DDN
Drink and Drugs News
26 April 2010
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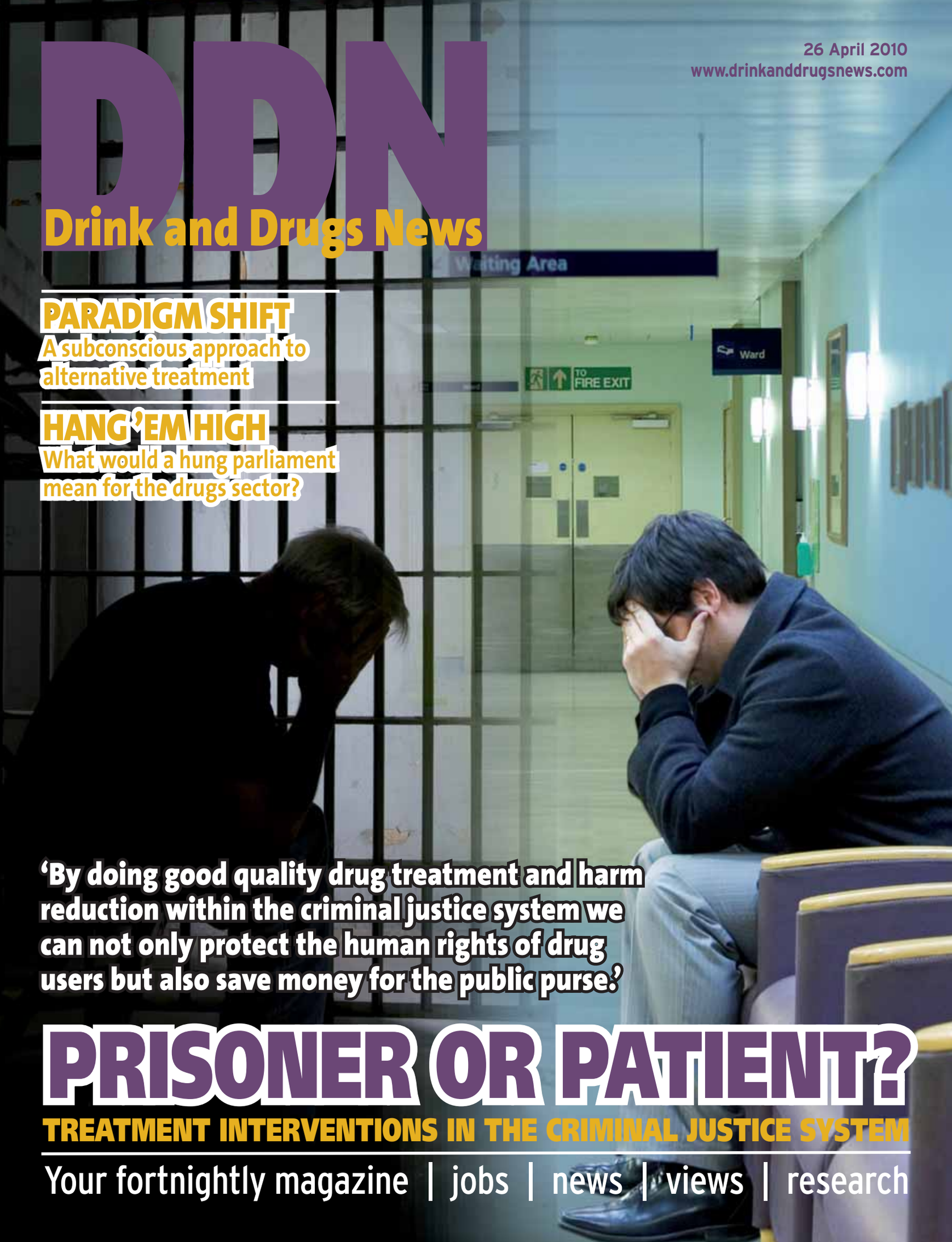

PARADIGM SHIFT
A subconscious approach to alternative treatment

HANG 'EM HIGH
What would a hung parliament mean for the drugs sector?

'By doing good quality drug treatment and harm reduction within the criminal justice system we can not only protect the human rights of drug users but also save money for the public purse.'

PRISONER OR PATIENT?

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Westminster Drug Project

Working with individuals and communities to tackle drug and alcohol misuse

Our Vision

Our vision is of a society that is healthier and safer because it is well informed about drug and alcohol use: where people adversely affected can get effective help

WDP services are rated at least 8 out of 10 by 93% of service users

WDP stakeholder surveys 2010

WDP is the best provider in the UK for assessing service users who are Class A drug users

Home Office dashboard averages (10 month period to February 2010)

WDP is "One to Watch" in the Sunday Times Top 100 Best Companies To Work For 2010 Awards

We are at the International Harm Reduction Association conference in Liverpool this week.
Come to Stand 16 to find out more about our services, jobs and volunteering opportunities.

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DDN Drink and Drugs News

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Website:
www.drinkanddrugsnews.com
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Jelly Pics

DDN is an independent publication, entirely funded by advertising.

PUBLISHERS:

CJ Wellings

PARTNER ORGANISATIONS:

fdap
Federation of Drug and Alcohol Professionals

SUPPORTING ORGANISATIONS:

Adfam
Alcohol Concern
The Alliance
ANSA
drugsandalcoholtoday
EATA
European Association for the Treatment of Addiction
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Editorial – Claire Brown

No patient game

Tough talking on crime as the election draws near

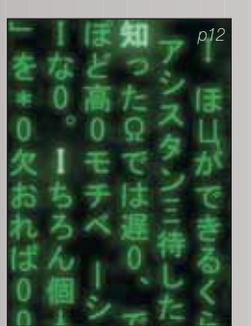
Election campaign sparring has brought tough talk on crime from the party leaders, ahead of concern for prisoner welfare. After all, safer communities are a hot election issue throughout the land; pleasing 85,000 incarcerated people who don't have the vote is not.

Our cover story this issue (page 6) gives insight to the slow steady progress on prison welfare reform, focusing on health and harm reduction. Practice in other countries in Europe and the US is constantly informing suggestions of radical change in our own criminal justice system. The picture is of painfully slow progress in treating drug-using prisoners as patients and giving them the standard of sustained care we would expect in any drug treatment unit in the community. How important then that we don't interrupt this progress for the sake of tough talk from the new broom – whoever it should be.

Our commentators from EATA encourage a steady view of the prospect of a hung parliament – and by the time you get our next issue, the suspense will be over. Steve Rossell and Katie Hill urge us to offer creative ideas to the parties to influence them on safeguarding services in our sector. If any politician needed convincing of the need to stop issuing knee-jerk reactions to every new drug discovered and address the massive issue of alcohol addiction, they might gain insight from reading Julian's story on page 11. It's a sobering reminder that drinks advertising is everywhere and in your face, quite apart from the subliminal messages in every facet of the media. Can you picture a sports team with the name of a drug dealer on their shirts?

Politics is an increasingly ludicrous game this week, with the party leaders vying to show muscle against Europe, America, each other, whoever. Let's hope the politicians don't lose all continuity in dealing with those who most need them, in their quest to be the party of change.

This issue



FEATURES

REGULARS

News in Brief

Continuous care

A new service to make sure offenders receive continuous care between prison and the community has been launched by the Essex Drug and Alcohol Partnership (EDAP). EDAP has commissioned the Westminster Drug Project (WDP) to deliver targeted interventions as part of the government's Drug Systems Change pilot scheme. 'The new service will redirect the lives of the most problematic drug users in Essex, and improve the lives of their family and carers and the wider community by reducing re-offending and increasing reintegration,' said strategic manager at Essex DAAT, Donia Slyzuk. *See page 6 for our special criminal justice feature.*

Friday 40

One in ten young people in Manchester, Liverpool and Chester interviewed by researchers from Liverpool John Moore's University on Friday and Saturday nights said they expected to have drunk more than 40 units of alcohol by the time they went to sleep. 'The British drinking culture is entrenched and this shocking evidence of excessive alcohol consumption in the North West reinforces the worrying attitude we have towards alcohol,' said Drinkaware chief executive Chris Sorek. 'Drinking more than 40 units in one night – equivalent to 20 double vodkas – is exceeding the daily unit guidelines by ten times for a man and over thirteen times for woman. By educating people on the harmful effects of drinking and offering them tips on how to cut down we can encourage people to take a closer look at their relationship with alcohol and make positive changes.'

Treatment manifesto

Alcohol Concern has called on election candidates to support alcohol treatment services in their constituencies by demanding a national alcohol treatment target and increased funding. 'Although many commissioners now understand the need for better alcohol services, we need a national alcohol treatment target to focus attention on ensuring access is available to all who need it,' said chief executive Don Shenker. 'This can only be supported by a huge funding boost so that services can help government to reduce alcohol harms.'

Mephedrone banned

Mephedrone and its related compounds have been banned and made class B drugs. The ban follows recommendations from the Advisory Council on the Misuse of Drugs (ACMD), said home secretary Alan Johnson, and includes generic compounds to prevent suppliers from switching to new versions of the substance.

'The advice we have provided to government is generic legislation encompassing a wide range of cathinone derivatives,' said ACMD chair Professor Les Iversen. 'This is, as far as we are aware, a world first for cathinones. By proposing this chemically complex legislation we expect that our drug laws will be more robust and more difficult for chemists to develop new substances to flout the law.'

'Mephedrone and its related substances have been shown to be dangerous and harmful, but it is right we waited for full scientific advice so we can take action that stops organised criminals and dealers tweaking substances to get around the law,' said Alan Johnson. The ACMD had expressed concerns about the potential health effects of mephedrone, citing evidence that it could cause 'hallucinations, blood circulation problems, rashes, anxiety, paranoia, fits and delusions'.

There has been widespread criticism that the government's actions regarding mephedrone have been driven by media coverage of the substance (*DDN*, 29 March, page 4), along with continued questioning of the role of the ACMD, two more members of which have now resigned.

