DDN
Drink and Drugs News
21 May 2007
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Vernon Coaker wants fresh ideas and focus

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Editor's letter

Whatever you feel about existing data collection systems – and we know that many of you feel very strongly that they have taken over your job and burrowed into client time – there is no doubt that the NTA has consulted carefully before introducing the new Treatment Outcomes Profile system (page 10). Its designers, addiction researchers Dr John Marsden and Dr Michael Farrell, have taken on board the need to combine time-saving on bureaucracy with the goal of improving careplanning.

With recent DDN letters pages in mind, it seemed worth including feedback from the system's testers – in case it helps you at the teething stage. Many of the stakeholders at the launch conference were optimistic that it would give greater efficiency alongside the much called-for monitoring of progress – as well as a barometer of the effectiveness of individual services, that would strengthen and steer commissioning. The real test will be seeing how easily teams adapt, particularly keyworkers, to using it to its much-needed potential.

In a week when the charity Mind warns of unnecessary prescribing, we shine our torch into the doctor's surgery to find Tony Birt (page 6). Five years ago he was dying from lack of holistic care. These days he is a passionate advocate for better treatment, and particularly understanding for drug users within primary care.

We know there are doctors out there who care about drug users. As well as those who spoke at the RCGP conference recently (page 7), there are inspiring examples around the country, such as the Cornwall group who carried out an audit to improve their referral process (page 13).

There's plenty of inspiration in this issue: for young women through the Young Women Now movement (page 12), and for prison workers looking for an excuse to innovate, on page 14.

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In this issue

Government challenged over consultation

The government last week came under fire for its refusal to carry out a full consultation on its new alcohol harm reduction strategy, due for release later this summer.

Securing a private member's debate in the House of Commons last Wednesday, Conservative MP David Burrowes criticised the government's approach, saying it denied key stakeholders – such as service providers and people addicted to alcohol – an opportunity to improve strategy that was 'too limited'. This lack of consultation, he continued, was further evidence that alcohol was 'still the poor relation in drug and alcohol policy'.

The current strategy, released in 2004, was too narrow in its approach and focused too explicitly on binge and chronic drinkers. With the all the economic, health and social damage attributable to alcohol, the government needed to review its approach, he said.

'A more strategic approach is needed, recognising the impact of price, regulation and availability and giving alcohol misuse the same public health status that tobacco and obesity currently have,' said the Enfield MP.

The government had to give the country's alcohol problems the same priority it gave drug problems. In the same way that the government had set clear targets for getting problem drug users into treatment, targets on getting problem drinkers into treatment also needed to be set. The imbalance between drugs funding and alcohol funding needed to be urgently redressed, he said.

'In 2006-07, of the 39 primary care trusts that supplied separate figures for alcohol and drugs services, the average spent on alcohol was £424,500, compared with the average of £3.83m that is spent on drug treatment. So, alcohol receives about 11 per cent of the amount that is allocated to drug treatment,' Mr Burrowes said.

Responding to the criticisms, public health minister Caroline Flint said that although a formal consultation was not being carried out, there had been a 'series of detailed discussions that have informed [the government's] thoughts and views on how to take the strategy forward'. Once the strategy was published, there would be further opportunities for stakeholder input.

She defended the government's track record, stating it was becoming clear that the mechanisms put in place in 2004 were beginning to have a positive effect. And, she said, most of the commitments in the previous strategy had been delivered on – particularly underage sales and alcohol related violence. 'That is not to say we should be satisfied by where we are, but the indications are that such offences have fallen,' she said.

Review follows surge in European cocaine use

A comprehensive literature review on the effectiveness of current treatments for problematic cocaine use has been published by the European Monitoring Centre for Drugs and Drug Addiction.

The review followed a surge in cocaine use throughout the Europe, with the drug responsible for 8 per cent of all EU drug treatment demands. Cocaine was now the third most common reason for people to seek drug treatment.

The report concluded that treatment of cocaine dependence still frequently included the use of anti-depressants, despite the low level of evidence that they were actually effective. More promising results were experienced from topiramate and other anti-epileptic drugs. However the report stated that, to date, the 'most innovative treatment' currently being tested was the cocaine vaccine, which aimed to block the desired effects of cocaine and thereby reduce its potential for abuse.

However the lack of 100 per cent effective pharmacological treatments meant that European professionals relied heavily on psychosocial interventions, particularly drug counselling and cognitive behaviour therapy. A therapy developed in the US, known as contingency management, was incentive-based and offered rewards for those who were able to demonstrate abstinence from drugs. Despite positive trial results, there were questions over whether this therapy was effective in the long term.

The review also called for urgent research into poly-drug use, noting it had now become the rule, rather than the exception. Multiple substance use often had a negative impact on treatment outcomes, the review stated, and there were 'important gaps in our knowledge'.

Treatment of problem cocaine use is online at www.emcdda.europa.eu/ ?nnodeid=18945

UN support for random drug tests on drivers

Random drug testing should be introduced to curb the incidence of drug-related accidents on the road and at work, according to Antonio Maria Costa, executive director of the United Nations Office on Drugs and Crime.

Speaking at the 14th Mayors' Conference of European Cities Against Drugs, Mr Costa said it would not be hard to win over public opinion, given that most were already in favour of alcohol testing – which had been proven to be an effective deterrent.

'No one wants to be killed or maimed by a drunk driver. So society accepts police controls to check if someone has been drinking,' he said. 'Public opinion is waking up to the fact that some people are driving cars, public transport, operating heavy machinery or even flying aeroplanes while on drugs. Road testing works for alcohol, it will work for drugs.'

He particularly praised efforts by the UK, the US and Australia to introduce such measures. However, he noted that any efforts to apprehend those with substance misuse problems had to be matched by efforts to provide them with the best possible treatment. UNODC was building up TREATNET – an international network of drug dependence treatment and rehabilitation resource centres, with 20 branches around the world. 'But I want to see 100 times more centres in this network,' Mr Costa said. 'I urge you to identify well-run drug treatment and rehabilitation centres and link them up to the TREATNET.'

He also urged 'cities to help other cities' and suggested exchange programmes where experts discover new and better way to tackle drugs and crime.

Campaign on ketamine

A new information leaflet on the dangers of the drug ketamine has been produced by the Forest of Dean Crime and Disorder Reduction Partnership.

The leaflet – believed to be the first of its kind in the UK – was developed after the drug was identified as an escalating problem in the area.

'The dangers of this drug are not widely known as it is fairly new on the drugs scene,' said Melanie Getgood, chair of the CDRP's substance abuse action group. 'This leaflet is specifically aimed at young people and provides essential information about what ketamine is and what makes it so dangerous.'

The drug – which is a type of anaesthetic – can cause death and makes users vulnerable to being robbed or sexually assaulted.

Q&A next issue

The latest readers' 'question and answer' feature has been held over to appear in our next issue. Please continue to send answers to the question below, by a deadline of Tuesday 29 May, to appear in the next issue. Please email answers to the editor: claire@cjwellings.com

Reader's question: I used to have a drug problem, but since getting clean have enjoyed my job as a drugs worker. A few months ago I relapsed for the first time. I took leave from work and booked myself into treatment, determined to sort myself out. My problem is that my counsellor at rehab is threatening to tell my employer about my relapse, saying that she has a duty to protect my future clients. I am horrified, as I thought my confidentiality was protected when I went into treatment. Please can anyone advise me on my position? *Amy, by email*

Caroline Flint: 'Brave but grown-up approach.'

Action on Addiction merger pools resources

Three well-known addiction charities, Clouds, the Chemical Dependency Centre and Action on Addiction have merged, taking their name from the latter.

The relaunched Action on Addiction announced at a reception at the House of Lords this week that they were pooling resources and expertise to offer treatment and rehabilitation on the 12-step model, prevention, education, professional education, and family support. The charity's chair, Dominic Castlewood, said that 'many a story in addiction hinges on taking a risk' and praised the individuals involved for putting their clients first. New joint chief executives are Nick Barton of Clouds and Lesley King-Lewis of the former Action on Addiction.

Public Health Minister Caroline Flint praised a 'brave but grown-up approach' and said she was impressed by how the voluntary sector had kept up with policy changes, in working out how best to respond to individuals' needs. She looked forward to working with Action on Addiction 'on issues that aren't always on top of everybody's agenda'.

Former client Emma explained her life transformation from attending Clouds and Hope House – a journey that had begun with recreational drug use at 15, progressed to crack and heroin use by 18, and saw her paralysed from the neck down for three months, after speedballing. Specialist care at rehab had 'slowly put [her] back together' so that she completed a three-year degree and now worked in the field.

Action on Addiction's chief executives emphasised their determination to continue helping people like Emma. 'We are not very good in this country at getting people into treatment when they need it,' commented Lesley-King Lewis.

