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LIFELINE TO CHANGE
Why the NHS needs your help in fighting liver disease

JUST A PARTY DRUG?
Long-term ketamine users give clues to treatment

IN SOLIDARITY
International remembrance day in Kennington Park

THE END OF THE ROAD?
British gypsy communities strain under growing drug problems

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Brief Interventions

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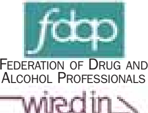

Editorial – Claire Brown

Disingenuous? Moi?

DDN is what it is... a receptacle for other people's ideas

A question about editorial control was put to me this week: should DDN be publishing articles that hadn't been vetted by a panel of experts? What were my criteria for including articles and letters? Was I actually qualified to make a judgement on what went in the magazine without the backing of an academic or charitable body to take forward a set of agreed objectives or further academic progress? Was DDN's claim to be an 'independent publication' (because we are not funded by any organisations) rendering us guilty of 'disingenuous neutrality' because we have to take enough advertising revenue to pay for the free circulation of each issue?

It's fair enough to ask what we're trying to do with DDN, and I've been thinking this over a lot during the week, while working on the issue. My obvious answer is that we're about communication, and from day one we've never tried to replicate or replace in-depth research or evidence-based material. We're the 'quick round-up', the taster to a subject, and hopefully the signpost to sources where our readers can find out more – particularly if the subject matter isn't directly on their 'patch'.

To take this issue... there's insight from Sussex on tackling the growing segregation of a minority community. There's progress from Bristol offered from experience with their service users on how to provide more effective advice on ketamine. There's an article on liver transplants by a clinician who asked me to highlight the desperate need for more involvement from the drug and alcohol field. And there's our experience of sharing International Remembrance Day with drug users, families, supporters and drug workers in Kennington Park last week. I'm not sure which of these pieces would have benefitted from expert review; they are what they are – a reflection of the diverse contributions to DDN, which at the end of the day is a melting pot of readers' experiences. We've a publishing break during August, so I'm off for a lie down. Keep your letters coming... see you on 8 September!

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Drug users 'could lose benefits'

Problem drug users would be required to seek treatment or else risk losing their benefits under proposals set out in the government's new welfare reform green paper. Claimants could also face fraud investigations if they do not declare an addiction to heroin or crack cocaine when applying for benefits.

Up to 100,000 problem drug users on benefits are not in treatment, says *No one written off: reforming welfare to reward responsibility*. 'Taxpayers cannot be expected to support a drug-dependent lifestyle, so where drug treatment is available and considered appropriate, then there should be an obligation that individuals will take it up,' it says. 'At the moment only 400 people on Jobseekers Allowance are recorded as having a drug problem – less than 0.05 per cent of the total.' A 'new approach to identification' would therefore see legislation introduced to enable the sharing of information between job centres, the police, probation services and prisons.

Drug users on benefits would be required to see a specialist employment advisor and draw up a rehabilitation plan with their help. The government is also considering changing the benefit rules to require all applicants to declare if they are addicted to heroin or crack cocaine – including potential 'contracted out drug testing' – with possible sanctions such as recovering overpayments and even fraud investigations for those who mislead.

Claimants could however receive 'treatment allowances' while they stabilise their condition. Drug co-ordinators could be appointed to JobCentre Plus by the end of next year – if successful the approach could be widened out from heroin and crack to include powder cocaine, cannabis and alcohol.

Incapacity benefits and income support are to be abolished under the green paper's radical measures. The new streamlined system would see just two kinds of benefits – the Employment and Support Allowance (ESA) for those who have a medical condition that prevents them from working, and Jobseekers Allowance (JSA) for everyone else. People would be assessed on 'what they can do, not what they can't' says the government, and unless severely disabled it would be 'made clear' to those receiving ESA that it was temporary situation to help them back into work. Conditions for eligibility for JSA would also be tightened up, with those unemployed for more than two years possibly being forced to take part in community work.

'Our proposals are based on a simple deal – more support in return for greater responsibility,' said secretary of state for work and pensions James Purnell. 'We will help people to find work, but they will be expected to take a job.' NTA chief executive, Paul Hayes, urged drug users and their families to register their views while the proposals are out to consultation: 'Service users are always telling us they want to get back into work. This is a real opportunity to remove barriers to work and maximise the routes into employment for those in treatment. Drug treatment services and JobCentre Plus will need to work together to persuade employers to give drug users in treatment a decent chance.'

Turning Point, however, warned against talking tough 'for the sake of it'. 'Let's do what works best, for the economy and for the individuals in question. Although some people will readily admit to substance misuse problems, others are more reluctant – often through embarrassment, fear or sometimes because they do not have a good relationship with their benefits advisor. Giving these people a criminal record for fraud will push them further from work, rather than closer to job readiness. We must acknowledge that for the most complex claimants who are furthest from the labour market, a stepped approach that gets them into work at a sensible, sustainable pace is the only effective way to prevent them becoming revolving door claimants.'

The majority of people in treatment wanted to come off benefits and into treatment, said EATA chief executive Sharon Carson, but they had to feel that support systems were 'safe and trustworthy'.

To download the green paper and register your views visit www.dwp.gov.uk/welfarereform/noonewrittenoff/ Consultation period ends 22 October.

Watch and learn: the parents of under-18s who have been caught drinking are to be sent a DVD by Windsor and Maidenhead DAAT. Smells like teen spirit, made by a local media studies student, shows what happens to a teenage girl during the course of an evening out drinking, and will be accompanied by a letter from Thames Valley Police. The film will also be used in school alcohol awareness sessions. 'The aims of the DVD are to pass on safer drinking messages to young people and to help parents openly discuss the risks of binge drinking with their children,' says the council's lead member for adult services, Simon Dudley. 'The DVD also makes young people aware that they are less able to react to unforeseen circumstances when under the influence of alcohol.' Pictured: film maker Marcus Eldridge with community safety sergeant Matthew Grey. Contact daat@rbwm.gov.uk for a copy of the DVD.

Drug use continues to fall

Drug use in England and Wales is falling, according to two new reports. The British crime survey shows that overall drug use among 16-59 year olds in the last year is at its lowest level since the mid 1990s, mainly as a result of declining cannabis use since 2003/04. The NHS Information Centre's Survey of smoking, drinking and drug use among young people in England, meanwhile, shows that use of any drug in the last year among pupils has fallen by 2 per cent to 17 per cent since 2005.

Class A drug use in the 16-24 age range is down from 8 per cent in 2006/07 to 6.8 per cent, the first reduction this century, although cocaine use has remained largely stable. Cannabis use has fallen from 20.9 per cent to 17.9 per cent in the same period, and from more than 28 per cent in 1997. The proportion of 11-15 year olds using cannabis, meanwhile, has decreased from 13 per cent in 2003 to 9.4 per cent in 2007. Four per cent of pupils had taken Class A drugs in the last year, a figure unchanged since 2001. The figures were 'evidence of the success of the drug strategy,' said Home Office minister Vernon Coaker.

'It is very heartening to see drug use among young people falling,' said Mentor UK chief executive Eric Carlin. 'We know that we can't be complacent about this issue – there remains a minority who are doing great harm to themselves, their families and the communities they live in. Nevertheless, it is worth celebrating the progress that is clearly being made to protect children and young people from the harms that drugs cause.'

Alcohol regulation might be mandatory

The days of voluntary self-regulation by the drinks industry could soon be over, as the government launches a major consultation on retailing codes of practice. Manufacturers will be given until the end of the year to put health warnings and alcohol unit information on bottles and cans – if they fail to do so, a mandatory scheme will be put in place.

The consultation comes as new figures estimate the cost of alcohol misuse to society at between £17.7bn and £25.1bn, taking into account healthcare costs, crime costs and productivity costs. The annual cost to the NHS is estimated at £2.7bn.

If the voluntary retail code were made mandatory it would mean a requirement to provide point of sale information on alcohol units, restriction of happy hours and other promotions deemed irresponsible, staff trained to refuse to sell alcohol to those underage or already drunk and a requirement that small as well as large measures are always offered.

'The drinks industry has a vital role to play if we are to change the country's attitudes to alcohol,' said public health minister Dawn Primarolo. 'Some sections of the industry are sticking to the voluntary codes – others are blatantly ignoring them. This consultation will decide whether legally binding regulations for retailers and manufacturers to promote sensible drinking are the way forward.'

Alcohol Concern said the ideas put forward in the consultation made 'eminent sense'. The drinks industry however has accused the government of over-reacting – legislation would be 'a sledgehammer that will not crack the nut,' said director of communications for the British Beer and Pub Association (BBPA), Mark Hastings. 'The government's approach should be to address the underlying culture and change attitudes, not just legislate and regulate,' he said. 'There also needs to be the right balance between individual and corporate responsibility. This is an industry that already bears the burden of one of the heaviest tax and regulatory regimes in the world.'

A series of independent reviews have also been published which, the government claims, show that voluntary codes are not being adhered to. One, by KPMG, found evidence of poor practice in alcohol promotion and another, on voluntary labelling, showed that more than 40 per cent of products surveyed failed to display unit information. The Portman Group, however, described the labelling review as 'shockingly flawed'.

The government has also published new figures that revise the way alcohol-related hospital admissions are calculated, measuring 44 conditions 'caused by or strongly associated with' alcohol consumption instead of limiting statistics to the three most common – alcoholic liver disease, alcohol poisoning and mental and behavioural disorders. Under the new methodology, there were more than 8,000 admissions in 2006, accounting for 6 per cent of all admissions.

Consultation available at www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086412 Consultation period ends 14 October

Local authorities hamstrung in dealings with venues

Many local authorities do not have the resources to deal with problem premises, according to a new report from Alcohol Concern.

The capped licensing fees brought in by the new Licensing Act have created a funding shortfall of £200m, according to *Unequal partners: a report into the limitations of the alcohol regulatory scheme*.

The agreement for licensees to adhere to voluntary codes of practice is failing to protect the public, says the report, which comes as the government launches a consultation on whether to introduce mandatory codes (see story above). The 'multi-layered web' of laws, codes and guidelines make transparency, accountability and effective regulation impossible, says the report, with licensees ignoring the codes when it suits them as there are 'no meaningful sanctions' for those found to be in breach.

Although test purchasing schemes have repeatedly found a 'hard core' of up to 15 per cent of premises repeatedly selling alcohol to those under aged, only 0.5 per cent have been called up for review under the Act, says Alcohol Concern, and more than 40 per cent of pubs have no disciplinary procedure in place for staff found to be breaking under age sales laws.

'The drinks industry's claim to champion responsible retailing is badly let down by the significant number of premises who persistently sell alcohol at cut prices, refuse to train their staff and allow under age people to buy alcohol,' said Alcohol Concern's chief executive Don Shenker. 'Self-regulation has clearly failed and we desperately need mandatory codes and an industry watchdog to stamp out the poor practice and the complacency that is characteristic of many of these venues. Only these measures can safeguard the public and cut down the alcohol-related violence that makes life a misery for so many.'

Full report available at ww.alcoholconcern.org.uk/servlets/doc/1361

Open house: Providence Row, the charity that provides support to rough sleepers, welcomed visitors to its day centre in London's Tower Hamlets for a summer barbeque. Chief executive Jo Ansell and Cllr Mohammed Abdus Salique, the Mayor of Tower Hamlets, were among those celebrating the centre's work in transforming lives by offering advice, support and practical help. Visitors were interested in the substance misuse table, where workers and volunteers used a props table to display different kinds of drugs and explain the effect of drugs and alcohol. Service users contributed an exhibition of artwork, while staff from Merrill Lynch donated support – including staff to flip the burgers throughout the afternoon.

News in Brief

Family fortunes

Adfam chief executive Vivienne Evans has been awarded an OBE for her services to the families and carers of people with substance misuse problems – Adfam is the leading national organisation providing support to families affected by someone's drug or alcohol use. Vivienne Evans has nearly 40 years of experience in the drugs, alcohol and family support sectors and has been chief executive of Adfam since 2002. 'As well as being very flattered by the OBE, I hope the recognition it brings can help Adfam in its campaigning work and in turn help the forgotten families that we aim to support,' she said.

Keep it safe

A best practice guide to help ensure the health and safety of people in clubs – particularly those who take drugs – has been launched by the London Drug Policy Forum with the Home Office. Aimed at venue managers, club promoters, police and fire officers, health promotion staff and licensing authorities, *Safer nightlife* covers issues like harm reduction, drug dealing and sexual health. Available to download at www.cityoflondon.gov.uk/Corporation/our_services/social_services/London_Drug_Policy_Forum/

Consensus..?