Even before the ban came into force on 16 April the government had moved to control availability of the drug by banning imports. The UK Border Agency was given permission to seize and destroy shipments of mephedrone from the end of last month, and the home secretary also wrote to local authorities urging them to use consumer protection and medicines legislation to seize the drug in advance of the ban.

The Association of Chief Police Officers (ACPO) said it 'broadly welcomed' the decision to classify mephedrone as class B as it sent out a message that it was 'a dangerous and harmful drug that should not be taken'. ACPO lead on drugs, chief constable Tim Hollis, said enforcement would 'initially concentrate on those people who sell and traffic this harmful drug rather than on the young people we may find in possession of it'. 'It is not our intention to criminalise young people,' he said, adding that the classification did not 'solve what has become an increasingly complex issue, and making something illegal does not stop it being sold, bought or consumed'.

There have now been seven resignations from the ACMD since the sacking of chair Professor David Nutt late last year (*DDN*, 16 November 2009, page 4) with Polly Taylor and former Drug Education Forum (DEF) chair Eric Carlin resigning earlier this month.

'The troubles of the ACMD are symptomatic of a deeper, less visible crisis in the process by which the government uses evidence and expert advice' Ms Taylor wrote in *The Observer*, saying that she had stood down because the government had failed to guarantee the academic freedom and independence of its science advisors. Eric Carlin, meanwhile, stated in his resignation letter that the decision to ban mephedrone had been 'unduly based on media and political pressure'. He had hoped that the ACMD could 'develop a work programme which would help prevent and reduce harm, particularly to young people', he wrote, but now had 'no confidence' that that would happen.

The Home Office has announced three new appointments to the ACMD – Hew Matthewson, Gillian Arr-Jones and Simon Gibbons. All will be for a period of three years.

Prisoners must work to get clean

Prisoners given sentences of more than six months must be made aware that they are 'expected to work towards becoming drug free' according to updated guidance on prison-based opioid maintenance prescribing issued by the Department of Health.

'There is currently some concern that maintenance prescribing is being initiated without systematic review arrangements in place as set out in the initial guidance and therefore the continuation of some prescriptions may be clinically inappropriate,' it says.

Under the new guidance, which aims to ensure that 'prisoners do not remain on open-ended maintenance regimes', the option of methadone or buprenorphine maintenance should be considered where a 'chronic opiate user' is received into custody on remand, where drug-dependent prisoners enter custody on a sentence of less than 26 weeks or where 'it is considered necessary' to protect the prisoner from the risk of overdose on release. 'However,' it states, 'prisoners should be made aware from the outset that, if they go on to receive a prison sentence of more than six months, they will be expected to work towards becoming drug free', adding that they should be supported to achieve abstinence and expected to participate in rehabilitation, educational and psychosocial opportunities.

There is also a requirement that periods of extended prescribing – 'whether maintenance or gradual reduction regimes' – are reviewed a minimum of every three months. However, slower reduction of maintenance will be allowed when 'it is considered that any other intervention, swift reduction or detoxification' would have an adverse effect on health, for example in the instance of serious mental problems or a history of injecting while in prison.

There has been press criticism of prison methadone prescription in recent months, with *The Times* in particular running a number of stories on the subject, one of which prompted DrugScope to write to the newspaper highlighting its concerns about the way the issue has been covered.

'Prisoners have the right to the same health and social care options as they would in the community – which for drug users includes access to methadone prescribing' said the letter from chief executive Martin Barnes. 'And it is no exaggeration to say that for many prisoners, a methadone script can be the difference between life and death.'

Home Office in the dark over £1.2bn drug spend

Lack of evaluation means the Home Office does not know the overall impact of the annual billion pound spend to tackle problem drug use, according to a report from the House of Commons Committee of Public Accounts.

Central and local government collectively spend £1.2bn a year to deliver the objectives of the 2008 drug strategy, says *Tackling problem drug use*, yet the Home Office 'does not know how to most effectively tackle' the issue.

'Given the public money spent on the strategy and the cost to society, we find it unacceptable that the Department has not carried out sufficient evaluation of the programme of measures in the strategy and does not know if the strategy is directly reducing the overall cost of drug-related crimes,' states the report.

Following recommendations by the National Audit Office, the Home Office will report on the value for money achieved from the strategy, with initial results 'from late 2011'. The committee wants to see annual reports setting out expenditure, outcomes and progress towards targets, as well as 'specific measures directly aimed at driving down offending by hard-core problem drug users for whom the Drug Interventions Programme (DIP) and drug treatment does not work'. It also wants to see evidence 'established quickly' to determine which housing measures are most effective, as up to 100,000 drug users in England continue to have housing problems despite local authorities spending £30m a year on housing support, and evaluations of the effectiveness of measures to reduce problem drug use among young people.

The committee was 'right to highlight the need for the overall drug strategy spend to be evaluated,' said DrugScope chief executive Martin Barnes. 'With the publication of this report, the public accounts committee have highlighted one of the major problems affecting the implementation of the current drug strategy – the lack of evaluation,' he said. 'Since the first strategy was published in 1998 there has been insufficient government investment in good quality, longitudinal research into some areas of the strategy's activities, most notably in establishing the evidence base on what is effective in supporting people to reintegrate into society after they have recovered from a drug problem, preventing relapse and stopping the cycle of drug-related offending.'

Release, meanwhile, said it was disappointed at the 'lack of any honest appraisal of the continued failure of present drug policies or serious discussion of alternative measures'. 'There is no recognition, for example, of the degree to which "problem drug use" is rendered more problematic, not less, by criminalisation or coercive treatment' stated the charity.

Report available at www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm

UKDPC and Demos research drug control 'fit for our time'

A research project looking at how policymakers should respond to the threats posed by new drugs has been launched by the UK Drug Policy Commission (UKDPC) and the Demos think tank.

Funded by the A B Charitable Trust, the project will look at new approaches to classification and the development of a new 'constitution' for drug control.

There are now 600 compounds controlled by the Misuse of Drugs Act but this has had 'little bearing' on drug use, says UKDPC. The project will bring together representatives from regulation, enforcement, medicine control and trading standards with the aim of formulating new control processes that are 'fit for our time' said UKDPC chief executive Roger Howard – 'so the strategic capacity of the system to react to new threats is improved and public, professional and scientific confidence is renewed'. The UKDPC recently proposed a new interim category – 'category x' – for drugs while a proper assessment of evidence of their harm is carried out (*DDN*, 29 March, page 4).

'The furore about drugs like mephedrone has put this issue in the spotlight,' said lead researcher at Demos, Jonathan Birdwell. 'This project will get past the hype and focus on what the evidence is, what the aims of policy should be – and how to reach them.'

Another fatal anthrax case for Scotland

The number of deaths in the Scottish anthrax outbreak has risen to 12, with Health Protection Scotland confirming a fatal case in Lanarkshire.

The death is the first for four weeks in Scotland and the first in Lanarkshire, while new cases have also been confirmed in the Greater Glasgow and Clyde and Lothian NHS Board areas. The Lothian case is the first confirmed in that area.

The number of confirmed anthrax cases in Scotland now stands at 35 since the outbreak began last December (*DDN*, 18 January, page 4), and there have also been confirmed cases in England and Germany (*DDN*, 15 March, page 4).

The latest cases emphasise that 'contaminated heroin still appears to be in circulation in Scotland and, as a result, further cases may come to light' said Health Protection Scotland. The number of confirmed cases could also rise as a result of retrospective analysis of 'borderline test results from patients earlier in this outbreak', said the agency.

News in Brief

Could do better

Government action to address alcohol has been slow, according the King's Fund report *A high performing NHS? A review of progress 1997–2010*. Consumption has increased along with rates of liver disease, it says, with no targets set. However, there was 'no doubt that the NHS is closer to being a high-performing health system now than it was in 1997'. Meanwhile, the mandatory code on alcohol, which introduces five conditions for retailers, including banning 'all you can drink' promotions, has come into force. The code's conditions on age verification and small measures will come into force in October, but a minimum price per unit of alcohol – recommended by many health professionals including the chief medical officer – was omitted from the final code (*DDN*, 23 March 2009, page 5). *Report available from www.kingsfund.org.uk*

Moving issues

A new report from the EU Monitoring Centre on Drugs and Drug Addiction (EMCDDA) looks at how harm reduction has moved from 'controversy to mainstream'. More than 50 authors study two decades of European harm reduction research and practice in *Harm reduction – evidence, impacts and challenges*, which also considers possible future directions. *Available from www.emcdda.europa.eu See the next DDN for a full round up of the 21st IHRA international harm reduction conference.*