Action on Addiction's website is www.actiononaddiction.org.uk

HIV: discrimination still an obstacle

Injecting drug users are being denied access to basic HIV prevention and treatment services, according to a UNAIDS senior official.

Opening the International Harm Reduction Association (IHRA) 18th Conference on Drug-Related Harm, held in Poland, UNAIDS regional director for Asia and the Pacific, Prasada Rao, told delegates that of the estimated 13 million people globally who inject drugs, just 8 per cent had access to some kind of HIV prevention service. Access to antiretroviral treatment in particular was unacceptably low. Mr Rao blamed exclusion, lack of information, stigma and discrimination for the situation.

Yet this exclusion came despite the knowledge that injecting drug use was a major mode of HIV transmission. 'About 10 per cent of all new HIV infections worldwide are attributable to injecting drug use – if you exclude Africa, that figure rises to 30 per cent,' Mr Rao said. 'Evidence shows that HIV prevention programmes are particularly effective among people who inject drugs but they are regularly denied access to information and services.'

He said that in regions where injecting drug use is driving the Aids epidemic – such as south-east Asia, central Asia and Eastern Europe – focused harm reduction programmes which reach injecting drug users had to be built into national Aids plans.

He held up Portugal as an example of good practice. Here, in recent years harm reduction programmes and information campaigns aimed at injecting drug users were significantly scaled up, and the result was a drop of almost one-third in new HIV diagnoses between 2001 and 2005.

Media Watch

Scottish police forces have launched a new strategy aimed at the social conscience of the middle-class, to deal with the growing increase of cocaine consumption. This follows concerns that publicity campaigns that focus on the health implications and illegality of cocaine, are having little impact on Scotland's young. According to Gill Wood, the national drugs co-ordinator for the Scottish Crime and Drug Enforcement Agency (SCDEA), young professionals should be informed of the 'horrendous violence' associated with the supply of the drug – murders, serious organised crime and exploitation of women and children. SCDEA plan to get this message across through an ethical trade anti-drugs campaign at summer music festivals.
The Scotsman, 14 May

The number of Britons being prescribed antidepressants has increased dramatically in recent years despite warnings, from a leading mental health charity, that many patients may not need them. Mind's report highlights more than 31m prescriptions written by doctors for antidepressant drugs last year, with Seroxat and Prozac increasing by 10 per cent – despite guidelines from the National Institute for Health and Clinical Excellence, over reliance and possible side-effects. According to the charity, adult patients with moderate depression should instead be offered counselling and cognitive behavioural therapy. But many GPs kept prescribing because of the lack of alternatives to antidepressants, insufficient funding and patient demand for the drug.
The Times, 14 May

The UK's first drug and alcohol court will be launched in Camden, Islington and Westminster to provide a specialist service for the many substance related care cases in these areas. The court will offer same-day referrals for help, advice and support in cases where children face going into care as a result of their parents' substance misuse, and will include a judge, substance misuse specialists and social workers. This scheme is successfully used across the USA and has enabled more children in care to return home. The court is part of a three-year pilot scheme due to start in January next year.
Community Care, 15 May

Scottish children as young as 12 can now be prescribed nicotine replacement therapy (NRT) under NHS guidance to help them quit smoking. According to officials at NHS Health Scotland, young people have just as much right to the treatment as adults. GP surgeries and chemists are being issued with an update on good practice, which includes offering NRT patches and gum to teenagers. Originally NRT treatment was not recommended between the ages of 12-18 as their brains are still developing and could make them more vulnerable to addiction. However the Committee on the Safety of Medicines approved its use following research in 2005 that indicated there was no evidence it will be misused by adolescents. Tobacco researcher, Dr Linda Bauld, believes this new guidance will make it very clear to reluctant GPs that it is now acceptable to prescribe NRT to young people.
The Herald, 10 May

Looking beyond the drugs

All too often busy GPs treat a drug problem without seeing the person beneath. Tony Birt (pictured right) brings the patient experience alive, while doctors Chris Ford, Linda Harris and Francis Labinjo suggest how GPs can use changes in the primary care landscape to improve the patient experience.

Five years ago I was dying – quite literally and rapidly, on the waiting list for secondary care for my chronic, severe and enduring opiate dependency and chaotic poly drug use. The three reasons I'm still here to tell my tale are The Alliance, evidence-based practice and a vital mission to improve drug treatment in primary care – to normalise it, de-stigmatise it and reach a holistic approach.

Unfortunately I have to admit that primary care has absolutely nothing to do with me being alive today, but it is the reason I'm calling for change. Five years ago while on 'death row' – the waiting list – for 15 months, I was told time and time again by my GP that: 'We are a non-prescribing practice Tony and I would love to help you but…

- My partners would never stand for it, you see.
- I am not permitted to prescribe for you.
- We have to follow the protocols.
- I just don't know what to do for the best.
- I only had an hour drugs training and I was away that day, I think I had a cold or something…'

This list could go on. The point is that there are Tonys out there, all over the country – and still more who never saw the sunrise this morning because their GP, or anyone else with the professional capacity would not, or could not, help. Would we make such judgement calls anywhere else in the healthcare field? Would it be stood for?

Without real primary care involvement and commitment we will surely return to the bad old days of just two, three, four years ago, where the problematic substance users' only hope was the 12-week 'beggar's option' – 12 weeks' treatment, then back out to face the world – that sent me reeling back into chaos most of my life.

There are many people in my community who are dependent on benzodiazepines – just as I was, in the days when I was known as 'Benzo Birtie'. How is it that these very vulnerable people cannot get support through a prescription with their GP, but there are another hundred in the same town, even the same surgery, who get the supplies to sell to 'Benzo Birties' all over the country?

Would it not be more sensible – and safer for the community – to prescribe for, and look after the ones that are problematic and chaotic with these 'killer' drugs (that were introduced by the medical field in response to barbiturates)? At the age of 15 I was prescribed benzos (lorazepam – which was then marketed as Ativan) for barbiturate dependency – but there was no ongoing support when I transferred my addiction to the benzos.

The problematic substance user needs to be able to trust, accept and believe in primary care. This would be a huge step towards ending their isolation and keeping them in the net of long-term holistic care.

Tony Birt

Working with the patient not the drug

Drug treatment has traditionally focused on control of substances rather than considering the person as a whole and understanding the use of drugs in their life. This focus has led to the development of services which are sometimes difficult to access and often appear antagonistic to the people that they are designed to serve.

People with drug problems are often viewed as untrustworthy and incapable of recognising their own needs – a pervasive belief and a destructive generalisation that reduces the effectiveness of services at every level. It is counterproductive for both patients and staff, and leads to fear in staff and patients.

Patient-centred care challenges our attitudes and prejudices towards our patients and their drug use. Its core principles are listening, trusting and empowerment. We need to listen and patients need to be heard. We need to believe what patients say and work with them – at the stage they are at, and not where we think they ought to be. We need to increase the person's sense of power over their own life and have transparency about what we are doing to help them and why, explaining how the system and law works and sharing information. We should help the patients work out their own care plan so they can decide what's best for themselves. Rather than just attempting to coerce the person to stop taking drugs, we can empower them to take control of their own lives.

In doing this, we can attempt to move clinical practice beyond fear and control and care for the person rather than just concentrating on the drug. We must be mindful to deal with them as an individual,

exchangesupplies.org conference archive

"There are many people in my community who are dependent on benzodiazepines – just as I was, in the days when I was known as 'Benzo Birtie'. How is it that these very vulnerable people cannot get support through a prescription with their GP, but there are another hundred in the same town, even the same surgery, who get the supplies to sell to 'Benzo Birties' all over the country? "

and not generalise, when we discuss their choices and behaviour. We need to build and maintain a patient-centred relationship, which can be used to support the whole spectrum of care, including harm reduction, abstinence and substitute prescribing.

How can we do it? We need to listen, ask and trust our patients. It's a win-win approach that removes the barrier of fear.

Dr Chris Ford

A changing landscape

The provider landscape is changing and almost every public sector organisation and agency is facing whole system change.

In the substance misuse field we have always had to use the strength of evidence based practice to ensure patients get the best deal.

But GPs and primary care practitioners have an opportunity to be involved in shaping a 'brave new world'. The baton for commissioning is being passed to them, and PCTs are being urged to broaden the base of care and widen patient choice.

By engaging in the commissioning process GPs can help PCTs, through their knowledge, leadership and championship, to understand how public health interventions and prevention can make huge returns on quite small investments now. The battle is to get them to listen, so that drugs and alcohol are moved up the list of competing priorities.

For the entrepreneurs, there are opportunities to move 'beyond prescribing' by the creation of alliances, a move toward a business – and dare I say it – a customer focused approach, to deliver on the social determinants of care.