The UK Drug Policy Commission (UKDPC) recovery consensus group's Vision of recovery document is now available to download at www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf

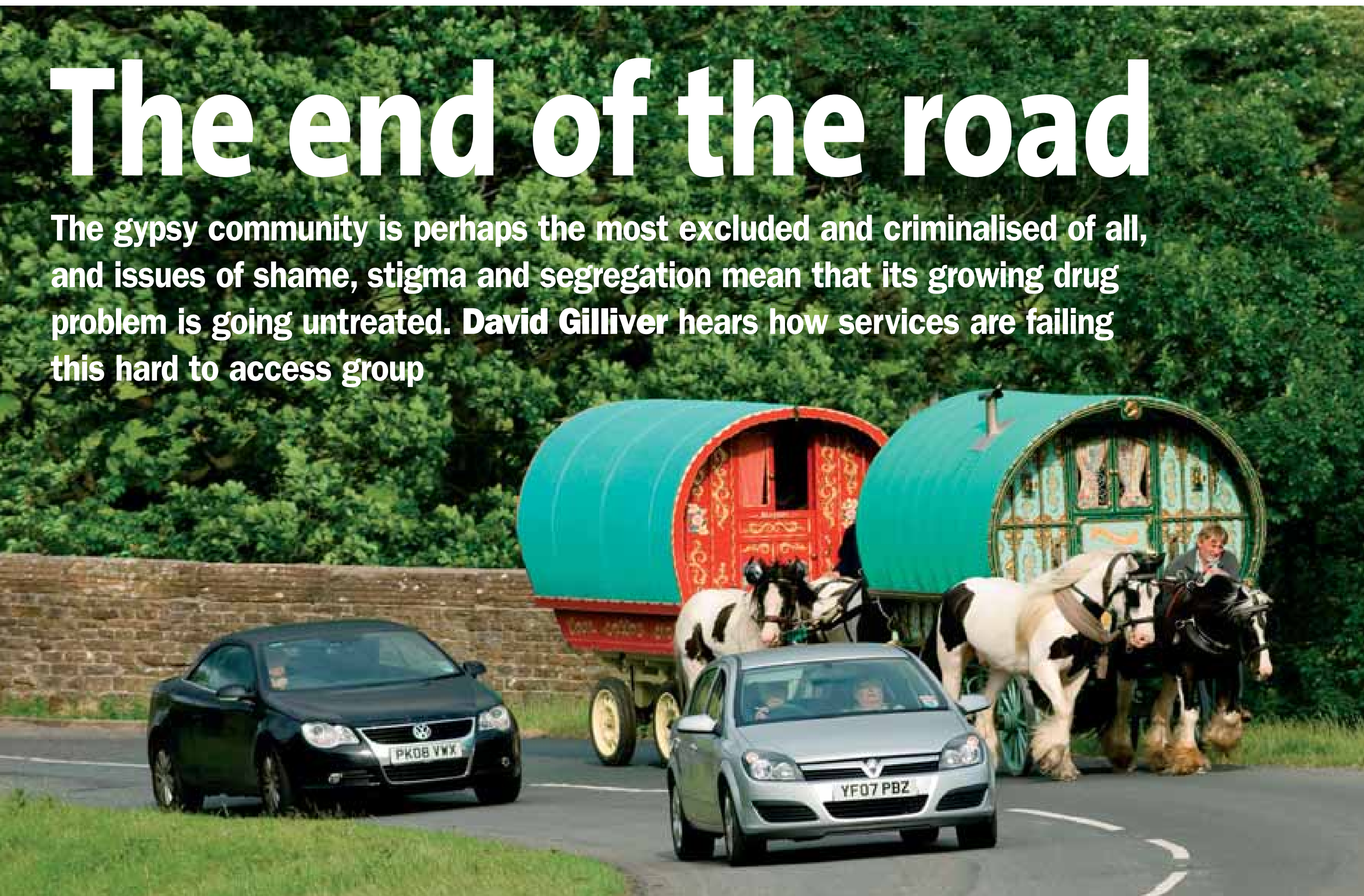
'We hope that this project prompts debate and further consideration of the practical implications of a recovery focus: what being recovery orientated means for users, services, commissioners, the NTA, funding, workforce development, monitoring and evaluation,' says the UKDPC.

It's the beer talking

SABMiller plc, brewers of Grolsch, Miller and Peroni Nastro Azzuro among others, has launched TalkingAlcohol.com, covering issues like how beer is brewed and its effects on the body, as well as information on the alcohol content and ingredients of more than 100 beers. The English language website will soon be available in other languages including Italian, Spanish, Polish and Russian.

The end of the road

The gypsy community is perhaps the most excluded and criminalised of all, and issues of shame, stigma and segregation mean that its growing drug problem is going untreated. David Gilliver hears how services are failing this hard to access group



Of all the minority ethnic groups in the UK, perhaps the most excluded, criminalised and demonised is the gypsies. And this exclusion and criminalisation has brought with it a serious and growing substance misuse problem.

Historically, the highly nomadic, self-sufficient and self-contained lifestyle of the gypsy population meant that it rarely came into contact with drugs. The vast majority of gypsies, however, now have settled bases from which they travel – if they travel at all – as legislation has made the travelling lifestyle increasingly difficult to pursue. And, as the community has become more settled, so the problems of substance misuse have taken hold.

In common with many other minority ethnic populations, a powerful sense of shame and stigma in the community has made it extremely hard for gypsy people to access drug treatment services – if they are even aware of their existence in the first place – and there remains widespread ignorance in the community and among parents about drug misuse, both how to recognise it and how to address it.

One problem, says gypsy journalist and film maker Jake Bowers, is that bitter experience has led the community to view all manifestations of authority with suspicion. 'What you have to bear in mind is that gypsy people have survived in this country for 500 years despite the best efforts of the British state,' he says. 'It's effectively been 500 years of laws attempting to wipe us out. What that's created in the culture is secrecy and segregation. Our culture in this country is outlawed – we're not talking about history, we're talking about the present day – so the attitude towards authority in general is one of great suspicion. One of the results of that is that when you get diseases in the community – which I guess is what drug addiction really is – people don't really want to talk about it or access the services that can help deal with it. It's all part and parcel of the bigger picture.'

He has made a film, *Ladged no longer*, to raise awareness of drug misuse both within the gypsy community itself and among service providers – 'ladged' in Romany means ashamed. The film, recently shown to delegates at the 12th annual Sussex drug and alcohol conference, explores issues of substance misuse in the community through first person accounts – both negative histories of crack and heroin problems and positive stories of those who have overcome addiction to go on and help others.

'Authority is viewed with suspicion because it's very rarely brought any form of provision of any service whatsoever to our community, but at the same time there's a huge need for health services,' he says. 'Our health is the worst of any ethnic minority in the country. Our drug problem is big and has been for years, and it's getting bigger. There's a dire need for education and support services – a massive unmet need.'

So what kind of scale has the community's drug problem reached? 'It's huge,' he says. 'I would say that the biggest problem drug is alcohol, but there are serious problems with everything from nicotine – travellers are three times more likely to smoke than people in the wider population – through alcohol and the whole range of illegal drugs. Cocaine and heroin are major problems.'

Issues of shame and stigma mean that confidentiality is absolutely paramount for any service provider dealing with this community, but more important even than that is letting the communities know you're out there to begin with, and that you're not a part of any kind of repressive state apparatus.

'Awareness in the community about the fact that these services even exist is very, very low, and a lot of people in the gypsy community think that any contact with people in authority is going to lead to some kind of enforcement,' he says. 'Confidentiality is very important but so is the very basic thing of telling people that, if they decide to access services, it's not going to lead to any kind of legal proceedings against them.'

Some delegates at the Sussex conference said that they did provide services for the gypsy community – except they had no clients. So it's essential

Wayne HUTCHINSON / Alamy

'Our health is the worst of any ethnic minority in the country. Our drug problem is big and has been for years, and it's getting bigger. There's a dire need for education and support services – a massive unmet need.'

that services are proactive, Jake Bowers stresses. 'Diversity and equality guidelines mean that in a lot of cases people provide the services in principle, but in practice they deliver nothing. Diversity and equality really means understanding who your audience or client base is and tailoring your services – going out and finding them and delivering services actively.'

But given the high levels of suspicion in the community, what can providers realistically do? 'Just turning up on a gypsy site with loads of information about drug and alcohol services isn't necessarily going to be that effective,' he says. 'It's not a bad thing to do – you would be well-received and treated with respect – but there are people who have very good relationships with the gypsy community and one of the best ways of reaching the community is to go through them. There are specialised health visitors who are very, very good at this, as are the traveller education services provided by local authorities, and in some parts of the country there are some very good gypsy support groups. It's about making people aware of what's available through those services.'

Another key issue, he points out, is that many children from the gypsy community still leave full time education comparatively early, and so there can be issues around literacy to contend with as well. This means service providers should think about using more culturally appropriate means to get their message across.

'The best ways are through audio or visual means, which is why we produced the DVD,' he says. 'I made that film four years ago, but nothing has been done on any large scale to engage the gypsy community since we distributed it – there's still a lot more work to be done.'

It's not just substance misuse itself that's a problem, however. As the community has become increasingly marginalised and cut off from its traditional ways of life and livelihood, many have drifted into drug dealing as a way of making a living. 'It's been a double whammy,' he says. 'People have been forced to settle so they've had more contact and closer contact with the settled community, and in some cases that's meant more negative contact. With that have come social ills like drug addiction, but the other thing is that as the community has become increasingly criminalised so it's inevitably had more contact with criminal elements in society, which means that it's got more involved in dealing.'

Some local authority trading standards departments, for example, have now banned cold calling, with 'no cold calling zones' established in different parts of the country. 'Knocking on doors to sell a service has always been a perfectly legitimate form of trade, but since it's been banned a lot of young gypsy men can't earn a living in the way their ancestors did,' he says. 'If you criminalise a whole culture, then elements within that culture will inevitably end up becoming criminals. For some young gypsy and Irish traveller men that means turning to dealing and everything that comes with that.'

As with other communities, one way of reaching out and encouraging people to engage with services is to recruit members of that community into the services themselves. But the same marginalisation and suspicion of authority that is exacerbating the substance misuse problem in the gypsy population means that very few if any become drugs workers or counsellors.

'It's happening on an informal basis within the community,' he says, 'but it's extremely rare outside of that. There haven't been any extensive studies done, but one thing that we do know is that gypsy and traveller people are massively over-represented in prison. In some young offenders institutes they constitute anything up to 10 per cent of the prison population, and we are half of one per cent of the national population. That means we're up to 20 times over-represented in the prison population, and the evidence coming through from the prison service is that a lot of that is drug related. So you can see the scale of the problem.'

Drug and alcohol services who would like either a copy of the DVD or more information on the issues raised in this article can contact Jake Bowers at jake.bowers@btinternet.com or 07966 786242.

Lifeline to **change**

With the demand for liver transplants at an all-time high, the NHS desperately needs proactive involvement of substance misuse professionals to help turn around the waiting lists.

Ian Webzell gives a clinician's perspective

Liver transplantation is a successful treatment for end-stage cirrhosis, with a 75 per cent five-year survival rate. Over the past five years, the number of liver transplants in England and numbers of people waiting for a transplant have consistently risen.

In 2007/8, 619 liver transplants were performed in the UK, with 256 people on the waiting list for liver transplantation on 31 March this year. However, there is limited availability of organs for donation – a situation that has remained constant for the past ten years.

The key risk factors for liver disease are excessive drinking, infection with hepatitis B or C, and obesity. More than 40 per cent of all adult liver transplants throughout the UK, Europe and the US are conducted for end stage liver cirrhosis for either hepatitis C virus or alcohol related liver disease, the first and second most common indication for liver transplantation.

In common with many other parts of the NHS, the chronic consequences of alcohol and drug consumption are increasing the demands placed upon liver transplantation services. There has been a marked increase in liver disease and reports of rising morbidity and mortality, particularly in younger age groups – trends that have become apparent over time and look set to continue into the future.

In recognition of these trends, King's College Hospital is one of four of the seven liver transplant teams in the UK with a dedicated substance misuse professional, who is employed to assist in the psychosocial and substance use evaluations of liver transplant assessment patients. Their role is to engage, support and monitor patients who have a history of substance misuse, before and after their liver transplant. Units elsewhere rely on interested hospital liaison psychiatrists for their assessments.

An increasing number of assessments are provided for patients with hepatitis C secondary to intravenous drug use. Given the common relationship between drug and alcohol use, there is a growing need to consider poly-substance use and dependence in relation to their potential harm to the liver and also indirect consequences of substance use such as poor programme compliance or initiation/resumption of harmful alcohol use.

The process of liver transplantation is a demanding affair. The patient needs to commit to abstinence from harmful substances, as well as medical treatment, for the rest of their lives. Before the candidate can even be placed on the waiting list, transplant professionals need to holistically evaluate every aspect of them and their family, to ensure as far as possible that liver transplantation is appropriate for them. They will then need to go through the necessary process of obtaining living tissue from the donor, with the family's approval. Approximately 20 per cent of listed individuals will die before they can have their transplantation.

The financial cost to the NHS for the procedure is individual to each patient, but estimates vary between £40,000 and £60,000 with additional costs incurred from intensive care support, in-patient care and lifelong medical and immunosuppressive support. Yet for the fortunate people that successfully go through the process, it provides an extraordinary revival of life.

Typically, post-transplant individuals experience a much improved quality and longevity of life and are bursting with desire and a lust for life that has to be seen to be believed. Having been confined by their illness for so long, liver transplantation can provide the life individuals have missed for so long; a return to family, work, leisure, enjoyment and good times.

Sometimes, however, while in recovery from the 'sick patient' identity, people can return to past behaviours and this sometimes involves a return to alcohol and drug use. Working with 'the chronic relapsing condition', it is appreciated that relapse is a reality and feared by transplant professionals for risk of harm to the liver graft and a perception of failure of the intervention. Fortunately this is a comparatively infrequent outcome, with around six

per 100 patients per year returning to any alcohol use and even less returning to harmful alcohol or drug use.

Despite comparatively positive outcomes, those who do relapse remain of considerable concern. It is a problem that needs to be addressed by substance misuse professionals, to ensure that all transplanted organs are given the optimal chance of success. How and why the outcomes are comparatively so successful is unclear but there are many factors involved, with individuals' past physical illness driving their continued substance use behaviour change.

