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19 May 2008
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Drink and Drugs News

19 May 2008

Editor's letter

If you are born into an addicted family and spend your childhood in and out of dealers' houses, how likely are you to escape a life that's entangled with drugs? Mark Ashby's article (page ten) really hammers home the lack of choice some kids have – and their random chance of getting relevant support before they are beyond reach. It's not so much 'hidden harm' as really obvious harm, and when the lack of dedicated support services for the young client group are highlighted, there is no justification for not catching them earlier.

If adults who enter drug treatment environments and the criminal justice system are vulnerable to learning from those with more extreme habits, how much more at risk is a young person? Mark surely has a point when he points to the woeful gap in bespoke treatment units for adolescents. The Kidsco charity is about more than just steering children away from drugs. It does its best to fill fundamental holes in their lives, which could be a daunting remit when the issues they arrive with are way more adult than they are.

For as long as *DDN* has been going, we've printed raging arguments over maintenance treatment versus abstinence. Our cover story (page 6) has a different – and in my view important – purpose. It explains why we are often failing clients by giving them insufficient information about the likely outcomes of each treatment to inform their choice properly.

Methadone maintenance suits many people and can be a very useful route to stability and reintegration. But are we making it plain to clients that it is not a logical route to abstinence, that they can't veer easily from one mode of treatment to the other – and if that is what they are hoping for then they need to look at a different set of options for support? The four respected authors present the evidence for an argument that could shake up the current default options for offering treatment. Let us know your views.

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In this issue

News in Brief

Eye on recovery

A residential alcohol reduction unit run by Homeless charity St Mungo's is taking a new approach to helping people stabilise their alcohol intake. In addition to group work, the Kings Cross-based unit is using structured activities like visits to the London Eye as well as reflexology and other complimentary therapies. The unit has had 11 residents since last November, with the majority moving on to further detox, rehab or abstinence. 'This is an exceptional beginning, with preliminary feedback showing a high percentage of residents, who previously slept rough and drank heavily, are not only going on to further treatment but are also staying well,' said regional director David Devoy.

Family focus

Funding has been announced for 'family pathfinder' programmes in 15 areas to offer intensive support to disadvantaged families, with the aim of making sure that children do not end up having to take on caring roles themselves, says the Cabinet Office. The areas that have successfully bid to test the government's 'think family' approach include Blackpool, Bolton, Brighton and Hove, Gateshead, Leeds and Sunderland. 'When parents face multiple problems in their own lives the impact can be severe and enduring for both themselves and for their children,' said children and families minister Beverly Hughes. 'We need to give disadvantaged children and families the extra support they need. This is especially important for children from the most vulnerable families where children are five times more likely to struggle with reading and writing, eight times more likely to be suspended and ten times more likely to get in trouble with the law.'

Reaching out

A further 800 voluntary drug educators are to be recruited by drug education charity Hope UK, with the aim of reaching 500,000 children and young people a year by the end of 2011. Formerly known as UK Band of Hope, the charity's volunteers work within churches, communities, schools and youth and parent groups. Volunteers are taught in a 120-hour Open College Network accredited course.

New research project redresses balance by targeting older users

A major international research project has been launched to help improve the health of older people in Europe who use drugs, as existing drug policies have concentrated almost exclusively on young users.

It is estimated that the number of older drug users on the continent will more than double by 2020, and that the number of over 50s needing drug treatment could have risen by up to 300 per cent, according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (*DDN*, 7 April, page 5).

The project will be co-ordinated by a coalition of NGOs and academics from Poland, Germany, Austria and Scotland, with the Scottish Drugs Forum (SDF) the only active UK-based partner. Co-operating organisations will include the EMCDDA, the Scottish government and the European Centre for Disease Control.

'There is a growing population of senior drug dependents, aged between 35 and 45 and older in all European countries,' said SDF's director David Liddell. 'Most of them are polydrug users, often injecting opiate users – most have mental health problems and many will suffer from infectious diseases. In Scotland, a large proportion of drug related deaths occur within this age group but we also strongly suspect that many lives are cut short due to the impact of bloodborne viruses and other chronic health conditions associated with problem drug use.'

Among the 30-month project's priorities will be to establish accurate numbers, ages, and genders of long term drug users up to the age of 70 in cities across the continent, as well as looking at health-related and other problems. It will also promote guidelines for community-based and residential care, identify good practice and establish what living and care arrangements drug users themselves would favour in their old age.

The focus of drugs policy up to now has been almost exclusively on young people, said David Liddell. 'Only a few actions take place at national level that focus on senior drug dependents and their care and treatment needs. The Scottish Government has pledged to make Scotland a fairer and healthier country and sharpen focus on improving public health and reducing inequalities, which is why we welcome their interest in this project.'

EMCDDA report Substance use among older adults – a neglected problem available at www.emcdda.europa.eu/html.cfm/index439EN.htm

Home Office: 'Robust enforcement' will back up cannabis reclassification to Class B

A more 'robust enforcement against cannabis supply and possession' will accompany the reclassification of cannabis, the Home Office has stated.

As was widely expected, the government has announced that cannabis will be reclassified as a Class B drug, reflecting the fact that the market is now dominated by the stronger 'skunk', it says.

'Skunk' accounted for 30 per cent of the drug available in 2002 but that has now risen to 81 per cent. It is also essential that the declining trend in use of the drug 'must not be allowed to reverse', the Home Office maintains.

'Cannabis is and always has been illegal,' said home secretary Jacqui Smith. 'It now dominates the illegal drugs market in the UK and is stronger than ever before. There is accumulating evidence, reflected in the Advisory Council on the Misuse of Drugs report, showing that the use of stronger cannabis may increase the harm to mental health. Some people may be "binge smoking" to achieve maximum possible intoxication which may be very serious to their mental health. I make no apology for erring on the side of caution and upgrading its classification. There is a compelling case to act now rather than risk the health of future generations.'

The home secretary has asked the Association of Chief Police officers to make it clear that 'penalties for adults must be escalated following any cannabis warning and that police officers will not be precluded from arresting for a first offence'.

From early next year, those repeatedly caught with cannabis will not just receive warnings, and 'aggravated sentencing factors' will also be introduced, such as for supplying the drug near further and higher education establishments and mental health institutions, among others. There will also be moves to curtail the sale and promotion of cannabis equipment and a 'new strategic and targeted approach' to cannabis farms. The government has also promised an updated public information campaign on the drug.

There has been widespread criticism of the policy 'u-turn' in recent months from the drugs and mental health sectors alike, despite the government's insistence that the re-classification was based on mental health concerns.

'The government has made a mistake by choosing to reclassify cannabis as a Class B drug,' said director of public affairs for mental health charity Rethink, Paul Corry. 'This decision goes against all the evidence. Use of the drug has gone down since it was downgraded to Class C in 2004 and our research shows that only 3 per cent of users would consider stopping on the grounds of its legal classification. The reclassification process will be costly and time consuming, and a waste of valuable resources. It is clear that the government has bowed to political pressure and chosen a criminal justice rather than health-focused path.'

Treatment numbers up but hep C a concern

More than 195,000 people were receiving drug treatment in 2006/07 – up from 85,000 at the end of the 1990s, according to a new review from the Healthcare Commission and the NTA.

There were, however, 'significant deficits,' it says, particularly around provision of hepatitis C treatment. 'As 90 per cent of all hepatitis C diagnoses are associated with injecting drug use, this is a key area of concern.'

The report is based on a series of questions put to 149 local drug partnerships across England, with each area then rated on a scale ranging from 'weak' to 'excellent.' No partnership fell into the lowest category, while 21 per cent were 'fair', 45 per cent 'good' and 34 per cent 'excellent'. Although the results revealed widespread good practice, they also demonstrated that many areas did not have a good understanding of local needs assessments, it says.

Almost all hit their care planning and treatment discharge systems targets, while 60 per cent attained the maximum score for financial management. 'The improvements in commissioning shown by this review are very welcome,' said NTA chief executive Paul Hayes. 'However, the review also highlights inconsistent practice across the country in key areas of delivery such as testing for and treatment of hepatitis B and C. The NTA will be working with all partnerships to spread best practice more consistently and has agreed action plans for improvement with the poorest performing areas.'

Healthcare Commission chief executive Anna Walker called hep C testing and treatment 'patchy'. 'Similarly, access to clean needles provided by out of hours exchanges varies considerably,' she said. 'These are the areas that need to improve if the health of those who inject drugs is to be tackled effectively, and drug related deaths reduced.'

