service users to:

- **tell us how they really feel about their drug treatment**
- **comment on their satisfaction with their treatment service**
- **contribute to the treatment effectiveness agenda**

The annual service user satisfaction survey enables service providers to:

- **better assess their clients' needs**
- **retain clients more effectively in treatment**
- **put the needs of service users at the heart of the treatment system**
- **contribute to the forthcoming improvement reviews**

The survey will be conducted over a five week period in July and August. Questionnaires will be available from drug treatment services throughout England and the NTA would like providers to encourage **as many people** as possible to respond.

The results from the survey will contribute to the overall score for DATs, through the 2006 improvement reviews.

Full details of the user satisfaction survey will be distributed shortly and will also be posted on the NTA website at www.nta.nhs.uk

Findings of the 2005 survey are now available on the NTA website:
www.nta.nhs.uk/home/UserSat2005.pdf

For immediate queries contact:

Anna Cosgrave
Research assistant
National Treatment Agency
Hercules House
Hercules Road
London SE1 7DU
020 7261 8950
Anna.cosgrave@nta-nhs.org.uk
More treatment, better treatment, fairer treatment

drink, drugs and edp

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

CARAT WORKER – REF: 30.06

- Based: HMP Dartmoor
- Hours: 35 Hours
- Salary: £20,894 rising to £24,708 (NJC Scale: 26-31)

We are seeking to appoint a CARAT worker to join the multi-disciplinary team at HMP Dartmoor. You will engage and motivate adult male prisoners to enter drug treatment programmes and will provide broad-based services including assessment, care planning and group work. You will have a good understanding of the drugs field and the criminal justice system including the Drug Intervention Programme. You will have an organized, efficient and solution focused approach to work and will need to be enthusiastic about working in the challenging environment of a local prison. A formal qualification in a relevant discipline is desirable.

EDP employs individuals who possess:
A motivation to achieve, a commitment to evidencing professional responsibility and accountability in all that you do, a desire to learn, develop and reflect upon practice and an enthusiasm for working in this sector.

EDP will provide you with:
Training, support and supervision and opportunities for career development within the organisation. An excellent employee package, including 5% employer pension contribution and annual leave entitlement which rises to 30 days per year

Enquiries after receipt of the application pack to: Phil Hawksley, Head of EDP Prison Services (01392 666722) or Meg Richardson, Prison Team Leader (01822 892063).

Closing date for applications:
2nd August 2006 12noon.

Application forms available from: Georgina Burford, Human Resources Officer, EDP Drug & Alcohol Services, Dean Clarke House, Southernhay East, Exeter, EX1 1PQ. Or email **recruitment@edp.org.uk** quoting the reference number.

Cyngor Sir **Powys** County Council

Powys

Dual Diagnosis Worker (Mental Health / Substance Misuse)

CSSC464 Radnorshire, Mid Wales

£25,437 to £29,859
(bar) £30,843 to £32,487

This post is in response to the new expectations contained within the Welsh Assembly Governments 'Substance Misuse Treatment Framework - for co-occurring Substance Misuse and Mental Health Problems' and will be based within the Community Mental Health Team (CMHT) in Llandrindod Wells.

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

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

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

For information please ring David Waring, Team Manager on 01597 827102. For Applications please call the Workforce Planning Unit on 01597 826887; or email allyson.boswell@powys.gov.uk or apply on line at www.powys.gov.uk

Closing date: 4th August 2006

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

The National Offender Management Service

(Hampshire and Iow Probation) invites applications from suitably experienced organisations to tender for the provision of a substance misuse service working with offenders on community orders. The service would include assessments,delivering brief interventions and structured programmes,aftercare and general advice and support to offenders with drink/drugs problems.

It is particularly important that the successful service will be able to focus services around tier two and three in respect of alcohol problems and be able to work to agreed protocols with Health in accessing statutory services for tier four treatment.

The contract has a proposed commencement of January 2007 with an initial length of 3 years.

Please note that transfer of undertakings(protection of employment) regulations 1981 may apply to this service

Organisations interested should apply for a tender pack to
Chris Mitchell, Director of Interventions, Friary house, Middle brook street, Winchester S023 8DQ, tel: 01962 842 202,
by no later than **11 August 2006 by 5.00pm**
For further information contact
David Kiely on Portsmouth 0239 272 8300

The contracting authority undertake to use reasonable endeavours to hold confidential any information provided in the tenders submitted subject to the contracting authority's obligations under law including the freedom of information Act 2000. If the applicant considers that any of the information submitted should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive.The contracting authority will then consider the information before replying to any requests under the Freedom of Information Act 2000.