There is understandably a great emphasis from society and transplant professionals to work with an abstinence ideology for patients with a history of substance misuse, to avoid recurrence of harm to the liver graft. But how can this be achieved? People do return to substance use and occasionally return to harmful substance use following transplantation. How can substance use and transplant professionals intervene?

The urgency and professional motivation to intervene is dominated by a need to 'save' the liver graft. Like substance misuse professionals across the field, we can only remotely influence continued behaviour change, relying on a limited range of psycho-therapeutic tools and support from local specialist teams. We have no international evidence of how effective this is in liver transplantation. Given the substantial investment in transplanted individuals, surely research into effective interventions in this population is overdue?

People who do relapse following transplant typically appreciate the significance of their relapse, as they have already experienced the most severe consequences their substance use can cause. Like service users across the country, access to specialist services is limited by geography, service provision and speciality. Finding an empathic specialist who can act urgently is practically impossible. It would be useful for this small population to gain some recognition with the National Treatment Agency, to emphasise their specialist need.

Seemingly, shock statistics in the press about the burden of alcohol and drugs upon the NHS, in A&E, general medicine and in chronic liver disease do little to assist managing the problem on a practical level, given the continuous rise in hospital admissions for alcohol and drug related harms. Substance misuse treatment headlines focus upon young people, dual diagnosis, homeless, offenders – all justifiably so, but there are also a small population of individuals who have in some respects 'cost' more to society and yet receive little or no national attention, from the press, from the National Treatment Agency or from researchers. This important population would have so much to gain from effective interventions and sustained substance use behaviour change.

Ian Webzell is alcohol and substance misuse clinical nurse specialist at the Institute of Liver Studies, Kings College Hospital

Better planning, more communication… participants at Conference Consortium's conference in Warwick wanted a more structured approach to filtering harm reduction through the criminal justice system, as **DDN** reports

Diverting from crime

'Harm reduction is not just added on bits and pieces, it's a way of thinking and should be at the very heart of drug policy,' said Professor Gerry Stimson at last week's 'Drugs, Alcohol and Criminal Justice' conference in Warwick.

It should also pervade the criminal justice system more effectively, according to speakers. Lack of communication was reported by delegates working in prisons and probation – particularly with their colleagues in aftercare services, an essential part of breaking the chain of dependence on crime.

With half of the 80,000 prison population identified with substance misuse problems, we should be using their incarceration as 'a chance to think, a moment of introspection – and a place to give them the tools to minimise health risks,' said Dr Eamonn O'Moore of Offender Health. Their health gains in prison should be an opportunity to take harm reduction back home with them: 'These people haven't been beamed down from Mars, they've come from communities,' he pointed out.

Some specific harm reduction measures were still controversial, and delegates asked speakers whether they supported needle exchanges in prison. Dr O'Moore said Offender Health would not back the initiative until there was more evidence that it would not introduce a greater problem. Injecting decreased in prison, he said, and the environment offered an opportunity to take up programmes to tackle drug dependency. Prof Stimson warned that 'people who inject when they go to prison continue to inject, but in riskier circumstances,' and said needle exchanges were needed to limit the spread of blood borne viruses.

John Podmore added a note of scepticism from his experience as governor or Brixton Prison: 'Drug free wings are like sugar free doughnuts – they don't exist.' Sebastian Saville of Release said there had to be a will within every prison to prioritise harm reduction before progress could be meaningful.

Andy Stonard, chief executive of Rugby House, was determined that alcohol harm reduction should form a major strand of the conference. Not only were alcohol problems 'so obvious and so enormous – yet nothing happens', but the link between alcohol and offending made ignoring alcohol-related harm reduction nonsensical, he said. Most police, when polled, agreed that alcohol misuse was the most significant factor in public disorder problems; forty per cent of violent offences were committed under the influence of alcohol; half of physical assaults by men to their partners were committed under the influence of alcohol – and it was a common trigger for drug use, burglary and shoplifting.

Mr Stonard called for widespread introduction of harm reduction measures beyond the 'seriously flawed' tool of counting alcohol consumption by units. There were models of good practice, such as teaching self-risk assessments and triggers, anger management, understanding drinking in relation to drug use, and encouraging keeping a drink diary to understand patterns of behaviour. Better liaison between services (including wet houses), criminal justice and health services – from GPs to A&E – could help many of those who were becoming caught up in a pattern of offending.

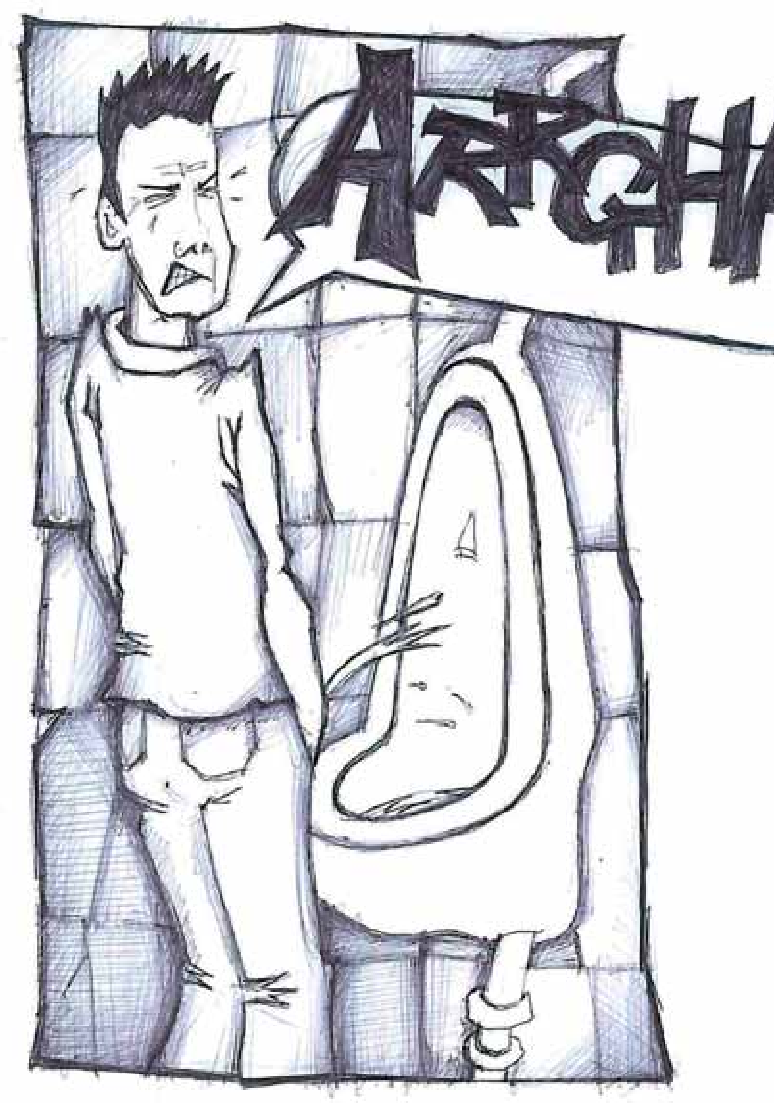
The NTA's chief executive Paul Hayes highlighted how far harm reduction had come since its first emergence in the 1980s, when it had tackled the 'under-resourced and dramatically unsuccessful' services of the '70s. The significant increase in resources in the 2000s had meant harm reduction could be embedded in practice and policy, he said.

Disagreeing with the conference reader's mention of a 'damaging and crime obsessed agenda', he credited a crime-led agenda for £800m a year spent on drug treatment – compared to £200m on alcohol treatment, which had to take its place in the NHS pecking order.

Using harm reduction as an excuse for not helping people to get into abstinence would be a false choice, he added. 'People are different, timing is crucial. The last thing they need is pushing them out of treatment before they're ready. It's about choice and personalisation – having a system that maps into the individual.'

The challenge now, said Mr Hayes, was integrating harm reduction more fully and effectively, encouraging more consistent delivery of services.

'It's better to engage the willing than to dragoon the unwilling,' he said, when questioned about how GPs could be engaged in harm reduction. And the big question of bureaucracy that follows him wherever he goes? It was equally relevant to effective harm reduction, he said: 'Everyone hates bureaucracy, but everyone wants to know what's happening… it gives impetus to the care planning process.'



Ketamine:
just a harmless party drug?

When Kat Deans, Rachel Ayres and Pete Weinstock began to see more long-term ketamine users at Bristol Drug Project, they joined forces with local urologist Angela Cottrell to devise more targeted advice

At the beginning of this year, Sue visited the daily drop-in at the Bristol Drugs Project (BDP) asking to see a drugs worker to talk about her ketamine use. She was experiencing unwanted physical and emotional side effects from using up to 7gm of ketamine a day, but finding it extremely difficult to cut down. Sue was also seeing her GP on a regular basis for treatment for chronic cystitis, but as the prescribed antibiotics weren't alleviating her symptoms, Sue's GP referred her to a urologist. At this point neither Sue nor her GP were aware that there could be a link between her urinary tract problems and her ketamine use.

Sue was not the only service user being seen by BDP for help with problematic ketamine use, and we realised that two other ketamine users were being treated by urologists in the area. We liaised with Dr Angela Cottrell from Bristol Urological Institute at Southmead Hospital, who told us that the local urology department was seeing an increased number of patients with similar symptoms who had a history of heavy ketamine use. She informed us that that there had been reports of urinary tract problems associated with chronic ketamine use in Hong Kong and Canada, but no published reports in the UK.

Back in January there were seven young people being investigated by local urologists for possible bladder damage associated with ketamine use; by June this number had more that doubled. It was clear that we as drug service providers, as well as our colleagues in urology, needed more information on the scale of the problem.

We began by running two well-attended workshops for users, and another for professionals – which to our surprise, attracted 45 people. In April of this year the first UK case of urinary-tract pathology associated with ketamine was published in the *British Medical Journal*. We responded with a letter highlighting the increasing number of cases in the South West. As we began to ask service users at BDP about urinary problems, it became apparent that many ketamine users had experienced similar symptoms – in fact this was common experience among heavy users. Chronic ketamine users told us of a list of typical symptoms varying with severity, such as pain and burning on passing urine, blood in the urine, necessity to pass urine frequently and suddenly, and leakage of urine. These effects seemed to be directly related to the damage done to the bladder lining, which bled as it became inflamed. More worryingly, the scarring found in the bladder might also appear in the ureters (tubes from kidneys to bladder) and ultimately lead to kidney damage.

Some patients were unable to cope with the severe and frequent pain and had had a catheter inserted; one patient in the South West had their bladder removed as their symptoms were so bad. With patients tending to be very young (in their 20s), these were not decisions to be taken lightly. The prognosis of patients who have bladder damage following ketamine use is unknown. Some patients' symptoms worsen as they continue to take ketamine; others improve if they stop, but others continue to get worse despite stopping ketamine. There are reports of similar cases following long-term prescribed use of 'pure' ketamine for pain control.

Since the beginning of the year, our understanding of the short and long-term problems related to ketamine has increased greatly and we have been able to get a better picture of the problem. We are aware that ketamine (classified 'C' in January 2006) is widely used in Bristol and surrounding areas, particularly among young people. It is cheap to buy, at between £6 and £10 a gram. The general perception, both locally and nationally, seems to be that users do not experience major physical problems if they are taking small amounts. Recreational users with low tolerance will experience a mild 'trippy' euphoric feeling from a dose (a 'bump') of 10-30mg.

As the dose increases, the dissociative effect that most users seek, becomes more marked. This state can be reached with around 50-100mg, the size of a small line. At higher doses (anything over 100mg) users talk about entering the K hole, when the body starts to pass from a dissociative state to anaesthesia. As to be expected from an anaesthetic drug, this means that the user may become unconscious or paralysed for a while. In these situations ketamine users are extremely vulnerable, and unable to look after themselves and their belongings. Ketamine is associated with socially and sexually risky behaviours and can be a serious compromise to personal safety.

The majority of our local ketamine users snort the drug or take it orally. However,

'Despite severe health problems, many people find it difficult to stop using ketamine, and tolerance of the drug and dependence on it can follow surprisingly rapidly.'

many of the older injecting drug users using the needle exchange at BDP inject ketamine as part of their poly-drug repertoire, as it seems to temporarily reduce their tolerance and therefore increase the effectiveness of opiates.

Like Sue, many of the ketamine users that we have seen this year have also suffered from 'K-cramps' – prolonged and severe abdominal pain – and may need to be admitted to an A&E department. Our workshops revealed a wealth of acquired wisdom about the origin of K-cramps, including swallowing rather than snorting, and ketamine being cut with other substances. Several online user-forum sites advise using pharmaceutical grade liquid ketamine only, to avoid this.

Despite severe health problems, many people find it difficult to stop using ketamine, and tolerance to the drug and dependence on it can follow surprisingly rapidly. As users move from recreational use of less than 1mg once or twice a week, to several grams per day, they seem to stop experiencing the originally desired effects and find themselves using to feel well, and even to control the pain from their unwanted symptoms. The shift from recreational to problematic use is poorly understood. We don't know how long it takes for tolerance to build up, or which groups of users are at risk of this happening.

Habitual daily use may leave users feeling paranoid and with a diminished capacity to cope with everyday life situations and emotions. Several workshop participants reported feeling anxious, having poor concentration and longer-term memory loss.

In our still-limited experience, anxiety and depression seem to be a feature of ketamine withdrawal. Ketamine is known to stimulate the production of dopamine in the reward parts of the brain, as well as producing adrenalin and endorphins. Perhaps low mood following a reduction, or cessation of use, is not surprising and may be treated symptomatically, as for stimulant detoxes.