Scrumpy scrap

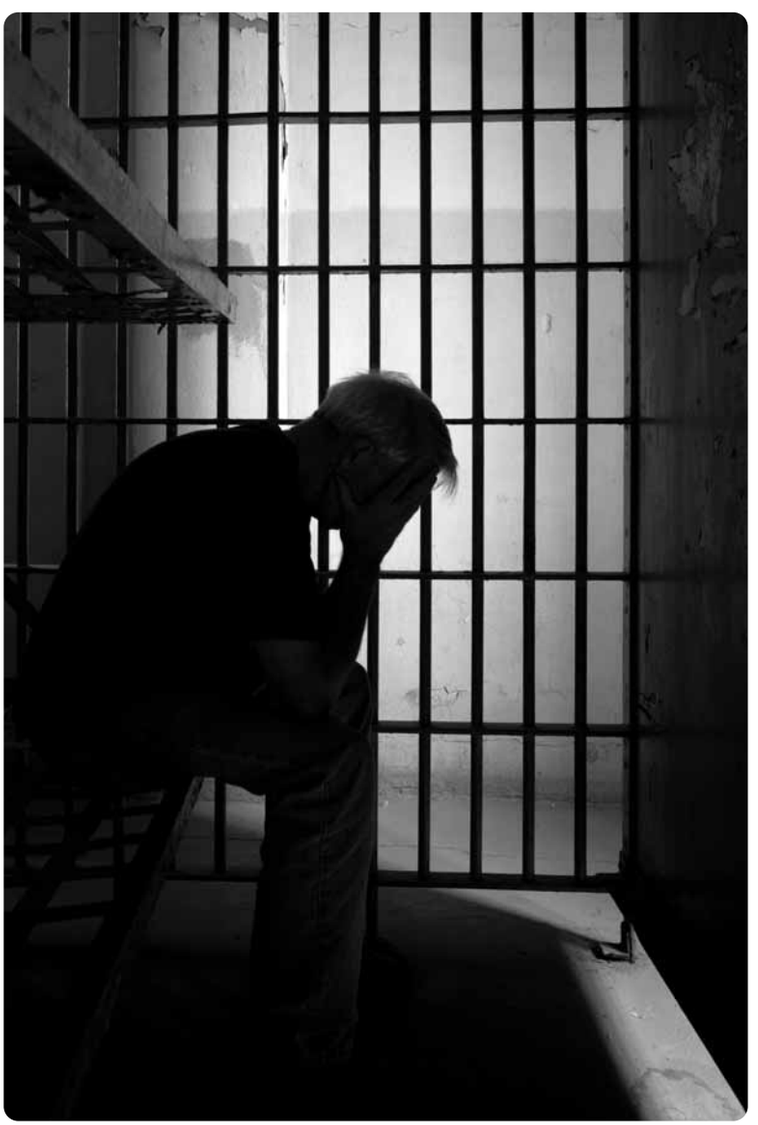
A 10 per cent increase on duty rates for cider introduced in the last budget (*DDN*, 29 March, page 5) has been scrapped as a result of opposition from cider manufacturers and lack of legislative time before the election. The move was intended to target higher strength brands.

Viennese whirl

The United Nations Office on Drugs and Crime (UNODC) has published its 2010 annual report, *Promoting health, security and justice*. The report, says UN secretary general Ban Ki-moon 'is further proof of how Vienna has become a hub for human security issues and how the UN can deliver assistance in the field to save people from the misery of drugs and crime.' *Available at www.unodc.org*

PRISONER OR PATIENT?

This summer a major two-day conference in London will look at the ethics, effectiveness and economics of drug treatment interventions in the criminal justice system. **David Gilliver** sets the scene



To people living in a country that often feels as if it's governed by the tabloid press, it can come as a surprise to learn that the first needle exchange inside a Swiss prison opened in 1992, and that by 1996 there were seven such schemes operating. Professor Ambros Uchtenhagen, widely credited with being one of the architects of Swiss harm reduction and still very much involved at 82, will be making a rare UK appearance at the Connections Project's conference, *Drugs, alcohol and criminal justice: ethics, effectiveness and economics of interventions*, in London this June.

Professor Uchtenhagen will be talking about the impact and cost-effectiveness of harm reduction measures, obstacles to evidenced-based policies, international standards for caring for drug-dependent people in prisons and ethical guidelines and their practical implications. People have long been calling for effective harm reduction services in prison equivalent to those in the community – is that something that's actually happening in Switzerland? 'It is,' he says. 'We don't have needle exchange programmes in all prisons, but we've tested it, we've evaluated it, it's available and all the findings are positive. There's no indication of more consumption and no use of used syringes as weapons against staff or any of that kind of thing.' What's particularly striking is that there were actually very few objections from the Swiss media, he says. 'The main resistance came from prison staff and from people arguing against any harm reduction measures. It was less of an issue for the media and the public in general.'

Organised by the Conference Consortium and supported by *DDN* and probation officers' union NAPO, the event will be the second Connections conference since the project launched three years ago. Managed by the European Institute of Social Services at the University of Kent and part-funded by the European Commission's public health programme, the project's aim is to promote joined-up responses to drugs and drug-related infections across the criminal justice systems of the EU.

No one needs reminding of the squeeze facing the public finances and the conference will be exploring which combination of treatment interventions offer best value for money, and one of the key themes will be around evidence of what really works. While there has been more questioning of aspects of prohibition in parts of the press in recent months, any attempt to move drug treatment in the criminal justice system in a decisive harm reduction direction would face a hostile response, to say the least. How should policymakers tackle that? 'There was a lot of opposition to the idea of expanding methadone in prisons, but methadone treatment – whatever people think of it – is the standard treatment now that should be offered to people assessed as in need of it, whether that's in the community or in prison,' says Connections project director Dr Alex Stevens. 'We need to increase the pressure here, to say that just because people are in prison it doesn't mean they lose the right to the most effective and appropriate treatment.'

This relates to another major theme of the conference – the question 'prisoners or service users?'. 'If the most appropriate treatment for them is needle exchange or it involves heroin-assisted treatment then, just because they're prisoners, the public clamour against it does not deny their right to the most appropriate treatment,' he says. 'The government has signed up to an equivalence of treatment and encouraging steps have been made in that direction, partly through the provision of health services in prisons being done by the NHS rather than prison doctors and partly through the Integrated Drug Treatment System (IDTS), but more needs to be done to raise the level of equivalence between treatment within and outside the criminal justice system. That's not just for harm reduction – we should be looking at providing greater levels of abstinence-based treatment as well.'

'Drug-dependent prison inmates are prisoners and at the same time patients, as are prisoners suffering from somatic conditions or mental conditions,' says Uchtenhagen. 'The issue of human rights of prison inmates has been dealt with extensively by the World Health Organization, providing clear guidelines for policy and practice. Research has evidenced the advantages in terms of safety, reduced mortality and morbidity and reduced risk behaviour after discharge – resulting in large returns for invested resources.

At the first Connections conference Stevens told delegates that it was essential to reduce the use of imprisonment (*DDN*, 18 May 2009, page 10) and praised the Portuguese model of decriminalising possession of drugs for personal use, defined as up to ten days' supply. Is it still proving effective? 'That's good practice in keeping people out of the criminal justice system, which is one of the best ways to avoid people coming to harm within it and over-burdening it with drug users,' he says. 'Since they've decriminalised drug use there's been a significant fall both in

the number of people in prison and in the overcrowding rates in prisons.'

Alongside decriminalisation, the Portuguese have set up community referral panels and expanded the treatment system itself, he points out. But when it comes to work within prison itself, Switzerland is the beacon of good practice and – although Eastern European countries still tend to have high rates of imprisonment and Russia remains extremely punitive – countries such as Moldova have also made 'very rapid steps to introduce humane and effective treatment within the criminal justice system' he says, and he is optimistic about the way things are moving in Europe as a whole. 'We did a study in '98 of developments since '95 and things were starting to move then, and they've definitely rapidly improved since. That doesn't mean the problems are solved – we still have too many people in prison, huge problems assuring continuity of care and we're still not using the most effective and cost-effective treatments across the European criminal justice system. There's a lot further to go.'

Uchtenhagen, as well, is cautiously optimistic about the overall direction of policy. 'The European Union is following a pragmatic course of action in its policy, recommendations and research programme,' he says. 'The present administration in the USA seems to be moving towards a more pragmatic course than the last, while Russia is still dominated by prohibitionist repression and in Asia some countries are engaged in a pragmatic policy while others are still mainly repressive. The UN has opened a door to more pragmatic views, but the future is still unpredictable.'

Closer to home, however, the Local Government Information Unit issued a report last year stating that nothing short of 'radical restructuring' could save the British criminal justice system, as two thirds of adults re-offend within two years despite us spending more on law and order as a percentage of GDP than any other OECD country (*DDN*, 27 July 2009, page 4). One thing that will inevitably dominate any discussion on treatment and criminal justice in the UK is partnership working – or lack of it. When DDN questioned politicians last year, both Labour and Conservative MPs said joint working between the criminal justice and treatment sectors was failing dramatically, while former chief inspector of prisons Lord Ramsbotham called joined-up working a 'myth' (*DDN*, 27 July 2009, pp9-12).

'The problem is that the criminal justice system is inimical to partnership working,' says Stevens. 'When you take someone out of the community and put them in prison – as the whole point of prison is to lock people away – it therefore makes it harder to provide continuity of service to that person. One of the things we should be doing is using less imprisonment, and if we are imprisoning people we should invest more in the system and the funding to make sure people can get continuity of treatment.'

One of the areas where lack of joined-up working is felt most keenly is at the point of release when other agencies like accommodation and benefits should be stepping in. 'That's a major area for improvement,' he says. 'There are steps to try and improve that coordination, the Drug Intervention Programme (DIP) being one of them and IDTS being another, but there's a long way to go to ensure that people's journey through the criminal justice system does not interrupt their treatment needs. Accommodation is obviously a huge issue for people coming out of prison, as is the risk of overdose. There are encouraging steps to make the links better, such as the Through the Gates service provided by St Giles Trust. I'm sure that other people are doing similar things, but this idea that people should be met at the gate when leaving prison is an important one.'

At the *In somebody else's shoes* criminal justice event last year the most-heard complaint from delegates was that the target culture had distorted priorities in the service to the detriment of people's health and wellbeing (*DDN*, 27 July 2009, page 6). Does Stevens go along with that? 'It's double-edged sword,' he says. 'The target culture has helped to drive improvements in the number of people who get treatment, but it's also hindered the ability of practitioners to work holistically with their clients. What we need to work out is a way to expand the treatment system – including within the criminal justice system – in a way that enables people to build the therapeutic relationships that are most effective.

'One of the things we want to stress at the conference is that this isn't just a question of humanity and ethical choices, it's of effectiveness and cost-effectiveness. We're all moving into straitened times and we're going to need ways to work effectively so that we can target our resources on the people who need them most. By doing good quality drug treatment and harm reduction within the criminal justice system we can not only protect the human rights of drug users but also save money for the public purse.'

Drugs, alcohol and criminal justice: ethics, effectiveness and economics of interventions, London, 24-25 June 2010. www.connectionsproject.eu/conference2010

'We need to increase the pressure here, to say that just because people are in prison it doesn't mean they lose the right to the most effective and appropriate treatment.'