The world is changing, but I remain optimistic that primary care will continue to dominate the substance misuse treatment field. I hope that as we enter this watershed between strategies, we can reflect and plan how we are to take a central role in reshaping the future of care for our patients.

Dr Linda Harris

Adapting to change

I firmly believe that substance misuse services should be delivered within primary care, with other specialists, including hepatologists and psychiatrists, brought in as needed. United we stand; divided we fall, fail, or both.

Every individual has the potential to make a difference to the service that they are working in and are committed to, and teams of patient-centred individuals can truly transform the way they work. The Department of Health Guidance, New Ways of Working for Psychiatrists (NWW), has implications for the risk exposure of GP addiction specialists and for shared care, as consultant psychiatrists will no longer see follow-ups or cases other than complex ones, making more use of advice and consultancy to the multi-disciplinary team for less complex cases.

There are emerging new challenges. More addicts are growing into older age, with many over 65. At the other end of the scale we are finding an increasing number of younger people with Attention-deficit hyperactivity disorder (ADHD) and autism spectrum disorders such as Aspergers', who are growing up to become young adults with substance misuse problems.

If we are to reduce drug taking, harmful behaviour and drug-related deaths, we need to promote better engagement with service users.

Better Ways of Working can help to improve the quality of drug treatment within primary care, but we need common ownership of the agenda and to identify 'change champions', communicate better, co-ordinate referrals, record outcomes and change our working culture, which is currently too territorial.

We need a united approach between mental health, primary care, criminal justice agencies and the independent sector, under the steer of the NTA, and I believe that future training of addiction specialists should involve spells of experience in both addiction psychiatry and general practice.

Dr Francis Labinjo

Contributors to this article were all speakers at the RCGP 12th national conference on the management of drug users in primary care, held in Birmingham.

A different outlook

Peter Bates suggests a fresh approach for primary care into treating drug users, based on his work with the National Development Team.

As always in working with people, attitudes matter as well as technologies. We are regularly told that there is no community to join, or that this (non-existent) community will close ranks to keep out people with unattractive, criminal or incomprehensible behaviour.

We are also sometimes told that it is not the task of health professionals to assist people to retain or rebuild social roles and relationships, and sometimes even that health professionals can do their work without knowing anything about the ordinary aspirations of their patients.

The National Development Team (NDT) vigorously opposes such blind pessimism by finding out what helps, by pointing out the myriad examples of hope, and by defiant enthusiasm. Founded in 1976 NDT has had a key role in promoting socially inclusive practice by undertaking research; developing conceptual frameworks and resources; and conducting service evaluation and staff training.

Tools are available to train staff in inclusion capabilities, specify inclusion interventions, audit inclusion practices, and measure inclusion outcomes. Promoting social inclusion has been a key feature of services for adults with learning disabilities since the 2001 White Paper *Valuing People* and of adult mental health services since the 2004 report from the Office of the Deputy Primer Minister *Mental Health and Social Exclusion*.

We suspect that it may be possible to adapt some of these resources for use with drug users and in primary care - indeed, many of the 'inclusion on prescription' projects have been doing similar things for years. We would be glad to hear from anyone interested in a further conversation and mutual learning.

Peter Bates can be contacted at pbates@ndt.org.uk; www.ndt.org.uk

We invite Home Office minister Vernon Coaker to give us insight to his approach to revising the Drugs Strategy. He explains his direction of travel.

'I want fresh ideas and a focus on what works'

This week I am looking forward to national tackling drugs day, a chance to celebrate the wonderful work that often goes on, often unsung, around the country. On Wednesday, groups in places as diverse as Camden, Durham, Blackburn, Milton Keynes and Ceredigion will highlight the dangers posed by drugs and the work that goes on to tackle this menace.

A drug treatment centre will be officially opened in Barking and Dagenham, there will be information stalls across the country and Gateshead will host a concert with a song, called 'Kick It', written and performed by a former drug user.

On Wednesday drug action team partnerships will be organising events to support the day, from police crackdowns, information stalls in supermarkets, sports activities for young people to balloon releases to mark the numbers of people in treatment, and football and rugby matches featuring people involved in the effort to tackle drug misuse.

In all, six ministers will be out and about, demonstrating just how much of a priority this government places on tackling drugs and reducing the harms they cause. I will be leading the ministerial activity by opening a new treatment centre in Barking and Dagenham. Alongside other ministers, I will be playing a football match against Lambeth North Positive Futures scheme and the Hull-based charity, Dads Against Drugs to launch the Tackling Drugs Changing Lives Awards 2007.

This isn't just talk: since 1998, when we launched our ten-year Drug Strategy, this government has made tackling drugs a top priority. We have backed our strategy with unparalleled investment of over £9 billion in enforcement, education, early intervention, and treatment.

We have spent this money well: overall drug misuse has fallen by 16 per cent since 1998 while the misuse of Class A drugs has stabilised. I am particularly heartened that drug misuse among young people has fallen by over a fifth in the last ten years.

More and more people are entering and staying in drug treatment. Nearly four-fifths of the 181,000 people who underwent drug treatment programmes in the last financial year completed their programmes.

Despite these successes, I am keenly aware the debate over drugs remains highly charged and the challenge for government is to navigate a way through competing demands. I fully understand the strong emotions involved; but too often the debate is framed in extreme terms – some people argue for legalisation while others argue for tough enforcement – leaving little space for a rational debate in the centre ground.

For example, in recent months we have heard from people who think drug legalisation would be the answer to solving the social problems associated with drug misuse. On the other hand, I do not have to go far to hear from people who call loudly for even tougher enforcement against drug dealers and drug users. Others will refer to drug policies abroad, whether in the Netherlands, Sweden or the United States, and say we should adopt the extreme policies of zero-tolerance or legalisation.

Each country has to tailor the drug strategy that is appropriate to its own culture, history and traditions. But the truth is that any drug strategy cannot succeed without a comprehensive approach that focuses on enforcement, education, early intervention and treatment. Tough enforcement stops criminals and takes harmful drugs out of circulation; education empowers young people with knowledge of the harms caused by drugs; early intervention with vulnerable groups in order to prevent them from becoming drawn into drug misuse and treatment improves individual lives, and cuts crime and anti-social behaviour.

Our latest figures show that more than 15,300kg of cocaine and 2,200kg of heroin were taken out of the supply chain in 2005/06. Almost 200 illegal criminal gangs were disrupted and £30 million of drug related assets were seized. That matters. I know, when I meet people in my constituency and elsewhere, that people want tough action on dealers, the people who drag down their communities.

However, as a former teacher I know that drug education has a significant role to play. We no longer wag the finger at young people and tell them simply not to do drugs. Instead, through the multimedia FRANK campaign, we empower young people by warning them of the harms caused by drugs and the risks involved with drug misuse, targeting vulnerable young people who are most at risk and providing specialist interventions for young people with developing drug problems. This approach has paid dividends with drug misuse falling among young people.

After a decade of success, we are looking to renew our Drug Strategy and will shortly consult on the way forward for coming years. I want to hear fresh ideas on how we can enhance the drug strategy, but I am clear that I want to focus on what works: enforcement, education, early intervention and treatment.

In talking to drug treatment professionals it is evident to me that drug classification is important in setting out the legal framework for drug control. It has stood the test of time and I want to focus on the most important aspects of tackling drug misuse: how we can enforce the law against dealers and supplies; how we can empower our young people with knowledge of the harms illegal drugs cause; and how we can provide treatment most effectively so that even more drug misusers are treated for the benefit of them and their communities. This strategy has worked and I want to enhance it.

I remain fully committed to our strategy of enforcement, education, early intervention and treatment, focusing at all stages on harm reduction. Working together, we can reduce even further the harm caused by illegal drugs.

At last some common sense

Prof Howard Parker's succinct assessment of the current drug strategy and for his suggestions for interventions that work, (*DDN*, 7 May, page 6) was a joy to read.

The Royal College of Psychiatrists describes alcohol as the nation's favourite drug. while estimating that twice as many people become addicted to it as compared with all other drugs combined. Other sources attribute 44 per cent of all violent crime to alcohol abuse. The NTA's denial of alcohol as a drug, and prohibiting services to record alcohol as the primary problem, while simultaneously claiming to use evidence-based practice, highlights the hypocrisy that emanates so frequently from that source.

Professor Parker's comments on the NTA's obsession with the 'numbers in treatment', without any corresponding goal for numbers in recovery, echoes the findings of Liverpool John Moores University which concluded that the higher the numbers in treatment, the greater the drop-out rate. When one considers that there are no goals of drug free recovery and rehabilitation in the current strategy, such conclusions are not surprising.

