DDN
Drink and Drugs News

22 October 2007
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Drink and Drugs News

Editor's letter

Interviews pulling apart drug strategy are two a penny at the moment – inevitable as the consultation closes for the new strategy. But the interview on Radio 4's *Today* programme was particularly disturbing – not just for the the points it raised, but for the way it raised them (page 4).

Yes, it is always legitimate to question how vast amounts of public money are being spent. But to accuse mainstream treatment services of handing out illegal drugs as a reward system to 'junkies' was a potential body blow at a time when the field needs all the political support it can muster. Drug workers are used to fighting prejudice and stigma from the public day in and day out, but it doesn't help to have misleading information aired on the BBC's flagship breakfast programme, and it's concerning to reflect on the nature of this attack at such a politically sensitive time.

The shame was that the argument boiled down to such pitiful logic: that drug patients need to be motivated towards treatment with vouchers and incentives – effectively bribed to do anything positive for themselves.

The following morning, Dr Michael Ross featured on the programme to make essential balancing points: that the main reward for patients is that they are entering treatment for themselves. 'Most patients hate being addicts,' he said. 'What's needed is to reinforce their self-esteem... giving up drugs has to be the patient's own idea, and very frequently it is'. By his brief statements he rehumanised the argument, taking it back from the plethora of contested statistics and refocusing it on improving people's quality of life. Of course our drug services always need to be accountable on whether they are effective. But we should not let the assumption raised in the programme – that a minute proportion of drug treatment works and that public money goes towards helping treatment centres to indulge in bad practice – be the inaccurate picture that sticks.

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In this issue

News in Brief

Prison problems

The health of prisoners with substance misuse problems is being placed at risk because of underfunding and overcrowding, according to the British Medical Association (BMA). Prison healthcare services are struggling to cope with the record numbers of prisoners, warned chair of the BMA's civil and public services committee Dr Clare Jenkins. 'Prison doctors do not have the resources, infrastructure or time to assess and treat the large numbers of inmates who enter the penal system with severe mental health and drug addiction problems that in many cases have led to their convictions,' she said. *See the next DDN for full reports from the 'Prisons and beyond' conference about managing substance misuse in prison*

Mediterranean liquid diet

Binge drinking, once thought to be the preserve of northern European countries like the UK and the Scandinavian nations, is on the rise in southern Europe, according to a new Spanish study published in *Alcoholism: clinical and experimental research*. While southern European countries have historically had high alcohol consumption rates, this has mainly been in the form of wine with meals. However, the research – based on interviews with more than 12,000 people in the Madrid region – found that weekend binge drinking among young people was on the rise, with most choosing spirits rather than wine or beer. See *www.blackwell-synergy.com*

'Holby' hammered

Drinks industry body the Portman Group has complained to the BBC and to OFCOM about an episode of *Holby City* which it claimed featured a 'highly irresponsible portrayal of excessive and rapid drinking'. The show featured a scene in which two doctors drink several shots of tequila in rapid succession – 'it was also implied that their drinking would lead to a sexual encounter' it says. 'There are strict controls on alcohol advertising and marketing but the impact of these rules is being diluted by irresponsible programming,' said Portman Group chief executive David Povey.

Alcohol Concern looks at the influence of TV advertising – this issue, page 10

NTA dodges fire to announce more clients in treatment

The National Treatment Agency has published its latest figures showing more drug users in treatment. The statistics, collated by Manchester University from the National Drug Treatment Monitoring System (NDTMS), show 195,464 people in contact with specialist treatment services in 2006/7 – an increase of 130 per cent in the past eight years.

The good news announcement continues with an increase in the number of people staying in treatment or completing successfully (80 per cent of those in treatment this year) and an increase in successful completion rates of 42 per cent since March 2006.

NTA chief executive Paul Hayes said: 'This is good news and represents a real achievement by services in England. More people are receiving the treatment they need and three out of four are also staying three months or longer, which means their treatment is likely to be more effective in the long term.'

Minutes of the NTA board meeting on 9 October reflect the NTA's caution at the 'slowing improvement' in the numbers accessing treatment. However Mr Hayes' report says the emerging picture for drug treatment over the next three years is positive and he is confident that the Treatment Outcomes Profile (TOP) system, introduced this year is addressing the much-needed emphasis on quality and effectiveness of treatment.

But the day before the drug strategy consultation drew to a close on 19 October, the NTA's confident line failed to emerge during an interview on BBC Radio 4's *Today* programme. An interview that began by questioning Paul Hayes about the moral efficacy of contingency management – giving drug clients incentives to stay in treatment – turned into an attack on the state of drug treatment in the UK. In response to Mr Hayes' assurances that the NTA oversees drug treatment to improve its quality, the reporter, Mark Easton, asked: 'What kind of oversight is it when you've clearly got people inside the government's treatment system handing over free drugs and extra drugs, and in some cases apparently, anti-depressants and other illegal drugs, to *junkies*?'

He went on to highlight figures obtained 'by digging through the NTA's data' that just 6 per cent of people on a drug treatment programme emerge free of drugs at the end of their treatment; 70 per cent did not finish their treatment; and only 1.7 per cent were still drug free a year after they finished treatment.

Public Health Minister, Dawn Primarolo faced a similar line of questioning from John Humphries later in the programme. The anchorman challenged: 'There haven't been huge steps forward. This [drug treatment] programme isn't working, is it?'

'The evidence is in the numbers of treatment,' Ms Primarolo countered, to be told by Mr Humphries that being in contact with treatment services was not the same as receiving treatment. Some of those included in the statistic on people in treatment, he said, had 'received no treatment whatsoever'.

'You're spending half a billion pounds of taxpayers' money on this programme… you're now proposing you'll continue this approach in the next stage of your programme?,' he asked. The minister emphasised the difficulty of the client group and said 'we're making progress, we're leading Europe' [in getting people into treatment].

Priorities for the future included piloting support mechanisms for people, to make their drug treatment more effective, she said – which was why the NTA was looking at how contingency measures had been used in the US, as just one of a range of support options.

See letters, page 9

Underage alcohol sales falling

Fewer pubs and shops are selling alcohol to those underage, according to the results of the Home Office-backed Tackling Underage Sales of Alcohol Campaign (TUSAC).

Less than 15 per cent of the 9,000 premises targeted by police and trading standards officers sold alcohol to children, compared to 20 per cent last year and 50 per cent in 2004.

Children were involved in test purchases over a ten week campaign targeting premises known to be problematic. However, less than one per cent of premises targeted by the campaign 'persistently' sold alcohol to children, classed as on more than three occasions.

'These results show that the situation in relation to underage sales has improved and the industry has played a major part in delivering this improvement,' said Association of Chief Police Officers' lead on alcohol, deputy assistant commissioner Chris Allison. 'However, underage sales still remain an issue and the industry needs to maintain its focus.'

Police authority backs law review

North Wales Police Authority has backed a review of drug policy after chief constable Richard Brunstrom called for a scrapping of the class A, B and C system and for the Misuse of Drugs Act to be replaced by a 'substance misuse act' based on a 'hierarchy of harm' that also included nicotine and alcohol.

The authority has agreed that his report should be presented to both the Home Office's drug policy consultation and the forthcoming one from the Welsh Assembly Government. 'It is hugely significant that the call for a legal regulation and control of drugs has now been publicly supported by the North Wales Police Authority,' said director of Transform Danny Kushlick. 'There are many high profile individuals who support this position but this sort of institutional support really puts the debate centre stage.

'We hope to see other police authorities following their lead,' he continued. 'The government must now engage with the significant and growing body of mainstream opinion calling for pragmatic moves away from prohibition towards evidence based regulatory alternatives.'

Floating pre-voters: around 80 children from London secondary schools got a chance to put their questions about drugs to Home Office minister Vernon Coaker at a special event on board HMS Belfast recently. They were asked to give their views on issues such as what schools can do to prevent drug use, and what are the best forms of support to help young people avoid drugs. The event formed part of the government's consultation on the future of its drugs strategy. 'We can never be complacent about the scourge of illegal drugs and remain committed to tackling drug use through education, enforcement and treatment,' said the minister.

Middle class areas top 'hazardous drinking' table

People living in the comparatively wealthy areas of England – predominantly in the south east – are the most likely to be drinking at 'hazardous' levels, according to the new local authority alcohol profiles for England from the North West Public Health Observatory at Liverpool John Moore's University.

Hazardous drinking was categorised as consuming between 22 and 50 units of alcohol a week for men, and between 15 and 35 a week for women. Those in the poorest areas, however, were the most likely to be drinking at 'harmful' levels – more than 50 units in a week.

The study found that the hazardous drinking hotspots included Waverley, Woking, Runnymede, Surrey Heath, Guildford, Mole Valley and Elmbridge – all had more than 25 per cent of adults drinking at this level. Manchester topped the 'harmful' drinking table, however, followed by Liverpool, Salford, Knowsley, Rochdale, Tameside and Leeds, which also figured in the 'hazardous' table. Across all local authorities, hazardous rates of drinking ranged from 14 to 26 per cent of adults, while harmful rates ranged from 3 to 8 per cent.

'While much attention has been paid to binge drinking, less discussion has focused on the damages associated with routinely consuming too much alcohol,' said director of the North West Public Health Observatory, professor Mark Bellis. 'Across England, around one in five adults are drinking enough to put their health at significant risk and one in 20 enough to make disease related to alcohol consumption practically inevitable.'