CONFERENCE NEWS

DDN reports from workshops at the *Drugs and alcohol today* exhibition in London

Meph, spice, all things nice

Dealing with legal highs is hampered by lack of communication and reliable information, according to Diederick Martens, a young persons' drug and alcohol worker from Kent-based charity KCA. The problem, said Mr Martens, was that young people wrongly equated 'legal' with 'safe'. Coupled with the lack of authoritative information, they were prone to combining the drug with alcohol to create dangerous compounds, having little awareness of their dosage levels.

Dr Ornella Corazza from the RedNet project (Recreational Drugs European Network) at the University of Bedfordshire continued the argument for better communication by explaining two key elements of the new EU-wide technology based project. The first, the Psychonaut Web Mapping Project, was a database compiled in eight languages, and looked for all drugs available over the internet. So far, 419 substances had been identified. The second element related to providing accurate information to young people and professionals through a variety of technologies, such as SMS, email, and social networking sites. The approach offered a fresh alternative to traditional prevention formats, which were seen as 'fear based, moralistic and theoretical', said Dr Corazza.

Chairing the session, Harry Shapiro from DrugScope added that 'trying to sort the sense from the sensational is the job for people like us'.

Supporting the family

With the drug strategy identifying that families need support, 'we need to roll our sleeves up and make sure they get it,' said Viv Evans, chief executive of the family support charity Adfam.

Natalie Pallier, project co-ordinator, said the charity had been looking at the links between substance misuse and domestic violence and considering how to support people affected by both issues. Focus groups for children and young people had explored their understanding of healthy relationships and shown that children of different ages acknowledged the impact drugs and alcohol could have.

Family abuse was not limited to being from parent to child. Older children could abuse their parents financially, emotionally or psychologically, said Ms Pallier, with parents unwilling to disclose abuse because of stigma and a wish to protect their child. A report by Dr Sarah Galvani would be available on 30 April on the website, www.adfam.org.uk

Joss Smith, head of policy and regional development, said Adfam was keen to discover if the political debate on better support for families was translating to local and individual practice – the impetus behind the charity's five-point manifesto (*DDN*, 29 March, page 6).

Workforce development update

'It will be illegal to employ people who haven't been vetted,' Carole Sharma reminded delegates, in the session *Workforce development – where are we now?*

As FDAP chief executive, Ms Sharma was well-placed to advise on the Independent Safeguarding Authority's Vetting and Barring Scheme. 'If you're giving out information and advice, you're going to be regulated,' she said.

'So far the ISA has interacted with our sector quite well,' she commented. Effects of the scheme were far-reaching, with even AA and NA staff working in prisons needing to be vetted. The first-stage implementation deadline was fast approaching – new workers needed to be registered from July 2010. Existing employees and volunteers with no CRB checks had to apply by 2011 and all workers needed to be registered by 2015. The NTA was currently developing specific guidance for the drug and alcohol field.

Supporting the development of the specialist alcohol workforce was another of FDAP's key concerns. With 8m people estimated to be drinking in a way that could cause them harm, brief interventions were seen as a successful way of raising awareness. The Department of Health's alcohol team were keen to support widespread teaching of brief interventions, including doctors' and pharmacists' training, and the RCGP was putting GPs and nurses through the post graduate certificate for alcohol in primary care.

'We need behaviour change interventions, working with public health to ensure workforce development resources are available,' said Ms Sharma.

'I am glad to believe the evidence and have learned from this experience that people do find different ways, walk different paths.'

Flexible in AA

I would like to reply to the letter by Sean Rendell (*DDN*, 29 March, page 8). I sympathise totally with Sean and feel concerned that his experience of AA has been the way it was. My sponsor, while truthful with me, carried the message of recovery to me differently from how it seems to be today. Bill W in *Working with others* particularly emphasises 'being careful not to moralise or lecture', 'show how they (the principles) worked for you' and 'offer him friendship and fellowship'. Mention your own experience, perhaps make suggestions – there are no rules.

Alcoholics are people who already carry much shame, and apparent 'failure' leads to hopelessness, depression, and the belief that AA is not for us. Alcoholics need simple facts about the illness and the AA programme – guidance, encouragement and learning by example, so they can begin to trust and follow. Lecturing isn't helpful; alcoholics are usually anxious and afraid underneath their defences. It is a programme of action, not endless analysis and debate.

I regret that Sean's experience of AA has been unhelpful but fear that it is not unique. The fault does not lie within the 12-step programme, which is open to a very wide variety of interpretations, but in the thinking of those who believe it is a series of prescriptions to be applied rigidly to all situations. AA, after all, has no hierarchy and no way of imposing an orthodoxy.

There is a fairly widely held sense that we 'have to get it all out' when having experienced early trauma. Where childhood abuse of any kind is concerned, this needs special help, maybe only appropriate a little later in recovery when a firmer foundation of abstinence is acquired. I am very sorry that Sean's experience of the 12-step programme seems to be that the programme is making him feel that the abuse was all his fault and nobody else's. Absolutely not the case.

If someone in early

recovery needs to process traumatic experiences it must be with specially trained and experienced professionals. It can re-traumatise a person by pressure to open up, to talk and feel before s/he is ready and has enough support (perhaps this is how Sean believes he was made to feel it was all his fault).

It is documented that alcoholics gain recovery in different ways, and I have the experience of my own six children, who all became addicted/ alcoholic. My late husband was a recovering alcoholic when we met, and I was not even an occasional drinker at the time so alcohol did not appear to be a problem when we had our large family.

Considering the genetic theory of alcoholism meant our children all had a double-dose of the genes (much researched). I have two sons and a daughter now in stable recovery in AA. I have another two sons who somehow, with no help from me, have managed dramatically to raise their level of functioning from an exceedingly worrying and dangerous 'rock bottom' to manage much better socially, intellectually, within relationships and employment, even though they still may use or drink. I do not understand this and personally never managed it. I am glad to believe the evidence and have learned from this experience that people do find different ways, walk different paths.

Christine Wilson,
Hemel Hempstead

SMART futures

In recent months, there has been a sometimes heated debate about the direction of SMART Recovery in the UK, in part triggered by financial problems and loss of the only paid post. A letter recently published by the Board of Trustees addressed the fear being expressed by some members that SMART Recovery was being taken over by treatment providers.

The Board responded... 'It is the unequivocal view of the Board that that the heart and soul of SMART Recovery is the peer-facilitated meeting. The number one objective and measure of success for the organisation should be the growth in availability and quality of these meetings', although the board was '…minded to develop an approach to partnership with treatment services that offers benefit to them, as well as growing SMART Recovery'.

Partnerships with treatment providers already exist in many places across the country, such as the Alcohol Concern pilots and at a variety of projects run by Addaction. These are proving very popular but are attracting some criticism from people who fear that such partnerships undermine the mutual aid aspects of the movement.

The Board of Trustees is seeking to identify an approach to partnership with the treatment sector that would work to help build the SMART Recovery movement but maintain the central importance of peer-led meetings. A consultation document with outline proposals will be published and a full consultation process launched. This will include at least three consultation events, online questionnaires and discussion materials passed down to meetings.

If you are interested in participating in the consultation, please visit *www.smartrecovery.org.uk* or contact me on *richard@drugsandalcohol.net*

Richard Phillips,
SMART Recovery

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

STIGMA AND DOGMA

Christopher Hallam and Sebastian Saville challenge assumptions behind the recent stigma debate in DDN

PROFESSOR MCKEGANEY'S ARTICLE ON STIGMA (*DDN*, 15 February, page 14) provoked impassioned responses both for and against his point of view. Whatever one feels about the piece, it highlights some of the structural conflicts and contradictions that usually course silently through drug policy and treatment. There is a fairly evident clash, for example, between the imperatives of 'user involvement' (both in the sense of having input to treatment decisions, and in the wider sense of including drug users in social life) and the fact that these users' drugs are illegal – which is to say, they are stigmatised in a continuous, formal, institutionalised way.

Rather than engaging in further 'is he right or wrong?' deliberations about this professorial intervention, we want to look at assumptions underlying the argument, and explore their implications. The argument is grounded in two essential points: one, that drug use is a bad thing for society, and two, that stigmatisation is an effective modality of prevention.

Let's take the first then, that drug use is bad for society. Many people take this as such a self-evident fact that to question it is itself regarded as a sin. But if we put aside this reflex response for a moment and think about it, it's obvious that this is an enormous generalisation, and like all such generalisations, it lacks precision.

Most people who believe in this principle continue to drink alcohol, but define it as something other than a drug. When it comes to alcohol, without the reflex stigma response kicking in, most people would probably judge it reasonable to say that alcohol can be bad for society, but it depends on how it is used. Historically, alcohol has at times been very harmful for UK society, but we have, by and large, learned how to regulate and to live with it, and for many people it contributes pleasure and conviviality to life.

Onto the second point – that stigmatisation is an effective technique for drug use prevention. Again, this is often assumed to be an obvious truth. Sweden is an unswerving believer in both of these principles, and Sweden does indeed, have low levels of drug use. Oddly though, the United States is equally strongly committed to them, and has the highest levels of drug use in the world. Russia is similarly placed. So, does stigma work or not? It seems there are others factors in play.