At BDP we continue to support Sue through our community detox programme. However, we now know of two ketamine users that have recently completed ten-day inpatient detoxes in Bristol, and these were managed symptomatically, as for a benzodiazepine detox. Our next priority at BDP is to further develop and promote our harm reduction and detox support guidelines. We need to be imaginative in how we get messages out to people who do not traditionally come to drugs agencies and we need to adapt them to different target groups. Some questions still remain: What are the risks of using ketamine during pregnancy? What is ketamine cut with? Do manufacturers have a record of patients experiencing similar problems where ketamine has been prescribed therapeutically?

It seems that as ketamine use increases recreationally, so more users will move into problematic use and present to us, as well as to medical services. Locally there is an increasing demand for information; since writing the first draft of this article we have run another well-attended workshop for professionals in Bath, have one planned for local youth workers next week and two more user workshops planned before mid-August, for which we have a waiting list. We are keen to continue to gather information and get clear messages out to ketamine users, other services and to our local GPs.

Kat Deans is harm reduction worker, Rachel Ayres is volunteer manager, and Pete Weinstock is senior practitioner for community detox and shared care plus at Bristol Drugs Project. 'Sue' is a fictional name, representing actual service users at BDP. For more information or feedback, contact Bristol Drugs Project on 0117 987 6000, or email Kat.Deans@bdp.org.uk or Rachel.Ayres@bdp.org.uk

Angela Cottrell is clinical research fellow at Bristol Urological Institute, Southmead Hospital, Bristol. If you have any experience working with people with bladder symptoms associated with chronic ketamine use, please email her at angecottrell@hotmail.com

Full references for this article are available by emailing claire@cjwellings.com

Cartoon by Chris Keegan, volunteer at Bristol Drug Project.

Reducing risk

BDP offers some basic harm reduction advice to ketamine users

Guard against vulnerability and forgetfulness by making sure you're with people you can trust. Mixing ketamine with other drugs or alcohol will make problems worse.

Avoid severe and long lasting abdominal pain (referred to as K cramps) by not swallowing the drug – there is a strong belief that ketamine in the stomach makes cramps worse. Seek medical advice and mention your ketamine use to the doctor. If you sit in the bath to soothe the pain there is a risk of unconsciousness and drowning.

If you have a panic or anxiety attack stay with your friends. Make sure someone is looking after you. Relax through slow, controlled breathing.

If you experience urination problems be aware that the symptoms will not respond to cystitis treatments. Drink plenty of water. Seek medical help, tell your GP that you use ketamine and ask for a referral to an urologist to reduce the risk of permanent harm.

If you find yourself needing to use higher and higher doses and are using more frequently than intended, monitor yourself. Give yourself breaks from using if you can.

If you feel depressed and anxious when stopping or reducing ketamine use, get some professional help to manage your symptoms during a gradual reduction. Try to distract yourself with purposeful and enjoyable activities.

Injecting ketamine brings the additional risks of damaging your veins, skin infections and contracting blood borne viruses such as Hepatitis or HIV. Get safer injecting advice from your nearest needle exchange.

How do you support a ketamine detox?

Encourage a slow reduction so the body can adjust to lower dose levels and new, positive routines can be built into their day, advises Pete Weinstock, who drew up guidelines in consultation with BDP's local prescribing service, in-patient detox unit and service users. Each symptom should be treated separately, but chlordiazepoxide (Librium) can alleviate anxiety. Short-term promethazine (Phenergan) and complementary therapies can also be useful.

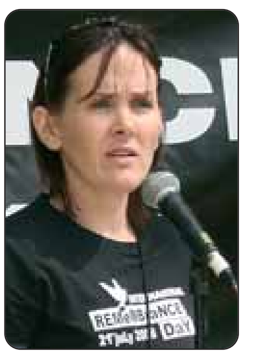
The person is likely to have difficulty sleeping initially or may need a considerable amount of sleep during the first few days of detox, and they will feel lethargic. Their mood may be low and they will feel demotivated, as serotonin and dopamine levels will be depleted by their drug use. Plan routine and structure, using meaningful and enjoyable activities to stimulate and reinforce positive progress.

Encourage users to eat and drink regularly and healthily, and to avoid isolation. Engaging in a social support network can help to continue reduction and abstinence.

In solidarity

International Remembrance Day was commemorated on 21 July 2008 in Kennington Park, London. Organised by Black Poppy magazine, Lambeth Service User Council, and GLADA Women's Voices, it was 'a day to remember those who have died as a result of drug use and/or misguided drug policies… an opportunity to come together and stand in solidarity, without judgement and in unity with thousands of others across the globe'.

The event welcomed drug users, their families, friends, workers and supporters from the drugs field to participate in an occasion of solidarity and remembrance. Throughout the afternoon tributes were read out to friends and relatives that had died; at the closing ceremony 21 white doves were released as 'bearers of peace, a symbol for letting go, and to bring honour and dignity in a fitting tribute to those we have lost'.



Erin O'Mara, founder and editor of *Black Poppy*

'This day is dedicated to casualties, known and unknown, in the war against drugs… people who have been stigmatised because of their addiction. It's for those who gave up hope and their struggle; and who died in poverty and alone.

'At *Black Poppy* we have become alive to hypocrisy, alive to neglect and injustice. There is constant invalidation of drug users. They are trivialised and forgotten.

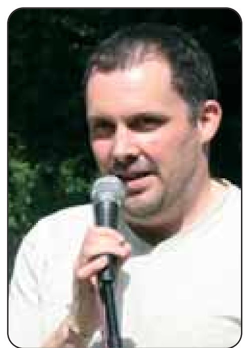
'This event is for all those compatriots who have fought for justice but who didn't live to see that day.'

Claire Robbins, clinical lead at Soho Rapid Access

'We've seen massive changes, particularly in injecting materials, over the last 15 years but it's too late for many.

'We seem to be in an era of openness. We haven't had a death associated with our clinic for several years – and that has to be a good sign.

'It's difficult for services when a user dies. There's guilt. Sometimes drug policies are at fault. If we could be more open about mourning, we would be better at supporting each other.'



Rick Lines, International Harm Reduction Association
'People think of drug users as junkies, whores and criminals. It keeps people underground and away from services.

'Drugs kill, but the bigger picture is that drug policy kills.'

Rev Ken Leech, Founder of Centrepoint, the charity for homeless young people
'The war on drugs does more harm than the drugs themselves.

'I've been involved with the war on drugs since 1958 when I was 18 and worked in the red light district in Cable Street.

'I hadn't come across IV drug use, just amphetamine use as this point. Two members of the congregation were injecting, so I found them doctors. Through working with these lads and their parents I got to know them. Several of us were warning then that if drug policy continued going the way it was, we would have many more drug addicts.

'I don't know when I look at Centrepoint whether to feel proud of depressed – proud that it's still going, or depressed it's still needed.

'You cannot address people in difficulties without addressing the root of the problem. It's important to treat drug users as equals, and not to patronise them.

Lindsey Moon, who lost her brother last year.
'Others may have seen him as a drug addict. But to me he was my brother, my beautiful brother.'

Notes from the Alliance

The pursuit of contentment

Daren Garratt was among those paying tribute at the International Remembrance Day

The pursuit of contentment, the pursuit of euphoria, of numbness, of oblivion, of elation, of detachment, of feeling good, of feeling nothing, of escape, intensity, relief, belief, awareness, confidence, stability, of great times, of doing whatever you need to do to get by, of being yourself, of simply BEING...

These are all a fundamental part of the human experience and our shared, brief, faltering attempt at existence. And regardless of how we choose to attain them – be it through our interactions with other people, with ourselves, with our environment, with our work, with our food, with politics, with religion, with fashion, with consumerism, with sport, with sex, with art, with literature, with films, with music, with drink or with drugs – they're all valid and they should not be denied anyone.

Yet here we are at this essential, overdue, poignant event – because people we have known and loved have been lost to us largely because of the hypocritical relationship our society has with – what I personally would argue – two of those integral components of the human condition; namely drink and drugs.

Why do our precious ones suddenly stop feeling valued when drink and drugs enter the fray?

Why does primary care, social care, community care suddenly stop caring when drink and drugs enter the fray?

Why does criminal justice suddenly become unjust when drink and drugs enter the fray?

Why does the welfare system stop being fair when drink and drugs enter the fray?

Why does public and patient involvement stop involving the public or patients when drink and drugs enter the fray?

Why do communities stop communicating, societies stop being sociable and charities stop being charitable when drink and drugs enter the fray?

Why do the dear and irreplaceable ones suddenly become cheap and disposable when drink and drugs enter the fray?

Why? I don't know why, I can never pretend to know why, and I hope I REALLY never get to find out why, but these are the questions we need to keep asking because although, as individuals, we may never fully understand or come to terms with the frustration, pain and anger we continue to live with following the loss and disregard of our loved ones, unless we collectively work to highlight that it's often the attitude that our society has to the users of mood enhancing or altering substances that proves more problematic than the actual substances or users themselves, then we'll have done our future generations an unforgivable disservice. And that's why I welcome a day like today.

The war on drugs is bullshit; drugs won that war long before it was even declared, yet we continue to lose lives because of it – innocent lives. And that includes the kamikaze pilots, by the way.

I've been honoured to stand here and address you all today. I feel humbled and I feel proud, yet if truth be known I also feel uncomfortable. I can't speak for the drug-using community. No one can.

Remembrance is a personal thing, and I sincerely hope that everyone gets something they need from today. But the personal is political. Please don't forget that.

This is for my good mate Charlie and my own unspeakably wonderful Mom, who're not with us, and my dear beloved Spenna who to greater or lesser degrees, still is....

Daren Garratt is executive director of the Alliance.

'Far be it from me to tell you how to edit your magazine, but if some of the claims made in your letters page were placed in the advertising section (where they seem to belong) I could complain to the Advertising Standards Authority. As it is I can only write you a letter expressing my opinion.'

We are family

I was interested to read David Gilliver's article referring to family members and carers affected by someone else's substance misuse and saying that they are 'woefully neglected' (*DDN*, 30 June, page 6). Hooray, we get a mention at last.

Families can, and certainly do, play a huge role in someone's recovery – although in some cases they can hinder it. I think a lot of drug treatment services still feel that families do hinder their relative's recovery or are the cause of their drug use.

Ten years ago my own daughter, Lauren, who had become addicted to heroin at 16 years old, sadly died as a result. I was only aware of her addiction for six months before she died and I can honestly say that I knew nothing of drug addiction and what it all entailed. I'm from Derby and at that time there was no support or anywhere to go for information for myself and the rest of the family. I had to take Lauren's word for everything – and of course she could tell me anything and I believed her. As a family (she has two younger brothers) we lived through the lying and stealing, and I funded her habit while she was on a waiting list to go into detox.

After she died I felt so cheated and found that I couldn't just sit back and do nothing – I was pretty sure that there would be other people out there going through the same as me. After doing a piece for the press, I found that there were many families experiencing the same as me and some had been living with it for years and years.

After a couple of years speaking out to services and professionals (DATs etc) I founded Lauren's Link. We are now a full-time service supporting those families and carers affected by someone else's substance misuse. We will support any family through whatever decision they feel comfortable with, *ie* asking the drug user to leave home or supporting them in their home.

I would definitely advise against paying for rehab, giving a drug user money, or buying drugs for them as some sort of control. What drug users must realise is that when they are on their road to 'recovery', by whichever means, then their families and loved ones will be much slower in catching them up and it will take a long, long time for the trust element to be as it was – so please everyone, be patient and hang on in there.

Annette Rodgers, Lauren's Link, Derby
www.laurenslink.org.uk

Don't treat me bad

Once again my favourite ideologue is spread across *DDN*'s letters page (*DDN*, 14 July, page 10).

I'd like to point out that in terms of public expenditure many of his beloved 12 steppers are costing just as much. If you consider me, I've never been prosecuted for any crime, my pick-up has always been about weekly (thus lessening dispensing costs) and I've recently got back into work and off incapacity benefit. The cost: seeing a GP once every two weeks to monthly, the cost price of 7 x 360mg morphine sulphate dispensed weekly.

Compare this to many of the 12 steppers I know who are living in dry houses, costing the public purse £160 a week in housing benefit. Despite being abstinent these people are encouraged not to work, because the dry houses are doing very well financially thank you very much – the given reason is because they are still too 'sick' or vulnerable. (Real reason: they can't work because they can't afford the astronomical rent.)

You only have to go around a few fellowship meetings and you will find people still claiming sickness benefit who are five years drug free (and I hate the word 'clean' as it suggests the rest of us are dirty).

Just get off your high horse and open your eyes – your clients don't represent the whole picture. Many of your 'born-againers' will have been on MMT for many years but will now parrot how awful it was because they need to reinforce this message to themselves in early recovery.

I liked the UKDPC description of recovery by the way, although personally I'd steer a mile wide of the word 'recovery', as it's just too loaded a term.

Good luck to everyone out there struggling with addiction; our struggles are far more real than the dry debates of dinosaurs.

Brian, by email

Shameless marketing

The letters page of *DDN* is, quite rightly, a forum where people with a variety of beliefs and experiences about drugs can express their views and opinions without the need of evidence or even government statistics to back up their arguments – long may that continue, as it can be constructive and personal I like nothing better than to read a good slanging match.