Scottish drug-related deaths show big rise

The number of drug-related deaths reported by Scottish police rose by 42 per cent, from 254 to 374, between 2005 and 2006 according to the National Programme on Substance Abuse Deaths' (np-SAD) new annual report.

Overall deaths, however, for England, Wales, Scotland, the Isle of Man and Channel Islands were down by one per cent, from 1,382 to 1,366, for the same period. Deaths in Northern Ireland fell from 52 to 22.

More than three quarters of the deaths were males, and the average age of death was 38. Most died either in their own home or a friend's house, while 18 per cent died in hospital and 8 per cent in a public place. Most deaths were accidental poisonings involving opiates either alone or in combination with other drugs. The highest number of drug-related deaths per 100,000 population was recorded in Blackpool and Fylde, at 19.4, followed by Brighton and Hove and Western Cumbria.

Constant monitoring of drug-related deaths in Scotland was necessary to determine the reasons for the trends and put measures in place to prevent avoidable deaths, said director of the International Centre for Drug Policy at St. George's, University of London, Professor Hamid Ghodse. 'Prevention of the loss of life at any age, especially of the young, due to the scourge of drug abuse has to be the priority for any government,' he said.

Report available from St, George's, University of London at £15 email: npsad@sgul.ac.uk

Scotsmen twice as likely to use class As than women

Scottish men were twice as likely to have taken one or more class A drugs in the last year than Scottish women, according to new figures.

Drug misuse in Scotland: findings from the 2006 Scottish crime and victimisation survey also found that lifetime use of drugs was highest among 20 to 34-year-olds, while use in the last year and last month was highest in the 16 to 19 age group, and among those in manual occupations, those who had never worked and students. Eighty per cent of current drug users said they found it 'very easy' or 'fairly easy' to obtain drugs, while 38 per cent said they had taken another drug while under the influence of the drug they used most regularly. Eighty per cent had consumed alcohol under the influence of drugs.

The figures are based on interviews with almost 5,000 people. Levels of lifetime and current drug use were higher than before but the survey concluded that 'methodological changes mean that it is not possible to make meaningful comparisons'.

At www.scotland.gov.uk

News in Brief

NTA updates clinical guidelines

An updated version of the Drug misuse and dependence – UK guidelines for clinical management, widely known as the 'orange book', has been published by the National Treatment Agency for Substance Misuse (NTA). The evidence-based guidelines, which update the 1999 version, reflect the changes in drug treatment in that time as well as current NICE guidance, and provide a UK-wide framework for the clinical treatment of drug misuse. Available at *www.nta.nhs.uk/areas/Clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf*

Leicester links

New resources to help people in Leicestershire and Rutland get advice, information and support about drink and drugs issues have been launched by local DAATs. The campaign centres on a new website www.drugs.org.uk which provides details of local and national services, as well as information for other professionals and practitioners. The site had been 'developed to give those who need and advice about drink and drugs an easy way to find out about the services that are available to them,' said co-ordinator for Leicester DAAT, Kate Galoppi.

Counselling cash

People arrested for alcohol-related offences in Liverpool will be required to pay £30 towards the cost of their counselling to help fund Alcohol Arrest Referral Projects (AARPs) in Ealing, Manchester, Liverpool and Cheshire. Under the AARPs, people taken into custody are given advice by resident alcohol specialists about alcohol issues. Some may then be referred to more advanced alcohol advice sessions, and failure to attend may result in prosecution for the original offence. The pilots will be used to assess whether brief interventions reduce offending among those arrested for drink-related offences. 'People need to face up to the damage that excessive drinking can do to themselves and those around them,' said Home Office Minister Jacqui Smith. 'These powers will complement powers already available to the police to tackle alcohol-related disorder.'

'This is a rose, a multi-coloured rose.
It floats about, it's in a cloud.
It doesn't have any other flower friends,
It floats about on its own.'
10-year-old girl living with her mother in a residential rehab unit.

Home truths

This summer saw an exhibition in Glasgow of art created by the children of people with drug and alcohol problems about the impact their parents' addictions had on them. The works on display were shocking, upsetting and often very moving. **David Gilliver** talks to one of the organisers.

'My da, years and years ago, when I was a wee boy, left a packet of tic tacs sitting on the table and told me not to touch them. I ate half the packet and spewed up all night. My dad said they were adult tic tacs.'

These words accompany an art work of a doll lying next to a mess of drug paraphernalia. Its creator, now 16, is one of a number of children of parents with substance misuse issues whose works were exhibited in a groundbreaking exhibition Trying Childhoods, held this summer in Glasgow.

The original impetus came when Professor Marina Barnard of Glasgow University's Centre for Drug Misuse Research saw the Kids Company's Shrinking Childhoods exhibition at London's Tate Modern a couple of years ago. 'I thought why can't we do that in Scotland?' she says. 'I couldn't think of a good reason, so I immediately set about trying to raise the funding.'

'I'd done research on drugs and families over the last seven years, but I've been a drugs researcher for about 20,' she says. 'We got in contact with groups that I knew were working with kids – a church group, a voluntary group, a young carers' group – and where I knew a very high proportion of kids came from families where substance misuse was an issue. And this really is a major problem in Scotland.'

The exhibition had two main aims – that it was a rewarding experience for the children but also got the message across about the impact of drugs and alcohol on their lives. 'We made sure it was fun and that they wanted to do it,' she says. 'We weren't pushing them to a place they didn't want to go to, but we were always up front that we were putting on an exhibition. We wanted it to be a strong voice to a

largely unknowing public about what it was like to live with drugs in such close proximity.'

The centre engaged the services of artist and trained art therapist Liz Mitchell, and animator and illustrator Jana Prcalova. Nearly 80 children were involved in all, with ages ranging from as young as three to 18, working with media including painting, drawing, video and animation.

'Some of the kids really leapt at the chance to do it,' says Professor Barnard, 'particularly in the better-supported groups where they'd done a lot of talking work, while some had no expectations at all. It always had to be safe – we couldn't say to them "you've got to represent your mum or your dad" or something like that, because part of the burden for them is that people are always pointing the finger.

'For a child living around drug or alcohol addiction it's a very secretive world they inhabit,' she continues. 'They can't tell others because of the shame and the fear that it might lead to them being taken away from their parents. Even if things are really bad, that's the reality they know and to be taken out of that into another circumstance is terrifying.'

The university put up half the money, and fundraising brought in the rest. 'When I think back on it was completely mad at one level because we had no idea whether we'd produce anything that we'd be even be able to exhibit,' she says.

One of the most striking pieces in the exhibition was the work of a group of six boys who were involved in local graffiti and gang culture. 'When Liz, the art therapist, started to work with them all they could produce, week after week, were 'menchies' [stylised graffiti signatures],' says Professor Barnard. 'They are expressive but incredibly restrictive, and doing anything else was very difficult for them.'

The project with the boys was supposed to last 11 weeks, but took a year. 'Children take a long time to open up. Over time Liz got them to make a representation of their neighbourhood. It was a big map of the east end of Glasgow, with things like pharmacies and a big graveyard – a lot of people had died. The whole landscape was littered with knives, violence, prostitutes, needles and degradation, and underneath are their quotes about people who've died, and their experiences with drugs. It was a real journey for them, and it's a very powerful representation because kids often think in very clear black and white terms.'

The exhibition is now in storage, but will soon be transferred to the Scottish Parliament, where it's being sponsored by former justice minister Cathy Jamieson MSP, and there has been widespread interest from other organisations, both in the UK and overseas. 'It's a fantastic lobbying opportunity because it speaks a fairly powerful language about the impact of drugs on families and communities,' says Professor Barnard.

A separate launch was held for the children the day before the exhibition opened to the public to maintain their anonymity. 'Some really wanted their names on it but we thought it was best to keep it anonymous because it's a sensitive issue,' she says. 'They were very proud of what they did – one girl was so moved that her picture was there that she cried. They liked the idea that other people were going to know. We didn't set out for it to be therapeutic but I think it was.'

The powerful and striking nature of Trying Childhoods meant that it was a big hit with the local press and media, but for Professor Barnard and the other organisers the important thing was that it struck home with audiences. 'The people who came to see it were genuinely moved, and that for me was its success. They were shocked and saddened, and I think you should feel sad that it's so hard for such a large number of children.'

Some of the people who signed the comments book described the emotional impact it had had because of their own substance misuse issues. 'People who had lived with their own addiction were very moved by it,' she says. 'Seeing the work of children and their description of that pain is a useful therapeutic tool. One of the reasons people come out of addiction is because of their children, and this helps reinforce that – when you're in addiction all you see is your own preoccupations. When you come out of it you see the costs to the people you love, so I think used in a safe way it's a vehicle for helping people understand the price children pay and the importance of providing another kind of life from them.'

'I think it's a very powerful statement and an important resource,' she says. 'It has therapeutic value, it has scope to really move things on, and I think it speaks a language that bureaucracy can't. *Hidden Harm* talks about 350,000 kids in this situation but ultimately it's just a number – you see a representation of a child's pain and it has another impact. I do think you have to connect with these issues emotionally, otherwise what hope do these children have? There were three or four different pictures where children had written the word "help" – it's a strong statement about living with the burden of all this.'

Getting through to the body beautifuls

David Gilliver reports from the conference *Performance and image-enhancing drugs in the 21st Century* in Liverpool earlier this month.