In the same issue (page 4), a new organisation, the Drugs and Health Alliance (DHA), which is made up of a number of familiar names, urges us to have a drug policy embracing public health. It is therefore puzzling that notwithstanding the holistic sounding name, and their declared claim to turn the escalating addiction problems of this country into a health issue, which it surely is, there is no mention that the treatment for all which is urged, should embrace drug free recovery or rehabilitation. Surely the objective of all health treatment should, insofar as possible, be recovery? The latter in the cases of addiction is not possible without becoming drug free. To that extent it is difficult to distinguish what the DHA propose from the current policy.

We do need a new and effective drug strategy, and we already have all the research we need to implement it. Scientific research that is currently being reported by Professor David Clark (page 15), if implemented within the framework of the transtheoretical model of change, would in the long term drastically improve treatment outcomes. What is lacking is the will and courage to realise it.

A further obstacle to implementing treatment based on scientific, tried and tested evidence, is the unrelenting activities of those organisations who, regardless of their enlightened and humane sounding agenda, are hell bent on the legalising of addictive drugs, thereby wittingly or otherwise, spreading the scourge of addiction that is polluting our country.

Peter O'Loughlin,
The Eden Lodge Practice

Fear and bureaucracy

I would like to respond to two of the letters in your last issue (*DDN*, 7 May, page 10). Firstly, the one from Dr Bray: dead right, doctor, we are operating in a culture of fear. I have written to *DDN* twice in the last few weeks on the subject of the obsessive micro-management of drug services and I have criticised the army of bureaucrats who see themselves as far more important than the lowly people who actually work with drug users. So, in light of my views, my job would be at risk if I didn't ask for my name to be withheld.

Secondly, the letter from Luke Kelly about NDTMS. You're dead right Luke, it surely won't be long before we are also required to record a client's shoe-size, eye-colour and whether they are left or right-handed.

We have reached the point where the rules have become more important than what they were originally put in place to govern.

For instance: a prison drug worker now has to complete nearly 50 pages of paperwork just to get a case up and running, then many other pieces of paper at various stages to ensure the database can 'track' what's going on. At the same time, that worker is told they can only engage a prisoner in a maximum of six one-to-one interventions. They are forced to spend endless time on paperwork but are only allowed to scratch the surface when it comes to actually working with the client. What does that tell drug workers about what really matters? And, crucially, what does it tell the prisoner about the quality of the 'treatment' on offer?

I believe that prison and community drug workers' roles are now so tightly prescribed that the services they are allowed to provide to their clients are less efficacious than they were at the start of the ten-year strategy, back in 1998, long before the bureaucrats hijacked treatment. Any voices still out there?

Prison & community drugs practitioner, name and address withheld

Notes from the Alliance

Mind your language!

Negative words can easily pervade our language without us realising the negative effect. Time to take stock, says Daren Garratt.

The recent RSA Commission on Illegal Drugs, Communities and Public Policy report, *Drugs – facing facts*, highlights something that many of us have known for years; many people are able to manage their drug use and bring no harm to themselves or others. Now, of course, I am not suggesting that drug use doesn't lead to harm because the effects can be blindingly devastating, but it's not inevitable.

Yet I wonder how many of us unknowingly contribute to the continued demonising of drug use and drug users by using words and phrases that allow such negative stereotypes to perpetuate?

I know I do it.

I was talking to a colleague last week about the importance of language and the messages we reinforce, when I was struck by how many times I've heard people – myself particularly included – habitually juggle the words 'dependent', 'problematic' and 'chaotic' when discussing an individual's heroin use. I realised that they've become almost interchangeable terms in this field, and that's wrong.

I wouldn't like to guess how many people reading this magazine are dependent on a substance, but I'd suggest that the majority who admit it would in no way feel that their use was in any way problematic. And for those who may have to concede that, unfortunately, their using has started to have a worrying impact upon their health or social functioning, it's certainly not a given that this is due, or contributing, to a loss of control and spiralling chaos.

We all fall into different patterns of use at different times, but the important thing to do is try and have an awareness of that fact, and to try and respond effectively should things start to get too much. At the end of the day, some people can regularly use drugs like alcohol and heroin in a controlled way while others sadly can't, but that all depends on the individual and a myriad influences and reasons.

So why does the message that heroin users can be 'normal people' (or conversely, 'normal people' can be heroin users) still seem to be getting lost?

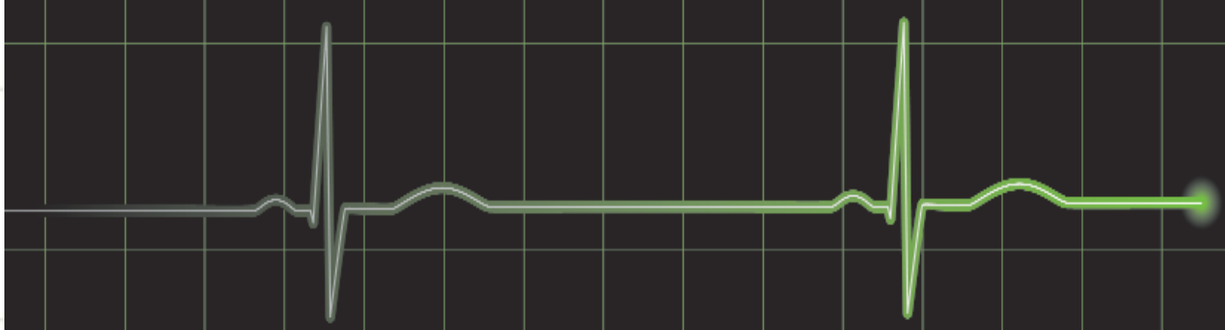
Well, maybe by subconsciously equating heroin use with chaotic and problematic dependency, our language merely reinforces the public's stigma, ignorance and fear of what a user is.

Language is a social construct and the words we use influence the image that society creates of us, therefore the terminology we choose has the power to change that image and, in time, people's perceptions and opinions. Be they positive or negative.

And I know that arguments rage on about whether it really matters if people use words like 'detox', 'addict', 'clean', or 'abuse' when there are people dying on the (drug) war-torn streets of Britain, but if it means that by using lazy language we reinforce the image of a drug user as something, toxic, powerless, dirty and abusive, I think it does.

Daren Garratt is executive director of the Alliance

Monitor to deliver



Will the new client monitoring system 'TOP' restore faith in data collection by giving a picture of real outcomes? **DDN** was at this week's launch.

Hoping to move on from the trials and tribulations of the National Drug Treatment Monitoring System (NDTMS), this week the National Treatment Agency launched TOP – the Treatment Outcomes Profile. Researched by respected addiction experts, it pares down the information-gathering process to what's needed, and at the same time goes beyond the remit of NDTMS data, to show how well each client is doing in treatment, and the effectiveness of services and partnerships.

The new system will be used for each client that enters Tier 3 and Tier 4 services in England and will be used as a structure for their care planning and review process. The client is asked a short set of questions four weeks before treatment, then asked the same questions as part of the care planning and review process. By reviewing the changes over time, the key worker will be able to keep track of how their client is doing, and monitor their overall wellbeing.

Launching the system to invited stakeholders, Public Health Minister Caroline Flint said: 'This is a world first and we need to bang the drum about this.

'This system can help everyone – providers and commissioners. It measures and records real outcomes – drug and alcohol use, psychological health, social functioning.' The breakthrough was in measuring real instead of proxy measures, she said.

Clients would get a sense of whether they were receiving good treatment and the evidence-based information would help to prevent drug-related deaths. Commissioners would be able to use the information to make sure adequate harm reduction services were in place, said the Minister.

Importantly she said, TOP would 'keep us under scrutiny', shouting about what's not working – and also about what is.

The experts

TOP is a simple but effective way of collecting data, says Dr John Marsden of the National Addiction Centre, one of the two outcomes experts who designed the system.

While it was a work in progress, and results at this stage were 'robust but provisional', the system had the ability to capture change. It showed drug use and changes in behaviour, to give a 'reasonably reliable picture of use'.

Beyond current data, which started with the period before the client was admitted to treatment, its four-weekly data updates would build up a picture of the client's physical and psychological health, and quality of life.

'I am confident we have a brief, valid and reliable instrument, readily understandable to all key groups,' he said.

'This had to be done in a way workers would use,' said Dr Michael Farrell, co-designer of TOP. 'We wanted to build a little rowing boat, not the titanic.'

One of the criteria in developing the form was to keep it to a page of A4, to counter the current criticism that data collection is burdensome. 'It's as brief as it comes, to make sure we get full implementation of it,' he said.

Produced in a format that workers would use for their own purposes, it could be bolted onto other quality assessments, and should contribute to effective care planning. It could also be used to manage case mix, 'to make sure that workers have a reasonably balanced case load of complicated and less complicated people'.