The review is the second of three to assess the performance of substance misuse treatment services. *Commissioning drug treatment systems and harm reduction services* available at www.healthcarecommission.org.uk/_db/_documents/Improving_services_for_substance_misuse_Commissioning_drug_treatment_and_harm_reduction_services.pdf

Scotland picks up £2bn alcohol misuse tab

The cost of alcohol misuse in Scotland added up to around £2.25bn in 2006/07, according to figures released by the Scottish Government.

The total pulls together figures from the health, social and criminal justice services, as well as wider economic and 'human and social' costs.

'Due to the lack of data in certain areas, the figures are potentially underestimates of the true costs associated with alcohol use and misuse,' says the government. The costs were estimated at £405m for NHS Scotland, £170m for social work services, £385m for criminal justice and the fire service, £820m wider economic costs and £470m human and social costs.

In terms of health costs, GP consultations were estimated to total approximately £4m, while for A&E attendances a 'mid point' estimate of £32m was used, although it is thought the figure could be anything up to £59m. Outpatient visits were estimated at £53.5m, and ambulance journeys at £31.5m, although this too is thought to be an underestimate.

It is estimated that a quarter of community service orders and probation orders were for alcohol related crime, while alcohol is thought to be a key factor in 40 per cent of violent offences like murder, attempted murder and rape.

'The total cost of policing attributable in response to alcohol misuse is estimated at £228m,' says the report, while prison places add up to £78m excluding the cost of treatment programmes. Alcohol also plays a role in deliberate and accidental fires, with the cost to the fire service estimated at £6.2m.

In terms of the wider economy, the cost was arrived at by adding up alcohol-related absenteeism and 'presenteeism' – turning up to work hungover – as well as unemployment and premature mortality, arriving at a total of £820m.

Agencies build momentum by tackling drugs all week

Agencies around the country are taking part in this week's National Tackling Drugs Week, with the aim of raising awareness of their activities in tackling drug misuse and the treatment and support options available.

The week is intended to build on the momentum generated by previous National Tackling Drugs Days, the Home Office says.

Project workers in Teeside will be dressing up as support worker Snow White, drug dealer the wicked witch and seven dwarves Moody (steroids), Stoney (cannabis), Easy (ecstasy), Speedy (amphetamines), Snorty (cocaine), Dizzy (alcohol) and Snoozy (prescription drugs).

'We thought that by giving the Snow White story a thought-provoking twist more young people would take note of important messages about the effects of drugs and alcohol,' said Debbie Simmons of Platform, part of the DISC (Developing Initiatives Supporting Communities) charity. 'Our storyline depicts the good, the bad and the vulnerable and shows that there is a way to seek help if your drug or alcohol use is causing you concern.'

Other agencies will be mounting awareness-raising events such as roadshows, talks and open days as well as distributing leaflets and posters. Teachers TV, meanwhile, will be showing a series of programmes looking at how schools can best address drug and alcohol use among young people. Shows will include guides to teaching drugs awareness through PHSE lessons, as well as a five part series Drugs and the brain. All are available to download for free on www.teachers.tv/phse

News in Brief

Educate us, kids urge

Children at a Drugsline reception at the House of Commons this month called on MPs and ministers to give drug education the same importance as sex education in schools. Chaired by 13 year old Taylah Miller from Ilford, *We are all vulnerable – young people's views on drugs* was attended by young people who had taken part in Drugsline's education programme.

Hep talk

Westminster Drug Project's Harrow Road service is holding a hepatitis C awareness raising event on 23 May. One in 12 people worldwide are living with viral hepatitis B or C – around 500 million – the vast majority without even knowing it. The event will be held at Paddington Arts and speakers will include Sebastian Saville of Release, and Charles Gore of the Hep C Trust. www.wdp-drugs.org.uk

Cannabis con

Hounslow council is warning landlords to be vigilant over tenants converting their properties into cannabis factories, following a series of complaints. Once trust had been established, tenants had ripped holes in walls and fitted industrial coolers and gardening equipment, says the council. 'Landlords are being lured into a false sense of security by tenants who seem reasonable, check out perfectly, pay their rent on time but have turned their properties into cannabis factories once a level of trust has been achieved,' said the council's deputy leader Mark Bowen. 'Our advice to landlords is to ensure you do proper checks on tenants and make visits every six to eight weeks.'

Buddy up

The government is encouraging more local authorities to offer peer mentoring services to help prevent youth homelessness, as people under 25 still account for 39 per cent of all new cases of homelessness. 'We need to support homeless young people for as long as they need, offering to help them return to their families, find the right education, training or employment and to lead a healthy lifestyle and help them on the path to success,' said department of children, schools and families minister Beverley Hughes.

DIFFERENT ROADS

Is recovery possible? Only when we acknowledge that maintenance and abstinence are paths than run in different directions, say **David Best**, **Jessica Loaring**, **Safeena Ghufran** and **Ed Day**.

There is an old saying about addiction treatment – 'if you want drugs, go to treatment services; if you want to stop drugs, go nowhere near drug services'. The current debate about abstinence and its safety and viability as a treatment option has at its heart this question of whether long-term addiction treatment and unaided abstinence are two different roads to travel, or are merely variants on an equally positive outcome.

The UK addiction field has recently been energised, and to some extent split, by the debate about what we mean by 'recovery', prompted by a discussion paper by the Betty Ford Institute Consensus Panel (2007) defining recovery as 'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship' (Betty Ford Institute Consensus Panel, 2007). The paper goes on to differentiate stages of recovery, classed as 'early sobriety' (the first year), 'sustained sobriety' of between one and five years, and 'stable sobriety' of more than five years.

In response, the UK Drug Policy Commission has circulated a discussion paper which generates a similar conclusion – that a useful definition of recovery should also incorporate 'medicated recovery'.

The argument presented below will argue against this position by suggesting that this model not only misleads those entering treatment about what is on offer, it creates a self-fulfilling prophecy that may well act as a barrier to the more liberating (but riskier) recovery that is not reliant on the prescription pad and the concomitant therapeutic baggage.

Why is sustained and treated recovery not the same?

The fundamental premise here is that 'treated recovery', particularly that based on maintenance prescribing, is fundamentally different in aetiology and in character from abstinent recovery and that to create a taxonomy that classes them together is disingenuous and misleading. The philosophies and measures of success are different – good treatment outcomes tend to be measured in terms of public health and public safety – *ie* crime reduction and reduced spread of disease, supported by long-term retention in treatment. Because of the 'chronic, relapsing condition' assumption of maintenance treatments (O'Brien and McLellan, 1996), retention in treatment is also seen as a success. As drug addiction is seen as being the equivalent of diabetes or hypertension, there is no 'cure' and so ongoing compliance with the treatment is seen as 'success'. For opiate addicts, this means indefinite prescribing. Here success is indefinite compliance associated with stable housing, employment and effective 'social reintegration'.

We are not aware of studies, and certainly not UK studies, that have evidenced the rates of new entrants to maintenance prescribing services who achieve the Betty Ford definition of 'stable recovery' – which is not of course to say that it is not possible, only that it may be markedly less common than the hinterland of 'methadone, wine and welfare' described by Preble and Casey (1998).

From an addiction careers perspective, there have been claims since Winick (1962) that the majority of opiate addicts will 'mature out' and that, even without

treatment, there is the possibility of a 'natural recovery' (Granfield and Cloud, 1996), akin to that typically associated with successful smoking cessation. However, in a study of long-term abstinence, Dennis and colleagues (2005) have found that having more than two prior episodes of formal treatment is actually associated with reduced likelihood of sustained abstinence. In other words, an additional aspect of the 'public health' versus 'individual wellbeing' debate is the prospect that longer time and more episodes of treatment may lead to better outcomes from the perspective of disease spread or crime prevention, but at the same time lower likelihood of achieving lasting abstinent recovery.

This is not inconsistent with the argument advanced by Ashton in 'The New Abstentionists' that, given the limitations of detoxification, remaining on maintenance is the safest way of preventing overdose and possibly other causes of mortality. However, this is not a justification for starting all but the most chaotic clients on this journey – a journey that may often be without hope or promise of recovery or change. Our own work on treatment effectiveness for the NTA (Best *et al*, forthcoming) has shown both that statutory service workers (which includes all of the maintenance services in the city of Birmingham) have poorer clarity of mission and lower team cohesion, and that workers' perceptions have a direct effect on their clients' treatment satisfaction and therapeutic relationships, mirroring the original findings within Simpson's Treatment Process Model (Simpson, 2004).