Doctors must engage

The role of GPs in providing care for users of performance and image-enhancing drugs (PIEDs) was one of 'damned if you do, and damned if you don't', according to medical officer at Drugs in Sport Clinic and User's Support (DISCUS), Rob Dawson. 'You're damned if you do get involved and damned if you don't – but doctors should be damned if they don't' he told delegates.

More than 40 per cent of patients accessing needle exchanges in the North East of England were now anabolic steroid users rather than heroin users, he said, but even these figures were likely to drastically underestimate the scale of the problem. 'Many of them will be collecting for others – a gym owner might be collecting for 200 people so the figures are wildly inaccurate. It's the tip of the iceberg – but it wasn't the tip of the iceberg that sank the Titanic, it was what was underneath.'

Users could be split into four main groups, he said. The first was people seriously involved in sport, where it was essential to gain their trust and show the damage that could be caused. The second was those who had recently become involved in sport, and perhaps intended to use PIEDs as 'a shortcut to the body beautiful.' With them, GPs should explore their rationale and offer alternatives like diet, he said.

The third main group was occupational users like doormen, police and prison warders who often felt they were using them to help society and didn't want to feel penalised, he said. 'I always advise not to use at all, but this is often met with a wry smile'. The last was recreational users, who used the drugs to enhance aggression and stamina and foster a sense of wellbeing and were the hardest to reach because they could not be accessed through gyms, he said.

The rationale of getting involved from a medical point of view was one of harm minimisation, he said. 'Some athletes have even said they are prepared to die, so how do you influence their behaviour? They will try anything – they are literally their own chemical testing units.'

It was extremely unusual to just use one drug, he said, and admitted there were almost certainly drugs the medical establishment was unaware of. Injection was safer with some PIEDs because it was less damaging to the liver. 'We need to be engaging in a two way dialogue,' he said. 'It's vitally important that they have access to safe injecting equipment, and we need to show them injection techniques and injection sites.' GPs should also be doing full health checks on PIED users, including heart, ECG and testosterone levels, he said.

Use of PIEDs could cause all kinds of problems, ranging from acne to hypertension, cardiovascular problems, infertility, musculoskeletal disorders, aggression, paranoia and liver damage, he said. There were also the dangers associated with the large number of counterfeit drugs on sale, and the risks associated with injection, such as abscesses, HIV and hepatitis.

'PIEDs are not safe and nobody should use them,' he said, 'but we still need more evidence. If the evidence isn't there, then we can't moralise. Education is the key. PIED users are as entitled to our services as anyone else and we must encourage them to come forward.'

PIED use becoming 'normalised'

The use of performance and image enhancing drugs was becoming 'normalised' in parts of the south Asian community, outreach worker for West Yorkshire-based voluntary drug and alcohol agency Project 6, Naveed Khan, told the conference. 'It's seen as normal and legal, not something that's "dirty" like heroin,' he said.

Needle exchange records showed an explosion of PIED use in the areas covered by Project 6, he said. 'It was between five and six per cent a few years ago – now it's 25 per cent. There is a definite failure of services to provide specific provision for PIED users.'

Users were attracted by the fact that the drugs were cheap and the gains were almost immediately noticeable, he said, and use was not contained in one age group, with some users under 16, and many were using very high doses. 'People will just jump start and use all the substances at once,' he said.

Better delivery of drugs education targeting PIED use was essential, he stressed, as the available literature was sparse and much of it jargon-heavy. Harm reduction interventions on the streets were also vital, as were referrals to primary care and continuous monitoring of data. 'There's no middle ground with steroid use, so it's about harm reduction,' he said. 'They're always going to use, so you have to encourage them to use lower doses.'

Understand the culture

It was essential to understand gym culture when doing proactive outreach work around PIED use, manager of North Surrey PCT's health promotion outreach team told delegates. 'You need staff who know and understand gym culture because it's such a closed world,' he said.

Staff didn't necessarily need first-hand experience of PIED use, he said, A knowledge of harm reduction was more important.

PIED users were a hard-to-reach group, but persistence paid off, he said. 'It's about going out there and being bold and approaching people like gym owners. Word of mouth is very important – eventually clients will come to you, when you've built up trust.' Use of peer education and needle exchange records was also vital, he said.

Barriers to the work included a lack of time as the client group was increasing, ever more drugs coming on to the market and issues of politics. 'Some people question whether we should even be doing this work,' he said. 'There's a school of thought that says you should concentrate on the class As, people in the sex industry, gay men. But at the end of the day, PIED users are injecting drug users, and a very large proportion are also using cocaine, for example. We need to keep it on the political agenda.'

Image pressure drives gay men to steroid use

Around ten per cent of gay men attending gyms in the London area were steroid users, according to substance misuse worker Roy Jones from Turning Point's Hungerford Drug Project. 'There are transmission risks around HIV and hepatitis B and C but many of the people we work with are reluctant to go into drug services because they don't see themselves as drug users,' he said.

The project had launched the Steroid Users' Support Service (SUSSED) in association with CLASH (Central London Action on Street Health) the outreach service of Camden PCT. Their main client group was gay men in their 30s with disposable income, he said, and around 25 per cent were HIV+. The service taught safer injecting techniques, and promoted itself through word of mouth and editorials in the gay press. 'When we started only one gym would allow us any access,' he said.

Among his client group, PIED use was almost exclusively for image reasons. 'It's all about the way you look,' he said. 'It's a quick, affordable route to bigger muscles.' Some of his clients were commercial sex workers who used PIEDS to attract customers, and there was intense pressure in gay club culture to look good: 'It's all about tops off and "disco tits" – if you don't fit into that group you can feel very marginalised – especially if you're young.'

On my radio

Like many people, we were horrified by the recent Radio 4 *Today* interviews on treatment. Here are just a small number of our serious concerns.

1. In response to the stern challenge of John Humphries concerning the nature of treatment, the minister stated that 'these are people who are actually in treatment receiving support, counselling and proper direction'. Maybe we should have an independent study that reveals what proportion of people in treatment receive counselling by trained counsellors – and how much they get – to test the veracity of the minister's statement? We know few people in treatment who get proper counselling, but many say, 'alongside my methadone I get 20 minutes a fortnight with my keyworker'.

2. The minister stated that we are having more success than anywhere else in Europe. How can she make this statement when long-term outcomes are not measured? (As an aside, *DDN* should send her a copy of Neil McKeganey's article in last issue.)

3. The first piece of evidence the minister provided about the effectiveness of treatment was that it is reducing crime – rather than saying more people are reducing or overcoming their drug use problems. Sadly, this is a reflection of the political agenda that drives the treatment system.

4. One of the major reasons that the treatment industry in the US collapsed (1980s-1990s) was that it over-promised what it could achieve. The industry eventually got caught out. Sadly, we in the UK are making the same mistake in over-promising ('Treatment Works') and potentially setting clients up for failure. We need to think beyond treatment, and focus on recovery and the role that treatment can play. We must take a long serious look at how our treatment system is managed and operates. It is time that we stopped thinking about treatment for treatment's sake and focus on what we should really be doing – helping people achieve long-term recovery, using treatment as only one important way of enabling people do this.

5. Key factors underlying recovery are support and acceptance in society. Social stigma is harmful to recovery, but the reporter was allowed to get away with using the socially isolating and stigmatising label 'junkie' without being challenged by a leader in the field.

PS What an excellent article by Neil McKeganey on San Partignano, a truly extraordinary place (*DDN*, 24 September, page 6). It shows what can be achieved in this field with a thoughtful and caring nature, and the right application. We, in this country, need to take note and act!

Professor David Clark, director of WIRED and Lucie James, WIRED

(See Prof Clark's recovery article on page 15.)

Inadequate response

Your coverage of the Addictions Report in Breakthrough Britain (*DDN*, 16 July, page 4 – 'Flying in the face of evidence: agencies attack Tory drug proposals) was disappointing. Starting with the title, it was misleading and inaccurate on a number of counts. It was, furthermore, a very thin response to a very thick report.

This was one of the most researched and wide-ranging inquiries into drugs and alcohol policy ever conducted. It was our second and final report. In our 18-month process we took evidence from over 50 organisations and over 100 individuals; we researched and reviewed all relevant Home Office and DoH research reports, the NTA's own investigations and independent academic research projects, including NTORS and DORIS. We produced seven research briefings to the first report – ranging from the residential rehab beds referral crisis, to a full analysis of capacity of treatment and efficiency, to a critique of the government's Supply Reduction Strategy.

Research briefings for our second and final publication included a full review of prison treatment services and a comparative analysis of policy implementation in Holland and Sweden. We published detailed evidence from Alcohol Concern and the Institute of Alcohol Studies, especially researched and prepared for us.

Where and how our proposals fly in the face of the evidence mystifies us. Unfortunately you did not elucidate. Rather, your news report seemed to rely entirely on the opinions of two lobbies who simply appear to dislike our emphasis on abstinence-oriented treatment – perhaps because it does not fit in with their ideologies or moral positions? They do not seem to have any evidence-based reasons for decrying it (or at least these are not argued in your report). This is obviously controversial territory but we have set out the evidence-based reasons for asserting that it's important.

You ignored entirely the crisis of care we highlighted with regard to the prison population, families and children and our positive proposals to address this. Furthermore you allowed a completely inaccurate representation of our public health policy proposals concerning *inter alia* needle exchanges and viral testing without checking what we said or noting that they were squarely based on concerns already raised by the NTA on quality and practice failure.