'The system doesn't take over in any way from the extensive clinical training that we expect people to have,' said Farrell. 'But instead of being bludgeoned around retention times... [teams can] review care plans and assess the progress they're making [to look at] the broader impact of their performance.'

The testers

Julia Cottier, a service manager at Chester and Ellesmere Port Drug Service, took part in testing TOP.

With four sites offering Tier 2 and 3 drug services across Cheshire and the Wirral, Cottier was optimistic that her service could meet engagement targets for the field test, which ran from November 2006 to April 2007, but the reality was a little different.

'We didn't meet our targets on engagement and follow-up – maybe because interviewers weren't clients' own keyworkers.' She also questioned whether they had promoted the trial in the right way to encourage involvement.

Feedback from keyworkers had been 'very enthusiastic': TOP had been easy to use, after they had taken a bit of time to get used to it. The most important work in the roll-out was 'to make all partners realise the difference this has on demonstrating the impact of treatment,' she commented.

Services would need to work out a timescale for incorporating TOP in their own system, and the team's workload would need to be adjusted to take account of completing TOPs every three months. 'Staff will need support to balance their existing workload, and there will need to be more supervision and training for staff who see clients stay the same or deteriorate,' commented Cottier.

Judith Costello tested TOP at Addaction in Blackpool, where 60 per cent of

'This is a world first and we need to bang the drum... This system can help everyone – providers and commissioners. It measures and records real outcomes – drug and alcohol use, psychological health, social functioning.'

clients are on Drug Rehabilitation Requirements (DRRs) and come via the courts.

At the beginning of the trial Costello was 'very concerned how we were going to do our own assessment as well as the questionnaire'. She had also had concerns about having to ask DRR clients for yet another drug test, when they were already being tested twice a week.

The reality was very different. 'The clients didn't mind testing, didn't mind personal questions... in reality it was better than our own assessment,' she said. 'It was fantastic to hear about the client in such a short time – it made my job much easier.'

As 'someone who doesn't find data management easy' she had no difficulty in using the new system, and easily exceeded a testing target that she had been worried she wouldn't be able to meet.

Costello believes that monitoring clients for every three-month period could help with motivational interviewing and better client engagement.

The NTA manager

'NDTMS is usually prefixed with a word that means 'damned',' admitted Malcolm Roxborough, the NTA's information manager.

Receiving 440,000 treatment records a week that are used to monitor central government targets, local government performance and to inform commissioning and treatment planning, there were many demands on the system.

Information had, until now, been taken on first contact with the client – their demographic, drug use, treatment need, housing circumstances. 'But we don't have a picture of how this changes throughout their journey – and this is what we're hoping to change through TOP,' said Roxborough.

'Care monitoring could be much more effective with the new system,' he said. 'It will be a more consistent way of helping clients review their progress.'

It could also steer the development of services in different areas, through better evidence-based commissioning. 'If you're involved in commissioning, it's as important to know where you're not achieving and what's not working,' said Roxborough.

During the bedding-in period for TOPs, he invited feedback from services and clients, and was certain that the all-round effort would be worth it: 'Drug treatment will be measurable in a way it's never been before – and that will be the key to ensuring investment continues in drug treatment.' **DDN**

The questions...

The panel of speakers (quoted left) was joined by Paul Hayes, NTA chief executive; and Annette Dale-Perera, director of quality, to answer questions from the stakeholder audience.

Will TOP be able to follow people in and out of different services over years? Will they need a new one if they move services within a couple of weeks?
Malcolm Roxborough: This will rely on a degree of local co-ordination. The intention is not to get the same questions asked of the same clients. We're working closely with prisons in the hope of managing people's information as they move through prison and community services – and yes, we'll be able to monitor them over years.
Annette Dale Perera: We don't want a TOP done each time a client joins a new service.

Can you give reassurance that data collection is not a replacement for service user involvement?
Paul Hayes: It would be criminal if we downgraded information from service users. Service user reps will have better information they can use – between services, service users, commissioners, the NTA; all of us and communities. TOP should enhance all those dialogues.

Is TOP for drugs and alcohol? And young people?
Annette Dale Perera: It has been validated for alcohol as well as drugs. But we're testing it with drugs because we're the NTA. It has been validated for use with people of 16 plus.

Overdose is not included in TOP. Why not?
Annette Dale Perera: It should be included as part of your normal review. Just because it's not on [this form] doesn't mean you shouldn't address it.

Which groups of clients are we expected to report back on?
Malcolm Roxborough: We're expecting data on Tier 3 and 4 clients. But we could also take data from Tier 2.

When there's been no obvious improvement by the client, how is this fed back to them? How might this be dealt with, without being negative?
John Marsden: Each person's data is their unique fingerprint. Positive data can be a positive reinforcement. But the form is designed over four weeks so you can capture little lapses, little snapshots [of behaviour]. So failure is less relevant.
Judith Costello: It gives you the chance to keep focusing on the careplan.

Will there be any financial support for voluntary organisations rolling this out?
Annette Dale Perera: There's no extra money to implement TOP – it's part of the normal NDTMS. But we will be working with commissioners to make sure there's provision to do it.

Most service users will see this as just another form. What's the point of participating?
Julia Cottier: It's about how we implement it. TOP has to be seen as the most effective way of doing what we do.

Will TOP help to manage staff?
Julia Cottier: I'd like to think it will be used in a most supportive way, to redress demotivation, [an opening to say] we're not offering the right group of things.
Paul Hayes: Obviously this has to be managed sensitively, but we all have to be helped to improve what we do. We need to understand it to do something about it. Some of us might turn out not to be in the right profession... some service users might turn out not to be in the right service. As long as we do this sensitively and cautiously and take everyone with us, we have a chance to break down stigma, improve services – and do what it says of the tin.'

Now tell us

what you want..!

Harninder Athwal (pictured), founder of a new movement called Young Women Now, tells **DDN** how listening to what young women want can divert them from drugs and destructive behaviour and towards a healthier lifestyle.

Provocatively clothed female singers performing their single 'promiscuous fantasy', is not an opening you would expect at your average conference. Yet the Young Women and Health Event 2007 was definitely something different.

Marking the launch of the Young Women Now movement (YWN), the event aimed to inspire positive change among young women by giving them the confidence and motivation to lead a non-destructive lifestyle. It showcased an impressive array of strong, creative and successful female speakers who promoted wellbeing and self-respect to the young delegates.

Organiser Harninder Athwal, communications officer for The Federation, started up YWN with Tammi Gillett, a consultant for In-volve, after coming into contact with an increasing number of cases of young girls self-abusing and seeing that there was little help on offer. Her previous roles in a youth offending team and as a probation officer involved her with young women with multiple problems and made her realise her frustration at the lack of sufficient services available to work with them – and made her determined to do something about the situation. At the outset she wondered where on earth she was going to start, but now she says she can 'imagine that it is still like that for many practitioners'.

Athwal is passionate about her cause and believes it's important to provide services with the skills and knowledge to work with women effectively, responding to their needs. 'At YOTs the main focus is on the offending. But, often this is the last thing that needs to be addressed. They might have been sexually abused, which is why they used drugs, which leads them to commit an offence – and the reason why they end up here,' she says.

During the conference, Athwal spoke about 'overcoming the war on women' and raised issues around rape, domestic violence and boys being favoured over their female siblings in some families – all of which could lead to low confidence and subsequently substance abuse. Young women who turned to misusing drugs were denying themselves their own self-discovery and potential, she said – potential that needed to be recognised and used to help them.

She hoped that the conference would encourage young women to have a voice. 'A common issue for young women is identity. Who am I? Where am I coming from and going to? The journey for women sometimes gets lost,' she says. Early intervention could teach them about self-worth before they come into contact with the criminal justice system or drug rehab. 'Intervention needs to start at home – giving parents the skills and knowledge to parent effectively,' she says. 'Then it's the education system and equipping teachers, and then society. They all have an impact on how a young woman will turn out.'

Dinah Senior, senior consultant for In-Volve, who described today's young people as 'Lord of the Flies but with guns, money, crime and drugs', gave the conference an intense portrayal of her life from child to womanhood. She spoke about having negative feelings about her body image as a child, and was in an abusive relationship in her twenties, but now successfully manages strategic projects for In-Volve and works to help those within socially excluded communities.

Treatment agency Addaction explored the pressures of society on young women with a filmed case study about a 15-year-old girl addicted to ecstasy. She would consume two tablets a day for a period of two months to overcome feelings of low self-esteem and a negative body image.