As Professor Clark asserted in the 21 April issue of *DDN* (page 15), the main 'concern is the temporal course of addiction and how this influences the treatment system we should be offering to people'. If you have workers in a system that is predicated on a belief of crime reduction and chronic disease management, the self-fulfilling pessimism permeates the client and the worker and generates limited goals.

Why is abstinence an important option for clients?

Given that, for chaotic clients in particular, not being in treatment is associated with a significantly enhanced mortality risk from overdose (Warner-Smith *et al*, 2001), and with a markedly increased risk of relapse (Ashton, 2008), why would anyone aspire to achieving total abstinence?

At its most basic, this is what most people want when they are ready for making changes – methadone and other substitutes are perceived generally as a poor substitute for heroin and is not generally seen as a desirable treatment option. Our own work on 'recovery journeys' (Best *et al*, in press) would suggest that those seeking abstinent recovery do so to improve the quality and meaning of their lives and to leave behind a lifestyle (often including statutory treatments) that they have grown weary with. In our experience, few new treatment seekers have a goal of long-term maintenance prescribing! Furthermore, if workers were honest about prescriptions at the start of treatment – by admitting that the evidence base would suggest some initial gains but no evidence-based techniques for when, if ever, the prescription would stop – would many drug users wish to plough this furrow?

However, the point of this article is not an attempt to prove that complete abstinence is 'better' than maintained stability, but to acknowledge that it is something of a completely different order. And that something completely different is hope – in more academic terms, what the ex-user in a rehab or the 'clean' member of an NA group provides is not only support and mentoring but modelling and social learning that demonstrates recovery is possible and is achieved by a wide diversity of people in a huge range of ways. However, this process will often include the acquisition of meaningful social investments (jobs and family commitments) that provide the client with the engagement and commitment that protects against subsequent relapse. From a careers perspective, there is no question that drug addiction is of a variable, protracted and returning nature, yet its chronicity is not the same as regarding it as permanent.

For the UK addiction field to move forward, it is not enough for us to pretend that abstinence and maintenance can be happy bedfellows, with customers selecting between them according to their preferred method of recovery. They are, for many, diametrically opposed visions of recovery, whose incompatibility is intrinsic to their relative merits and evidenced outcomes. Whether clients can progress from one to the other is a moot point; what seems clearer is that the philosophies of each are so incompatible that clients attempting to juggle both are unlikely to succeed.

Dr David Best, Dr Ed Day and Safeena Ghufran are at the Department of Psychiatry, University of Birmingham. Jessica Loaring is at the Institute of Psychiatry, King's College, London.

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'After hours of comfort and listening, and partly because of your latest issue (DDN, 5 May 2008), we both agreed I would become her power of attorney... secure her future, and prevent her from relapsing and losing the plot. Going back to old behaviour is one of the biggest fears.'

Addiction is never cured... but behaviour can change

Today a friend of mine came round who is 32, in good recovery from heroin, alcohol and eating disorders, has been in the prison system and after seven years has moved on, has a lovely new council flat and is now beginning the gradual process of going back to work.

However, today she came in in floods of tears. Her father died of a brain tumour on Tuesday, her mother left home when she was a child, and she has no other family. She is in total shock – scared and unable to cope with all the practical matters in events like this. After hours of comfort and listening, and partly because of your latest issue (*DDN*, 5 May 2008), we both agreed I would become her power of attorney, deal with the funeral, the selling of the property and make all the necessary funeral arrangements, and will set up a discretionary trust fund for her with two trustees to protect her, secure her future, and prevent her from relapsing and losing the plot. Going back to old behaviour is one of the biggest fears.

I know I have taken on the biggest support compared to others to date, yet without it I can visualise people who are still addicted taking advantage of a very vulnerable young lady, so will make sure I myself have all the support that I need.

I had just read Professor David Clark's article (*DDN*, 5 May, page 15) and this really influenced my thought processes on supporting my young friend, stating that often treatment services give the impression at discharge into the community that 'cure has occurred'.

I know from my own experience that the total opposite is true. Although I am disabled through my own addictions and childhood upbringing, I have a full-time job just looking after myself and being a loving caring father for my daughters.

I am so pleased I read your magazine – I learn all the time and am so grateful for Professor Clark's article. He is teaching me all the time.

Name and address withheld

Choosing residential treatment

DDN's Directory of Residential Centres provides a useful guide for workers already in the drug field (*DDN,* 5 May, centre-page pull-out). However, there are thousands of families, plus their solicitors and GPs, who would value additional vital information to guide them.

If it were hotels or colleges being listed, they could expect a system of ratings giving an indication of the type of result aimed for and achieved by each establishment. May I therefore suggest an alternative star rating system to the new CSCI ratings (outlined in *DDN*, 21 April, page 6).

One star:

Those establishments that successfully (in over 70 per cent of cases) wean users off street drugs and onto prescription medication such as methadone, essentially for life.

Two stars:

Those establishments that wean users off street drugs and on to prescription medication, and which then reduce prescription dosages to zero in more than 70 per cent of cases.

Three stars:

Those centres that successfully withdraw users from street drugs by some form of 12-step system before recommending them to their local AA, NA or CA for help in continuing fraternally supported abstinence.

Four stars:

Those programmes that graduate their clients in a fully withdrawn and abstinent condition which, in over 70 per cent of cases is maintained for at least 12 months after programme completion, and involves no usage of substitute medication or continuing fraternally supported abstinence.

Five stars:

Those programmes that graduate their clients in a fully withdrawn, trained and abstinent condition which in over 70 per cent of cases is maintained for at least two years after programme completion and, in addition to involving no usage of substitute medication, expects to see graduates with the following attributes:

- fully convinced that he or she will comfortably abstain for life;
- taking responsibility for his or her own life and family;
- no longer needing or wanting further rehabilitative support; and
- also taking responsibility for, and contributing to, his or her community.

Because most rehabs keep in touch with former clients at birthdays, Christmas and other anniversaries, collection of the indicated progress data is a relatively simple operation.

E. Kenneth Eckersley, CEO Addiction Recovery Training Services, former magistrate and retired justice of the peace.

Hard to reach?

Thank you for the excellent coverage you gave the Royal College of General Practitioners Management of Drug Users in Primary Care 13th National Conference, *Meeting the needs of diverse populations: hard to reach or easy to ignore?* (*DDN*, 5 May, page 12) which I feel captured the theme and feeling of the conference very well.

We would like to share the conference consensus statement with *DDN* readers:

- This conference recognises that people who use drugs have complex and diverse needs.

We welcome your letters

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

- To work with them we must have a range of services and a range of responses to provide a flexible, accessible and person centred approach that offers choice.
- In order to do this, services must be self-aware and listen to patients and their communities.
- Many of the participants have felt challenged, concerned and enlightened by the 13th conference 'Meeting the needs of diverse populations: hard to reach or easy to ignore?' and we call upon the RCGP to respond to the conference question: 'How do we meet the needs of diverse populations?'

Next year's conference theme is *Family medicine: from cradle to grave* and the event will take place at the ACC in Liverpool on 14-15 May 2009.

Kate Halliday, conference programme director and SMMGP associate

No single model

While it was great to see a supportive letter from one of our students in the last issue (*DDN*, 5 May, page 10) there was something potentially misleading in it.

Annmarie is doing her work placement in a residential setting, but I want to make it clear that it is possible to do the placement for the degree in other settings, and we have placed students in a range of agencies including those working with a harm reduction philosophy such as Bristol Drugs Project, as well as structured day programmes.

Our foundation and honours degrees are transtheoretical and are not wedded to a particular philosophy of treatment.

Tim Leighton, director, Centre for Addiction Treatment Studies, Action on Addiction

Pained surprise

Sebastian Saville has suggested that I wilfully and offensively misread his letter in my suggestion that he may have felt personally threatened by the development of more university based education and training in the drug treatment field. (*DDN*, 5 May, page 10).

I am surprised that he should have felt so pained since he concluded his own letter with the statement that 'we replace such people [ie those who have experientially acquired skills and a "feel" for drug work] with institutionally trained technocrats at our own and our clients' grave peril.'

That reference to 'our' here is as clear a statement as one is ever going to get that Sebastian did indeed feel threatened by the proposals for more university training in the drugs treatment field. If he does not now feel 'in grave peril' at the suggestions in my article, then I for one am very happy since I don't feel the drugs field has anything to fear from further developing the provision of university training and education.

Neil McKeganey, professor of drug misuse research, University of Glasgow

Fact file

Service User Groups

Kate Langan

Islington clients of drug and alcohol services (ICDAS)

When and why did you start your group?