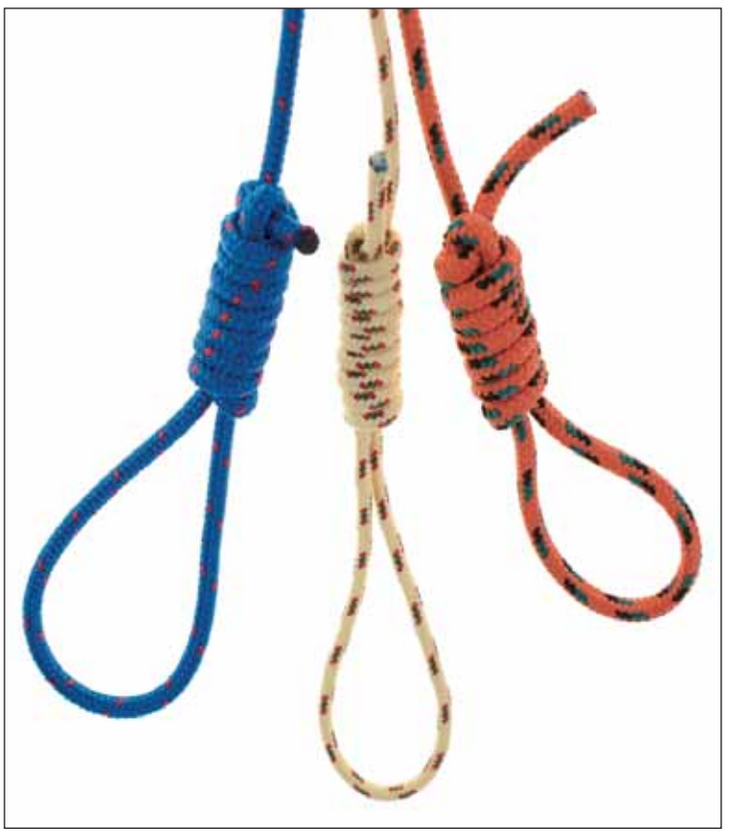
McKeganey calls for a sort of 'hate the sin but not the sinner' approach to drug use. But the problem is more fundamental – are those two core assumptions valid? We can see from the example of alcohol (which, if used unwisely, is perhaps the most devastating of drugs) that whether or not drugs are bad for society depends on how they are used. It's possible that the stigmatising mechanism of the law, while it may or may not have prevented some drug use has actually functioned to slow down the process of developing social and cultural norms to manage it. It has also provoked drug use amongst those who wish to rebel.

The fact is, human beings have always resorted to drug use to change their state of mind and find forms of ecstatic experience. Given this reality, we need techniques of guidance. Cultural norms develop regarding what is cool or not; the blanket disapproval of the law may have hindered them, since it has long been obvious to significant pockets of our youth that much so-called drug education is mere propaganda on the part of a generation that hypocritically leaves its own drugs out of the debate.

We should acknowledge that society is now a very pluralistic place, and currently illegal drugs have become a normal part of life for a sizeable minority of citizens. There is, consequently, no overall agreement about which behaviours should be disapproved of (stigmatised) and which should not. The drug laws, unfortunately, are rooted in a time when 'democracy' was, in practice, the tyranny of the majority. The stigmatisation of drugs went hand in hand with that of homosexuality, 'living in sin', inter-racial sex and all those countless other transgressions linked to a historically and culturally specific outlook, and having little in common with real crimes like murder and rape, which are subject to practically universal condemnation.

This is why the drug laws appear so anachronistic to many people in today's heterogeneous cultural landscape, and why the dogma they expound and the stigma they direct is so ineffective.

Christopher Hallam is a freelance writer and researcher. Sebastian Saville is executive director of Release



Hang 'em high

What could a hung parliament mean for the drugs sector? **Steve Rossell** and **Katie Hill** speculate

POLITICAL PUNDITS HAVE BEEN FORECASTING a hung parliament after the election and much has been said about how this could paralyse government. Many people working in our sector might be concerned at the effect of a hung parliament on drugs policy and on funding. But what might this relatively rare event in political life mean in practice?

The kind of questions we have been considering at the European Association for the Treatment of Addiction (EATA) are: Would the NTA come under pressure to change, or even be culled? Would government drugs programmes be delayed or altered? Would a recovery agenda be taken more or less seriously? Would there be a shift to drugs policy based on health rather than crime?

Of course we are not going to get firm answers. So what could the situation mean for us? The most important aspect of the British system is that the elected government of the day must enjoy the confidence of the House of Commons. A recent Hansard report states that 'traditionally hung parliaments have been viewed as unwelcome aberrations that produce short-lived and ineffectual governments'. In Britain, there is no written constitution and this means that conventions in constitutional practice have evolved to keep things moving.

Guidance from the latest manual from the Cabinet Office, published in February, puts forward the 'caretaker principle' which, until a new government is formed, allows the prime minister to remain in post and to sanction the civil service to assist other parties in their negotiations. Media reports suggest that this might mean parliament may not reconvene for nearly three weeks, rather than the usual six days. Senior Whitehall sources have said that in these circumstances Gordon Brown could try to create a working majority, even if the Tories were to win most seats.

The way government is managed is perhaps of less concern to us in the treatment sector. Of more interest is that the Lib Dem leader Nick Clegg said that his party would not want to enter a coalition government, but would support the party that gained most support. If that were the Conservatives, it is conceivable that support would be given in return for adoption of one or two of the Lib Dems' flagship policies. The Lib Dems have made it clear that they would not support cuts being made in the deficit during the first year of a new government, whether Labour or Conservative, but have made their own proposals.

The potential disappearance of the NTA and other such bodies matches Lib-Dem thinking about the culling of quangos – and if rumours are right, this might fit with Conservative Party intentions. How the disappearance of the NTA would affect the treatment sector is debatable, with assumptions about removing unnecessary administrative overheads ignoring the agency's wider function.

On a broader level, the financial markets would need to be reassured, because negative impact of any uncertainty brought about by a hung parliament could impact badly on our economy and the room any government has to manoeuvre.

A hung parliament if it happens will not last forever, although frustration levels will inevitably increase as decision making slows down and current programmes of government policy are delayed or revised. A new general election could be called within months. But the outcome could change the balance of power between the executive in government and the House of Commons as government becomes more dependent on the goodwill of the MPs in the legislature. Parliament itself could actually be made stronger. While this outcome might have no immediate impact on the way drugs policy is oriented or delivered, it does open up greater potential for change. Voices in favour of a recovery orientation and a shift towards a drugs policy based on health rather than on crime might find they have a greater chance of being heard and bringing influence to bear.

There is no point in panicking about a hung parliament. It will not alter the overarching trajectory of policies of the principal political parties, all of whom will make cuts in public sector budgets. Where the axe will fall, and how hard, will depend on all of us and the influence we can bring on the parties. We must rise to the challenge and offer creative ideas that will bring benefit to drug and alcohol users and wider society.

Steve Rossell is the chair of EATA and chief executive of Cranstoun Drug Services. Katie Hill is acting chief executive of EATA

History of hung parliaments

'Hung parliament' or 'minority government' describes a situation where no party has overall control. This has happened four times in the 20th Century – in 1910-1914, when Irish nationalists kept the Liberals in office; in 1924 when after nine months of a Labour government supported by the Liberals, Ramsay MacDonald called another general election; in 1974 when Harold Wilson gambled on winning another election; and in 1977-78 when Jim Callaghan negotiated with the Liberals and entered a formal Lib-Lab pact.

Coalition or 'national' government is different to a hung parliament, describing situations before 1945 in this country, where governments were formed to deal with national crises such as war and economic slump.

MANIFEST DESTINY

Looking for detailed, lengthy proposals on drug and alcohol policy in the main parties' manifestos? **DDN** saves you the trouble

Anyone searching for extensive or progressive discussion of drug and alcohol policy in the current election manifestos is likely to be largely disappointed. Where the issues do get a mention, two of the main parties seem primarily concerned with tough talking to appeal to the press.

'On drugs, our message is clear: we will not tolerate illegal drug use,' states Labour's manifesto. 'We have reclassified cannabis to Class B and banned "legal highs".' The party would 'switch investment towards those programmes that are shown to sustain drug-free lives and reduce crime,' it says, and does promise that 'alcohol treatment places will be trebled', albeit to 'cover all persistent criminals where alcohol is identified as a cause of their crimes'.

The Conservative manifesto pledges to 'use abstinence-based Drug Rehabilitation Orders to help offenders kick drugs once and for all' and says the party would 'engage with specialist organisations to provide education, mentoring and drug rehabilitation programmes to help young offenders go straight', as well as launch a pilot scheme of single agency Prison and Rehabilitation Trusts. Alongside promising a 'refocused' Serious Organised Crime Agency (SOCA) to help crack down on drug trafficking, the Tories would enable councils and the police to permanently close any shop or bar found persistently selling alcohol to children and double the maximum fine for under-age alcohol sales to £20,000.

The Liberal Democrats state they are in favour of 'the principle of minimum pricing', subject to 'detailed work to establish how it could be used in tackling problems of irresponsible drinking'. They also pledge to make sure that drug policy is always based on 'independent scientific advice', which would include 'making the Advisory Council on the Misuse of Drugs completely independent of government'. The party would ensure that resources are focused on treatment instead of 'unnecessary prosecution and imprisonment of drug users and addicts' and introduce a (much derided in the press) 'presumption against short-term sentences of less than six months' to be replaced by community sentences. Prisoners with drug problems would also be moved into 'more appropriate secure accommodation' on release. Transform's blog, however, comments that 'whilst the Lib Dems appear to have made the intellectual journey on drug policy reform, they have still shied away from it when it comes to frontline politics'.

Post-its from Practice

Family ties

Remember the family in its own right, says Dr Chris Ford

I FIRST MET 44-YEAR-OLD ANGELA a few months ago in the emergency surgery. I saw from her notes that she was a frequent attendee usually with low grade 'stress' and chronic chest problems. She told me that she thought she had another chest infection, so I asked her how many cigarettes she smoked and whether she smoked anything except tobacco. She stopped and thought for a moment; then said no, but her son did – he smoked that horrible smelling stuff (crack).

Angela then poured her heart out. Her oldest son David, aged 23, still lives at home. He lost his job due to absenteeism about six months ago and since then has spent most of his time smoking crack. He hasn't signed on and either Angela was paying for his drugs or he was stealing to pay for his habit. Her younger son, Alan, aged 21, moved away partly for work but mainly to get away from his brother. David has been smoking crack for several years but has always refused treatment.

Angela always tried to support him – she even took him to a drug service twice. She tries hard not to give him money and to get him to sign on but she worries about him going to jail. She mentioned that their father was alcohol dependent and had left the family when the boys were young. She had reached her lowest point only two days previously when returning from a lovely week's break with Alan and his wife, when she had found David had sold her prized laptop which she had saved for a year to buy. Her stress and smoking had increased which had brought her to the surgery.