DDN owes it to itself to give our report and the issues highlighted more informed and enlightened coverage. Perhaps you would like to give us an opportunity to respond?

The Addictions Working Group: Kathy Gyngell (chair), David Burrowes MP, Professor Chris Cook, David Partington. Andy Horwood

Ed's note: Our news report was a round-up of reactions to 'Breakthrough Britain', not analysis of its content, and opinions were those of agencies quoted. We have invited an article from the group.

Notes from the Alliance

Talking to the hand

Are you really listening, Daren Garratt asks the Home Office – or is the drug strategy consultation a foregone conclusion?

I'm writing this column the day before the closing date for submissions to the Home Office's Drug Strategy Consultation exercise and The Alliance, like many partner organisations, have had conflicting feelings about the whole process.

Has this been a genuine attempt to listen to the views of all stakeholders and interested parties and shape a pragmatic, robust and effective drug policy that responds appropriately to complex and wide-ranging, physical, mental and socio-economic issues, or a cynical, tokenistic attempt to placate us into believing we're actually being listened to when final decisions have actually been made?

Personally I suspect the latter, but as a national user-led organisation that has sought this level of consultation for many years we have simply had to engage, regardless of how flawed, lopsided and dismissive of the role of users this process has appeared to be.

For instance, although the consultation paper does acknowledge that 'Users and carers play a vital role in helping drug users remain in treatment and reintegrate into society as their treatment progresses', the consultation process provides no question about the importance of the role and how we should be integrated into future developments, and merely asks if there is 'a place for role models, including those drawn from peer groups, in drug information campaigns?'

This is a classic example of non-inclusive consultation; the type of consultation that merely asks you to comment on a series of closed questions relating to predetermined ideas as opposed to a non-directed, blank-sheet approach that simply asks, 'what works?' Although, that said, we could only really identify 'what works' if we had a comprehensive audit/review of the last strategy, but that's a different argument for a different day...

So we submitted a response, but we refused to answer their questions. Instead, we felt we that we could best represent the needs of our constituency by both engaging with the consultation process in order to suggest recommendations (particularly with regards to treatment options, harm reduction and public health) and highlight concerns, by writing a critique of the process, highlighting its failings, illegitimacy and how it doesn't respond to or reflect users needs, while simultaneously making the criticisms we have of that process public where necessary.

Time will tell how effective this whole process will ultimately prove to be, but if we feel that our views have not been considered, or that a strategy already exists as a *fait accompli*, then we'll respond to that in an appropriate way, at an appropriate time. Policy consultation should not be a time-limited, stand alone event; it should be an ongoing process of monitoring, evaluation and review.

So if any users out there do have concerns about existing government policy, the consultation process or the new strategy, the Alliance/*DDN* User Conference 'Nothing about us without us' in Birmingham on 31 January could be the ideal opportunity to raise them directly with the Home Office itself.

PS Thanks to Peter Mc Dermott for drafting the Alliance's response and general spiritual guidance.

Daren Garratt is executive director of the Alliance

Not in front of the children

The government's updated alcohol strategy, Safe, Sensible, Social aims to reduce the number of under-18s who drink and the amount they drink. But Alcohol Concern found that many children are being openly influenced by alcohol advertising during their favourite programmes, as **Don Shenker** explains.

Alcohol Concern decided to investigate the extent to which children were being exposed to alcohol advertising, by looking at the scheduling of alcohol adverts. In particular, we wanted to see the extent to which they appear on television before and after the 9pm watershed and whether any of them are placed within programmes aimed at children. We were also keen to look at whether the current rules on the scheduling of adverts are adequate.

Our investigation focused on two separate weeks of broadcasting, looking at when alcohol adverts appeared and within which TV programmes. A small sample of individual programmes were then analysed for demographic breakdowns to see the percentage of children viewing at the time. We found that most alcohol adverts actually appear before the 9pm watershed and in programmes where large numbers of children are viewers.

Previous studies have shown that young people are increasingly adept at interpreting the cultural messages contained in alcohol advertisements. Research on alcohol advertising among 10- to 17-year-olds, conducted by Strathclyde University in 1988, indicated that 88 per cent of 10- to 13-year-olds and 96 per cent of 14- to 17-year-olds were aware of alcohol advertising and 76 per cent of these could identify three or more advertisements when the brand name was masked.

Four years later, it was shown that young people, even 10- to 12-year-olds were adept at interpreting the messages, images and targeting of alcohol advertisements, in the same way as adults. The authors concluded: 'In essence, the more aware, familiar and appreciative young people are of alcohol the more likely they are to drink both now and in the future.'

The World Health Organisation's European Charter on Alcohol states that: 'All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages. A long-term national study in the US, published in January 2006, concluded that for each additional dollar per capita spent on alcohol advertising in a local market, young people drank 3 per cent more.

Research on young people's alcohol consumption rates carried out last year showed a marginal decrease in the numbers of young people who had consumed alcohol in the past week. However children who do consume alcohol are now drinking more units than previously. Alcohol Concern's *Glass Half Empty* report showed 11- to 13-year-old boys drinking 43 per cent more units in 2006 than they did in 2000, and 11- to 13-year-old girls drinking 82 per cent more units.

Looking at the broadcasting and regulatory framework for advertising highlights areas of inconsistency and confusion. Ofcom's own research carried out in 2004 around alcohol advertising and its impact on children declared much television alcohol advertising (of alcopops in particular) to be 'closely aligned to youth culture and of strong interest to underage drinkers'.

The Advertising Standards Authority scheduling and the Committee of Advertising Practice (Broadcasting) rules dictate that no alcohol adverts should be shown during programmes 'particularly likely to appeal' to audiences below the age of 18. A programme is considered to be of particular appeal to children if the proportion of children watching is 20 per cent greater than the proportion of children in society – a very high threshold.

The Committee of Advertising Practice rules for non-broadcast advertising state that 'no medium should be used to advertise alcoholic drinks if more than 25 per cent of its audience is under 18 years of age' – a much lower threshold.

It is unclear why non-broadcast rules are different to broadcasting ones. But this means that an alcoholic drinks advert scheduled on television has fewer restrictions in relation to protecting children than if the same advert was placed in a tube or railway station.

Alcohol Concern carried out unique research into alcohol adverts in two separate weeks (11 to 17 December 2006 and 19 to 25 March 2007) to see how many alcohol adverts featured before the 9pm watershed, and which TV programmes these were placed during. We also looked at the age breakdown of a small sample of programmes potentially aimed at, or attractive to, children.

We looked at the distribution of alcohol adverts before and after the 9pm watershed in a seven-day period in December 2006. Our study showed the majority of alcohol adverts were shown before the 9pm watershed. There

Advertiser	Alcohol Product	Channel	Time and Date	Programme	Total (number of 4-19 yr-olds watching)
William Morrison's (supermarket)	Special Offer: Grolsch 2-pack	Five	6.13pm 11 December 2006	Home and Away	6,000 *(regional figure for just ITV West viewers)*
Lidl (supermarket)	Fine Wines & 'Low Prices 3'	ITV	7.46pm 15 December 2006	Coronation Street	237,300
William Morrison's (supermarket)	Special Offer: Grolsch 2-pack	ITV	1.53pm 17 December 2006	The X Factor – The Final	1,126,000

were also twice as many supermarket alcohol adverts shown before the watershed than after.

There was also a rising number of alcohol adverts shown from 3pm to 5pm, coinciding with the time when most children return from school. It would be a reasonable assumption that most people in employment will not have returned home until after 5pm, so the marked spike in alcohol advertising between 3pm and 5pm is, at the very least, puzzling.

Alcohol adverts were shown during a number of programmes where a significant share of the audience included children, including *Home and Away* and *The X-Factor*.

In some popular soap programmes such as *Coronation Street*, there are likely to be more than one million children watching the programme. Although the programme may not be judged as likely to appeal to children, the large numbers of children viewing is of great concern. At the time of our study, 11 per cent of the audience was shown to be between four and 19 years old – representing 1,126,000 young people.

Supermarket advertising appears to particularly aim to reach early evening audiences, with double the amount of supermarket alcohol adverts appearing before 9pm.

Similarly, *The X Factor* and *Home and Away* are clearly programmes viewed by children and likely to appeal to a young audience. The 20 per cent rule, which says that programmes are deemed to be unsuitable for carrying alcohol advertising if the proportion of children watching is 20 per cent greater than the proportion of children in society, is not only unnecessarily complicated, it also means that hundreds of thousands of children are regularly being exposed to alcohol advertising in this country.

The Advertising Standards Authority is responsible for dealing with public complaints about advertising but the system used for assessing whether a programme is suitable for alcohol advertising is complex and not well publicised, and this makes it difficult for the public to complain.

It is not clear why the Committee for Advertising Practice's non-broadcasting regulations, stating that alcohol adverts should not be shown where under-18s make up more than 25 per cent of the audience, are different from the broadcasting regulations concerned with programmes 'likely to appeal to under 18s'. It could be argued that all of the programmes analysed by Alcohol Concern are likely to appeal to under-18s.

In spite of various codes and regulations, alcohol adverts are appearing in programmes that appeal to large numbers of children and where the total number of under 18-year-olds watching is significant.