MIDDLESBROUGH PRIMARY CARE TRUST

(on behalf of the Safer Middlesborough Partnership)

Middlesbrough NHS

EXPRESSIONS OF INTEREST

user led throughcare and aftercare service

Safer Middlesbrough

Middlesbrough PCT (on behalf of the Safer Middlesbrough Partnership) is inviting expressions of interest from suitably experienced organisations for the provision of a user led throughcare and aftercare service.

The successful organisation will be expected to develop a service that has as its central focus the recruitment of ex service users/service users into paid posts and the utilisation of these workers in supporting current clients in drug treatment services. The service will form part of the SMPs community based response to substance misuse in Middlesbrough and will include the following components:

- A service that is predominantly staffed by ex service users/carers at all levels of service
- Aftercare/throughcare support for clients by ex service users/carers
- Assertive outreach/follow up support by ex service users/carers
- Basic awareness training for tier one staff
- A peer advocacy service to users
- Lead agency support for the development of appropriate user representation
- Abstinence based interventions and support
- Research into the utilisation of service users/carers in drug treatment services

The PCT/SMP would welcome expressions of interest from organisations within the substance misuse related sector but also from those with a history of service user involvement/employment in other related sectors.

The indicative Budget for this service held by the Safer Middlesbrough Partnership is (full year) £118,000. Part of the evaluation of the tenders will be an assessment of the tendering organisations ability to attract additional resources to develop the project, e.g. by grant aid or charitable sources

The contract is expected to be awarded in the first instance for the period to 31 March 2008 and is expected then to be renewed for a further 12 months subject to satisfactory performance and commitment of finance by the Safer Middlesbrough Partnership.

Expressions of interest in tendering for this contract should be submitted in writing by Friday 28th July at 12 noon and should be sent to: David Jackson, Joint commissioning Manager, Safer Middlesbrough Partnership,2 River Court, Brighouse road, Middlesbrough,TS2 1RT, Email; d_jackson@middlesbrough.gov.uk

CDC - CHANGING LIVES

The Chemical Dependency Centre (CDC) has been helping vulnerable people with alcohol and drug dependency for over 21 years at its four treatment centres. We are now in the process of merging with two other key charities in the field, offering new and varied career opportunities to staff and a greater stake in the future of addiction treatment. We have the following vacancies at our LONDON and LIVERPOOL Projects:

THURSTON HOUSE, based London SW4
COUNSELLOR* / PROJECT WORKER

Part-time, 4 days per week. Salary: £23,114 p.a (£18,491 pro rata)

THURSTON HOUSE is a residential, second stage, treatment centre for men and requires an experienced substance misuse counsellor/project worker. Working as part of the clinical team, you will carry a personal caseload of clients with complex issues, both individually and in groups.

SHARP, based London SW10
ADMISSIONS WORKER / COUNSELLOR*

Full-time. Salary: £23,114 p.a

SHARP is a structured day treatment programme for men and women. A role has become vacant for someone to closely support clients on our waiting list, and keep them positive, stable and committed to treatment until a place becomes available. Duties include screening potential clients, preparing detailed files, liaising with other professional agencies and assisting in providing a professional, helpful and welcoming service.

* Those applying for counselling roles must hold relevant counselling qualifications. You must also have experience in the substance misuse field, excellent communication skills, initiative and sensitivity.

SHARP, based Liverpool, L1
RECEPTIONIST / ADMISSIONS WORKER

Full-time. Salary: £21,459 p.a

You will be the first point of contact for this busy project and will need excellent interpersonal skills, a courteous, helpful and professional manner and a flexible and adaptable approach.

You will provide administrative support for staff using word-processing, spreadsheet and database packages and will have experience of working in a busy, customer-focused, service orientated environment. Duties will also include taking referrals and carrying out assessments and admissions.

Benefits of working for CDC include: training and development opportunities and high quality supervision within a supportive, friendly and stimulating environment. CDC offers a non-contributory pension scheme, attractive leave entitlements and is an organisation committed to work-life balance and equal opportunities for all.