I let her talk about how she blamed herself – in her eyes she thought his problems had to be a result of his childhood. She was torn as to what to do, especially in terms of money, but she knew that 'enabling' him to use crack was also not the answer. We are very fortunate to have an excellent family therapy service nearby – however she declined this, Families Anonymous and all other outside help, mainly, I think, because of her feelings of shame. We talked some more and she agreed to return. After a few short sessions she said she felt better and was able to see that the best way to support David was by giving him clear boundaries and a firm recommendation that he found his own flat.

David has now got his own bedsit and has attended the local open access service. He came to see me to thank me for helping his mother. He is still smoking daily but he has started a back-to-work scheme and feels much better.

Addiction of all sorts is a family disease. When one or more members of a family are using substances or being troubled by another addiction, the whole family is affected. As GPs, I feel we are uniquely placed to manage the individual addictions and support the family unit. And as Adfam's manifesto for families states, families need support in their own right. I feel certain Angela's attendances at the surgery will now decrease and she will be able move forward for herself and continue to love, yet not enable, her son.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP. To become a member of SMMGP and receive bi-monthly clinical and policy updates and be consulted on important topics in the field.visit www.smmgp.org.uk.

PARADIGM SHIFT

Brett Moran describes a new technique that he believes has the potential to fundamentally change the treatment field

Matrix reimprinting (MR), which has evolved from emotional freedom technique (EFT), is a cutting-edge technique that has changed my life personally and professionally. I want to share this positive work as far and as wide as possible. Not only has this technique turned my life around and made me see things in a clearer light, but it is changing the lives of those around me – other professionals, service users and young people.

MR is having some amazing affects on the clients I work with on a day-to-day basis. For those in-the-moment situations such as cravings it can completely diminish the urge for the individual to use, as well as reduce anxiety, fear, anger and sadness. It is also having extraordinary long-term effects on a wide range of areas such as life choices and physical and mental health, and helping people to conquer destructive thought patterns imprinted in early life.

It doesn't matter what phase of addiction a person is in, MR can help them see their situation in a new light. By helping uncover underlying issues such as abuse, trauma, neglect and abandonment, MR can help people understand what makes them use and what is preventing them from moving forward.

MR can help individuals to reimprint the original traumas and defuse the emotions and intensity around past memories. It enables the individual to create new positive fields and new positive patterns. I believe MR is going to change the direction of how we work with clients. Working in the substance misuse field for several years I have come across a range of approaches, interventions and techniques and have seen colleagues do some outstanding work with their clients, but the question I hear so many times is why do so many individuals relapse?

MR brings together all the pieces of the puzzle, such as thoughts and beliefs, biology, genes, environmental signals, the first six years of one's life and even quantum physics. Through the process of tapping on acupuncture points and asking powerful questions, individuals revisit past traumas and memories with the same emotional intensity and work with their younger self, known as an ECHO (energy consciousness hologram).

By getting the clients to tap into their ECHO (called the inner child in other therapies) while we tap on the client, we begin to defuse the emotional pain that has been stored. We then offer the ECHO all the tools and resources that he or she needed at the time of the original trauma to get through situations with a new approach.

Allowing the ECHO to rewrite the original trauma in whatever form he or she chooses is invaluable. ECHOs get to say or do things they wished they had done at the time, or they can take themselves away from the trauma in the first place. The client can see why they are in the situations they are in and release the negative emotions and pain from the past. If the memory has no intensity the client's present becomes more bearable.

Clients can let out their anger in any shape or form, say their goodbyes to loved ones, express hatred towards perpetrators or say they are sorry to others for their actions, filling the hole in the soul step by step. By doing this they are letting go of negative energy and in their subconscious they begin to release their pent-up emotions and tension. Once the trauma is reimprinted and there is no intensity around the memory, the ECHO is offered the chance to go to a new positive place. A signal is sent out to every cell in the body that this is the new reality. Clients can address memories, traumas, phobias, physical pain, core beliefs, negative thought process, limiting beliefs, destructive behaviour and any other issue they bring to the table.

MR works with complex areas such as quantum physics and morphic fields. Simply put, it is known that we are made from energy and surrounded by energy. The unified energy field that connects us all is where our subconscious messages are stored. The collective consciousness is part of each and every one of us. In MR we believe that we tune into these morphic fields and that this is where our subconscious messages are also stored. Each memory has a morphic resonance

and we tune into this habit or behaviour on a daily basis. To break it down, we look at the brain and mind as separate.

The brain is not part of the mind – it is simply part of our body, something that can be operated on by surgeons. The mind is not a physical object and cannot be seen – it has to be somewhere other than inside the body or the brain. Think about when your body is relaxed and calm, but your mind is still darting around from one place to another, obsessed with past memories or future worries. Messages imprinted into your mind in the early stages of life by trauma or abuse will in turn create morphic fields. Events in the here and now can act as a catalyst and remind us of past horrors, with just as much resonance as the original trauma. The subconscious mind does not understand that the event that has triggered you today and the one that was imprinted in early childhood are different. It thinks they are the same and the mind and body will act accordingly.

We need to work with underlying issues, as it is these that keep so many of our clients in the positions they are in. We need to reimprint limiting beliefs that keep them stuck in dark places and unravel how these were imprinted in the first place. All of this work needs to be addressed not only on a conscious level but on a sub conscious level, with a mind-body healing process.

People are on autopilot most of the time and autopilot is the subconscious mind. It immediately engages with learned behaviours without the help of the conscious mind. Many of our clients are aware that their thought processes are destructive and damaging but do not know how to change them, or what caused them to think and feel this way.

It has also been claimed that we are in control of our genes, instead of the old belief that the genes are in control of us. There is a new field of science that shows that genes are controlled by environment signals, known as 'epigenetics' – 'the control of genes from outside the cell.'

Now I am not a cellular biologist nor do I pretend to be one – to be totally honest I used to be a scaffolder and a drug dealer from a council estate in Carshalton, without any higher education or GSCEs, but here goes.

Genes are activated by our inner and outer environments. Inner includes emotions, biochemistry, mental process, our sense of spirituality and so on. Outer includes toxins, substances, food we eat, our social rituals and so on. Genes are switched on and off in response to signals from these inner and outer environments.

Our biochemistry, mental and physical processes and cellular activity are controlled by our inner and outer environments. The signals in our bodies are what keep us alive, but what happens when they go wrong? There are three main factors that interfere with this signalling process: trauma, when an accident causes a disruption in the brain signal; toxins, which interfere the body's signalling chemistry, and the mind.

Why would the mind send wrong signals to your body? The answer is perception. Our brains have thousands of tiny receptors and these receptors are what enable your cells to read the environment. Each time the mind reads a negative event or relives a past negative memory, on a cellular level this will create new neural connections making the connection stronger each time, but we can have a healthy and positive outcome just by retraining and reprogramming our thinking.

'We need to work with underlying issues, as it is these that keep so many of our clients in the positions they are in. We need to reimprint limiting beliefs that keep them stuck in dark places and unravel how these were imprinted in the first place.'

I am sure there are many practitioners out there who are thinking that this is not new – positive thinking is the way forward, common sense. So why do clients still relapse? It's the work on a subconscious level that needs to be addressed – thinking positively on a conscious level will not last forever. This is where matrix reimprinting is on the edge of revolutionising the field and shifting therapy into a new paradigm.

So many of our clients are swimming upstream, and so is our system. What are we doing with long-term methadone prescribing, all the group work and DRRs? The current system is missing the point – it is focused on working on a conscious level. Every therapy, intervention and medication has its place but we are focusing in the wrong direction. Willpower alone will not save anyone from addiction or destructive behaviour. Something bigger needs to be addressed and something stronger needs to be created.

Finding out what is going on underneath the surface and what the underpinning and underlying issues and traumas are on a subconscious level is vital for any positive change to take place.

It's about understanding the negative core beliefs and repetitive negative messages that are being played over and over again in the client's mind.

Consciously we may want to change, and willpower will serve a purpose for so long, but if the messages on a subconscious level are playing out darker negative images then this is what we will attract.

I see private clients from my practice in Harley Street and I also travel to other services for talks and trainings on EFT and matrix reimprinting. There is far more research, knowledge, wisdom and science on these areas than I can explain but I would be more than willing to discuss ideas and share thoughts with all of you on how we can work together to make a positive change.

Please contact me at www.matrixmind.co.uk
brett.matrixmind@googlemail.com or on 07931553218

Seize the day

Tough times are often the best times for change –the sector needs to grow up and face the challenge, says **Peter Martin**

THE ARCTIC CLIMATE THIS WINTER has metamorphosed into bitter economic permafrost unlikely to disappear any time soon. We might wish to second guess the politicians and busy ourselves securing more contracts, while tightening our belts for the bumpy ride ahead, but it might be better to spend time getting a more realistic assessment of the external world out there. Communities across the country are beginning to heal themselves and it is there that we should be focusing our attention, asking where and how we can get involved and help. If we don't, many of us may find the world has moved on without us.

Periods of turmoil are often the best times for change, not retrenchment, and I think this is a time of opportunity. A new direction for our sector must encompass an honest appraisal of our past, our victories and our failures in order to reach a new maturity. It is certainly time to abandon ineffective treatment systems. We need to develop and facilitate recovery solutions and, where appropriate, provide the necessary specialist expertise. In short, it is time to grow up.

Increasingly hard choices will be made on public spending at the local level. But if we know our communities well enough and develop strongholds of recovery, fear can be replaced by hope. A recent survey by DrugScope found that the public agree with drug and alcohol treatment. However, there is a dissonance between public perceptions of what drug and alcohol treatment currently offers and reality.

If we had a streamlined treatment system with end-to-end linkages then recovery, health, wellbeing and responsibility would become the end game. Most of us have heard it said that there is no vote to be had in drugs policy. But this is not entirely true – the problem we have is a drugs policy that started courageously but with the bar set too low. The right thing to do is raise the bar.