In 2004 three activists from Islington approached the commissioner regarding an aftercare proposal to run a club called the Haven for recovering drinkers and drug users. You just needed to be clean and or sober on the day and then you could use the facilities in the club which included pool, bingo, a hot meal and many other social activities. This club is still going on a Monday night, run entirely by clients. RICDAS (which went on to be ICDAS) was set up by two of these activists to look at the three-year service user strategy. This also included being part of the interview panel to recruit a client participation coordinator and set up a client council. The coordinator was recruited and began to help us build up ICDAS from three members into a more truly representative group of service users of Islington's agencies.

How many members do you have?

We have had about 12 to 15 members over the last year. Some of these clients have gone to work full time or have dropped out for various reasons. We get about eight to ten regularly attending our meetings, and we have a lot more interest just recently with more people coming on board and wanting to get involved.

How did you obtain funding?

The substance misuse commissioning team allocates funding from the treatment plan to run the Haven, ICDAS and other service user involvement activities like training and small projects. One of those projects was a group called FACT (Families addicted coping together) which runs on a Friday afternoon for parents/carers with children under five. This group was the idea of a service user, Susan, at ICDAS.

Where and how regularly do you hold meetings?

We have meetings on the last Wednesday of the month at Islington Town Hall or in local treatment provider N7. Most people come along as observers first to see if it is for them, and then we take it from there.

What do you hope members get from attending?

It is a chance for members to feed back what is happening in their projects and talk through any difficulties. We also have guest speakers from the commissioning team to local providers and voluntary organisations. We also hope that members start to understand how treatment is funded and how decisions are made in the borough.

How do you keep it going?

Sometimes it can be hard as some people are still in treatment or drop out and have their own issues to deal with. However we all try to be as supportive of each other as we can. It is hard work sometimes attending meetings run by professionals and trawling through all the jargon they can speak – especially when we want to put our point across and make sure things are done! We mostly get by, with plenty of encouragement and enthusiasm from staff and clients alike.

What have been your highlights so far?

The highlights have been

- Getting our members on strategic important groups like Islington's drug reference group, alcohol reference group and the joint commissioning group.
- Taking seven people to the *DDN*/Alliance conference in January to represent ICDAS.
- On two occasions being able to reverse decisions to close or restructure services that clients think highly of by writing letters in support of those agencies.
- Our first placement (Martel) in the DAAT and subsequent placements set up with voluntary sector organisations in the borough.
- Getting on the tender panel for three new services in Islington.
- Our chair Jimmy getting a civic award for services to the others and the Haven club from the Mayor of Islington!

How do you communicate with your members?

By email, writing to home addresses, texting and telephoning. We have also had newsletters which have gone out to all the projects in the borough, and a blog, which acts as our free website. It was set up by one of our members, Richard, who maintains it and shares information with clients and providers. He welcomes any comments (at the address below).

Have you any tips for others starting a group?

Never take no for answer and go for it! You'd be surprised how many people want to get involved. It is crucial that you get financial support from your local DAAT or commissioners, and it really helps to meet regularly and keep in touch with each other.

Kate Langan is client participation co-ordinator, Drug and Alcohol Services, Community Safety Partnerships Unit. Get in touch with ICDAS by emailing Kate (kate.langan@islington.gov.uk) or through the blog: http://icdas.blogspot.com

In a recent United Nations survey the UK was put at the bottom of an international table of child wellbeing. Proof of this was visible much earlier to psychotherapist Camila Batmanghelidjh who set up children's charity Kids Company in 1996 and has seen the effects of drug and alcohol abuse on young clients.

According to Iranian born Camila, the second wave of children that entered the Kidsco Arches in South London were mainly the children of drug addicts. The elder boys managed to fend for themselves by crime, but the younger ones weren't so lucky; she was shocked at these children who were gaunt and losing their hair, children who had to scavenge for food.

The kids of Kidsco mainly self-refer and many do not have a father figure – 87 per cent according to Kidsco's records. It is a double edged sword: though some are not parented well, others are 'actively traumatised' by their carers. The charity's innovative *modus operandi* is to sustain relationships with these vulnerable and damaged children, in a secure, safe and stimulating environment. Here they can get fed nutritiously, receive clothing, and access leisure facilities. At the Arches (and also at the Urban Academy), these youngsters make good use of the comprehensive education, social, medical, therapeutic and psychiatric interventions that are available.

The Arches is in a world of its own in Camberwell – spacious, yet not big enough. The main building is surrounded by huts, used as therapy rooms and the like for the children. Entering this building is to enter a vividly coloured and functional oasis, Camila's Persian roots apparent in the Eastern theme that runs through the main hall. A well-stocked library, comfy armchairs, alcoves where all

'Adolescence as we've come to know it is a modern phenomenon. In previous societies and tribal cultures, the adult usually merges quickly out of childhood through participation in puberty rites... Today our youth reach out to grasp adulthood in rather dangerous ways. By participating in religious cults, by the abuse of increasingly more harmful substances, by running away from home, by their symptoms of self-starvation, self-mutilation, self-destructive suicidal attempts. The affirmation of self, once the aim of the so-called search for identity, has become for some adolescents a search for self-negation.'

(D. Gentry, 1989, audio tape)

Love

Too many children are born into drug problems, suffer in silence, or grow up to repeat the pattern sown by their family. **Mark Ashby** visits Kidsco and sees how a responsive and nurturing environment can transform their expectations

can repair to – and on the days that I was there the most fantastic West Indian food available. A buzz of activity filled the place – the staff on duty constantly required to attend to a myriad of requests. Everybody needed something.

Here it felt safe; people actually do care. In many ways Kidsco is doing a job that should already be done by the official service providers. But Camila has found these services to be overrun and under resourced – snowed under with cases of sexual and physical abuse. The understanding of the plight of these most vulnerable members of our society is often terribly underestimated; maybe it is too hard to believe. Maybe the stamina and diffidence required to stand by these and similar youngsters are thought to be too much. Sometimes they are overwhelming and loud, they sometimes nick the change from your jacket and they may not look you in the eye – but they are collectively our responsibility, like it or not.

Camila recalls the time when she sat in court with a 13-year-old boy arrested for possession with intent to supply. The judge explained to the jury that no one in court would wear the official rigmarole as the defendant was young; he didn't want the boy to be intimidated. It's an extraordinary paradox, as the boy had been involved with drugs for the previous two years, had carried a knife, attacking people while travelling between one dealer and the next. Intimidated by a wig and robes?

She had wished that the boy was an exception, but for her the reality is that the psychological profile this kid represents replicates within our society at an alarming rate. This resourceful woman knows the reasons for all this are complex – though in her experience, 'the causes can often be traced to a breakdown of relationships in the home environment. The result is emotional coldness on the part of a growing number of children.'

One of the kids swallowed her mother's methadone when she was a toddler. Fast-forward a few years later and her mother takes her to her dealer's house – where an armed man bursts in and throws the dealer out the window of the multi-story block. Her older sister, just coming into adolescence, was already involved in prostitution, bringing in much needed money. The stories are legion – the damage and pain caused to these kids vividly apparent as they grow older. In Camila's book *Shattered lives* she states: 'Overwhelming feelings often seek suppression through the use of mind altering substances and children may use drink or drugs, or both, to reduce flashbacks of abuse, and diminish feelings of emotional pain. Medical and psychiatric interventions can be experienced as repeating the abuse.'

These feelings can run alongside the availability of drugs, the curiosity involved in drug-taking and the initial enjoyment of it. Add to that peer pressure and the influence of 'gangsta' culture: It was recently reported that every third song children hear contains references to drug abuse – normally presented as positive – and if they are listening to rap, the references double. The drug abuse was positively linked to sex, violence, money, socialising and humour.

In a recent open letter to Gordon Brown, a Kidsco client explained how he spent his teenage years as a male prostitute and drug dealer – a reaction, he feels, to the treatment he received from his addict mother and his bizarre and chaotic home life with a woman who could not look after herself, let alone a child. He explains how all the state services failed him one by one, not reading the situation properly and letting this boy sink into self-harm and further sexual abuse.

In her reply, children's minister Beverly Hughes stated that by 2010 all schools will provide 'wraparound' activities from 8am to 6pm, swift referral to specialist services and support for parents. This is all fine if you actually go to school, are not excluded or do not play truant for whatever reason. Many of the children who go to Kidsco are not even registered with GPs because of the unsettled nature of their circumstances.