In light of our findings, Alcohol Concern has made the following recommendations:

- There should be no alcohol advertising (either branded or supermarket) from 6am through to 9pm regardless of the predicted age of audience of a programme. In other words, there should be no alcohol advertising before the watershed. In our view this is the only sure way to protect the majority of children from alcohol advertising.
- In programmes which run after the watershed but are still likely to appeal to some children, such as sporting events, alcohol adverts should not appear where more than 10 per cent (one in ten) of the audience are, or are likely to be, children.
- The regulations covering alcohol adverts should state clearly who is responsible for monitoring scheduling and what sanctions exist when these are contravened. This information should be publicly promoted.
- Inconsistencies between the CAP non-broadcast and broadcast codes should be resolved, with a clear definition of programming likely to appear to children identified and promoted.

Our research highlights how easy it is for drinks advertisers to show alcohol adverts during the times that children are more likely to be at home, watching TV, and during programmes that appeal to them. We need to explore how we can do more to protect children from alcohol harms and promote a safer, more responsible culture in relation to young people and alcohol.

This subject will be explored at Alcohol Concern's conference 'Too Much Too Young' on 7 November in London. See www.alcoholconcern.org.uk for more information on the conference and AC's report.

Don Shenker is director of policy and services at Alcohol Concern

What's the point of needle exchange?

Needle exchange programmes (NEPs) have been described as the most visible component of harm reduction. They permit those who inject drugs to exchange potentially contaminated syringes and other works, for sterile ones. Besides syringes, clean water, citric acid, tourniquets, and other works may be offered, and there are often staff on hand to offer literature and advice on wider harm reduction issues relating to substances and sexual health.

First introduced in Amsterdam in 1984, NEPs were a response to the public health threat of HIV/AIDS. This virus was increasingly found in injecting drug users (IDUs), being spread through the sharing of contaminated works and to their partners through sexual transmission. In the USA in the mid 1990s, injecting drug use accounted for nearly half of new HIV infections, clearly demonstrating the need to prevent an epidemic. NEPs are also a response to the threat of other viruses spread through blood borne pathogens such as hepatitis B and C, and human T cell lymphotropic viruses, as well as addressing wider problems caused through sharing and reuse of the same needles, such as increased risk of endocarditis, cellulites and abscesses.

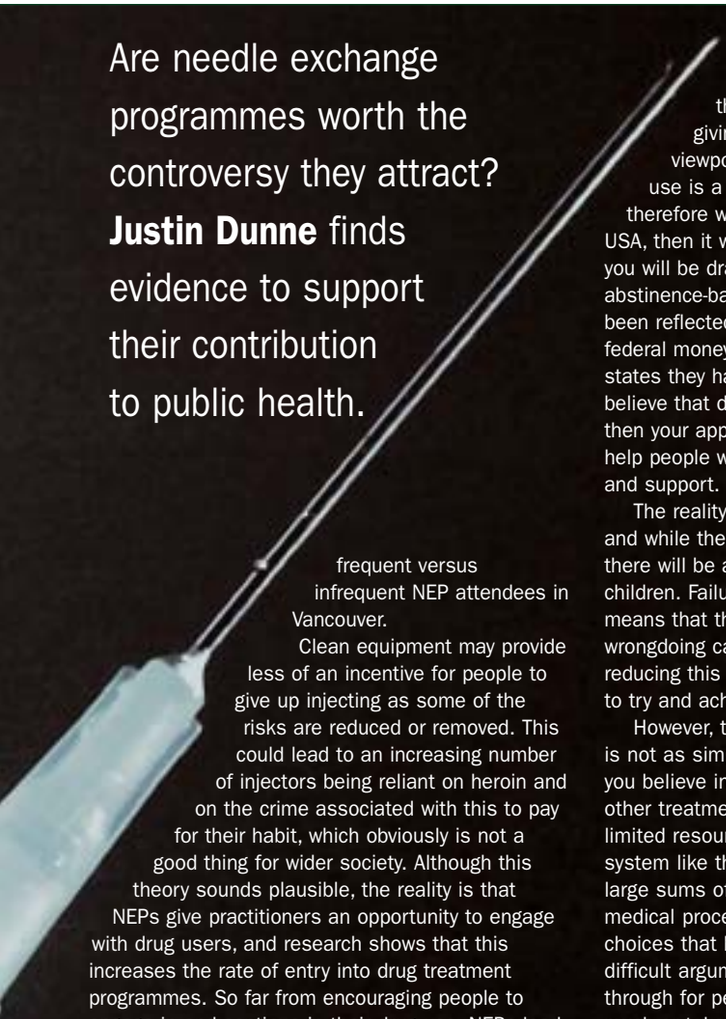
NEPs have caused a great deal of controversy. Those who want to stress their advantages will cite overwhelming research evidence that NEPs work from a harm reduction point of view. Some who stress the disadvantages will refer to a small number of key studies that say NEPs do not work and may even increase the spread of blood borne viruses. However, those against NEPs more often argue that these programmes are wrong from a moral and ethical viewpoint. Evaluating the evidence relating to NEPs indicates that they are necessary for public health reasons, and are in fact ethically sound.

One argument against NEPs suggests that easy availability of sterile equipment could assist the transition to injecting and encourage earlier onset of this practice. This is clearly a risk, although anecdotally, I would have to say from experience of working with IDUs and other drug users, this does not seem to be the case. Injecting drug use is still frowned upon among many drug users. Most who progress to injecting do so because smoking heroin simply does not have the same effect any more because their tolerance has increased, and so injecting is a matter of need not desire. And far from NEPs encouraging the use of injecting, the reverse may be true. An Amsterdam study showed a decline in injecting among those involved in NEP programmes.

Some say that needle exchanges do not achieve their goal of harm reduction and there have been some studies that suggest this is the case. An HIV outbreak among IDUs in Vancouver in 1997 followed the introduction of a high volume NEP area. A study in 1999 showed no benefit of NEP attendance upon incidence rates of HBV and HCV among IDUs in Seattle. In Montreal, a 1977 study showed that there were higher HIV incidence rates among NEP attendees compared to non-attendees. However, these findings seem to contradict the many studies between 1995 and 2003 that have shown that NEPs do achieve their primary goal in reductions of incidence of HIV, HBV and HCV infections. A decade ago, a comparison between 29 cities with established NEPs, showed they decreased HIV prevalence dramatically – by 5.8 per cent a year on average, compared to an increase in HIV of 5.9 per cent in 51 cities without NEPs. A New York City study backed up the fact that NEPs were associated with a dramatic decline in HIV incidence, and further research has shown that NEPs were effective in reducing risky behaviours such as needle sharing.

So, what are we to make of the mixed evidence? Selection bias has been suggested as an explanation: those who obtain syringes from other sources could have accounted for the higher HIV incidence observed among

Are needle exchange programmes worth the controversy they attract? **Justin Dunne** finds evidence to support their contribution to public health.



frequent versus infrequent NEP attendees in Vancouver.

Clean equipment may provide less of an incentive for people to give up injecting as some of the risks are reduced or removed. This could lead to an increasing number of injectors being reliant on heroin and on the crime associated with this to pay for their habit, which obviously is not a good thing for wider society. Although this theory sounds plausible, the reality is that NEPs give practitioners an opportunity to engage with drug users, and research shows that this increases the rate of entry into drug treatment programmes. So far from encouraging people to engage in and continue in their drug use, NEPs lead to a reduction. Because of this, it has been suggested that NEPs should offer incentives such as financial reward to encourage attendance and to be involved in vaccination programmes – an initiative that has been shown to treble attendance rates.

It is argued that NEPs will increase crime in the areas in which they are located, but a study on trends carried out in 2000 showed that they do not. Research the following year demonstrated that there is no association between living close to NEPs and reported violence; nor were people living close by more likely to be robbed. The simple fact remains, whether people recognise it or not, that drug users live among the community already and the presence of an NEP there is not likely to change their current activity – apart from positively, if they choose to engage.

Researchers have pointed out that sharing equipment is associated with socialisation in drug sub-culture, so some users will always continue to share, regardless of the hazards. Although this is true, it is not a reason to deprive those who do want to take note of the risks. Some people will always make risky choices, but others will engage with services if they are available, and studies clearly show that NEPs do not contribute to the formation of high-risk needle sharing networks.

From an ethical point of view, practitioners may not want to feel that they are condoning drug use by giving out needles. If your ethical viewpoint comes from a belief that drug use is a moral and criminal problem and is therefore wrong, as is often the case in the USA, then it will be hard to support NEPs because you will be drawn towards a zero tolerance abstinence-based approach. In the USA this has been reflected in policy, which means that no federal money can be given to NEPs and in some states they have become illegal. However, if you believe that drug use is a health or social problem, then your approach is likely to be one of trying to help people work through these issues with help and support.

The reality is that drug use will always be there, and while there is a health threat to drug users, there will be a health threat to their partners and children. Failure to provide treatment and care means that those innocent of any crime or wrongdoing can become casualties of drug use, so reducing this risk is surely the morally right thing to try and achieve.

However, the argument about protecting health is not as simple as it might first appear. Even if you believe in the health benefits of NEPs and other treatment, there are always going to be limited resources available in a free healthcare system like the NHS. Should the NHS be spending large sums of money on IDUs, at the cost of other medical procedures on people who have not made choices that have put them at harm? This is a difficult argument, as we would need to follow it through for people who drink, smoke, eat too much or take too little exercise. Where do you draw the line?