If those who know about, and believe in, recovery-oriented treatment could really make themselves heard in the right places and were able, for example, to persuade a home secretary, health secretary or prime minister that the sector can indeed deliver far greater numbers of long-term recovered, and that this would save money and would mean less crime and less benefit dependency, they might actually be inspired enough to listen.

The challenge for commissioners comes when they attempt to reposition local treatment strategies with alignment to the recovery model. Quite rightly, they don't want to chuck the baby out with the bathwater. We still need harm reduction but this is not an end in itself. However, recovery-oriented treatment should begin from day one, offering explanations, role models, choice and options.

Drug and alcohol professionals need to become architects of choice. Clients should dictate the pace, and when they opt for detoxification the sector should work with them. The greatest assets we have are the users who have recovered. Those new to treatment trust those that have already recovered, and they are instilled with the belief that recovery is possible.

The NTA's *Commissioning for recovery* guidance is very welcome and recommends nudging clients towards self-help groups such as NA, AA and SMART to help users reintegrate. Payment by Results (PbR) has been tried and tested in the health field in different parts of the world and rewarding of recovery-focused outcomes could be provided by an adapted PbR system. The mental health field is already preparing itself for it and is looking with interest at the acute health care sector where PbR is already in use.

The PbR system has three central components. Firstly, activity-based funding that contrasts with block contracts – service providers can generate more income by being more productive. I do think, however, there needs to be more outcome-based commissioning logic involved, with clear and measurable outcomes based on, say, three and six months abstinence, reduced recidivism and accommodation. Outcome incentives could be attached to volunteering, education or employment.

Secondly, in the health sector work tends to be measured within the demarcation lines of healthcare resource groups, and the problem in substance misuse is that that leaves the outcome question silent. Thirdly, payment is made according to a national tariff – this in effect means that commissioners do not have to negotiate price but can concentrate on quantity and quality.

Building a simple system for outcome measurement and reward will incentivise providers to change the way they do business and support clients into recovery in all its domains. We already have the understanding and methodology to apply outcome measurement to the drug treatment and recovery sector. The time is right to effect the necessary changes, but by keeping it simple. PbR might be the answer to dramatically improving treatment outcomes and also sparking new models of treatment and recovery that are far more community orientated.

Ultimately, when given real choice, clients generally choose freedom from dependence. The story of treatment can be reinvigorated and believed because the evidence will speak for itself. Both the public and the media will finally gain confidence in treatment. The recovery model is here to stay and it is very exciting – the choice to the individual to re-discover themselves and their true potential, and regain a place in society.

Peter Martin is a freelance consultant in substance misuse and recovery systems, peter.martin@iconism.net

IT'S FEBRUARY AND I AM WATCHING SKY TV on a 'chipped box'. I'm waiting for *The Simpsons* to come on because there is nothing else to do on this cold Sunday afternoon. The chipped box cost £70 and means that I can watch all of Sky's channels for free – probably illegal, but I don't care because it's not mine and I'm in a friend's house. An advert appears on the screen in front of me advertising Smirnoff vodka and saying that 'Smirnoff sponsors Sky Movies' – just in case I want to watch Sky Movies later with a drink in my hand? I am just about to watch a family-based programme that I am sure young people will see. They may think that it is cool to drink. Last time I looked it was against the law to buy drink under the age of 18, but not to watch *The Simpsons*.

Sky are telling me how nice it would be if I went out later and bought some 37.5 strength alcohol and sat and paid them to watch a film on their channel. I watch the film later anyway, and resist the urge to buy Smirnoff vodka, because I don't need it. I'm an alcoholic and there is already a cheaper bottle in the icebox. It is early yet and the bottle will be close to empty by the time I stagger home.

Before the film starts I am reminded that this film was brought to me by Russian Standard vodka – and suggests I would like to try some of that too. Blimey! Russian Standard vodka is a nice drop. I've had it. It's 40 per cent and 28 units per 70cl bottle – lethal by anyone's standards. It retails at around £14, which is out of my price range, but when Tesco were selling it in January for £10 a bottle I was hooked like a donkey on a carrot. That is a fair price for a 'superbly smooth and pure tasting classic' – their words not mine. But 'alkies' do not care about the taste. It's the kick we are looking for.

Tesco are not alone in this act of generosity to all pissheads searching for that peach schnapps of a bargain. The other three of the 'big four' are also at it. Sainsbury's, Morrison's and Asda are all locked in a battle to get us to buy booze from them. Their weapon of mass destruction – advertising. It's a war and I am the cannon fodder. I doubt they mind if my liver gets pickled and my kidneys turn to mush.

I feel penned in and surrounded by drink advertising. It's everywhere – in newspapers, magazines and on the internet, on primetime and daytime TV, even on the radio. When I am out shopping, buses drive by and remind me that I may need a drink. My mobile has images of famous brands secreted in little windows. Sports events like football, rugby, cricket and even athletics advertise alcohol. The Welsh rugby union team advertises Brains beer on its shirts. In the street, giant billboards tell me where I can buy alcohol and sometimes for how much. And in the bottom right corner of the billboard is a little sign saying 'Drinkaware'. Does that mean that I should drink sensibly, or that I should be aware that there is plenty of drink out there if I want it? Drink is waiting for me with open arms. 'Come and get me,' it says.

We are carpet bombed with advertising for drink. Cash-sniffing fiends sit in sky-high offices and tell us how great it is to have a drink, how it makes us popular and more attractive. In 2004 the drinks industry spent £202.5m on advertising. £51million was on spirits alone – ah, vodka! That's a lot of tax revenue to the government. Today, we spend £2bn in the UK on alcohol alone each year – more revenue for the government and more profits for the drinks industry.

No one asked me to become an alcoholic and the supermarkets are not to blame. But it appears despite being in partnership with the Drinkaware campaign, they are more than happy for all alcoholics to continue to drink as much as possible for as little as possible. They are all about a responsibility to their shareholders and not to society as a whole. The drinks industry is no different.

So what happens if the status quo remains and the government's 'friendly' attitude to drink advertising is allowed to go unabated? For anyone who is considering going into detox, rehabilitation and drying-out, their struggle to stay sober will be phenomenal. More than any other substance users, alcoholics are more likely to fail the walk to normality. If drink advertising is allowed to continue to grow, more young people will take up the bottle and will be needing help in the future – whether or not they are lucky enough to get it. Where drink is concerned, there is a dealer on every corner.

Being aware of all of this has to spur me on. I will try to look at alcohol advertising like anything else I don't want in my life, such as the BNP – see it, acknowledge it, laugh at it and move on.

Billboard baggings

About to go into detox and rehab after six years on the bottle, **Julian** comments on the drinks industry's constant demands for his attention

DDN/FDAP WORKSHOPS

DDN Drink and Drugs News

fdap

8 June

Dual diagnosis – training day

DDN are pleased to announce a brand new one-day workshop focusing on working with dual diagnosis clients. Using practical case studies and examples of good practice, the trainer – Brendan Georgeson from Walsingham House – will examine how to build and sustain a truly integrated service, how to overcome the fears of working with this client group and the transferable skills required. This practical workshop is mapped to MHNOS 23 (Mental Health Occupational Standards), DANOS AF3 (Drug and Alcohol National Occupational Standards) and the Knowledge and Skills Framework - KSF HWB. *Cost: £115 + vat*

15 June

Masterclass – registration with Care Quality Commission

All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

15 July

Legal highs and other new developments in drug use

This workshop will look at some of the latest developments in the use of pychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

15% discount to FDAP members. All courses run from 10am – 4pm in central London, and include lunch and refreshments. For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. Or visit: **www.drinkanddrugsnews.com**

Action on Addiction

UNIVERSITY OF BATH

THE CENTRE FOR ADDICTION TREATMENT STUDIES

The Centre for Addiction Treatment Studies, in partnership with the University of Bath, offers a number of courses tailored to meet the different needs of individuals interested in embarking upon a career as an Addictions Counsellor or in enhancing their current role within the field.

We offer Foundation Degree and BSc (Honours) programmes in Addictions Counselling available on a full-time basis and, for practitioners already working in the field requiring enhanced and up-to-date skills, we provide the same programmes on a part-time basis.

Alternatively, we offer a range of Continuing Professional Development and Management units accredited by the University throughout the academic year and at our Summer Schools.

Half-board accommodation is available.
Our facilities include a specialist library and IT suite.

For further information see our website at www.actiononaddiction.org.uk (Training and Education) or contact Carol Driver on carol.driver@actononaddiction.org.uk or 01985 843782.

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UNIVERSITY OF BIRMINGHAM

College of Medical and Dental Sciences

Forensic Mental Health Studies – MSc/PGDip/PGCert
Treatment of Substance Misuse – MSc/PGDip/PGCert

If you are currently working with mentally disordered offenders, or those who require similar care, or within a drug or alcohol treatment service you will be interested in these courses. You can study for a full MSc qualification, a Postgraduate Diploma or Postgraduate Certificate. Alternatively, individual modules can be taken as standalone courses.

Forensic Mental Health Studies
If you are currently working with mentally disordered offenders or those individuals who require a similar spectrum of care and are interested in updating and expanding your knowledge of theory and practice, this course is for you. Contact Angela Oakley on 0121 678 3088 or forensic@contacts.bham.ac.uk or visit www.mds.bham.ac.uk/forensic

Treatment of Substance Misuse
This course is one of the first of its kind in the West Midlands region and is structured around the key elements of the National Treatment Agency's Treatment Effectiveness Strategy. Incorporating a range of evidence-based approaches it will equip you with broad clinical skills and knowledge of the problems that you are managing. This course will also provide you with an innovative and comprehensive framework for delivering medical and psychological treatments. Contact the Programme Administrator on 0121 301 2355 or treatment@contacts.bham.ac.uk or visit **www.mds.bham.ac.uk/treatment**

www.mds.bham.ac.uk

Alcohol Concern is the national agency on alcohol misuse, campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems.