According to official figures, the number of children between the ages of nine and 15 sent for drug treatment in the UK went up by a fifth last year, to more than 9,000. Experts in the field believe that this does not tell the whole story, that many suffer in silence and many refuse to accept they have a problem. A large majority were ordered into treatment by the courts after their drug related crimes.

According to an independent report of 925 children and young people using Kidsco services, 85 per cent arrived with problematic substance misuse issues and 90 per cent of these perceived that their families were instrumental in getting them on drugs. There are stories of the kids being used as couriers and dealers – and even being given methadone and cannabis as toddlers to make them more manageable. Fifty-seven per cent arrive homeless, and 85 per cent have identifiable mental health issues.

In working with young people and their substance abuse problems, Kidsco often pays for rehab placements for them. The lack of coherent and appropriate services for young people is gapingly obvious in this country – there are only about three units specifically designed for the younger client, whereas in the States you can barely move for adolescent rehabilitation units.

There is now robust evidence that the earlier a young person starts, the greater the chance that they will develop a full blown adult addiction problem. Time and time again the links are shown between drugs and problems at school, family disintegration and criminal activity. For those in their late teens and early twenties, it's been shown that there are links between drugs, unemployment, homelessness and prostitution. Much of this would be apparent from the Kidsco files.

Kidsco supports young people up to the age of 23, and finds it an anomaly that youngsters at this age are treated as adults – especially in the treatment field. These vulnerable kids have had to mix with hardcore alcoholics and addicts up to the age of 65 – where we all know that the problems in these different age groups are much different. One of the Kidsco workers mentioned that in these units there was little (if any) nurturing involved, and that they often added the problem of an active, ongoing drug culture. There are strong feelings about the need for therapy centres specifically for this client group. Some may say the horse has already bolted, but something does need to be done before we have yet another generation of 'hard core' substance misusers and the cycle continues.

Many of the kids I met from Kidsco were bright, talented, and creative. Some were powerful and highly wired; some were very aggressive (not always the males). For some, you could see the damage in their eyes – and not one of them had deserved any of what had happened to them. Nobody does.

But they were being shown a different way, where they could engage in the selection and details of the services they required. It is a 'power with' rather than a 'power over' model of care provision – the kids are worked with, rather than worked on. This constantly evolving organisation that has certainly made a formidable impact.

For further information on Kidsco visit www.kidsco.org.uk. Camila's book 'Shattered lives – children who live with courage and dignity' is now out in paperback, from Jessica Kingsley Publishers. Dr Carolyn Gaskell's 'Context, interventions and outcomes; an overview of Kids Company's client group, Kidsco Working Paper' was published in 2007.

Mark Ashby is a writer, researcher and a director of the Addiction Support and Care Agency (ASCA)

matters

A Polish experience

A trip to an international conference was the beginning of an unexpected adventure in taking acupuncture to Poland. **Anne Marshall** explains

Our Polish experience began when a delegation from Drugs and Homeless Initiative (DHI) attended last year's International Conference on Harm Reduction in Warsaw.

Two of the workers, Trish Thompson and Mick Webb, decided to travel on and see a bit more of Poland, and they began by accepting an invitation from Grzegorz Wodowski to visit the Monar Project that he directs in Krakow. They were immediately impressed by workers at the project, who have to cope with lack of funding and very limited resources.

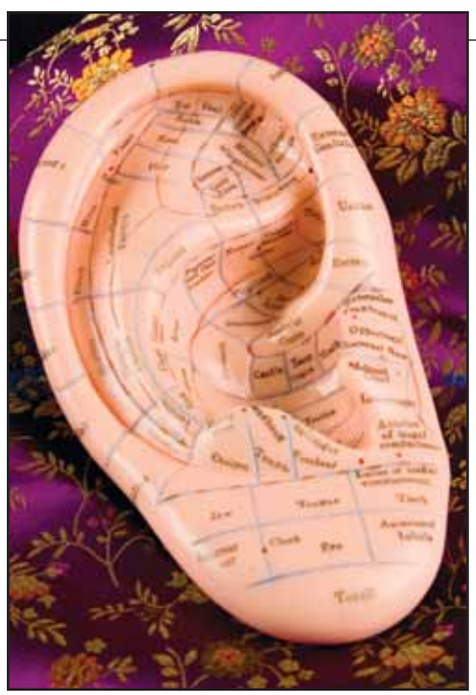
Both Trish and Mick are trained in Stage I (detox points) and Stage II (hepatitis C) auricular acupuncture and are assistant trainers for Acudetox Plus UK, as well as working at DHI. Fortunately, they had the foresight to take some ear acupuncture needles and equipment with them to Poland, so while they were in Krakow they offered some sessions of ear acupuncture to staff and clients. The response was overwhelming. This treatment was unheard of in Poland, so it was enthusiastically received and very much appreciated.

When they returned to Bristol elated by the response in Poland, Trish and Mick were determined to bring back ear acupuncture to the country. So when the next steering group (which regulates Acudetox Plus) met, we discussed the possibility of going to Poland to train some workers. All were in agreement on the plan and Acudetox pledged to finance the project if no funding could be raised in Poland.

In the meantime, Trish and Mick returned to Krakow last August for a holiday and did two drop-ins, where they treated more than 40 people. Grzegorz took on the mammoth task of sorting out training rooms and recruiting people from all over Poland to do the training. Back home, we at Acudetox had a lot of preparation to do, including getting our training manual translated into Polish by Zaneta, who is originally from the Monar Project but is now working for DHI in Swindon.

After months of preparation, Trish, Mick and I flew to Krakow. We were met by Grzegorz and felt immediately at home. He arranged for us to stay in an apartment in the old Jewish quarter of Krakow, Kazimierz.Training started the next day. There were 21 students from various cities in Poland – Krakow, Warsaw, Lodz, Szczecin, Torun, Wroclaw and Bielsko-Biala. Their eagerness and diligence amazed us – they were so keen to learn what we were offering. The atmosphere was happy, friendly and relaxed as they practised their needle technique to perfection and soaked up every bit of information we gave them. When asked to pair up to needle certain points, they did this quickly and well, and then went on to practise on several more people.

'The feedback from the students was so positive and encouraging; we have every confidence that the skills learnt from our training will very quickly be implemented and that numerous clients will benefit from the treatment.'



The practical sessions were great fun. The fact that Trish and Mick didn't speak Polish didn't seem to matter – they knew a few words, including the names of all the ear points. There was always someone in the group who could speak English and quite a few of the students understood English and enjoyed having the training in both languages.

The training finished on Friday, and everyone passed with flying colours. Their excitement and gratitude was overwhelming. Fortunately, we had taken a generous supply of needles and sharps bins and were able to give everyone a box of needles and every agency one or two bins. We also let everyone keep their rubber ears (used for practising needle technique) as a souvenir of the training. Many friendships were made among the students, as well as with us.

Our Polish experience was quite moving and emotional for us, as well as being interesting. We felt very privileged to be able to introduce ear acupuncture to drug workers in Poland, where it was so eagerly and gratefully received. The feedback from the students was so positive and encouraging; we have every confidence that the skills learnt from our training will very quickly be implemented and that numerous clients will benefit from the treatment.

We're planning to return in a year to do reassessments and to train some more workers and suitable service users. We hope that this is just the beginning of our Polish experience.

Anne Marshall is trainer for Acudetox Plus UK, which was set up in 2003 to provide training in ear acupuncture in the southwest. It goes much further afield and has recently become part of the CAAAD (Community Action Around Alcohol and Drugs) Project in Bristol.

The team now offers Stage I (detox points) and Stage II training. For details of forthcoming courses, email them at acudetoxplus@hotmail.com or call them at the CAAAD Project, on 0117 904 2297.

Can we talk?

David Wright imagines a dialogue between the voices of substance misuse and mental health

Substance Misuse – 'Why do we always fight?'

Mental Health – 'Because I have enough on my plate without you trying to send us people who have chosen to ruin their lives.'

SM – 'Some of these people have got mental health problems.'

MH – 'Well that's their problem. If they didn't take drugs they would not end up messed up.'

SM – 'How many of your patients have taken drugs?'

MH – 'Well, er, quite a few, but they are merely self-medicating.'

SM – 'What do you think my patients are doing?'

MH – 'Your patients brought it on themselves.'

SM – 'But when do my patients become your patients?'

MH – 'If they become psychotic, when it presents itself as a recognised mental illness.'

SM – 'But my patients try to self-medicate to stop this.'

MH – 'Well if they did not mess with drugs they would not have to "self-medicate".'