'The adolescent period is a time when girls are exploring themselves, finding out who they are,' comments Athwal. 'But the pressures from society are stopping them from finding themselves. These girls are so busy trying to please men that they actually forget who they are, which can mean them turning to substance misuse to create a numbness around them.' 'This delays the whole self-discovery process,' she says.

Floetic Lara, one of the poets to perform at the event, used her lyrics to explore self-respect, self-love and self-pride. Kat Francois' poem, *Essence of a woman* (right), looked at using inner-strength and female empowerment to rise above any negative issues faced within society.

Athwal was pleased with the reaction to different elements in the conference programme: 'Many young women took to the poetry and could relate to it, while others related more to the whole presentation,' she says. 'It's about getting a mixture of things to capture a lot of them in one form or another.'

Athwal intends the YWN conference to be an annual event, with next year set to raise issues around self-harm, eating disorders, crime and domestic violence. Information gathered from this year's event will feed into the Greater London Authority's Health and Inequalities Strategy.

Since the conference YWN have been using the networking website MySpace, to keep the issues alive, and find out more about what young women want. Feedback is already coming across loud and clear: 'A lot of young women are telling us that they want services that are more flexible at their approach – so they can walk in at seven on a Saturday morning and have access to help,' says Athwal.

'They also want passionate workers, people that actually believe in what they're doing, she says. 'It's not necessarily the service that's going to change a person, but that individual can motivate a person and help them through the process to a better life.' **DDN**

To find out more about Young Women Now, email Harninder Athwal: harninder@thefederation.org.uk. The MySpace address is www.myspace.com/youngwomenandhealth

ESSENCE OF A WOMAN

The time has come for me to free myself from this emotional slavery.
From this invisible but debilitating hold
that life seems to have over me.
To banish all negative thoughts
that only succeeds in creating inner confusion and distractibility.
I am the essence of woman
and I have been blessed with the most wondrous gifts
that life has to offer
No one can take these away from me,
regardless of what spiritual violence they may place upon me.

Cut me and I will bleed
beat me down and I will bruise,
I am made with mere flesh and blood too.
Sticks and stones will hurt my bones
and names will truly harm me.
I have the foresight to see into the future,
to a time when certain trivialities
will no longer matter to me.
I refuse to give into negative forces,
that falsely believe they are stronger than me.

I was raised better to lay down and cry,
Instead I will rise with the sun
and I will shine
like a phoenix coming out of the ashes
I will dust myself free,
and try over and over again if must be.
I am a daughter of Jah,
nothing has ever come easy for me,
from the moment that Adam took the apple from Eve
I was damned for all of eternity.

I am the essence of woman,
all women that have ever been used, abused,
physically, emotionally,
humiliated, rejected, betrayed.
I am all of these,
but I refuse to bend my head down
and not look my enemy in the eye,
nor will I become submissive,
for such actions do not come natural to me.
I do not have to shout or be aggressive,
to put up a worthwhile fight,
at times silence is the only answer.

As a women born to nurture and create,
there is nothing that can be done
to make me eternally bitter or angry.
For I possess strengths that no-one else can see,
that have held together nations
and built holds societies,
so do not underestimate me,
after days, months, years, decades,
of ill-treatment and disrespect,
I will no longer be held responsible for my actions,
or easily satisfied.
There comes a time when the essence of woman,
has to say enough is enough.

Kat Francois

Curing bad paperwork

Streamlining the referral process from GPs can significantly improve the patient's journey into drug services, as Dr Adrian Flynn**,** Dr Rupert White **and** Dr Omair Khan **found out from their recent audit in Cornwall.**

IN CORNWALL, as in many parts of the country, the specialist drugs service (CDAT) relies on referrals from general practitioners for clients with drug problems. These referrals relate almost exclusively to heroin injectors.

In an ideal world, the letters that accompany them would contain vital information on, for example, route of use, mental health and physical health needs, that can be used to prioritise the user into treatment, or signpost to non-stat agencies where appropriate.

Unfortunately this was not often the case, and so a few years ago we developed a standardised form that was distributed through the GP surgeries, to help with this process.

In 2006 we conducted an audit to find out to what extent GPs were providing the information that, ideally, we required. It was also carried out to establish whether more information was passed on through typed letters or referral forms, and to find out which system appeared to work best.

Fifty people were selected randomly, whose main cause of concern was illicit substances. We found that GPs preferred to refer 46 patients out of 50 through typed letters, and only four referrals out of 50 were made by using referral forms.

Although there was no difference in demographic information disclosed by the GP (age and sex *etc*) significantly more information was provided regarding method, frequency, complications and risks of drug use in referral forms, as compared to typed letters.

The insufficient information in the typed letters added to increased workload for the substance misuse team, as 10 per cent of people were being followed up for more information.

After the audit a gentle reminder, in the form of a letter to the practice managers, was sent to improve the quality of information in the letters – and to ask them if possible, to use the referral forms in place of, or in addition to, the letters.

In the re-audit it became evident that the number of referral forms used for referrals increased to 17 out of 50. Although the quality of information had improved generally in letters and forms, the referrals forms still held a significant edge in provision of crucial information.

The purpose of this audit was to improve the GPs' awareness about communication of important parts of information, to provide the best care to the service user and the method of transferring this information in an organised way.

It is reassuring to know that standardised forms can help in this respect, and we would urge teams with similar problems to follow suit. Of course over the next few years, information management within substance misuse will change a great deal and increasingly referrals are made electronically. This will change the media used to make referrals, but it will not change the basic principle that it is important that the links betweens primary and secondary care are nurtured and, where necessary, improved.

Dr Adrian Flynn is consultant liaison psychiatrist at Cornwall Partnership Trust; Dr Rupert White is consultant at Cornwall Drug and Alcohol Team; Dr Omair Khan is senior house officer (psychiatry) at Cornwall Partnership Trust.

Inside innovators

Supporting prison staff to find imaginative ways of tackling prison drug problems can have encouraging results, as **DDN** reports.

Why shouldn't innovation be part of prison life?, asks Peter Mason, chief executive of the Centre for Public Innovation. 'Innovation can work better than anything else I know. It can liberate energy and productivity,'

Furthermore, he believes that 'innovation works better under scarce resources. Necessity is the mother of invention.'

As chief executive of the Centre for Public Innovation, Mason has been an enthusiastic driver for improvements in prison health over the past five years. 'We've been delighted to support over 500 innovations in the prison system,' he told winners at the recent Prison Health Innovation Awards. This year the award focused on bright ideas to tackle substance misuse issues for prisoners and offenders.

The initiative had brought 'thousands of prisoners into contact with innovations' and encouraged improved relationships within prisons. Mason encouraged prison staff at the ceremony to be brave in capitalising on opportunity and tenacious in putting ideas in place.

'Innovation can be breathtakingly simple,' he said. 'But pound for pound it can work better than anything else I know.'

Presenting the awards, Richard Bradshaw, director of prison health for England and Wales said: 'The challenge for us is to take some of these ideas and make them applicable elsewhere. We can make the learning curve for others a lot shorter.'

Gemma Sayers and Debbie Sayers work at Lewes Prison, a category B male prison in East Sussex. Noticing the vulnerability of remand prisoners to drug deaths as soon as they were released spurred them on to develop Overdose Aid – a scheme to give inmates practical skills and knowledge.

Important information on how to recognise signs of overdose, when to call an ambulance, and resuscitation were taught through quizzes, demonstrations and a video, with support from their primary care trust.

'The information held quite a few surprises for prisoners,' said the mother and daughter team. 'We broadened it to include anaphylactic shock and other situations, so they could use their skills in everyday life.'

Katie Roberts and Louise Atherton wanted to tackle the issue of steroid abuse among many of the young men at Thorn Cross Young Offenders Institution. Initial thoughts of getting in a guest speaker transformed into a dynamic publicity campaign targeting the whole prison, from training as part of the induction programme to examining the dangers of steroids through performing a play.

'All of the trainees said it had made them think about lifestyle choices,' said Roberts. 'We set about building confidence and self-esteem. The difference in some of the prisoners was remarkable.' They now plan to take the information to local schools and colleges.

Michael Cowan wanted to help turn the attitudes of young men at Feltham Young Offenders Institution from negative to positive. With the help of psychiatrist Johan Reshiglues, he developed a boardgame called Spiral Choices, where players make lifestyle decisions about drug and alcohol misuse, with the help of a facilitator.

'Participants were amazed they could have choices,' said Cowan.

Moving forward with every throw of the dice to reach 'life' at the end, they learned a lot about teamwork, he explained. 'Scenario' cards along the way generated discussion on what they should do in different situations, and they received a certificate at the end.

'The certificate was good for them,' said Cowan. 'Some young people in prison felt they hadn't achieved anything in their life.'