Senior Account Executive

£29,577 - £31,935 p.a. **London**

Working closely with local councils and Primary Care Trusts, you will coordinate training events and tender processes, ensuring that contracts are delivered on time, on budget and in line with best practise. You will also oversee operational processes and marketing.

An experienced project manager with a strong understanding of alcohol training and consultancy delivery, you should also have a thorough knowledge of alcohol interventions and related local strategies. Budget management experience is also essential.

To apply, email: recruitment@alcoholconcern.org.uk, visit www.alcoholconcern.org.uk or call 020 7264 0511.
Closing date: 12 noon, 12/05/10. Interviews: 27/05/10.

Alcohol Concern is an equal opportunities employer and welcomes applicants from all sections of the community.

Alcohol Concern
Making Sense of Alcohol

Stockton-on-Tees Borough Council

Stockton Drug and Alcohol Action Team

NHS Stockton-on-Tees

EXPRESSION OF INTEREST

ALCOHOL TREATMENT SERVICE CONTRACT AND ALCOHOL TREATMENT/ALCOHOL SPECIFIED ACTIVITY REQUIREMENT PILOT

Stockton Drug and Alcohol Action Team wishes to invite expressions of interest from suitably qualified and experienced organisations for the provision of an alcohol treatment service within the Borough of Stockton-on-Tees.

The contract will be for a period of two years, commencing 1st October 2010, with the option to extend for 1 year. It is likely that TUPE will apply. The contract value is estimated at approximately £300,000. The Pilot will be for a period of 1 year, with an estimated value of approximately £50,000.

Applicants will, in the first instance, be required to complete a pre-qualification questionnaire.

Please see the Stockton-on-Tees Borough Council website for further details. http://www.stockton.gov.uk/business/conpro/tenopp/

The Children's Society Essex Young People's Drug & Alcohol Service (EYPDAS) is an established project delivering services to children, young people and families to support them to achieve better outcomes, enabling them to stay safe, be healthy, enjoy and achieve, make a positive contribution and achieve economic well-being.

The Project currently delivers services to children and young people at risk of, or involved in, substance misuse and delivers largely targeted and specialist services with some/limited universal services to meet their needs.

Substance Misuse Trainer

£26,309–£29,969 pa Ref: SO1749/DDN

On behalf of the Essex Drug & Alcohol Partnership we wish to recruit an experienced Trainer to deliver high quality drug & alcohol training to professionals who work with young people and adults in order to equip staff with the skills, knowledge and confidence to deal effectively and appropriately with issues around drug & alcohol misuse.

You'll need extensive experience of developing and delivering training on a wide range of subjects to a wide range of audiences and a sound understanding of drug & alcohol misuse issues and the impact on children, young people and families.

You should be qualified to degree level in a care related discipline or be able to demonstrate that you have the skills and knowledge to operate at this level. Previous experience of managing and supervising staff and/or volunteers is essential.

Substance Use Intervention Worker (Transitions)

£21,909–£24,958 pa Ref: SO1763/DDN
County-wide

We wish to recruit an experienced Substance Use Intervention Worker to provide comprehensive assessments and care planned therapeutic work including group work to young people who are either using or vulnerable to using substances.

You'll engage and work in partnership with a wide range of professionals internally and externally to ensure that young people receive timely and appropriate services. You'll take the lead in planning effective transitions for young people, ensuring that their needs are met and that appropriate policies and procedures are in place between services.

You'll need significant experience of working with children and young people and have a professional qualification in a relevant discipline such as counselling, youth & community or social work or demonstrate that you have extensive experience of working with young people in a similar field (paid or unpaid).

The Children's Society is a leading children's charity committed to making childhood better. We work with children across the country, providing the right support at the right time. We commissioned The Good Childhood® Inquiry; the UK's first independent national inquiry into childhood. Its aims were to renew society's understanding of modern childhood and to inform, improve and inspire all our relationships with children.

The Children's Society

Both posts are 37 hours per week and are funded to 31st March 2011, with the potential to extend for a further year.

As well as a strong commitment to your development, we offer generous holidays, contributory stakeholder pension, childcare vouchers and flexible working.

To apply, please visit **www.playyourpart.co.uk** or call us on 0121 354 3892, quoting the relevant reference number.

Closing date for all posts: 10th May 2010. Interview dates: w/c 17th May 2010.

All our recruitment documents are available in alternative formats.
Please note that CVs will not be accepted.

We strive to be an equal opportunities employer

Charity Registration No. 221124

Capita Social Care and Housing

Leading provider with Drug and Alcohol Services for both temporary and permanent recruitment.

Currently recruiting for vacancies within Greater Manchester, Merseyside, Cheshire, Cumbria and Lancashire within the following specialisms:

- Community Drug Workers (Core / Shared Care)
- GP Liaison Drug Workers
- Time and Recovery Roles (STR)
- Needle Exchange Workers
- DIP and DAAT
- Commissioning
- Substance Misuse Service Managers
- Arrest Referral

For an initial chat please call Julie Mitchell on **0161 274 8514**
or email your CV to julie.mitchell2@capita.co.uk

CAPITA
SOCIAL CARE & HOUSING
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Employment agency and business.

Recruitment • Training • Consultancy

Drug & Alcohol Recruitment Specialists

Experienced team providing recruitment solutions in the Drug & Alcohol and Criminal Justice sectors. Our clients are currently recruiting for vacancies across London and the Home Counties within the following fields:

- Drug & Alcohol Practitioners
- Arrest Referral
- Youth Offending
- Dual Diagnosis
- Supported Housing
- Ex-Offenders & Resettlement
- Commissioning
- DIP and DAAT

Contact Dan Essery on: 020 7556 1154
dan.essery@synergygroup.co.uk

Synergy Group
Employment Agency

www.synergygroup.co.uk

RAPt

THE REHABILITATION FOR ADDICTED PRISONERS TRUST
stopping addiction. stopping crime.

Lambeth End2End Case Management Service

RAPt are part of an exciting project in Lambeth, the End2End service, which is improving the quality of case management delivered to offenders with drug misuse issues by combining the functions of DIP, CARAT and other support in a single team. The service provides support to substance misusing criminal justice clients from point of entry into the criminal justice system. The aim of the project is to maximise motivation and retain clients in treatment, as well as work with clients on all areas of need.

Enhanced Case Management Workers (ECMWs)

London, SW9. Starting salary £27,140 (inc. of London Weighting), 37.5 hrs p/w

The successful applicants will have experience of working with substance misusers, good knowledge of the effects of substance misuse, and experience in motivational interviewing. ECMWs will work across police stations and prisons for which police and prison clearance is required. It is also a requirement for clearance at police custody suites that all applicants have been resident in the UK for 3 years or over. Flexible working hours will be required including evening and weekend work and some bank holidays.

CARAT Workers

HMP Holloway & HMP Pentonville, London, N7.
Starting salary £24,165 (inc. of London Weighting), 40 hrs p/w

The successful candidates will have a good understanding of the drugs field. Experience of working with this client group is essential for these positions as is possession of NVQ Level 3 in Health and Social Care (or equivalent qualification or substantial experience providing addictions services). Previous experience and a clear understanding of the CARAT system are also desirable.

Community Alcohol Team Worker

Tower Hamlets Community Alcohol Project, London E14.
Starting salary £24,165 (inc. of London Weighting), 40 hrs p/w

The Tower Hamlets Community Alcohol Service, delivered by RAPt, will offer a truly integrated system incorporating expert training and support to other agencies, case management of people with alcohol issues, and delivery and co-ordination of medical, nursing and psychosocial interventions and treatment. The successful applicant will have a recognised counselling or teaching/training qualification, or equivalent and experience in the alcohol and/or drug field. You must also have the ability to carry out screening and referral assessment and have experience of recognising indications of substance misuse and refer individuals to specialists.

To apply for any of the above positions, download an application pack at www.rapt.org.uk. Alternatively, please send a SAE with 90p postage to: Human Resources Dept, RAPt, Riverside House, 27-29 Vauxhall Grove, London, SW8 1SY. Closing date for completed applications: 14th May 2010 at 12 noon.

RAPt strongly encourages applications from Black and Minority Ethnic individuals and from those in recovery from addiction.

Build a brighter future

Centrepoint Vauxhall Cross is a longer stay (6-24 months) service based in the London Borough of Lambeth, catering mainly for young people with complex support needs. We value being innovative, empowering, inspirational and professional.

Service Leader - London

£32,966 - £33,954 pa **Ref: SL1004e**

You will provide leadership and management to a group of local services including Vauxhall Cross (a complex needs service based in Lambeth) and floating support across Richmond, Wandsworth and Southwark - working closely with stakeholders to ensure high standards in everything we do.

An experienced housing services manager, you should have excellent planning, communication and networking skills.

Deputy Service Leader - London

£28,935 - £29,804 pa **Ref: DSL1004e**

Managing a complex needs service for young people, you will ensure high standards in everything we do - helping the young people we support to achieve their goals by the time they leave Centrepoint. You will also maintain effective links with local voluntary and statutory organisations.

Strong management and communication skills are essential, and you should also be highly organised. Housing management experience is also key.

Support & Development Worker - London

£22,443 - £23,922 pa **Ref: SDW1004e**

You will work closely with young homeless people who have high support needs, ensuring they have access to tailored, holistic and integrated support and helping them to achieve their goals.

You must have a strong track record of delivering a housing or homelessness service, along with experience of working with homeless young people from a wide range of backgrounds. NVQ preferred.

For further information and to apply, visit www.centrepoint.org.uk

Closing date: 10/05/10 12noon. No agencies please.

We seek to challenge discrimination and are committed to fairness and equality within Centrepoint. We welcome applications from anyone with direct experience of homelessness or using young people's services.

centre point give homeless young people a future

DO YOU PROVIDE TRAINING?

This is your last chance to catch the Summer edition of DDN's Training and Development Directory

The Summer 2010 edition will appear as a pull out and keep section in the 24 May issue of DDN. To make this the most comprehensive training listing available, make sure you don't miss out on your free listing.

Faye: 020 74632205 or faye@cjwellings.com