SM – 'So you just treat the ones who are ill before taking any illegal chemicals?'

MH – 'No I'm not saying that, we treat patients who have taken drugs before their illness.'

SM – 'But you do refuse people psychiatric treatment if they are on drugs.'

MH – 'Not if they are severely mentally ill.'

SM – 'What about that man we brought to you last week? His GP had written a letter for emergency admittance, he did not have the ability to hold a conversation plus he was HIV positive so all the hostels did not want to know – and you turned him away?'

MH – 'We were very busy that night, plus people like that on the ward complicate things and before you know it they are bringing drugs onto the ward.'

SM – 'So you were happy that the man ended up back on the streets with no hope?'

MH – 'Of course not, but if we admitted all of your referrals we would be out of beds in a day, and we've stretched our budget to the limit.'

SM – 'You've hit the nail on the head. It all comes down to money not care.'

MH – 'So what is the answer?'

SM – 'I think it's time the government had the balls to take drugs out of the black market and give more powers to doctors to prescribe.'

MH – 'Hold on, you talking about legalisation?'

SM – 'You have a better idea? More and more people are taking heroin and crack cocaine as we speak.'

MH – 'But legalising it will make more people take drugs.'

SM – 'The facts say the opposite, look at countries with liberal policies like Portugal and Germany compared with zero-tolerance countries like America. Per head of population, countries with stricter drug laws have far more drug abuse. People who think we are ever going to win the drugs war are insane.'

MH – 'Well I suppose we've been fighting it since the 30s and it's just got worse.'

SM – 'The only way you will win it is to stop trying to fight the war and price the criminals out by giving the doctors the power to prescribe – 'doctors not dealers' – then spend the billions wasted on drug crime to build the beds and rehab centres with follow-on care.'

MH – 'I agree we need a vast amount of money to build hospitals for those who want to come off drugs, and even have separate wards for those who have mental health problems as well.'

SM – 'Yes and if we could also look into why people start to stick needles in their arms or spend all their money on crack, even if it means going without food or shelter, we might find a connection with mental illnesses, like depression for instance.'

MH – 'I have a gut feeling it is because we live in such a competitive world which this government has encouraged. It's left a lot of lost souls who do not want to compete.'

SM – 'Hence escapism.'

MH – 'We must team up and talk about how we can work together.'

SM – 'Because we both aren't in it for the money or we would be a lawyer or a politician.'

MH – 'Or a drug dealer.'

David Wright is a member of Recovering Addicts Peer Support (RAPS), an independent peer support group based at In2change in Newport, South Wales. He is editor of the quarterly newsletter Offit, which can be viewed online from the Alliance's website: www.m-alliance.org.uk

My great escape

Bri sees a new life opening up – but will he be able to stay on track? He tells the fourth part of his story

Thinking and talking about this new way of life was an odd experience for me and I found it hard to mingle with the new family that were suddenly claiming to be my brothers and sisters. They dressed and talked very differently from me and never seemed to swear!

The place I was staying in on the south coast of England used to be an old folks home. As I sat in that huge house I knew my time there was limited, and as my health improved and I began to have fewer sleepless nights, I wanted to do something constructive. I started to look around for something that I could do and be a part of.

I found a place in Sussex called Abbotts Leigh. It was a Christian centre run by a community called the Bethany Fellowship that had 50 acres for me to wander in. It had 24 rooms and was not a drug rehab but a place where people like me could rekindle the life that had drained out of them. The fact was, I was not only wrecked physically, I was also very badly affected with all kinds of mental issues – mainly paranoia and a deep sense of rejection that had afflicted me since childhood.

The centre was geared around a regime of rebuilding people's lives with a living faith and belief in God. I decided I wanted to check out this wonder drug, this wonder faith – whatever it was I was hungry for it. During my time at Abbotts Leigh I met people who had similar backgrounds to me, all with drug problems, and they told me of how their lives had changed and been rebuilt.

Most of my time there was spent in the grounds working and sweeping leaves off the land, but I became fed up with that very quickly. I had had enough, and I needed to move on again.

I moved to Brighton, a place full of addicts. It was a dangerous place for me to be – and I knew it. I found a bedsit in the Kemptown area and worked for the fellowship in a coffee bar inside a disused cinema. We called the place 'the city' and the cinema part was used for all sorts of meetings.

During this time my love for a lady who was helping me cope with life grew deeper, and after two years we decided to move on and have our own life. I felt that God had started to work on me and my old attitudes changed dramatically. We moved to Hampshire in 1984 and later on that year my wife gave birth to our son. My once broken-down mess of a life was changing. My free will was still there – I just did not want to stick needles into my body anymore. I had found myself changing from the inside out.

In 1985 I decided to go to Winchester Agricultural College to qualify as a tree surgeon, working with trees and hedges. During this time there were many tests put before me – I had several bone breakages, where using morphine was the only drug that helped.

'I moved to Brighton, a place full of addicts. It was a dangerous place for me to be – and I knew it.'

One day I went onto a shed roof to repair it, even though my wife had asked me not to go on the shed alone and to wait for help – she was right as usual. I decided to try and repair it on my own and I had a terrible fall, breaking my leg and my hip. I was in agony for many weeks and was given 5mg diamorphine dispersable tablets, 50 tabs at a time.

Truly this was the greatest test yet – and I failed miserably. The doctor called one night, but not to see me. He had come to tell my wife I had used 1,400 tabs in eight weeks, and I felt my world crash around me. I felt I had gone right back to square one.

Next issue: Bri struggles to regain control.

Events

23 May – Dublin
Alcohol and drug use in young people: A world of solution
Organised by Juvenile Mental Health Matters. This conference aims to present a high level of problematic substance use and misuse in the context of evidence based intervention strategies and long-term community solutions. *www.juvenilementalhealthmatters.com*

24-26 May – Athens
The 9th Stapleford International Addiction Conference
Organised by Stapleford. For details on this year's event visit *www.stapleford-athens.net*

06 June – London
London Drug Policy Forum
Organised by LDPF. This one-day conference aims to look at the implications of *Drugs: Protecting Families and Communities* for local partnerships and explore issues faced in creating the systems and services for the future. *www.cityoflondon.gov.uk/NR/rdonlyres/C05EC1CD-FE2E-42D9-832B-85109A60AFC1/0/SS_LDPF_Joiningitup Flyer2008.pdf*

10 June – Glasgow
Drugs and Alcohol Today – Scotland
Organised by Pavilion and others. This is the Scottish equivalent of the London *Drugs and Alcohol Today* event and is now in its third year. More information and a booking form from Pavilion. *www.pavpub.com*

11 June – London
Treatment and reintegration: Delivering the drug strategy
Organised by NTA. This one-day conference aims to debate on the meaning of the new drug strategy. More information and a booking form from Pavilion – *www.pavpub.com*

30 June-1 July – Birmingham
UK national smoking cessation conference
Organised by Exchange Supplies. This 4th annual conference aims to provide a unique forum for professional development and knowledge sharing in the smoking cessation field. More details – *01305 262244, www.uknscc.org*

3 July – London
Dual diagnosis – substance misuse: the challenges for mental health professionals
Organised by Pavilion. This conference addresses substance misuse from a mental health perspective and ask how we turn good practice into reality. More information and a booking form from Pavilion – *www.pavpub.com*

8-10 September – Stockholm
The International Conference, World Forum Against Drugs.
Organised by World Forum. This conference aims to exchange ideas and share experiences on how to develop methods and move forward to the visionary goal of a world free from drug abuse. Details at www.wfad08.org

27-28 October – London
National Conference on Injecting Drug Use
Organised by Exchange Supplies. The NCIDU conference aims to develop the field, share information and learn by bringing together clinicians, researchers and users. More details – *01305 262244, www.exchangesupplies.org*

Nature of the problem: Addiction as a chronic disorder (part 3)

In this Briefing, Professor David Clark emphasises that we must be careful how we communicate the message about the chronic nature of addiction.

In earlier Background Briefings, I looked at an excellent paper by Bill White and Thomas McLellan that focuses on the chronic nature of addiction and on the need for a chronic or continuing model of care for helping people find recovery from addiction.

I also emphasised that the terminology used to describe addiction can be influential in a variety of ways. It can shape people's attitudes towards whether they can overcome addiction, shape the way we deliver treatment and the way we help people along the path to recovery, and influence society's attitudes towards people with substance use problems.

We need to be very careful therefore how we communicate the message about the chronic nature of addiction, particularly as it can arouse strong feelings and generate unintended, harmful consequences.