Mike Underwood set himself the challenge of improving prisoners' knowledge of drug misuse and sexual health for their return from Everthorpe Prison to the outside world. With freebies from Durex, who were keen to support the initiative, he engaged prisoners in designing a harm reduction pack. Alongside condoms, the pack had information on where to go to access services in the community, and a survey asked them if they had found the pack useful and used the contents – which was free to post back, with the chance of winning an iPod.

Admitting that producing the pack was not easy – 'prisoners' attention span is so short' – Underwood said the project was worth the effort: 'If they use it once, it'll have done its job.'

A CARAT worker at Ashwell Prison, Scott Davidson wanted to encourage more prisoners to relocate to the voluntary drug testing unit. His task was not easy: plenty of drugs were finding their way into the open prison, so he thought about ways to challenge the boredom that led to drug use.

Believing that a programme of leisure activities would incentivise them to try a more positive approach, Davidson introduced bingo games and quiz nights, where participants played in teams. Those with negative drug tests had their names entered into a draw to use a Playstation for a weekend.

With the experiment achieving positive results, he now runs activity nights every Wednesday and Thursday, and has brought in an Xbox Console for football tournaments.

Charlotte Tompkins and Nat Wright, of Leeds Prison, chose producing a health promotion DVD to bring home the dangers of drug taking in prison. The film showed ex-injecting drug users talking about aspects of using drugs inside, and looked at using motivational enhancement therapy to change behaviour.

Working for North Lancashire PCT, Hilary Abernethy knew all about the high levels of blood borne viruses in the region. Conducting Kirkham Prison's health needs assessment made her realise the need for more sexual health education for prisoners, and she set up a training course that would go beyond teaching prisoners, to helping them become peer educators to other inmates. She trained up to ten prisoners at a time about blood borne viruses and sexually transmitted infections.

Working between the PCT and the prison had presented some difficult challenges – but, says Abernethy, 'giving prisoners responsibility for their own health renewed my somewhat flagging motivation'. **DDN**

What the science shows, and what we should do about it (Part 3)

Professor David Clark continues to describe the main findings and recommendations from a major new book based on the views of America's leading clinicians and researchers of how treatment would look if it were based on the best science possible.

Leading US addiction scientists met in 2004 at a 'think-tank' conference to share research findings in their respective areas and discuss possible implications for treatment and prevention interventions.

The conference resulted in a seminal book, in which the authors draw together the wealth of scientific understanding from the range of topic areas considered to produce a set of ten cross-cutting principles, and then reflect on their implications with ten recommendations for interventions.

In this Briefing, I continue with the last three principles.

8. Drug problems occur within a family context

Problematic use of drugs and alcohol is a risk factor for young people's drug use, and is also linked to a variety of family problems and more general risk factors.

Parents with drug and alcohol problems are less likely to provide the kind of parenting that reduces their child's risk. For example, children of parents with substance use problems are less likely to develop self-regulation skills, particularly if parenting is disrupted before the age of six – a critical age for learning self-control.

This is particularly true for children who have other developmental risk factors, such as a difficult temperament or attention-deficit hyperactivity syndrome.

The likelihood of domestic violence and child abuse is greatly increased when parents have drug and/or alcohol problems.

Conversely, family environments can be protective against future substance misuse. Factors that decrease first use of substances, decrease risk of future problematic use.

Parental disapproval of drug use is protective. An optimal parent style is one that is, 'consistent, supportive, and authoritative (moderately structured and midway between the extremes of permissive-negative and neglectful and authoritarian-punitive)'.

Parental monitoring of children's whereabouts, activities and friends is a particularly important factor. A family involvement in religion or other conventional activities is also a strong protective factor. In adolescence, these family factors counterbalance the influence of peers.

Children who are particularly susceptible to adverse peer influence include those who are 'extroverted, present- (not future-) focused, have low self- esteem and low grades, use avoidant coping styles, spend more time away from home (*eg* part-time work), and tend to be followers'.

Effective interventions with families have tended to concentrate on two factors. Firstly, strengthening family skills for positive communication and monitoring. Secondly, building family reciprocity in exchanging and sharing positive reinforcement.

'The clients of counsellors who are higher in warmth and accurate empathy show greater improvements in substance use problems. As early as the second session, clients' ratings of their working relationship with the counsellor are predictive of treatment outcome.'

9. Substance use problems are affected by a larger social context

An individual's larger social context influences the risk, severity and length of time of substance use problems.

Environments in which drugs are more readily available promote use. On the other hand, the availability of other reinforcers and activities is protective against substance use problems.

Social modelling can promote or deter use. Cultures in which abstinence is the norm, and in which drug use is stigmatised, have lower rates of drug use and drug-related problems.

On the other hand, criminal sanctions for use are relatively ineffective in suppressing drug use, particularly once it is an established pattern.

Norms about substance use play an important role. Clear norms and modelling of moderation influence drinking rates.

However, some people misperceive behavioural norms. Young people who overestimate the percentage of peers who smoke or drink are more likely to do so themselves, and start to engage in these activities at a younger age. Communicating the actual behavioural norms for a group (norm correction) can have a deterrent effect on use.

The normative social meaning of substance use, which often has symbolic value, is also important. When psychoactive drugs become marketable commodities, advertising tends to normalise use and to associate it with attractive and symbolic outcomes.

10. Relationship matters

There is something therapeutic about certain relationships. For example, it matters who is delivering a treatment for substance use problems.

Research has shown that the clients of randomly assigned counsellors often differ widely in outcomes, even if they are receiving the same manual-guided treatment.

The clients of counsellors who are higher in warmth and accurate empathy show greater improvements in substance use problems. As early as the second session, clients' ratings of their working relationship with the counsellor are predictive of treatment outcome.

Motivation for change seems to emerge in the relationship between client and counsellor, even in relatively brief periods of counselling.

Some counsellors have consistently worse outcomes than their colleagues. A confrontational style that puts clients on the defensive is counter-therapeutic.

The American addiction experts indicated that these ten principles suggest 'particular directions in designing programs, systems, and social policy to reduce drug use and associated suffering, societal harms and costs'.

I will consider their ten broad recommendations for addressing substance use problems in society in my next Briefings.

Rethinking Substance Abuse: What the science shows, and what we should do about It, edited by William R. Miller and Kathleen M. Carroll, Guilford Press, 2006

Westminster Drug Project (WDP) is a registered charity which provides information, advice, counselling and treatment services to drug users across London and beyond. We have recently obtained the contracts for service delivery in Croydon and Redbridge and we are currently seeking two experienced and talented individuals to join our teams in these boroughs. If you want to join an organisation that is always developing and where forward thinking is welcomed, then apply to WDP.

Project Manager – Croydon

£30,726 - £36,725 pa

WDP Croydon is a Drug Interventions Programme (DIP) service offering a range of interventions for drug users in the Criminal Justice System. You'll be in charge of a team of drug workers operating in police stations, prisons and courts throughout Croydon. You will use your knowledge of the Criminal Justice System to develop a service that makes real changes to people's lives. A proven history of managing a successful team of drug workers and using innovative ideas to make real changes to a community is essential.

BBV / Substance Misuse Nurse – Redbridge

Grade F/G and 6 • £20,220 - £28,070 pa

This role will provide on-site Blood Bourne Virus screening and Hep B vaccination along with ongoing harm reduction support, needle exchange and outreach for our service users. This role will play a vital part in developing our new Tier 2 Open Access service in Redbridge.

For information about either of these inspiring opportunities, please see our website **www.wdp-drugs.org.uk**

Closing date: 30 May 2007.

WDP is an equal opportunities employer and welcomes applications from members of BME communities.

Westminster Drug Project Ltd

ADS Alcohol & Drug Services

We are a leading charity operating in the North of England, providing services for those affected by alcohol and drug misuse in all sections of the community.

RESIDENTIAL SERVICE MANAGER

BENNETT HOUSE

Salary – £28,616 Per Annum
Full Time – 35 hrs Ref No – 07/64

Due to staff relocation ADS requires a Service Manager for its 16 bed Residential Project in Manchester. Bennett House is for men who are Alcohol Dependent and have identified therapeutic residential support and abstinence as a positive alternative.

Working with the Area Director you will be responsible for the Management of the staff team and ensuring the effective operation of the Project within the relevant legislative framework.

As an enthusiastic, motivated individual you will value the opportunity to manage such a dynamic Project which offers a structured and effective programme to its Residents.

Ideally you will have a minimum of 3 years experience as a Residential Worker, with at least 2 years experience at Management level, and be in possession of a relevant qualification (NVQ4, Diploma in Counselling, Dip Social Work etc) and willing to work towards a level 4 Management Qualification in Health & Social Care.

Application forms and further details are available from: Alcohol & Drug Services, Head Office, 87 Oldham Street, Manchester, M1 4LW. Tel: 0161 834 9777.