Now we all like to mention the achievements of our own services – Lifeline guarantee 100 per cent recovery (from everything) at all of our services and most of our clients have gone on to become world leaders, CEOs of multinational companies or are favourites for a gold medal in the upcoming Beijing Olympics – but there has to be a line somewhere between stating an opinion and the blatant free advertising you allow for private therapists/businesses and cults in your letters page.

In the last issue you printed another letter from 'E. Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS), former magistrate and retired justice of the peace' as E. Kenneth entitles himself, although strangely he does not mention his '47 years as a scientologist' or his involvement in the Scientologist organisation 'Narconon' (both these are given prominence on E. Kenneth's website). I presume E. Kenneth was talking about a group he is somehow involved with when he says 'the most effective residential

addiction recovery training services are delivering 69 to 84 per cent success… providing a permanent abstinence result and costing less than £17,000 to £19,000'. Sounds great E. Ken, do you take Visa?

Far be it from me to tell you how to edit your magazine, but if some of the claims made in your letters page were placed in the advertising section (where they seem to belong) I could complain to the Advertising Standards Authority. As it is I can only write you a letter expressing my opinion.

Michael Linnell, director of communications, Lifeline, former comedy acrobat and retired lounge lizard

It takes all sorts

We started out coming from an abstinent base – we had been asked to come up with a programme which would cater for women who didn't want to go to a residential programme and leave their children.

The programme ran for some years and was five days a week from 10.00am–4.00pm for 13 weeks. We taught relapse prevention, life skills and various workshops and therapy groups.

We were then asked to take those on DRRs who were still in addiction and taking methadone. We decided to keep the two groups apart, but to allow the DRRs to move into the abstinent group when they were ready, and we called this the Recovery Group and also took in voluntary clients. We found this a huge challenge working with harm reduction rather than abstinence, and it took us some time to adjust.

We then found that some were more motivated than others and through concerns over this, we split the Recovery Group and had the morning group for those still chaotically using, four days a week. This then allowed us to have the more stable ones in the afternoons till they reduced their methadone intake.

This does mean you need two group rooms and two separate chill-out areas, but we have found it caters for all types of client (except residential) and allows the freedom for people doing well to move up and for those still struggling to be moved down until they are more stable when they can move up again. We have the added advantage of having a twin project in the next area, so that if we have a couple they can both still have a service.

We are delighted with the fact that we can provide a service to clients who come from very different positions. We get a lot of satisfaction from moving clients up into the next group and we are grateful for the provision for those who are not ready yet but who need some form of treatment.

Everlie Turpin, Chrysalis Maidstone, Kenward Trust

'Addiction' technical bulletin

We have been running The SureScreen technical bulletin inserts in *DDN* for the last seven months. So far we have received a very positive response to the briefings which are written and produced by us, and supplied to *DDN*. We have been made aware that a few people have asked questions regarding the references and tone of the last insert on addiction, and I would like to take this opportunity to address these.

Most of the questions raised were over the alcohol biotype classification. This is a system we have developed based on research conducted by Joan Mathews Larson PhD, director of the Health Recovery Centre in the US. What readers should be aware of is that this classification as defined 'biotypes' has been estimated by Dr Larson from her clinical evidence of individual response to alcohol and not genetic studies.

The other area of the bulletin questioned was the success rate claimed by Cenacolo – a Christian rehab facility. The source for this was a recent Catholic news article (2006), which purveyed the 93 per cent recovery claim upon the opening of the first UK Cenacolo centre in Kendal. This claim has been widely circulated for almost two decades since the establishment of their first chapter house in Saluzzo, Italy.

We have over 163 references (many referring to our alcohol insert earlier in the series which was used as the basis for the biotype descriptions) and can also direct you to online presentations on the work of Cenacolo. I am happy to discuss further with anyone seeking clarification on any of the subjects covered in this, or any of our previous bulletins. I hope you will find our future bulletin on addiction and nutrition equally thought-provoking. All bulletins can be seen on our website as downloads.

Jim Campbell, SureScreen Ltd.
Jim.campbell@surescreen.com

Reasons to be cheerful

Readers keeping up with current debates on treatment policy could be forgiven for thinking that workers supportive of harm reduction and of methadone maintenance suffer from therapeutic pessimism, which denies the possibility of recovery and settles for the lifelong (or at least, decades long) second best of getting by while still using drugs – a pessimism which infects their clients and in turn really does obstruct their recovery.[1]

In contrast, embracing abstinence as a goal is associated with holding forth also the possibility of recovery and instilling optimism in the client. Optimism is indeed a crucial ingredient of successful therapy, and its deficiency is not good for the worker nor for their clients, one of the messages we detailed in our Manners Matter series. But is it really distributed in the ways suggested?

At last we have a little glimmer of evidential light on this issue – very little, very tentative, but an advance on the unevidenced assertions and implications to date.

Researchers at Birkbeck College in London piloted a methodology for clarifying attitudes and beliefs on 13 addiction therapists from a range of theoretical orientations and agencies.[2] Each was given 60 cards to sort according to the strength of their agreement or disagreement with the statement on the card. The statements were designed to explore their beliefs about addiction, addiction treatment, abstinence, and harm reduction.

What emerged were four distinctive patterns in how the cards were sorted – effectively, four constellations of ideas and beliefs which tended to go together: if you agreed/disagreed with one, you tended to agree/disagree with the others.

Seven of the therapists displayed what the researchers characterised as 'acceptance'. Crucially for the current argument, they were the people who most strongly agreed that 'many people with problems of addiction recover eventually'. On a scale of from -6 to +6, they scored +5. They were also the ones who most strongly agreed that 'a harm reduction approach is suitable for working with alcohol/drug users' and that 'I accept a client may not wish to aim for abstinence', and most strongly disagreed that 'abstinence is crucial for recovery'.

What of the six therapists whose response patterns included disagreement with the proposition that 'many people with problems of addiction recover eventually'? These patterns were also characterised by disagreement that 'a harm reduction approach is suitable for working with alcohol/drug users', with much less willingness or strong unwillingness to 'accept a client may not wish to aim for abstinence', and agreement that 'abstinence is crucial for recovery'.

In other words, the harm reductionists, the ones who didn't think abstinence was crucial, were the ones most optimistic about recovery. The ones who saw abstinence as crucial and rejected harm reduction were the most pessimistic about the chances of recovery.

I don't deny the risk of therapeutic pessimism or the experience of people who say they have seen this in the UK's under-resourced methadone services; when in practice you have neither the resources nor the cooperation from services outside the clinic to turn people's lives around, believing that this is simply not possible is a natural protective mechanism. But though this is a small pilot study, what it does show at the very least is that therapeutic optimism is not necessarily the preserve of abstinence-oriented therapists, and therapeutic pessimism is not necessarily the preserve of the harm reductionists – in fact, it can be, and in this study was, the other way round.

Mike Ashton, Drug and Alcohol Findings, http://findings.org.uk

1. Latest example in Daily Dose alert 17 July 2008: 'Professional Pessimism', referencing www.dawnfarm.org/2008/07/professional-pessimism.html.
2. Shinebourne P. 'Therapists' understandings and experiences of working with clients with problems of addiction: a pilot study using Q methodology.' Counselling and Psychotherapy Research: 2007, 7(4), p. 211 219. http://dx.doi.org/10.1080/14733140701726159

Continued on page 16 →

Less division, more reform

I have been following the exchanges on your letters page, on the subject of abstinence and harm reduction, with mixed feelings – respect for the continuing passion and commitment that your readers show for the subject, and despair that much of the debate seems to still be based around the 'either/or' language of the 1980s.

I thought that we had reached some sort of agreement as a profession that what is needed is a menu of services in each area that provide accessible and good quality care for drug users that is appropriate to their wants and needs. This menu of services – encompassing outreach, harm reduction, and various forms of structured drug free and prescribing-based treatments – was the basis of the treatment expansion strategy initiated in 1998, and the establishment of the NTA in 2001.

The vision was that any drug user would be motivated and supported to change their behaviour in ways that suited their individual needs and circumstances, whether that be immediate life-saving or health protection measures, help to stabilise their use and behaviour, or help to make significant changes or cease their drug use, and reintegrate into family and community life. These weren't complicated concepts in 1998, and they aren't now.

Of course there is a risk that too much reliance on abstinence-only services will not meet the needs of many users who need help, or that a focus on prescribing services undermines the wish of users to seek a drug free lifestyle – that is why the strategic objective must be for balanced and integrated provision, with assessment and referral based explicitly on individual needs.

The problem in the UK in 2008 is that, despite unprecedented investment in this sector over the last ten years, we have not yet created this balance and integration. Whatever the arguments about the motives and accuracy of the BBC's figures, or the sophistication of the Conservative Party's analysis, we have to acknowledge that, in most parts of the UK, it is far easier for drug users seeking treatment to access substitute prescribing services than it is for them to go into structured drug free programmes.

This is not an appropriate situation where more than half of the target population are not primary opiate users, and most want eventually give up drugs. Furthermore, too many referral and placement decisions are being made on the basis of what is available, or the preferences of the assessing authority, rather than the needs and wishes of the user. This is what needs to change.

These realities should not be seen as failures of the system (the expansion and improvement of the UK treatment sector over the last ten years has been fabulous to be part of), but as the key challenges for the next stage of development. My concern is that those who are responsible for managing the treatment system themselves fall into this 'either/or' mentality, or seek to defend the status quo. This is a surefire way of inviting increased disillusion from policy makers and the public about the vast amounts spent on our sector – disillusion that will eventually result in bad policy or serious disinvestment.

Watching the development of the treatment elements of the new drug strategy, I have observed an unwillingness to change the institutional and commissioning arrangements that have led to the current imbalance – if this continues, and meaningful proposals for addressing these issues do not emerge, I fear for the future of the well-funded, integrated sector that we fought so hard to create over the last 20 years.

So please, lets expend less energy on dividing into camps and swapping arguments, and devote a bit more time to the reforms necessary to achieve an integrated treatment system that balances the best of all effective services.

Mike Trace, Chief Executive, RAPT.

We welcome your letters

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

Getting stuck in

For many service users, entering user involvement can be daunting – a bewildering world of meetings, acronyms and jargon at a time when they're at their most vulnerable. But, said service user delegates at the *12th annual Sussex drugs and alcohol conference*, it's well worth sticking with it. DDN reports

'To begin with I felt fraudulent being there, because I'm not a commissioner – I'm a service user. But after a while I felt totally empowered and that it was completely worthwhile. It wasn't tokenistic at all.'

These were the views of one delegate describing his involvement in strategic planning at the 12th annual Sussex Drug and Alcohol Conference's session on service user involvement earlier this month. 'There is a lot of talk about tokenism and box ticking,' service user involvement manager for MIND in Brighton and Hove, Kat Marples, told delegates. 'But if things are working the way they should then the opinions of service users will feed into service provision.'

Supporting user groups, active networking with other organisations and learning from other people's involvement work were all vital, she said, and the field of mental health could provide a good example. 'There's a lot of good service user involvement going on out there that you can learn from. Empowerment of service users should be a core belief – it might sound a bit utopian, but you really need to look at the values of your services and what you want to achieve. Service provision should be about improving people's lives.'

There were different levels of engagement, she said, and MIND Brighton and Hove had published a service user strategy that mapped them out:

- *in individual care*
- *in service provision*
- *in group consultation*
- *in planning and strategic decision-making*

Examples could range from feedback forms on newsletters and suggestion boxes in drop-ins to consultation events, roadshows and running training courses with service users. Clearly, there would always be a good deal of overlap between the levels as well as countless different models, she said. MIND Brighton and Hove's service user involvement worker attends city-wide forums and there is also strategic input from service users and an annual consultation event. 'It really is as big as you make it,' she stressed.

Service user delegates were almost overwhelmingly positive about their experiences of user involvement. 'The only problem I had was with the jargon and acronyms, but they always explained it when I asked,' said one. 'They really do listen,' said another. 'I take what's said back to our monthly service user meetings so that everyone's kept in the loop without having to go through huge numbers of people – it's really important.'

Another delegate described how she became involved in service user engagement through a hepatitis C training course. 'I'd come out of recovery and needed focus,' she said. 'It's helped me to meet other people in a similar situation and given me that stability and focus. But most of all it's given me a voice. To come from addiction to that is amazing. When you first meet commissioners you think 'they've all got the alphabet after their names – they're not going to listen to me'. But they do, and they act on what you say. Unless people actually get involved, there's no point them complaining about services – they need to speak up about it.'

- **Date for your diary: the next DDN/Alliance service user involvement conference is on Thursday 29 January 2009. For information email info@cjwellings.com**

A journey into and out of heroin addiction

In this Background Briefing, Lydia concludes her journey out of addiction, considering what helped her the most.

'It was possible to lead a productive life after addiction. I could lead a normal life. I could get a job. I could have friends and go to the cinema or go shopping. I finally felt that I could have a future.'

I was finally accepted into treatment, after a wait that seemed like years. My first day there was horrific. I sat in reception shaking because I was so scared. Part of me really, really wanted to get off the gear once and for all. The other part of me wanted to run as far away as possible and curl into a ball.

I kept thinking that everything I touched or did turned bad. I was bad news. But then I realised that I hadn't always been like that, and the smallest glimmer of hope developed. That scared me even more; I'd learnt that it was dangerous to have hope. It always ended in failure and hurt. My head was swimming. I knew that I had to push all my thoughts away and concentrate my efforts on treatment.

The next few weeks were a blur. I can remember focusing all my effort on not walking out the door. It was then that everything changed; something came over me and I realised, and I think believed, that there was hope for me. It was like a huge weight had been lifted off my shoulders. I could see other people getting and staying off the drugs, so there was no reason why I couldn't do it. That day was a turning point for me.