On the one hand, we need people to realise that society must develop a treatment and support system that allows for the fact that some people need considerable help to overcome their addiction, some types of that support occurring over a prolonged period of time due to the chronic nature of the condition. On the other hand, it must be flexible enough to recognise that some people may overcome their addiction very much easier than others.

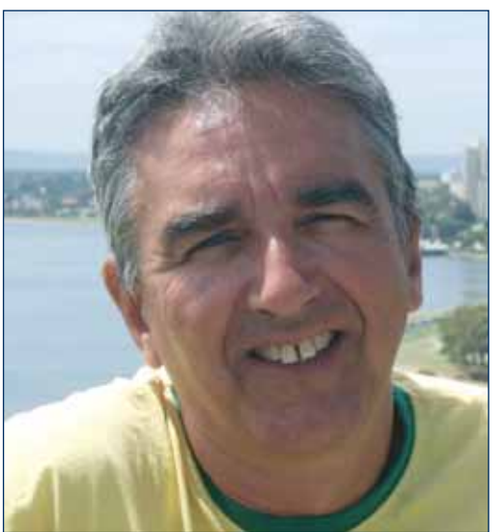
Knowing that they are suffering from a chronic disorder may help some people understand and relate to their problem much better, and this in turn may facilitate their recovery.

On the other hand, some people may feel disempowered by being told they are suffering from a chronic condition. Others who have gained and maintained recovery may even resent the idea that they have a chronic disorder. (I was a serious nicotine addict for over 20 years, but have had no inclination to smoke at any time over many years, even when sitting with smokers).

Some individuals in society may feel more positive towards people who are trying to overcome an addiction to substances if they are made aware of the chronic nature of the condition, while others may feel no sympathy at all and say that this is an abrogation of personal responsibility.

There are no simple answers here – what we must ensure is careful communication. In trying to facilitate better communication, White and McLellan looked at what the concept of addiction as a chronic disorder does not imply.

Not all substance use problems are chronic and have a prolonged time course. There is a continuum of severity of substance use problem. It is very difficult to predict which early substance use problems will develop into a chronic problem. However, in general, it is more likely that a therapeutic intervention will be successful if used with less severe than with more severe problems.



'Appropriate treatment for chronic addiction is not simply a succession of short term detoxifications or treatment stays. Appropriate continuing care requires personal commitment to long term change, dedication to self management, community and family support and monitoring.'

Not all people with substance use problems need specialised, professional treatment. Some overcome their problems on their own, while others may do so with the help of family and friends.

We do not know enough about identifying who is most likely to need professional care. However, we can make a generalised statement that people who need treatment tend to have more severe substance use problems and possess less recovery capital (internal and external resources to support the recovery process) than those who do not need treatment.

Among those people who enter treatment, relapse is not inevitable and all people who are addicted to (a) substance(s) do not require multiple treatments before they achieve a successful, long-term recovery.

The possibility of recovery exists for all sorts of people, even those who have relapsed on multiple occasions. In fact, most people make a number of attempts to change their behaviour before they are able to achieve permanent change.

Having the chronic disorder of substance addiction does not reduce a person's responsibility for making continued efforts to manage that disorder. They must manage their addiction.

White and McLellan emphasise that, 'Appropriate treatment for chronic addiction is not simply a succession of short-term detoxifications or treatment stays. Appropriate continuing care requires personal commitment to long-term change, dedication to self management, community and family support and monitoring.'

They also point out that current addiction treatment outcomes are not acceptable simply because they are comparable to those achieved with other chronic disorders.

I know that some people do not like the use of the word 'chronic' when we talk about addiction. However, if we do not accept the chronic nature of the condition, how is society going to accept that it must develop the resources required for that described by White and McLellan?

'Chronic disorders require strategic, sustained stewardship of personal, family and community resources. Core strategies for achieving long-term recovery from chronic disorders include stabilisation of active episodes, global assessment, enhancement of global health, sustained professional monitoring and early re-intervention, continuity of contact in a primary recovery support relationship, and development of a peer-based recovery support network.'

Professor David Clark runs 'the prof speaks out' and other blogs at http://davidclarkwired.blogspot.com

University of Kent | Kent Institute of Medicine and Health Sciences (KIMHS)

Training for Drug & Alcohol Practitioners

Programmes from 2008/09

Our university accredited, modular programmes incorporate the "Models of Care" framework, DANOS competencies and QuADS benchmarks. Being taught in five-day blocks, they are accessible to students living in or outside Kent, are ideal for those new to or returning to study. All programmes aim at a wide range of professionals in healthcare, counselling, criminal justice, the community and social care etc. who access clients with substance use related problems.

Certificate in Substance Misuse Management (Stage 1)

This access level Certificate provides a broad introduction for practitioners who work with problem substance users, or expect to in the near future. The programme is delivered in Canterbury and across the UK where there are cohorts of 10 or more students. It is a recognised benchmark for those seeking an accredited qualification. The programme also offers beneficial training for all social, health and education professionals whose work includes contact with problem substance users.

18 month programme from September 2008 or by negotiation

Certificate in the Management of Substance Misusing Offenders (Stage 1)

This Certificate is an access programme for prison and probation officers, drug and alcohol workers, health and social care professionals working with problem substance users in the criminal justice system. It includes NTA and Home Office strategies, eg. DRRs, CJIP, CARAT and DIP issues, ethics, cultural factors, managing challenging behaviour and working in multi agency, criminal justice settings. Available across the UK for cohorts of 10 or more students.

18 month programme from September 2008 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the biological, psychological and social perspectives of substance misuse, within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions, against the backdrop of current research and thinking in the field.

2 year programme from October 2008

BSc in Substance Misuse Management (Stage 3)

The BSc programme provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours, this includes training in ethics, research methods and the implementation of a small research project. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. POST-GRADUATE RESEARCH OPPORTUNITIES are also available in this area of study.

2 year (top-up of Diploma) or 4 year programme from November 2008

For further information and an application form, please contact:
Teresa Shiel, Programme Co-ordinator, KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent CT2 7PD
Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk KIMHS webpage: www.kent.ac.uk/kimhs/courses

Design & Print Centre 105884 02/08

DDN in association with FDAP

"The trainer worked at our pace, which helped us to learn in a relaxed environment"

"Well presented and interactive"

Essential workshops

Supervision, appraisal and DANOS
2 June 2008 – central London
This one-day workshop for line managers and HR directors covers supervision, appraisal and development of front-line staff against DANOS and other national occupational standards. It is run by Iain Armstrong – a leading expert in DANOS and workforce development

Performance management
9 June 2008 – central London
This one-day workshop for line managers and HR directors builds on the "Supervision, appraisal and DANOS" workshop (outlined above), and focuses on managing and developing practitioners' performance against DANOS and other national occupational standards. It is run by Iain Armstrong – a leading expert in DANOS and workforce development.

Cost: £110 + VAT per head (15% reduction for FDAP members/affiliates).
Rates for groups on application. Contact Tracy Aphra.
e: tracy@cjwellings.com, t: 020 7463 2085.

Institute of Lifelong Learning

Foundation Degree in Drug and Alcohol Counselling

Delivered by Distance Learning and on-campus in Northampton

These two courses are four-year part-time degrees which prepare students to work professionally as drug and alcohol counsellors.

The Distance Learning course is available to applicants already working with drug or alcohol-using clients. It runs via the Internet, supported by intensive yearly workshops.

The Northampton course is available to applicants without current clients, and runs on Monday evenings.

Contact: Course Administrator, University of Leicester Northampton Centre, Northampton College Building, Lower Mounts, Northampton, NN1 3DE
Call: 01604 736215
Email: couns.northampton@le.ac.uk
Visit: www.le.ac.uk/lifelonglearning/counselling

www.le.ac.uk

University of Leicester

Management training course & qualification

fdap ASET

Certificate in Supervisory Management & Leadership Techniques

This training course, designed specifically for line managers in the drugs & alcohol field, leads to a **level 3 qualification** from the awarding body **ASET**.

The course focuses on relevant units from DANOS, and the Management & Leadership and Education & Learning National Occupational Standards. Each course involves four days of classroom time, plus reading & preparation.

The next "open" course, for individuals and small groups, will be held on **14-17 July**, in Ladbroke Grove, **London**. [The course is also available on demand for groups of 8 or more.] For more details, or to book, please contact Jim Turner at **The Performance Group** - 0845 880 2255, www.tpgl.co.uk.