It has been argued that NEPs may be justified on economical grounds if drug users are predicted to have a reduced chance of contracting, and needing expensive therapy for, hepatitis and AIDS. One study demonstrated that every HIV infection averted saved $20,947, showing clearly that a prevention agenda through harm reduction is a far better option than long-term treatment.

Another anti-NEP argument put forward is that that giving out more needles will lead to more being discarded on our streets and the possibility of needle stick injuries to members of the public, who could contract blood borne viruses. Inevitably there have been isolated accounts of needle stick injuries occurring in cities with NEPs – but you can also find similar incidents where NEPs don't exist. And because NEPs encourage less needle-sharing, any needle stick injury that does occur is less likely to be from a needle contaminated with a blood borne virus.

Far from the picture of IDUs being irresponsible morally corrupt people who simply discard needles anywhere, they have been shown to behave extremely responsibly within these programmes. One study demonstrated a significant decrease in the numbers of needles found discarded in the street following the establishment of a NEP; another study showed that the overall worldwide return rate for needles was 90 per cent.

Clearly abstinence is the best approach to eliminating problems relating to drug use, as many opponents of the harm reduction approach point out. But this is quite simply not a realistic goal. Even with the best public health campaigns there will always be those who choose to use substances. This is especially true of adolescents who are going through a time when they are arriving at their own beliefs and values, where experimentation is perfectly normal, and where telling them to 'just say no' is likely to have the reverse effect. We will never live in an abstinent world and so we must deal with this reality and the dangers it poses. NEPs have been cited as a major reason why the UK has averted an HIV epidemic among IDUs, so are a practical response to a less than ideal situation. Although most of us would like to live in a world devoid of injecting drug use, this is a utopian dream.

We must recognise that any injecting, even with clean equipment, carries inherent risks. Bad technique will cause damage to veins and increase the risk of conditions such as deep vein thrombosis. Quite simply, frequent injecting is not a good health option and a scheme that encourages this has to be ethically questionable. However, good injecting technique can be taught to minimise risk, and engagement with IDUs is far more likely to result in treatment and the end of injecting use. Keeping people as safe as possible in the meantime must be a sensible option even if it does have an element of risk.

Weighing up the evidence, my only conclusion is that the use of NEPs worldwide should be encouraged and expanded. By 2000, there were 134 regions in the world with injecting drug use, 114 of which reported HIV among IDUs. Sadly only 46 of these regions had NEPs. Although this number has grown, there are still not enough to meet the worldwide need. Unfortunately, even where they do exist, uptake is not as good as it could be, with some studies showing that up to 80 per cent of IDUs reuse syringes and share needles, even when NEPs are available.

With such overwhelming evidence for the effectiveness of NEPs, we need to look at the idea of incentives to increase use as well as encouraging IDUs to be involved in vaccination programmes. The high cost of treatment for HIV/AIDS further justifies this approach.

Although there will always be moral objection to anything that is seen to support drug use, NEPs are necessary for public health reasons and are more likely to lead to the reduction of injecting use through effective engagement, rather than by telling people they are wrong and should stop.

Justin Dunne is senior lecturer in public services at the University of Gloucestershire.

Cleverly-written diversity policies will not connect black crack users with services. We need to look at fundamental culture change to make services relevant, says **Chris Robin**.

Beyond the crack

In the past the term 'diversity' was rarely heard. There was however, regular mention of the inadequacies of services in meeting the needs of possibly the largest minority population – people of African Caribbean descent. Today the term 'diversity' is understood to refer to all cultural groups and aspects of their difference including sexuality and gender identity, religion, age, education and status. What then has become of that defining group that spearheaded the movement that drew attention to 'difference'?

Many people from African Caribbean descent currently feel that their needs have been forgotten. Those that are drug users are more likely to be offered help in the context of the prison system. Black people are overly represented in mental health institutions and are still more likely to be stopped and searched, be refused bail and receive a custodial sentence than their white, or other, counterparts.

The concept of 'diversity' suggests that these inequalities are identified and addressed. Is this the case or does the term simply support the legal frameworks provided by the Sexual Discrimination Act, the Disability Discrimination Act and the Race Relations Act?

These pieces of legislation have been designed in part to ensure that public services and professional bodies no longer fail marginalised people. Those organisations are required by law to ensure that all policies and strategies incorporate their intent to address issues of diversity so as not to exclude any person because of their difference. The reality however, is often that the established culture of the organisation pervades by being perpetuated through its workforce. This allows the black client, whether in the service in a voluntarily or compulsory capacity, to conclude that services are not designed to understand or meet their basic needs.

This is exemplified in the case of the black crack cocaine user who is most likely to have initial contact with drug services through either the mental health or criminal justice systems.

To change this trend we must look not only at cleverly written policies, at training workers in diversity or lobbying senior managers. We must take a critical look at how services have been established and how their culture is perpetuated. We must ask who is not accessing services and ask them why. We must be prepared to challenge the status quo. We must explore the research and ask why so little has taken place within the black community. We must look for answers to why black crack users are not accessing services and we must effect change now! In doing so, we might consider the following questions:

- Do we meet 'difference' in an open and honest way with a commitment to meeting the needs of that person in a real way, or do we meet 'diversity' as a paper exercise with a tick box answer that enables us to cover our backs?
- In the 20 or 30 years that drug services have existed, are they still primarily geared towards white opiate or polydrug users, thereby denying the existence of the black crack cocaine user?
- Why does our society demonise 'crack' when it is in fact a smokeable form of cocaine – a drug that has for many years been acceptable in white middle class and entertainment circles? (A drug test that is positive for crack is still identified as 'cocaine'!)
- Why do we continue to view working with crack users as 'difficult'? Are the needs of crack users different? Of course they are – inasmuch as the needs of every individual client are different, irrespective of their difference. If we keep working in the same old way, we will continue to make the same mistakes.

The way forward has to be for us to take action to change the experience of the black crack cocaine user. Simply creating policies, training workers in 'diversity' or adjusting our services to work with polydrug users, does not do this. Nor is it done by predominately providing drug services to black people once they are already caught up in the criminal justice or mental health systems. For this we need to consult and engage with the black community and involve them in the development of services that are specifically designed for black drug users in order to provide them with real choices in their lives.

Chris Robin is training director at Janus Solutions. For information on training visit www.janussolutions.co.uk

Recovery and communities of recovery (part II)

Professor David Clark of Wired looks at recovery and treatment.

William White is author of one of the truly great books in this field, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

He points out that there have been three organising paradigms over the past 200 years to try and deal with the problems caused by drugs and alcohol in the US. Pathology, whether religiously or medically conceived, provided an organising framework from the late 18th Century through to the era of alcohol prohibition. This paradigm fuelled a debate as to whether alcoholism was a sin or a sickness.

The pathology paradigm was replaced by the intervention model, which 'buttresses multi-billion dollar industries aimed at preventing drug use, controlling drug supplies, punishing drug offenders, and treating those with severe AOD [drug and alcohol] problems'. It is assumed that investigations into the etiology and patterns of substance use problems and studies of the professional treatment of these problems will reveal the ultimate solution to these problems.

This model has generated significant new understandings that sparked calls to bridge the gap between research and practice in addiction treatment.

However, White and Kurtz point out that there has also been a disillusionment with this model because of the intractability of substance use problems at a societal level, resulting in a shift in focus to a third paradigm, one which focuses on resilience and recovery.

The recovery paradigm proposes that solutions to severe substance use problems 'have a long history and are currently manifested in the lives of millions of individuals and families and that the scientific study of these lived solutions could elucidate principles and practices that could further enhance recovery initiation and maintenance efforts'.

In the US, there have been calls to shift the design of addiction treatment from a model of acute biopsychosocial stabilisation to a model of sustained recovery management. Moreover, a new recovery advocacy movement has developed.

Now you might be thinking, 'What has this got to do with the UK?' We've got our treatment system, we have a mantra 'treatment works', *etc, etc.*

However, it has been pointed out to me on a number of occasions that in the treatment field we tend to be 15 to 20 years behind the US, which means that this shift in paradigm will be coming. Moreover, we must note that the treatment system in the US was effectively dismantled in the 1990s.

'Treatment is a tool, albeit a valuable one for many people, not an end in its own right.'

We also need to sit back and reflect on the current paradigm being used in the UK – the intervention model – and how we are using it. We need to ask ourselves whether we are so wrapped up in the idea of 'treatment' that we forget what we are really doing, or should be doing, for the majority of people who need help, *ie* helping them find recovery.

Some people who attend treatment are not particularly interested in stopping using drugs or drinking in the long term, or do not believe they are capable of doing so. They want some respite from the chaos and damage that their substance use is causing them. Support from street-based agencies can provide a welcome period of respite, while a methadone programme can be beneficial for people who have been using heroin.

However, a very significant proportion of people who access treatment want much more. They want to resolve their substance use problems permanently and go on to lead meaningful and fulfilling lives free of the substances that have caused their problems. On the basis of the definition below, they want recovery:

Recovery is the process through which severe alcohol and other drug problems are resolved in tandem with the development of improved physical, emotional, ontological (spirituality, life meaning), relational and occupational health. [My adaptation of definition from White and Kurtz, 2005]

Many of these clients have a variety of other life issues – some caused by the substance use problem, others that preceded it – which they need help from professionals in resolving.