Closing date for applications: 8th June 2007
Proposed Interview Date: TBA

www.alcoholanddrugservices.org.uk

We are an equal opportunities employer & welcome applications from all sections of the community

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looking for new opportunities?

bdp

Bristol Drugs Project is an **energetic** and **resourceful** service delivering effective harm reduction and treatment services to over 3,000 individuals a year. You will join us at a particularly exciting time as we have just marked our 21st birthday and are expanding.

SHARED CARE WORKERS (35 hours) - DD1

Bristol's successful Shared Care scheme provides treatment to over 1500 drug users, and we are expanding our staff team even further. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions & develop & implement a care plan. No formal qualifications necessary, ideally you will have experience of working with health professionals & a good knowledge of opiate substitute prescribing. If you are assertive, diplomatic, with excellent organisational skills & are able to work well within pressurised primary care settings, this is the job for you.

For an informal discussion contact Jayne Peters, Treatment Services Manager on (0117) 987 6019

DRUG USING PARENTS SERVICE WORKER (35 hours) - DD2

Delivering services to parents who are drug dependent within the community and as a core part of the Bristol Maternity Drug Service. You need experience of working with drug users, a Social Work qualification and experience of child protection work.

For an informal discussion contact Justin Hoggans, Structured Support Services Manager on (0117) 987 6007

Salary for both posts: £16,216 - £24,377 (pay award pending). Starting salary for suitably qualified candidates £21,621.

Closing date: Tuesday 12 June at 12 noon.

For an application pack please fax, e-mail or write, quoting the job reference, to: Ed Holder, BDP, 11 Brunswick Square, Bristol BS2 8PE. Fax: (0117) 987 1900 E-mail: recruitment@bdp.org.uk

Funded by Safer Bristol - Bristol Community Safety & Drugs Partnership

We are committed to anti-discriminatory practice in employment and service provision and especially welcome applications from Black and minority ethnic groups for all posts, as they are under-represented within our organisation. We also welcome applicants with past personal experience of problematic drug use.

No CVs agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

Environmental Services Department

DRUGS & ALCOHOL BUSINESS MANAGER

Scale PO 11-14 £34,146 - £36,636 p.a. pay award pending.
Salary subject to job evaluation
Post No: ES-NSDA-001
Hours: 37 per week - flexible
Base: Unity House, Westwood Park Drive, Wigan WN3 4HE

Wigan is on a journey from "Excellent to Outstanding" and we are looking to transform the way in which we provide services to our communities. The Neighbourhood Services Division of Environmental Services is looking to recruit an outstanding individual to complete its management team.

We are looking for a skilled and innovative individual to lead on the drugs and alcohol strategy for the borough. Working on behalf of the Community Safety Partnership, using your excellent visioning and influencing skills, you will continue to develop strategy to reduce drug and alcohol related harm. You will motivate and enthuse partners and providers to work together to achieve common goals. You will have excellent commissioning and resource management skills and to be a true team player who is resilient, confident and motivated by a desire to improve. You should have management experience in a related field and be fully conversant with all aspects of commissioning services to best value principles.

The ability to work in a political environment and using evidence of what works to achieve best results are key qualities we are looking for.

For further information about anything that is not contained in the application pack, please contact Nicola Yates, Assistant Director, Community Safety on 01942 828037 for an informal discussion.

To download an application pack visit: www.wigan.gov.uk/pub/jobs or email: jobs@wigan.gov.uk quoting the job reference number or telephone: 01942 827678 (24 hour). Minicom: 01942 827186.

Closing date: 8 June 2007. Interviews are likely to be held on 27 June 2007.

This post is subject to Standard Disclosure procedures.

"The Council is committed to Equal Opportunities in employment and welcomes applications from all sections of the community"

This Authority operates a No Smoking Policy

Wigan Council

We have recently been awarded a contract to deliver a multi-disciplinary stimulant service for the London Borough of Haringey combining outreach, direct access, structured interventions and healthcare. We are looking for a staff team to develop this new project and to fill the following posts:

Haringey DAAT Drug and Alcohol Action Team

Team Leader

£27,054 - £30,030 pa

You will deputise for the Service Manager, carry a restricted caseload and support the manager in the development and operational management of the service. You will need to demonstrate good supervisory skills as well as an in-depth knowledge of working with this client group. **Ref: BCDP/6/DDN**

Substance Misuse Nurse

£24,115 - £34,854 pa (Band 6)

You will contribute to a multidisciplinary approach to treating drug misuse through a process of assessing, planning, implementing and evaluating care packages. This may include health and social care assessment, substitute prescribing, harm reduction and relapse prevention counselling, vaccination programmes, and support and advice to those effected by drug misuse. You should be jointly registered as both RMN and RGN. **Ref: BCDP/7/DDN**

Substance Misuse Counsellor

£27,054 - £30,030 pa

You will provide and develop a range of quality care-planned counselling interventions to current and ex-substance users. You will also recruit, train and supervise student counsellors and support them to deliver services in conjunction with the staff team. You should have a minimum of a Diploma in Counselling with 450 hours of supervised counselling experience and appropriate professional membership with BACP, UKCP or BPS. **Ref: BCDP/8/DDN**

For an application pack for any of the above vacancies please telephone our response handling line on 01206 570706, email: info@peterlockyer.co.uk quoting the relevant reference number. Closing date for completed applications: 4th June 2007. www.blenheimcdp.org.uk

Blenheim CDP. Registered Charity No. 293959.

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

Blenheim CDP has recently been created from the merger of two leading London-based drug services – The Blenheim and Community Drug Project (CDP) – both with a long history of providing quality services in this sector. Together we have been providing services to reduce the harm caused by drug misuse both to individuals and communities for over 40 years.

We offer a range of benefits including: contributory pension scheme, generous holiday entitlement, flexible working and a comprehensive training programme.

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

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Alcohol and Drug Addiction Prevention and Treatment

The Diana, Princess of Wales Treatment Centre, Gimingham, Norfolk, NR11 8ET

Counsellors

We are looking to recruit Counsellors to work within a residential treatment centre service

Salary Negotiable

Diploma level required, experience within the Drug/Alcohol field an advantage. If you like a challenge and would be interested in furthering your career please contact **Anna Magee**, Senior Counsellor at the above address

Tel No: 01263 722344

DDN/FDAP workshops

fdap DDN

Performance management	30 May, London
Methamphetamine Awareness	21 June, London
Healthy eating for a better life	26 June, Sheffield 3 July, London

For more information and bookings please contact Ruth Raymond e: ruth@cjwellings.com t: 020 7463 2085

www.fdap.org.uk/training/training.html

Perfect in partnership

Head of Community Safety

£38,310 - £41,346 pa
(pay award pending) + relocation

You'll help us reduce both crime and the fear of crime, right at the heart of Swindon Borough Council's partnership with Wiltshire Police, the Police Authority, Primary Care Trust, Probation and Fire services. Together, we'll form a successful Community Safety Partnership Team. It's a high-profile, seriously rewarding role, in which you'll lead without dictating, inspire by enthusiastic example and put the community's wants, needs and aspirations right at the heart of everything we do. Eventually, you'll help us achieve our aim of reducing crime by 17.5%.

Our four-strong Drugs and Alcohol Action Team is a vital part of the Community Safety Partnership Team. Following major changes – including a complete re-tendering process for service providers - we are seeing dramatic improvements in performance. Now we're searching for two talented, inspired people to join us.

Strategic Development Manager (Substance Misuse)

£34,986 - £41,346 pa
(pay award pending) + relocation

You'll take the lead on Joint Commissioning with the Council and PCTs – working closely with substance misuse experts and other agencies to design, commission and deliver outstanding drug treatment programmes. Focused on getting service users involved on the development of provisions, you'll also manage contracts, monitoring quality and identifying opportunities for progression, expansion and improvement.

It's a high-profile opportunity, which will positively impact on many futures.

Adult Substance Misuse Co-ordinator

£28,221 - £30,843 pa
(pay award pending) + relocation

Passionate, driven and utterly committed to improving outcomes for adults with problems with drugs and alcohol, you'll really impact on the services we offer. Co-ordinating the Local Area Agreement sub-groups, you'll work in partnership with treatment service providers to ensure that Models of Care are delivered in line with the national guidance framework. We'll also look to you to deliver our newly developed Alcohol Strategy.

To apply or find out more, click your way to **www.perfectinpartnership.co.uk**

Closing date: 4th June 2007.

Did you know...

Swindon has so much to offer: a forward-thinking, up-and-coming Council, green space to grow and breathe, big plans for regeneration and a fantastic location minutes from rolling countryside and under an hour from Bristol and Bath.

We are an equal opportunities employer.

Swindon Borough Council