For further details visit www.thecdc.org.uk to download an information pack. Alternatively email enquiries to personnel@thecdc.org.uk or call the HR team on **020 7349 5763.**

Closing date: 5PM, FRIDAY 4TH AUGUST 2006

THE CHEMICAL DEPENDENCY CENTRE

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www.conwy.gov.uk

At Conwy County Borough Council the huge range of careers we offer is matched by an equally extensive list of employee benefits. If you're interested in working for the region's largest employer visit www.conwy.gov.uk/jobs email: jobs@conwy.gov.uk or call 01492 576124 to find out more.

COMMUNITY SAFETY FACILITATOR (Ref: 1015)

Substance Misuse, Public Protection, Colwyn Bay

Scale SO1/2: £23,175 - £26,928 - 2 Year Fixed Term Contract

Conwy Community Safety Partnership is seeking a Community Safety Facilitator (Substance Misuse) to support the work of the Substance Misuse Action Team in reducing the harm caused by alcohol and drug misuse within Conwy.

You will be responsible for facilitating the work of the SMAT, reviewing, implementing and monitoring the Substance Misuse Action Plan and enabling the commissioning of services in line with the plan.

This is a demanding role, your knowledge and experience of working within the substance misuse/Community Safety field, enthusiasm, good organisational and presentational skills will ensure that you make a tangible impact. The ability to converse in Welsh in addition to English would be seen as an advantage, working in a bilingual society.

For an informal discussion of the role please contact Hannah Dowell, Community Safety Officer on 01492 575190.

For a recruitment pack please contact the Personnel Section, Conwy County Borough Council, Bodlondeb, Conwy LL32 8DU. Tel 01492 576124 (24 hour), email: jobs@conwy.gov.uk or visit our website: www.conwy.gov.uk/jobs

APPLICATION FORMS TO BE RETURNED BY MIDDAY 07/08/2006.

If not informed within two weeks of the closing date, candidates must assume they have not been shortlisted for interview and will therefore not be notified in writing.

This post is subject to Job Evaluation.

A Criminal Records Bureau check may be required for the successful candidates for the above posts.

In promoting equal opportunities Conwy welcomes applicants from all sections of the community. All disabled applicants who meet the essential job requirements will be guaranteed an interview.

- ☑ Competitive Salary and Benefits Package
- ☑ Final Salary Pension Scheme
- ☑ Generous Leave Entitlement
- ☑ Excellent Training/Development Opportunities

KCA (UK) is an expanding and vibrant organisation providing a wide range of high quality and innovative specialist services. Founded in 1975 and currently employing over 200 paid and unpaid staff, it has an annual budget of £8 million and is becoming established as one of the leading service providers in the South East Region. Our aim is to deliver individually tailored care packages which are effective in reducing drug and alcohol related harm and are based on cost-efficient structures, processes and delivery mechanisms.

REF: 358 – DAY PROGRAMME CO-ORDINATOR - GREENWICH
Salary £23,175 - £27,492 pro rata (SCP 29-35)
plus £2,604 London Weighting
37 hours per week – Casual Car User Allowance

You will be a key member of a management team that plans, manages, monitors and evaluates the provision of services to ensure they are both appropriate to the needs of service users and fully meet contractual requirements.

You will be responsible for the management and support of the local team in progressing the assessment of service users, care planning and keyworking activities in a systematic fashion. In conjunction with the Service Manager, you will implement policies, procedures and protocols and establish priorities and goals in relation to Day Programme development and links with other community/statutory agencies.

You should hold a recognised professional qualification in a relevant discipline and have comprehensive experience of delivering and evaluating Day Programmes. To meet the challenges presented by both local growth and the developing national framework, you will need to be a resilient and positive individual, with a 'can do' attitude.

If you would like to discuss this role informally, please call Simon Eve, Service Manager, Greenwich between 9.00 am & 5.00 pm. Telephone 0208 316 0116.

For application forms contact: **KCA (UK), Dan House, 44 East Street, Faversham, Kent ME13 8AT. Telephone 01795 590635, Fax 01795 539351, Email marina@kca.org.uk, website kca.org.uk.**

Closing date: 28th July 2006
Interview date: To be confirmed

KCA (UK) is committed to the principles of equality of opportunity for all and welcomes applications from people with experience of substance use or who have had previous problems with substance misuse.
Charity No: 292824

We're all going on a summer holiday No more DDNs for a week or two!

The next issue will be out on 31 July.
We will not be publishing in August
Back 11 September...

Contact Ian Ralph ian@cjwellings.com 020 7463 2081 for advertising deadlines.