But is there sufficient help for those people who want to find recovery? And, are we getting carried away by the concept of treatment – and treating the symptoms, not underlying problems – to the exclusion of not understanding recovery (the real end-point) and helping people achieve it?

The resolution of substance use problems, or recovery, is something that ultimately comes from within the person. Treatment is a time-limited, circumscribed experience or set of experiences that helps this self-change process. Treatment is a tool, albeit a valuable one for many people, not an end in its own right.

For many individuals, recovery sustainability is not achieved in the short span of time that treatment agencies are involved in their lives. As I will explore in a later Briefing, we need something additional to help people to recovery.

I finish with a story I've often heard: A person who wants to stop using heroin is put on a methadone programme. He later asks that his dose be gradually reduced so he can work towards being abstinent. He is told his dose cannot be reduced because he will relapse.

Where is the focus: on his recovery (and wellbeing) or on treatment?

[To be continued.]

'Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches' by William White and Ernest Kurtz (2005).

www.facesandvoicesofrecovery.org/pdf/White/recovery_monograph_06.pdf

Substance Misusing Parents and their Children

Towards Effective Services

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Regent's College, Regent's Park, London, NW1 4NS

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Highlight the impact of substance misusing parents on children.

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- 12 step and holistic therapy

For further information please contact Darren Rolfe

CALL FREE 08000 380 480

Email: Darren@pcpluton.com
Web: www.pcpluton.com

AURICULAR ACUPUNCTURE TRAINING

Specialist short courses for professionals working with substance misusers.

This simple and effective therapy can:

- Attract more clients into your service
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- Increase staff and client motivation

We promise to deliver:

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- Recognised certification
- DANOS compliancy

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Email: info@acupuncturetraining.co.uk
Tel: 07999 816326

"Training For Practitioners By Practitioners."

Alcohol Concern
Annual Conference and AGM 2007

Wednesday 7th November 2007,
Glaziers Hall, 9 Montague Close,
London Bridge, London SE1 9DD

With rising levels of alcohol consumption among 11-13-year-olds, increased child hospital admissions and younger cases of liver cirrhosis, it's time to ask: "What can be done to reduce levels of harm among young people who drink? What part can parents, professionals, the industry and government play to promote resilience and protection?"

For further information and to book delegate places or exhibition stalls please contact Catherine Johnson cjohnson@alcoholconcern.org.uk 020 7264 0620 or see our website www.alcoholconcern.org.uk

Alcohol Concern
Making Sense of Alcohol

Nothing about us without us!

The first national service user involvement conference brought to you by DDN and The Alliance

31 January 2008, Birmingham

Your opinions will help shape the strategy of the future

Speakers Include:
Vernon Coaker MP, Minister for Drugs & Crime Reduction
Paul Hayes, NTA Chief Executive
Jimmi Grieves, NUN Chair
Service User group representatives

Plus! Evening benefit gig for The Alliance, featuring The Nightingales with special guests.

For details email: info@cjwellings.com
Full programme and brochure now available at
www.drinkanddrugs.net

2nd Addiction Psychology Conference

Glaziers Hall, 9 Montague Close, London Bridge, SE1 9DD

Friday 23rd November 2007

Beyond Stages of Change?

Alternatives to the Transtheoretical Model of Change

After the success of the inaugural event in 2006, the conference provides a unique opportunity for students and professionals involved in addiction psychology to experience and share ideas, discuss and promote dialogue for the future.

Tickets £78 for non students, £30 for students. Includes lunch and refreshments.

BOOK NOW quoting "2nd Psychology Conference"

E-mail: acmoss@sgul.ac.uk for further details and booking enquiries.

Our key note speakers;

- Professor Stephen Sutton
  Dept. of Public Health and Primary Care, University of Cambridge
- Dr Arie Dijkstra
  Dept. of Psychology, University of Groningen
- Professor W Miles Cox
  School of Psychology, Bangor University
- Professor Robert West
  Dept. of Epidemiology and Public Health, University College London

Chairing the discussion sessions;

- Professor Robin Davidson
  Consultant Clinical Psychologist, Belfast City Hospital

NATIONAL DRUG PROGRAMMES DELIVERY UNIT, HM PRISON SERVICE

The National Drug Programmes Delivery Unit is responsible in the Prison Service for the monitoring and delivery of high quality drug treatment programmes throughout the prison estate in England and Wales.

Manager G – Treatment Support Manager (1 post)

Salary range £ 23,434 – £30,676

The post holder will join the Programme Support and Audit Team of the National Drug Programme Delivery Unit, to provide support, advice and monitoring on all aspects of treatment to ensure a consistent approach to the delivery of CSAP accredited programmes. The post holder will provide support to prisons in the London, South Central and Kent and Sussex Areas but will also be required to visit other parts of the country to attend meetings and provide support.

Experience of accredited drug treatment programmes in a custodial or community setting is essential.

For further information about this post please contact Dr Lynne Lawrie (Head of Drug Treatment programme and Support) on 01902 703166. For an application pack contact Theresa Breuilly on 01902 703156 or e-mail theresa.breuilly@hmps.gsi.gov.uk

Closing date: 2 November 2007

Interviews will take place in November.

Please note that all Prison Service posts are open to part time and job share applications. Applicants are require to declare whether they are a member of a group or organisation which the Prison Service considers to be a racist. The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age (subject to being within normal retirement age for grades) sexual orientation, disability or any other irrelevant factor.

INVESTOR IN PEOPLE

HM PRISON SERVICE

NOMS National Offender Management Service

Working together to reduce re-offending

NDPDU National Drug Programme Delivery Unit

Essential workshops

Creative ways of working with anger
16 November – central London

Uncover many creative and practical ways to help you develop strategies in working with anger. This course is an opportunity to help you develop an understanding of anger. You will explore creative ways of approaching this complex emotion. During the day you will learn some useful techniques to help respond to situations rather than react and techniques to use with your client group. These workshops are led by one of the country's leading anger therapist workers. Becky Wright who advocates that to feel confident in working with anger in others you first need to be able to understand how to develop a personal model which allows for your own anger to be explored. Becky has worked within the field of substance misuse since 1989.

The essential drug and alcohol worker
3-7 December – central London

This five-day course provides a full introduction to many of the elements of effective drugs and alcohol work. It is run by Tim Morrison, a member of The Competence Group and author of *The Essential Drug and Alcohol Worker*. This workshop is delivered in association with DDN and DrugScope. Cost: £635 + VAT per head (15% reduction for FDAP members/affiliates) – rates for groups on application.

Supervision, appraisal and DANOS
4 February 2008 – central London

Performance management
11 February 2008 – central London

Contact Tracy Aphra – e: tracy@cjwellings.com, t: 0207463 2085.

DDN in association with FDAP

NEWLINK Wales

Substance Misuse Volunteering and Training Organisation

NewLink Wales provides training for professionals working in the field of substance misuse, throughout Wales. Besides the courses on its annual training programme it can also provide in-house training designed to meet specific needs. Courses are mapped to units within the Drug & Alcohol National Occupational Standards. The organisation is also a registered centre for NVQs.

NEWLINK WALES TRAINING COURSES, OCTOBER – DECEMBER 07

November

1 & 2	**Basic Substance Misuse Awareness Level One** (Carmarthen)	*(£110 – Voluntary Sector staff, £130 Statutory Sector staff)*
12 & 13	**Basic Substance Misuse Awareness Level One**	*(£110 – Voluntary Sector staff, £130 Statutory Sector staff)*
15	**Amphetamine & Methamphetamine**	*(£110 – Voluntary Sector staff, £120 Statutory Sector staff)*
19 & 20	**Dual Diagnosis**	*(£120 – Voluntary Sector staff, £135 Statutory Sector staff)*

November (cont)

26 & 27	**Basic Substance Misuse Awareness Level One** (Aberystwyth)	*(£110 – Voluntary Sector staff, £130 Statutory Sector staff)*
27	**Working with Drug Using Couples**	*(£110 – Voluntary Sector staff, £120 Statutory Sector staff)*

December

4	**Substance Misuse and Older People**	*(£110 – Voluntary Sector staff, £120 Statutory Sector staff)*
10 & 11	**Basic Substance Misuse Awareness Level Two**	*(£130 – Voluntary Sector staff, £150 Statutory Sector staff)*

Members of NewLink Wales are eligible for a 5% discount on training fees. All the above courses take place at our offices in Cardiff, unless otherwise stated.

For queries, booking forms or information on courses please call NewLink Wales on Tel: 02920 529002 or e-mail us at training@newlinkwales.org.uk.

Details of all the courses and workshops we offer can be found on our website: www.newlink-sw.org.uk

Registered Company – 4142393 Registered Charity – 1085545

SLOUGH DRUG & ALCOHOL ACTION TEAM

Slough Drug and Alcohol Action Team

are seeking written expressions of interest from providers with proven experience in delivering the Drug Intervention Programme (DIP). You will be required to provide the following services:

Arrest Referral, Assessment, PPO/Prison liaison, Through-care and Aftercare, Comprehensive Assessment, Urine Screening and Key Working with a case load that includes those accessing rapid prescribing.

The expected terms of the contract will be for two years with a possible two-year extension in twelve-month increments, subject to evidence of need, recurrent funding and satisfactory performance. You will be required to commence services on 1st April 2008.

Applicants will be required to show how they will ensure that the DIP is delivered as part of a wider adult drug treatment system. They should be able to identify other providers and explain how they will work with those providers to deliver a complete package of care.