I learnt that a couple of the staff were in recovery themselves. I was amazed! Just knowing that helped me to understand it was possible to lead a productive life after addiction. I could lead a normal life. I could get a job. I could have friends and go to the cinema or go shopping. I finally felt that I could have a future.

The other members of my group, especially the ones who had been there longer, were also a great encouragement. If they could do it then so could I. Over time I developed some really close bonds with some of the other residents. They would say so many things that I could understand. I started to realise that I wasn't alone. I wasn't the only person to have done these bad things.

It didn't take long before I started talking in group sessions. At first it felt weird, but soon I realised it helped to share in group. It felt good to get things off my chest. I knew I could trust the others. I even started looking forward to hearing their feedback. Together we went through some difficult times. But we got there.

One thing that I learnt early on is that addiction is not just a physical disorder – it is mental as well. I thought that I would be able to give up heroin once the methadone was holding me – but it wasn't as simple as that. The one-to-one counselling sessions were helping me with this, and at other times I would talk to my new friends. I learnt how to keep myself occupied and resist the temptation for heroin. I began learning ways to cope with things.

When my time came to reduce my methadone I felt more than ready. I didn't want to be on it anymore. I couldn't wait to be off everything. Looking back, I may have put too much pressure on myself. When I got to about 50ml I started to struggle. My emotions were all over the place, and the temptation to use was growing.

Now I can see exactly where I went wrong – I bottled everything up. But at the time I didn't want others to think I was struggling when I had been doing so well. I thought I was strong enough to get myself through it.

I ended up using one night. Afterwards the guilt was intense. The next afternoon I decided that I needed to tell my support worker. I was expecting to get the bollocking of a lifetime, but instead I got a sympathetic ear. She made me realise that it was not the end of the world. We agreed to slow my reduction down until I felt more able to cope.

I learnt a lot from that time. I learnt the importance of not becoming complacent. I learnt the importance of sharing my problems with other. I realised what I wanted out of life.

Living without drugs has been tough in so many different ways, but ultimately it is a better life than being an addict. I now have to worry about paying my rent and bills on time, rather than scrounging enough money to get a bag together and not caring about anything else.

I'm being careful to take each day as it comes. Looking into the future scares me, but it is becoming less and less scary. I'm learning to deal with life. I'm also learning about myself. I now have the opportunity to make choices in my life. I am in control. I can now work towards my dreams.

Written by Lucie James and Kevin Manley of Wired In.

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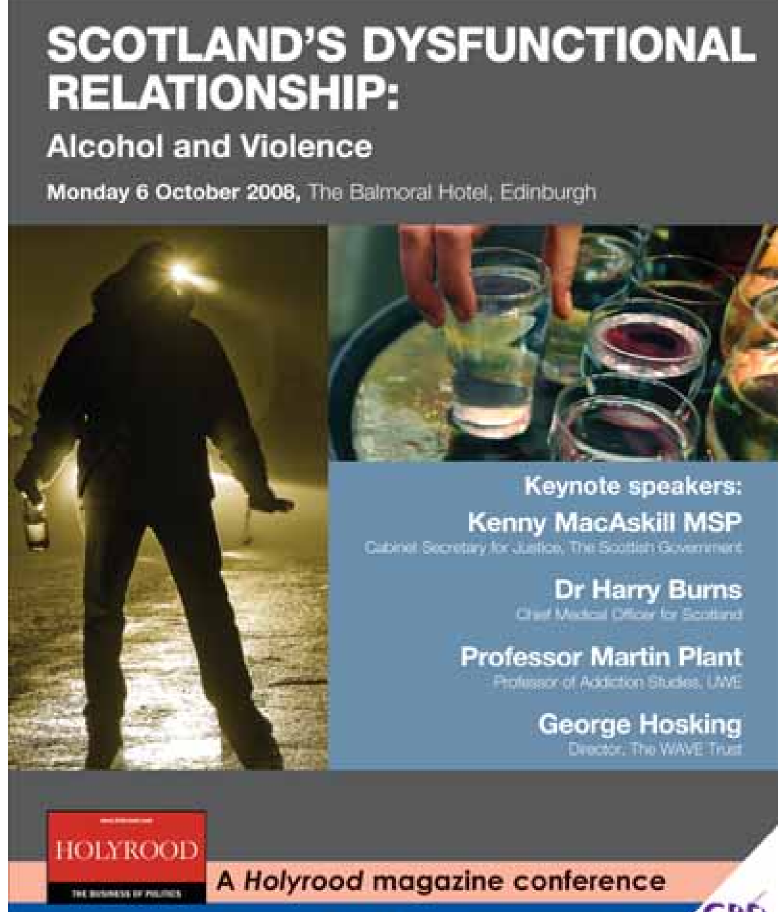
Email: couns.northampton@le.ac.uk
Visit: www.le.ac.uk/lifelonglearning/counselling

www.le.ac.uk



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October 2008 start

This course is aimed at anyone working within a drug or alcohol treatment service. It is structured around the key elements of the National Treatment Agency's Treatment Effectiveness Strategy, and incorporates a range of evidence-based approaches. It will equip you with broad clinical skills and knowledge of the problems that you are managing, and will provide you with an innovative and comprehensive framework for delivering medical and psychological treatments.

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Entry requirements

An undergraduate degree and experience of working with the relevant client group. Professional qualifications and work experience may also be taken into consideration.

Learn more

Contact Merce Morell, Programme Administrator, on 0121 301 2355 or 0121 415 8118, m.morell@bham.ac.uk or visit our website for full details **www.medicine.bham.ac.uk/treatment**

CONFERENCE

DRUGS RACE & DISCRIMINATION

Thursday 18 September 2008

Places are limited - please book early

Release's annual conference returns this year with an exciting panel of speakers and a topic that is guaranteed to stimulate and motivate you. Hosted once again by the exquisite Hampstead Theatre, London, this unique event will focus on discrimination faced by drug users in our society and overseas.

By highlighting the issues confronting people from an already marginalised background whose drug use leaves them open to further prejudice, this conference will tackle some of the most complex and interesting issues in drug policy today.

Chaired once again by Gill Norman-Bruce and joined by some excellent national and international speakers presenting original material, the Release Conference programme includes:

8:30	Coffee & registration
9:30	Keynote address Chris Huhne MP Liberal Democrat Shadow Home Secretary
10am	Access to health - unlocking the truth Dr Ben Goldacre 'Bad Science' columnist - The Guardian "How moral values get dressed up as 'science'"
	Dr Gordon Morse Clinical Lead, Turning Point, Somerset "Treatment dogma - the road to discrimination"
	Mandie Wilkinson BBV Team Manager, East London NHS Trust "Treatment for all with Hep C - including current users"
11:20	Coffee break
11:45	Caught in the middle - where is the child in drug policy? Professor Rod Morgan Former Chair of UK Youth Justice Board "Youth, drugs and discrimination"
	Damon Barrett Human Right Analyst, IHRA "Drugs, children and human rights"
	Panel discussion and Q&A
1pm	Lunch
2pm	Drugs and discrimination - a transatlantic race? Deborah Peterson Small Executive Director, Breaking the Chains "Racism in the war on drugs"
	Alex Stevens PhD University of Kent "The racial impact of UK drug law enforcement"
	Tiggey May, Senior Research Fellow Institute for Criminal Policy Research "Disproportionate cannabis policing in the UK?"
	King Downing National Coordinator Racial Profiling American Civil Liberties Union "Drug policy and racial profiling"
	Panel discussion and Q&A
4pm	Champagne reception

Only
£195 (+VAT) including delicious lunch.

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Contact Jacqui Olliffe:
020 7749 4044 or
jacqui@release.org.uk

Programme is subject to change.

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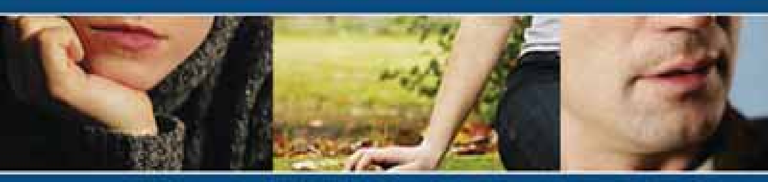
PRINSTED, Oldfield Road, Horley, Surrey RH6 7EP



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We may be taking a break – but don't let someone miss out on their big one!

Although we're taking a publishing break in August, you can still advertise your vacancies online at www.drinkanddrugs.net This will include featuring in our email job alert and a CV database search on your behalf.

If you are recruiting in the month of August and your closing date is before our 8 September issue, please contact Faye Liddle on 020 74632205 or email all enquiries to faye@cjwellings.com

The 1st

WORLD FORUM AGAINST DRUGS

SEPTEMBER 8–10 STOCKHOLM, SWEDEN

BE A PART OF THE new century's efforts against drugs! The first ever World Forum Against Drugs – WFAD – will take place in Stockholm, Sweden September 8–10.

AT WFAD PEOPLE from all over the world – NGO activists, professionals, self-help groups, scientists, politicians – will meet and exchange ideas and experiences on how to best prevent misuse of drugs and drug trafficking.

Some of the speakers at WFAD will be:

Antonio Maria Costa, Executive Director UNODC, Italy
Maria Larsson, Minister of Public Health, Sweden
John P. Walters, Director Office of National Drug Control Policy, USA
Mina Seinfeld de Carakushansky, President of Brazilian Humanitarians in Action, Brazil
Tony Clement, Minister of Health, Canada
Tania Major, Criminologist, Australia
Carlton Wilson, Senior Superintendent of Police, Narcotics Division, Kingston, Jamaica
Craig Nakken, author, lecturer, therapist, USA
General Khodaidad, Minister of Counter-narcotics, Afghanistan

The programme includes sessions such as:

Cannabis and the Brain
Random Student Drug Testing
Is Britain Changing Foot about Cannabis?
Abstinence Oriented Rehabilitation

Rugby House Residential Treatment Services

Rugby House Residential services provide a drug & alcohol free environment where men and women can tackle the underlying issues to their drinking and drug use. The holistic programmes are aimed at enabling people to move into the community with an increased quality of life.

Agar & St Augustine's **Tel: 020 7916 7634**

Agar & St. Augustine's registered care home was established in 1990, for men and women with long term problematic alcohol use who have abstinence as their long term treatment goal.
Agar & St Augustine's is a registered care home.

Herbert Street **Tel: 020 7916 5013**

Established over 11 years ago, Herbert Street is an abstinence based alcohol rehabilitation programme, which accommodates up to 9 men and women. The service is designed with a fully accessible disabled annex and works with those with complex needs.
Herbert Street is a registered care home.

Ravenswood Road **Tel: 020 8521 4486**

Established in 1999, Ravenswood Road is a small, homely eight bedded abstinence based residential drug & alcohol treatment programme for men and women. The service was designed for people with mobility problems and is fully accessible. We also work with those with more complex needs.
Ravenswood is a registered care home.

- *All schemes have care packages available and excellent CSCI ratings*

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Crystal Meth: Is it all it's Cranked up to be?

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- A brief history of methamphetamine
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- Exploration of methamphetamine the drug in scientific detail
- Signs and symptoms of methamphetamine use
- Methamphetamine addiction
- Treatment options

Course costs £200 for two days, includes lunch and refreshments.
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Email: nike.begbaaji@lewisham.gov.uk
For all other enquiries call Eva Harvey, Training and Workforce Development Manager: 0208 314 8078
Email: eva.harvey@lewisham.gov.uk

North Tyneside Council

Tender for North Tyneside Project ANSWER Criminal Justice Intervention Team (CJIT)

As part of Project ANSWER - a multi agency integrated treatment service for people with substance misuse issues in North Tyneside – North Tyneside Council on behalf of the North Tyneside Crime, Disorder Reduction and Misuse of Drugs Partnership wishes to invite tenders from established and experienced providers of services to deliver a Criminal Justice Intervention Team to undertake identification, assessment, triage, engagement and throughcare/aftercare of DIP Service Users.

Service Providers may be required to give a presentation of their proposal and it is envisaged that this would take place between 8th December 2008 – 11th December 2008.

The Partnership anticipates the contract to be awarded on 15th December, 2008 and work to commence on 1st April, 2009 for a period of 1 year with the option to extend for a further two years subject to satisfactory contract performance and continuation of funding through the Home Office. The contract will be let on the basis of quality of service, ability to perform and tendered prices.

It is anticipated that the Transfer of Undertaking (Protection of Employment) Regulations will apply to this contract award. Following award the successful provider will be expected to work closely and co-operatively with other providers in the drug treatment system in North Tyneside to ensure the most effective delivery of drug services

Further information may be obtained by contacting
Oonagh Mallon, Drug Strategy Manager on 0191 643 6434

Applicants wishing to register their interest against this tender should go to the web site located at *www.nepoportal.org/search*. Select North Tyneside Council in the drop down box and enter the *contract ID: QTLE-7GCC85* to arrive no later than 12:00 noon on Wednesday 1st October 2008. Tender documents will be issued by November 2008. Unregistered suppliers will be redirected to a supplier registration form to be completed.

Further information with regard to documentation can be obtained from Derek Russell, Strategic Procurement.
Tel: 0191 643 5654, email: derek.russell@northtyneside.gov.uk
No previous application or expression of interest shall be taken as an application for the purposes of this notice.