Next "open course" 12-17 July, London

(also available "on demand" for groups of 8 or more)

DANOS 2012

More about training & qualifications from FDAP - www.fdap.org.uk

West Sussex Drug & Alcohol Action Team

Data & Information Officer
Drug and Alcohol Action Team
West Worthing
£25,320 - £27,594 (pay award pending)

Be part of an exciting new project to implement our new client information system (HALO) across West Sussex. You will need to work creatively and efficiently to ensure that the collection, processing and analysis of data meet the needs of our diverse client group and agencies. With your expertise in the use of Microsoft packages, including Excel, you will deliver training and need to demonstrate that you are self-motivated to produce tangible results.

Post requires a Criminal Records check.
Closing Date 26th May 2008
Interviews will be held early June.

For further information please contact Jane Williams, Public Health Specialist on 01903 708683. For an application pack, please go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 642140 (24 hour).

RHOSERCHAN

Required: Counsellors

Rhoserchan seeks full time counsellor and part time weekend/ relief counsellor. Details on www.rhoserchan.org.uk
For both posts a diploma in counselling will be necessary.

Luton NHS Primary Care Trust
A teaching Primary Care Trust

LUTON BOROUGH COUNCIL

LUTON DRUG & ALCOHOL PARTNERSHIP

Tier 2 Drug Service including DIP
1/04/2009 - 31/03/2012 (3 yrs + 2 x 1yr option)
Luton PCT & Luton Borough Council

Luton Drug and Alcohol Partnership are seeking written expressions of interest from providers with proven experience in delivering tier two services including the local intensive drugs intervention programme.

You will be required to provide harm reduction services (including needle exchange) drug related information and advice, assessments, referral to other services, brief psychosocial interventions, complementary care, relapse prevention, after care, required assessments, follow up assessments, restrictions on bail and outreach to clients and prisons.

The expected term of the contract will be for three years with a possible two-year extension in twelve-month increments, subject evidence of need, recurrent funding and satisfactory performance.

It is envisaged that the contract will be awarded in November 2008 with the service commencing 1 April 2009.

Expressions of interest and Pre-Qualification Questionnaire (PQQ) to be requested via e-mail to **mike.squires@blpt.nhs.uk**

The final date and time for receipt of completed PQQ's is 16th June 2008 1200hrs.

Mike Squires, Head of Procurement
(Acting for Luton PCT)
1st Floor, Charter House,
Alma Street, Luton, Beds LU1 2PJ.
Tel: 01582-709012

COMIC RELIEF

Comic Relief: Alcohol Hidden Harm

Call for bids

Comic Relief has supported work around young people and alcohol for many years and now wants to fund a number of projects across England for up to three years that are supporting children and young people living in families where there is problematic parental drinking. Successful organisations will have the capacity to grow and expand existing work and have a clear understanding of strategic developments in this area and be able to show how the additional work will increase our understanding around effective models of intervention. We are looking to fund either direct work with children and young people or family based models that aim to reduce the risk to children and young people and help improve the protective factors that increase their resilience.

If you would like an application pack or would like to discuss your ideas before submitting an application please ring Peter Argall on 020 7820 5559. The deadline for applications is Friday 27th June 2008.

PUTTING YOU FIRST

Chief Executive's
Safer Merton Drug & Alcohol Action Team

Service User and Carer Co-ordinator

Temporary contract for 1 year **Ref: 3664**
£27,753 - £29,286 per annum inclusive, pro-rata for 21 hours per week

Safer Merton Drug & Alcohol Action Team are committed to Service User and Carer involvement and is recruiting a Service User and Carer Co-ordinator to continue it's excellent performance in this area.

In this role you will be responsible for co-ordination of the service user and carer involvement and consultation processes within the Borough of Merton to ensure service users and carers are involved in treatment planning and decision making, and are recognised as stakeholders in DAAT strategy, policy, procedures and practice. In addition, you will work to ensure that service users and carers are actively involved during development, change and evaluation of existing services.

Previous experience of the substance misuse field and demonstrable knowledge of National (NTA) guidance on Service User and Carer involvement are required.

A CRB check will be required for this post.

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

Closing date: Friday 23rd May 2008.

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

www.merton.gov.uk/jobs

Further information about the above job can be found on our website at www.merton.gov.uk/jobs where you can apply for this job online. Alternatively, you may request a pack by telephoning 020 8545 4055 (24hour answerphone) quoting the reference number.

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FULL TIME (40 hours per week Mon-Fri)

Salary: £18,000 to £22,000

We are currently looking to recruit a CARAT Workers (Counselling, Assessment, Referral, Advice, and Throughcare) to join our expanding Drug and Alcohol Team at HMP Lowdham Grange. This is an exciting opportunity for a self motivated, enthusiastic and resourceful individual who has a desire to work in the substance misuse field. This role will be varied and challenging with lots of prospects and growth.

If you are interested in joining us, you will encourage and motivate adult male prisoners to access treatment by using a case management approach. You will carry out assessments, care planning, one to one and group work. The successful candidate must have a positive attitude towards drug rehabilitation, have high levels of motivation and commitment, excellent problems solving and communication skills and experience of working within the Criminal Justice System is desirable. A clear understanding and experience of the CARAT process is desirable but not essential. You will be apart of a skilled, committed and multidisciplinary staff team.

Closing date for applications: 30th May 2008

If you are interested in this role, please contact us for an application pack by emailing ***recruitment.lg@premier-serco.com*** *or call our recruitment hotline (24 hour answer phone) on 01159 669 346.*

HMP Lowdham Grange is committed to treat fairly all staff, prisoners, partner agencies, visitors and members of the wider community regardless of race, skin colour, ethnic or national identity, language, religion, gender, sexual orientation, disability, marital status or age.

Serco Limited is an Equal Opportunities Employer. Selection for these posts will be on the basis of merit. The company is exempt from the Rehabilitation of Offenders Act 1974 (exceptions) Order 1975. All offers of employment are subject to Home Office Approval.

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Supplying experienced, trained staff:

Commissioning ❖ Service Reviews ❖ DIP Management ❖ DAT Co-ordination ❖ Needs Assessments ❖ Project Management ❖ Group & 1-1 drug workers ❖ Prison & Community drug workers ❖ Nurses (detox, therapeutic, managers) ❖ *plus many more roles..... call today*

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Wolverhampton City NHS Primary Care Trust

Expressions of Interest

for the supply of needle exchange packs for Wolverhampton Primary Care Trust.

Expressions of interest are invited from manufacturers and distributors to tender for a contract to supply needle exchange kits and other harm reduction equipment as may be necessary, for delivery to pharmacists and the specialist needle exchange service in the Wolverhampton area.

The expected term of the contract will be for 3 years with a possible extension of 2 years in 12 month increments, subject to satisfactory performance and need.

Wolverhampton Drugs Services take a pro active approach to harm reduction services and would therefore welcome partnership working with an innovative organisation.

Written expressions of interest and requests for tender documentation should be made by 5pm Friday 27th June 2008 to:

Wendy King, Contracts/Procurement Officer, Substance Misuse, Adults and Community, Wolverhampton City Council, Bond House, Suite 101-103, St Johns Square, Wolverhampton WV2 4AX.
Email: wendy.king@wolverhampton.gov.uk

Argyll Bute COUNCIL

Are you interested in joining the newly integrated Argyll and Bute heath and social care addiction team?

We seek an enthusiastic and experienced individual to join our newly integrated team based in Mid Argyll/Kintyre. In addition to assisting with the development of the new team, and alongside your health colleagues, you will offer a service to individuals and families experiencing difficulties relating to their use of illicit drugs and/or alcohol. You will work with a range of internal and external partners to develop and deliver integrated packages of care. You will have experience of working with adults with substance misuse related difficulties and preferably have knowledge of children and family services. It is essential that applicants have experience, in some capacity, of working with adults with substance misuse related issues, assessment and care planning and also experience of preparing formal reports. Candidates are expected to work within a team and to function as autonomous practitioners. The ability to work flexibly, including occasional evenings, is expected. It is desirable for applicants to have a social work qualification at CQSW, DipSW level and a Diploma/Certificate in Addiction studies. A full UK Driving Licence is essential.

Salary: With SW qualification – LGE11 £28,341-£31,936
Without – LGE10 £25,184-£28,341

Restrictions:

- *Applicants should note that this is an EXCEPTED POST, i.e. a post to which the Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Order 2003 applies*
- *Successful applicants will be subject to Disclosure Scotland vetting*
- *This post is also designated as 'Politically Restricted' under the Local Government Housing Act 1989*

Recruitment packs from 01546 604555
Closing date: 30/05/2008