Expressions of interest should be sent in writing to: Julia Wales, Slough DAAT, Town Hall, Bath Road, Slough, SL1 3UQ. julia.wales@slough.gov.uk and should arrive no later than 5th November 2007.

You will then be issued with a Pre-Qualification Questionnaire (PQQ), which must be completed and returned by 12th November 2007.

NATIONAL DRUG PROGRAMMES DELIVERY UNIT, HM PRISON SERVICE

The National Drug Programmes Delivery Unit is responsible in the Prison Service for the monitoring and delivery of high quality drug treatment programmes throughout the prison estate in England and Wales.

Manager G – Training Team (1 post)

Salary range £ 23,434 – £30,676

The post holder will join the Training Team of the National Drug Programme Delivery Unit. The post holder will be required to carry out assessments of potential facilitators, Treatment managers and Deputy Treatment Managers in all areas of the country and deliver a minimum of 80 days training per year.

Experience of facilitating/treatment managing accredited drug treatment programmes in a custodial or community setting is essential

For further information about this post please contact Andy Clark (Training Manager) 01902 703149. For an application pack contact Theresa Breuilly on 01902 703156 or e-mail theresa.breuilly@hmps.gsi.gov.uk

Closing date: 2 November 2007

Interviews will take place in November.

Please note that all Prison Service posts are open to part-time and job share applications. Applicants are require to declare whether they are a member of a group or organisation which the Prison Service considers to be a racist. The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age (subject to being within normal retirement age for grades) sexual orientation, disability or any other irrelevant factor.

INVESTOR IN PEOPLE

HM PRISON SERVICE

NOMS National Offender Management Service

NDPDU

Substance Misuse Jobs Across the UK

Service Care Solutions are a specialist agency for drug and alcohol staff across the UK.

To apply or register:
Email: info@servicecare.org.uk
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Land line: 01772 889722
Web site: www.servicecare.org.uk

We have vacancies across most of the UK. We offer free career advice and a free CV review service. Please call or email your details for more information

Lancashire Care NHS
NHS Trust

LANCASHIRE CARE NHS TRUST

Are interested in developing a range of strategic business partnerships. We wish to establish working arrangements with suitably experienced and resourced organisations with a proven track record in a number of areas:

Substance misuse services and community alcohol services
We are seeking to identify third sector providers who would be willing to work collaboratively with us in identifying innovative ways to provide a range of substance misuse services and/or community alcohol services in a partnership model.

Strategic development and exploitation of estates and facilities
We are planning significant strategic change in our extensive property portfolio including a complete reconfiguration of in-patient facilities. We would be interested in hearing from specialist organisations that can help us exploit the opportunities that will arise over the next decade.

Rehabilitation services and supported accommodation (including forensic)
We aim to develop our services in this area and are keen to talk to potential partners who can bring new approaches to managing accommodation or providing care or a combination of both.

Registered care home or nursing home providers
We are involved in a number of specialist services, such as Huntington's Disease, and would like to discuss innovative ways of providing integrated care pathways in these areas. We are again looking for new approaches to managing accommodation or providing care or a combination of both.

Written expressions of interest are invited from organisations. Please provide a summary of proposals (at this stage maximum three pages A4 for any of the four areas), together with supporting information about your organisation, including copy of latest financial information. The closing date for expressions of interest is 1 November 2007.

All correspondence should be via e-mail to:
partnerships@lancashirecare.nhs.uk
with subject 'Drink and Drugs News tender'

Based with the Staffordshire Drug and Alcohol Team, Stafford

Development Worker(Substance Misuse)

£26,928 - £29,859 pa (Pay Award Pending)

Staffordshire Drug and Alcohol Action Team (DAAT) is seeking to recruit to the full time post of Development Worker (substance Misuse). The unit has undergone a considerable review over the last year and is now looking forward to an exciting future.

You will work within the DAAT Secretariat and hold responsibility for key areas of work across the county of Staffordshire. You will possess excellent interpersonal and project management skills, the ability to communicate and work constructively with a broad range of people and organisations. You will also be able to clearly evidence sound knowledge of Substance Misuse Policy and Practice, have experience of working with the client group and demonstrate a good understanding of employment pathways for vulnerable people.

The DAAT is a multi agency partnership that is currently hosted by the Staffordshire County Council.

We are looking for an individual who can bring partnership working expertise to the team. The role will be demanding and exciting. If you think you have the talent and skills that we are looking for and would like to discuss the role further please contact: Louise Stone: Head of Service on 01785 223176.

To view and download an application pack please visit www.staffordshire.gov.uk/SCH444

To request a postal application pack please telephone (0845) 452 0539 (24 hour answerphone) quoting reference number SCH444.

Closing date: 23rd November 2007.

This Authority/school is committed to safeguarding and promoting the welfare of children and young people/vulnerable adults and expect all staff and volunteers to share this commitment.

This position is subject to a "disclosure" check under the "Rehabilitation of Offenders Act 1974". Further details regarding this check and Staffordshire County Council's employment policy will be found within the application pack.

The County Council is reviewing its pay structure and this post is included in the review. Please be advised therefore that the grade for this post may change.

Working towards equality for all

www.staffordshire.gov.uk

Staffordshire County Council

Pre-Qualifying Questionnaire Notice

Staffordshire Drug and Alcohol Action Team

1. We are inviting suitably qualified organisations to: Submit 2 Pre-Qualifying Questionnaires for a Staffordshire wide Prescribing and Inpatient Detoxification Service valued in the region of £1,750,000 to £2 Million.

   References for the PQQ's are as follows:
   PQQ code rfi 28554 SCDAAT All Services PQQ2.
   PQQ code rfi 28551 SCDAAT Prescribing and Inpatient only additional questions.

   The final date and time for receipt of the above PQQs is: Friday 30th November 2007 at 3.00pm.

   Following short listing successful applicants will be invited to participate in a scoping exercise which will be held during February to March 2008.

   It is envisaged that the contract will be awarded in September 2008 and that the Service will be operational from 1st April 2009.

2. In addition, the Supported Community Detoxification Service PQQ will be re-opened to accept new applications. The Contract will be revised based on constructive feedback from specialist sources. It will be awarded in April 2008 and be operational from July 2008.

   Submissions for a Pre-Qualifying Questionnaire should be made by Friday 9th November 2007 at 3.00pm and submission of the full Tender document by 30th November 2007 at 3.00pm

   The reference for the Supported Community Detoxification Service is:
   PQQ code rfi 28554 SCDAAT All Services PQQ2
   ITT Supported Community Detoxification Service.

   Information will be available and accessible on the website from the 29th October 2007. Please note previous applicants who have already submitted a PQQ for this service need not complete another PQQ but should complete the form of Tender by the due deadline.

The PQQ can be located by accessing the on-line 'BravoSolution' Electronic Sourcing system.
To download browse the Sourcing Portal:
www.wmcoe.bravosolution.com/web/login.shtml
Click the "Click here to register" link to follow the process.

DAAT contact details: Louise Stone, Head of Service, 01785 223176.

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Call today to discuss your consultancy and recruitment needs, or register on-line at
www.SamRecruitment.org.uk

The awarenesscentre

Two part-time posts on our Addiction Recovery Programme

Counselling Manager – 25 hours per week (£25k)
We require a part-time Counselling Manager to manage our programme. They must have thorough knowledge and experience of managing a 12-Step Treatment Programme, working with clients with dual-diagnosis and working with families. They must be accredited with either the BACP and/or UKCP and be a qualified supervisor.

Addictions Counsellor – 2.5 days per week (£27k pro-rata)
We also require a part-time Counsellor to work on our programme. They must have knowledge and at least one year's experience of working in a 12-Step Treatment programme, group work and one to one counselling. A minimum of a diploma qualification required.

For more information or to submit your CV, please contact Toni-Dee Downer at recovery@theawarenesscentre.com and we will send you an application form with the full job description.

Closing date: 16 November 2007
Interview date: 22 November 2007

41 Abbeville Road, Clapham, SW4 9JX
Tel: 0208 673 4545
www.theawarenesscentre.com

Brighton Oasis Project

Aiming to reduce drug-related harm to women and their families

Brighton Oasis Project, South East Winners of the 2006 Home Office Tackling Drugs, Changing Lives Awards are celebrating their tenth year this year and are seeking to appoint a new

Substance Misuse Worker

22.5 hours per week, (female*)
Salary: NJC point 26 £20,895 pro rata per annum

This post will join our Adult Services Team who offer Open Access, Key-Working, Structured Day Care, an Activities Programme and After-Care Support. Applicants must have an understanding of and experience of delivering substance misuse or therapeutic interventions and an ability to plan and review integrated programmes of care for women substance misusers.

Closing date for applications:
4pm on Monday, 5th November 2007

For further information, please call Jo-Anne Welsh, Interim Director on 01273 696970 and for an application pack (please note we cannot accept CV's) please ask Wezi or telephone 01273 696970 (24hr answerphone) or e-mail info@brightonoasisproject.co.uk (state your name, address and post you are applying

**This post is exempt under para 7 (2) of the Sex Discrimination Act*

BOP is committed to equal opportunities and welcomes applications from people with relevant life as well as professional experience, and those with disabilities who are currently under-represented in the organisation.
Charity no: 1065503 Company no: 3447762

www.oasisproject.org.uk