North Tyneside Primary Care Trust

Invitation to offer services

As part of Project ANSWER –– a multi-agency integrated treatment service for people with substance misuse issues in North Tyneside – North Tyneside Primary Care Trust, on behalf of North Tyneside Crime, Disorder Reduction and Misuse of Drugs Partnership, is seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of the following services:

1. **Structured Day Programme**
2. **Administration Service**
3. **Structured Psychosocial Service.**

In addition to evidencing the ability to deliver the required services, potential service providers must demonstrate innovation, creativity and commitment, together with evidence of integrated working with other partners.

It is anticipated that the Transfer of Undertaking (Protection of Employment) Regulations will apply to these contracts awards.

Following award the successful provider will be expected to work closely and co-operatively with other providers in the drug treatment system in North Tyneside to ensure the most effective delivery of drug services

The Crime, Disorder Reduction and Misuse of Drugs Partnership anticipates the following timetable:

1. Structured Day Service

Expressions of interest:	5pm, 29th August 2008
Tender documentation sent:	1st September 2008
Closing date for return of tender:	Midday 22nd September 2008
Contract awarded:	30th September 2008
Service to commence:	1st December 2008
Length of contract:	36 months subject to satisfactory performance and annual review.

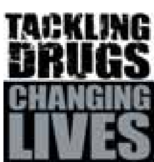
2. Administration Service

Expressions of interest:	5pm, 27th October 2008
Tender documentation sent:	31st October 2008
Closing date for return of tender:	Midday 21st November 2008
Contract awarded:	28th November 2008
Service to commence:	1st April 2009
Length of contract:	36 months subject to satisfactory performance and annual review

3. Structured Psychosocial Service

Expressions of interest:	5pm, 27th October 2008
Tender documentation sent:	31st October 2008
Closing date for return of tender:	Midday 21st November 2008
Contract awarded:	28th November 2008
Service to commence:	1st April 2009
Length of contract:	36 months subject to satisfactory performance and annual review

To register your interest please contact:
Simon Cox, Commissioning Support Officer, North Tyneside Drug Action Team, Town Hall, Wallsend, Tyne & Wear NE28 7RR.
Tel: 0191 643 6440, email: simon.cox@northtyneside.gov.uk



Expressions of Interest for the Provision of Drug and Alcohol Services in the Borough of Wigan

Expressions of interest are invited from suitably experienced organisations to tender for a contract(s) to deliver a number of services for drug and alcohol users in the Borough of Wigan. The borough is co-terminus with Ashton, Leigh and Wigan Primary Care Trust.

The expected term of the contract(s) will be 1st April 2009 to 31st March 2011 with possible extension to 31st March 2013 subject to recurrent funding and satisfactory performance.

Expressions of interest are invited to provide individual or both lots, from individual organisations or from agencies acting in partnership.

Lot 7 – Alcohol Extended Brief Intervention Service

Lot 8 – Pathway to Employability and Employment Programme (incorporating abstinence support)

Written expressions of interest and requests for tender documentation should be made to:

Mike Jones, Drugs Business Manager, Community Safety Partnership, Unity House, Westwood Park Drive, Wigan WN3 4HE (Email mike.jones@wigan.gov.uk)

We will be holding a meeting for all potential providers to meet the DAAT and discuss Wigan's vision especially in relation to the new service Pathway to Employability and Employment Programme.

The closing date for expressions of interest is 12pm on 8th August 2008

The timetable for the tender process will be as follows:

Tender documentation will be issued by 28th August 2008
Information day to discuss our vision 4th September 2008
The deadline for receipt of tender submissions 3rd October 2008
Interviews to be held week commencing 27th October 2008
Service to commence 1st April 2009

Expressions of Interest to participate in the tendering process for the following alcohol services

Telford and Wrekin Drug and Alcohol Action Team (DAAT) are seeking Expressions of Interest from suitably experienced and qualified providers as part of a tendering process to provide two separate services:

1 **Arrest Referral Scheme – Alcohol**
To provide alcohol interventions aimed at reducing alcohol related offending and improving health - mainly where offenders have been issued with Penalty for Disorder Notices, Conditional Cautions or where the offender voluntarily takes up the service.

2 **Structured Day Care Services – Alcohol**
To engage service users who are achieving abstinence. A Provider would deliver a Tier 3 (Models of Care for Alcohol Misusers) intervention with a focus on enabling individuals to recover and engage in training, education and employment.

Providers can bid for either or both of these services.

The tender process will be undertaken in two stages. Firstly the submission of a pre-qualifications questionnaire, secondly suitably qualified organisations will be invited to submit full tender documents.

Formal Expressions of Interest (including PQQs) should be made using the 'Bravo Solution' Electronic Sourcing system via www.hpc.bravosolution.com and must be received by 12 noon on 18 August 2008.

W/C 01.09.08: Invitation to Tender Packs to be issued.

30.09.08: Tender Returns due for evaluation and short-listing.

Should you have any queries please contact
Sharon Appleby, Category Lead, Healthcare Contracting Services, Healthcare Purchasing Consortium via email:
Sharon.appleby@hpc.nhs.uk or Tel: 08701 707075.

EAST SUSSEX COUNTY COUNCIL

TENDER FOR THE PROVISION OF A COMMUNITY SUBSTANCE MISUSE SERVICE IN HASTINGS AND ROTHER

NOTICE CALLING FOR EXPRESSIONS OF INTEREST

East Sussex Drugs and Alcohol Team (DAAT) invites Expressions of Interest from organisations or consortiums interested in being Invited to Tender for the provision of a Community Substance Misuse Service in Hastings and Rother.

The services will include:

- Needle and Syringe Programme
- Criminal Justice Integrated Team
- Specialist Prescribing
- Structured Psychosocial Interventions

It is proposed that the Council will let the services for an initial period of three years. Following the initial contract period of 3 years, the Council will have the option to exercise two subsequent twelve monthly extensions subject to the continued requirement and successful supplier performance and service delivery.

The organisations short listed to Tender will, in the first instance, be able to demonstrate:

- A proven track record of delivering similar services
- Resource and financial capacity and capability to deliver the services
- Extensive quality monitoring processes

Award criteria will be based on a combination of both technical and commercial capability and best value, detailed criteria will be provided within the Invitation to Tender.

Organisations expressing an interest should note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 may apply.

To Express your Interest and obtain a pre-qualification questionnaire please contact the Council's ASC Procurement Assistant either in writing at: East Sussex County Council, Adult Social Care Directorate, Contracts and Purchasing Unit, St. Mary's House, 52 St Leonards Road, Eastbourne, East Sussex BN21 3UU, by email: contractsforservices@eastsussex.gov.uk or by telephone on 01323 463284.

The deadline for receipt of expressions of interest is 13.00 on the 11/09/2008.

East Sussex County Council
eastsussex.gov.uk

STOKE-ON-TRENT SAFER CITY PARTNERSHIP PROCUREMENT OPPORTUNITIES

Young Peoples Drug and Alcohol Treatment Service

and

Adult Community Drug Treatment Service and Inpatient Drug and Alcohol Treatment Service

(ref no: CPU206)

Stoke-on-Trent Safer City Partnership has redesigned treatment services in line with the changing needs of the area and the aspirations of the local community. The new model of delivery will ensure a responsive treatment system is in place delivering accessible, quality services that meet the diverse needs of the people of Stoke-on-Trent.

Expressions of interest are invited via completion of a Pre Qualifying Questionnaire; the deadline for submission is 4.00 pm, 21st August 2008.

A seminar will be held on Monday, 11th August 2008 to provide interested parties with further information.

Please register with Bravo Solution www.wmcoe.bravosolution.com to express an interest and receive further details.

Invitation to become an Approved Provider of Drug Misuse Services in North Yorkshire

Invitation to Tender for Drug Misuse Services in Harrogate

North Yorkshire DAAT are planning to reconfigure all drug treatment services over the next two years, starting with tendering for services provided in the Harrogate locality.

North Yorkshire is England's largest county, with a geographical coverage of 3,200 square miles and a population of half a million. Having some of the most remote and rural areas in the country, which are sparsely populated, access to services in these areas is a particular challenge for service users. The county includes the coastal towns of Scarborough and Whitby as well as the large urban area of Harrogate. To the south of the county lies the former mining area of Selby. There are few pockets of severe deprivation in North Yorkshire, with less than 5% of the population living in neighbourhoods that are among the 20% most deprived in England.

If you are a local or national organisation, suitably qualified and experienced in the provision of high quality drug misuse services that meet the needs of individual service users, their families and the communities in which they live, then North Yorkshire DAAT invites you to apply to become an approved provider of drug misuse services.

Approved Provider of Drug Misuse Services

All interested parties are to contact the DAAT Office, by email, to request a pre-qualifying pack, no later than 12pm, 15 August 2008. Email daatoffice@nyypct.nhs.uk

The pack will include a covering letter, pre-qualifying questionnaire, checklist and the intentions of the DAAT's Joint Commissioning Group.

The deadline for submitting the pre-qualifying questionnaire and 12pm on 10 September 2008.

Invitation to Tender for Drug Misuse Services in Harrogate

If you wish to tender for Harrogate drug misuse services you will need to be an Approved Provider.

You will also need to complete the tender documentation. Please request this pack no later than 12pm, 15 August 2008. Email daatoffice@nyypct.nhs.uk.

The deadline for returning the tender is 30 September 2008.

It is expected that the service in Harrogate will commence from January 2009, for a period of three years, with one option to extend, dependent on performance review and continuation of funding. Organisations should be aware that Transfer of Undertaking (Protection of Employment) Regulations 2006 may apply

Under no circumstances will late applications be considered

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

Client Services Director

One year contract - London, SE5 £40,722 - £47,657 pa

Our current Client Services Director is due to take a sabbatical in October, therefore we are looking for you to join us on a one year contract with the possibility of extension after this. Blenheim CDP has expanded significantly in the last few years and we now run a total of 16 services across London with a growing reputation for delivering high quality, accessible and innovative services. We are also a leading provider of stimulant services in the capital.

We are looking for an experienced and knowledgeable senior manager with excellent leadership skills, who can continue to grow the organisation whilst ensuring high quality services are maintained. You should be a good performance manager with considerable clinical expertise and a sound understanding of the evolving treatment environment. Secondments will be considered. **REF: BCDP/16/DDN**

To request an application pack, please telephone our response handling line on 01206 570706 or email: info@peterlockyer.co.uk quoting the reference number. Alternatively, you can download an application pack from our website www.blenheimcdp.org.uk Closing date: 18 August 2008.

www.blenheimcdp.org.uk

Blenheim CDP: Registered Charity No. 293959.

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

NHS Norfolk

Alcohol Pilots and Needs Assessment

NHS Norfolk and Norfolk Drug and Alcohol Partnership wish to commission a series of pilots and a needs assessment to improve alcohol provision within the Norfolk PCT area.

Upon evaluation of the pilots and an assessment of their efficacy in reducing alcohol related admissions, funding is available long-term to further embed alcohol interventions into the treatment system for substance misuse in Norfolk.

Tenders for all, or part, of the pilots and needs assessment are invited; these will consist of:

- *Alcohol interventions into acute services pilot*
- *Place of safety in the night-time economy in Kings Lynn pilot*
- *Triage in the night-time economy pilot*
- *Clinical interventions to support the rehabilitation of offenders pilot*
- *Older people and substance use needs assessment*

Due to restricted time scale, please email Carol Bowen, Contracts Officer at the Norfolk Drug & Alcohol Action Team to request a tender pack. Email Carol.bowen.dat@norfolk.gov.uk Telephone: 01603 677570.

Requests for tender packs to be received by Friday 8th August. Tenders are to be submitted by noon on 1st September 2008.

Want to join a new and exciting team?

The Clifton Clinic – Bedfordshire

Admissions Manager

£20,000 + commission

You will be a dynamic and enthusiastic communicator able to engage with people at all levels; you will have empathy and understanding of addiction and recovery and an ability to understand and respond appropriately to clients' needs. You will be responsible for developing referral routes into the clinic and qualifying and closing sales leads. Good communications skills (verbal and written) are essential. Previous experience of the addiction field and sales is preferable.

Closing date: Friday 22nd of August 2008

Please send your CV and covering letter to: Veronica@thecliftonclinic.co.uk

For more information please call: Veronica Callanan on: 0845 1212 178 or 07507 852252

CLEVELAND POLICE AUTHORITY

TENDER FOR ARREST REFERRAL SERVICES

MAXIMUM 3+1+1 YEAR CONTRACT

Cleveland Police Authority invites expressions of interest from suitably qualified persons or organisations to provide an Arrest Referral Service to Cleveland Police Authority

Those parties interested should request the tender documentation in writing from: -

Procurement Department, Cleveland Police Authority, Headquarters, PO Box 70, Ladgate Lane, Middlesbrough, TS8 9EH or via email to: purchasing@cleveland.pnn.police.uk.

Your submission should indicate your experience and qualifications in this type of work.

Tenders should be completed and returned by 12 Noon 12th September 2008. If you require further information please contact the Procurement Department at the above address or by telephoning (01642) 301224.

The authority does not bind itself to accept any tender but every effort will be made to reach a decision on the award of the contract by 11th December 2008.

EDP Drug & Alcohol Services is well recognised as the leading non-statutory service provider of drug services within Devon. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

PEER SUPPORT PROGRAMME COORDINATOR

Based: Exeter/Newton Abbot
Hours: 17½ hours per week
Contract: Fixed Term Contract for 1 year
Salary: £26,067 to £28,919 per annum pro-rata (NJC Scale 32-36)

We are looking for a committed individual to develop and deliver a peer support programme with the aim of achieving accreditation. This may include group work, one to one coaching and workbook learning. Peers that will attend the programme will be current service users and will be trained to support other service users. You will need to demonstrate excellent delivery, communication, organisation, planning and report writing skills. You will also need an understanding of addictive behaviour and the issues related to working with substance misuse. You should be committed to working with this client group, setting and maintaining professional boundaries and also have experience of delivering programmes and conducting assessments. The individual will need to be flexible in the hours worked each week in order to meet the needs of EDP and to achieve best service delivery.

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

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

EDP is committed to equality of opportunity, aiming for the widest possible diversity in its workforce drawing recruits from every part of the community. In accordance with the Police Act 1997 this post is subject to disclosure through the CRB. A criminal record is not necessarily a bar to employment in these posts.

Application forms, which can be either posted or emailed to you, are available from: Wendy Murkin, Human Resources Administrator, quoting reference number 22.08.

Telephone 01392 666732, or e-mail: recruitment@edp.org.uk

Closing date for applications: Monday 11th August at 12 noon

www.dyfed-powys.police.uk

Dyfed Powys Police

Carmarthenshire Drug Rehabilitation Requirement Treatment Service

Dyfed-Powys Police Authority working in conjunction with Dyfed Powys Probation Trust and Dyfed-Powys Interventions Programme invites suitably experienced and qualified organisations to tender for the Carmarthenshire Drug Rehabilitation Requirement Treatment Service. Organisations will be required to work in partnership with staff from Dyfed Powys Probation Trust and will play an integral role in the delivery of substance misuse treatment intervention as part of the Drug Rehabilitation Requirement.

The service provider will deliver a full range of Tier 3 interventions as part of the requirement and will provide the treatment element of the overall sentence plan.

It is proposed that the contract will commence on the 1st January 2009 and will run for a period of three years with the option to extend for a further two years subject to annual reviews.

Organisations interested in applying should request a tender application pack via the "Bluelight" e-tendering website www.bluelight.gov.uk and selecting the DRR tender in the Dyfed-Powys Police section. The closing date and time for the return of tenders is Thursday 18th September 2008 at noon.

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

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

looking for new opportunities?

bdp

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,000 individuals a year.

STRUCTURED DAY PROGRAMME WORKER – (28 hours) – ref DD3
Along with partners Addiction Recovery Agency and Nilaari Drug Agency we are delighted to have been awarded a new 3 year contract to expand our Structured Day Programme. Do you believe everybody has the capacity for change? Motivating change for both active drug users and those who are free of their problematic drug use is your core business within our CHANGE programme. You will have well-honed group work skills and the ability to work collaboratively within a team. For an informal discussion contact Justin Hoggans, Structured Support Services Manager on (0117) 987 6007

SHARED CARE PLUS WORKER – (35 hours) – ref DD4
You will offer short term practical support in the community to people who are on an opiate substitute medication programme and need extra help to make progress with their goals. You will also plan individualised community detox packages and support people to detox at home. A valid driving licence and transport is essential and some early evening work will be required. For an informal discussion contact Jayne Peters, Treatment Services Manager, on (0117) 987 6019.

Salary scale for both posts: £16,617 - £24,980 (pro rata based on 35 hours a week), starting salary for suitably qualified candidates: £22,156. A pay award is pending. For both jobs you will need experience of working with drug users and we welcome past personal experience of problematic drug use.

Funded by Safer Bristol - Bristol Community Safety & Drugs Partnership

Closing date: Tuesday 19th August at noon

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

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation.

No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

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SUBSTANCE MISUSE PERSONNEL

PERMANENT - TEMPORARY - CONSULTANCY

Supplying experienced, trained staff:

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

NOW REGISTERING AND SUPPLYING NURSES

Register online **www.SamRecruitment.org.uk**

Do you want to transform lives?

Helping people overcome their dependence on drugs and alcohol is both challenging and rewarding. Our pioneering work with individuals, families and communities has made us one of the UK's leading providers of social care services in this complex area - and with your help we aim to become even more effective in the future.

TREATMENT MANAGER • £24,350 - £28,003

HMP DRAKE HALL (ECCLESHALL, STAFFS) – THERAPEUTIC COMMUNITY

HMP/YOI Drake Hall is a female resettlement prison which houses approximately 315 short and long term prisoners. Managing the Therapeutic Community there you will oversee the daily running of the programme in line with the programme manuals and audit baselines. You will also provide supervision and line management guidance to a team of five.

Formal qualifications are desirable and you must have a practical understanding of rehabilitation issues and experience of working with substance misusers and, or offenders. The hours to be worked are 37.5 over a five-day period Monday – Friday. The higher salary in the range may be achieved through annual performance appraisal.

In order to take up this post all applicants must pass the Interventions Groups Assessment centre.

Our dynamic environment will focus on your professional learning and development and you will benefit from all the peer support and opportunities available within a leading national organisation.

For an application pack please visit **www.phoenix-futures.org.uk** email **recruit@phoenix-futures.org.uk** or telephone **020 7234 9772** quoting the reference: 08/07/418/514121. Closing date: 11th August. Interview date: TBA.

Registered charity in England & Wales 284880 and Scotland SC039008.
Committed to a policy of equality and diversity.

Senior Nurse – Nights

Winthrop Hall, part of Success in Recovery, is a new company formed for the purpose of delivering groundbreaking treatment of drug and alcohol addiction in the UK, for the individuals who can fund their own treatment. Our first residential treatment centre 9 miles south of Maidstone opened in October 2007. Our goal is to establish a centre of excellence in this field.

We are seeking to recruit a Senior Substance Misuse Nurse, with the motivation and skills to deliver our programme achieving successful outcomes for our clients, working a night shift rota of 5 shifts on and 5 off. You will be a registered nurse with experience in the addictions field, and preferably further training in the addictions field.

Successful candidates need to be exceptional individuals committed to working within a Clinical Governance Framework to deliver safe, effective, evidence based care.

In return for your hard work and commitment in what is a ground breaking organisation, we offer extremely attractive levels of remuneration and company benefits.

If you are interested in applying please send a copy of your CV with covering letter to Diane Jenner, the Director of Human Resources via e-mail:
dianejenner@winthrophall.co.uk
Website: www.winthrophall.co.uk

Closing date for applications is: 8 August 2008.

This post requires an Enhanced Disclosure under the Care Standards Act 2000.

HAGAM is an Uxbridge based BACP accredited agency providing counselling, advice, complementary therapies and group support for adult substance misusers and the wider community affected by substance misuse.

We are pleased to invite applications for the following opportunity in HAGAM:

Head of Counselling

37 hours per week (Job share will be considered)
Salary scale £29,958 - £33,403 (Dependent on experience)

This is an exciting opportunity for a motivated and proactive individual to lead HAGAM's counselling service by combining effective management and direct delivery of counselling and group work. You will be part of an enthusiastic small team who are committed to making a difference to the lives of those affected by drugs and alcohol misuse.

Candidates will be experienced counselling professionals with clear commitment to ethical and professional frameworks. They will hold a diploma or equivalent qualification in counseling and have 3 years or more experience of counselling substance misusers. Experience of managing counseling or substance misuse services is essential.

Closing Date for receipt of applications
5pm Monday 6th August 2008.
Interviews will be held on 14th August 2008.

For further information or to request an application pack please contact us on 01895 207 788 or email help@hagam.org.uk. Alternatively application packs can be downloaded from our website www.hagam.com
Please note that we are not able to accept CV's.

The Seagrave Trust

Nurse Practitioner

based at HMP Belmarsh, Thamesmead, London

The Seagrave Trust is looking for a highly motivated NURSE PRACTITIONER to work as part of its team in HMP BELMARSH. You will be delivering detoxification as part of a multidisciplinary team in a challenging and rewarding environment. We offer individualized evidence-based treatment for prisoners with drug dependencies, including alcohol related problems. This post offers the opportunity for a Nurse Practitioner with at least two years' experience relevant to Substance Misuse to gain further experience in our Drug Misuse Unit at HMP Belmarsh, Thamesmead, London. This post will specifically appeal to Nurse Practitioners currently already working within the Prison sector

Salary Grade 6 depending on experience and qualifications. Security Clearance will be required.

Please visit our web site at this link:
www.theseagravetrust.org/nurse-practitioner-job-description.htm

If you would like to apply for this post please email your CV to rosemarylass@theseagravetrust.org

CLOSING DATE FOR APPLICATIONS: MONDAY AUGUST 11TH 2008

RAPt

THE REHABILITATION FOR ADDICTED PRISONERS TRUST

stopping addiction. stopping crime.

We are currently recruiting at HMP Bullingdon, Oxon for:

Treatment Manager
Senior Alcohol Counsellor

Closing Date: 08/08/08
For more information and to apply, go to www.rapt.org.uk/employment.php

Project Worker, Alcohol Brief Interventions

22.5 hours per week incl. 1 evening per week.
Dartford and Gravesham
Salary £21,952 rising to £23,421 (pro-rata (£13,350)

This is a new adult alcohol misuse service for Dartford and Gravesham. Action for Change works closely with a range of statutory and voluntary organisations and take pride in what we do.

Project Worker, Alcohol Brief Interventions, is a varied and challenging role where you will provide a range of Brief Interventions for adults accessing a new Open Access service for the area. You will work with a range of colleagues to provide the best level of support for this client group, and will be expected to develop strong links with other local services, as well as being able to work on your own. You will be expected to also contribute data and information into the evaluation of this project, and to be able to maintain your own administrative needs. We can offer a high level of support and development as well as a generous pension and leave entitlement.

Closing date: Friday 29th August 2008

For more details e-mail reception.hh@action-for-change.org or telephone 01424 460066. Our website: www.action-for-change.org will tell you more about what we do.

Unfortunately we do not accept CVs.

This post will require an Enhanced Disclosure from the CRB.

Action for Change is working to be an Equal Opportunities employer.

CRI North & Midlands

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

CRI are delighted to have recently been awarded contracts to deliver CARAT substance misuse services in the West Midlands.

Team Leader *(Ref NM068)*

HMP Shrewsbury
Full Time 37.5 hrs per week • Salary: £28,843 – £30,439

The existing Team Leader at HMP Shrewsbury is moving to another post and as such we are seeking to recruit a dynamic leader to drive the delivery and development of this service. You will work closely with the Prison establishment to deliver effective treatment interventions. If you can demonstrate the necessary experience of working in substance misuse and with offenders, the ability to build positive relationships with a range of stakeholders, you possess strong leadership qualities and the determination to make a difference this could be the opportunity you have been seeking.

2 x CARAT Workers

One at HMP Shrewsbury *(Ref NM069)*
One at HMP Stoke Heath *(Ref NM070)*
(both fixed term until January 2009 – Maternity cover)
Full time 37.5 hrs per week • Salary: £21,920 – £25,130

We are seeking applicants to provide fixed term maternity cover for CARAT worker posts at both establishments. You will have good knowledge of substance misuse issues, treatment options, the criminal justice system and community support services. Experience of assessment, care planning and strong client engagement skills are essential, along side the ability to form positive working relationships with team colleagues and partners across the prison and community.

Closing date for both positions: 13th August 2008

For an application pack and further information visit: www.cri.org.uk or call our recruitment line on 0113 380 4643 (24 hour answer phone) quoting the relevant reference number.

The successful candidate will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.

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want to join a successful, dynamic, expanding team?

Following a prolonged period of outstanding growth, opportunities have opened for innovative and dynamic individuals to step into these senior managerial roles.

Commercial Director
£50,000 – £60,000 (Luton or Warrington)
Company Car, bonus scheme, share option scheme (when available)

A newly created role of Commercial Director has opened within TTP Counselling, a rapidly expanding and successful substance misuse treatment provider offering Tier 2, 3 and 4 treatment. The role of the Commercial Director is to develop profitable, sustainable growth for the business by producing sound financial and commercial proposals; reporting to the Deputy Chief Executive Officer, the Commercial Director will lead a small team and take responsibility for all aspects of the commercial development and governance processes in the team. You must be able to plan strategies to attract new business opportunities and actively work towards expanding existing business services to promote a stronger commercial base. You will be hungry for success and have a strong commitment to getting things done. This role gives an ambitious candidate the ability to work in a fast paced, dynamic environment, and to lead the business development strategy. Most importantly, you will be working in an environment where you can really make a difference, where your ideas will be listened to, challenged and supported. Previous experience of working in the addiction field is essential, as is a very definite sensitivity to the needs of this client group. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/sober are encouraged to apply, but it is not essential.

Operations Manager
£28,000 – £36,000 (Luton)

You will have an instinctive ability to diagnose our current operational position and ideally an appropriate level of training to support your findings.The initial focus of this role will be to revise and implement our HR, Health and safety & Quality and Performance policies. You will help form our financial review team and deliver a programme of performance improvement targets within the business plan, identify and deliver upon opportunities for additional 'stretch' performance and report on their implementation. Ongoing training and support will enable the right applicant to hone their tactical leadership skills and, as our organisation becomes best in class, progress to Director level.

Business Development Manager
£20,000 – £36,000 OTE (South East)

Developing business relationships with both statutory and GP referrers. 2 years+ working within the substance misuse field and familiar with DAT/DIP/ Social Services referral pathways and purchasing of Tier 3 / 4 services.

To apply please email a CV and covering letter to: recruit@ttpcc.org.uk

TTP Counselling Centre Limited is an Equal Opportunities employer.

alcohol and drug rehab

www.trusttheprocess.org