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4 June 2007
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# Drink and Drugs News

4 June 2007

## Editor's letter

It's easy to think that the diamorphine crisis has gone away. Stocks have been building with the introduction of new suppliers, and there is optimism that supervised injecting trials could yield positive results.

But talking to Plymouth User Forum (PUF) gives an insight to how the disruption to regular scripts threw stable lives into turmoil (page 6). From just talking to them it's difficult to grasp what the impact on them must have been. But that's the point. With diamorphine scripts restored, they just get on with life. No trips to the chemist several times a day to take methadone – their life no longer revolves around their dependency.

Carrying out a survey among local service users who had been affected was not an easy job, say PUF. Many would-be participants did not want to risk upsetting the services that could control their care, despite assurances of anonymity. Of those who did complete their questionnaire, it would be easy to ignore the number – 12 service users – as too small to make an impact on local consciousness. But take a closer look at those results: apart from the fact that 11 out of 12 had suffered side-effects to their health, most had topped up their methadone with illicit drugs, 11 had increased contact with dealers; many had become involved in other crime. Families were falling apart, and there had been a violent death following destabilisation. And all of this when their prescribers thought they were doing OK on methadone?

The members of PUF had to cross geographical boundaries to find a sympathetic consultant, and they had the good luck of having a 'fantastically supportive' DAAT. They were also willing to shout about what was happening to them, and insist on better treatment. What happens if you're the person in the survey who said 'methadone makes me too drowsy for normal living?'

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## In this issue

# Government pledges £2m for harm reduction

**The government has pledged nearly £2m to improve drug treatment services in a bid to reduce the number of drug overdose deaths and halt the spread of blood-borne viruses.** The cash boost was revealed as part of the government's new drug harm reduction action plan.

Prompted by a rise in drug overdose deaths and the spread of hepatitis C, the plan outlines several major areas of work. In the first instance, a major health promotion campaign highlighting the risks of injecting drugs will be launched and targeted at those deemed most at risk – specifically heroin and crack users, homeless drug users and drug users within the prison system. A hepatitis B vaccination programme is planned to run alongside this.

New training and guidance for those working within drug treatment services is also in the pipeline, in particular on the establishment of effective needle exchange programmes. Efforts will be concentrated on some of the country's poorest areas, where the government will work with local services to develop and implement highly specific local action plans.

Work will also be undertaken to improve the quality of data on drug overdose deaths and blood-borne virus infections, in the hope this information will highlight the damage caused by drugs and push harm reduction measures higher on local health services' agendas.

Launching the action plan, public health minister Caroline Flint noted 'massive strides' had already been made in tackling the country's drug problem, and emphasised that the government was keen to do more.

'Still too many young lives are being wasted and young talent squandered because of drug abuse,' Ms Flint said. 'The harms, diseases and sometimes death cause by drug abuse are still a tragedy for those affected and the government is determined to reduce them.'

National charity DrugScope gave a qualified welcome to the plan. Chief executive Martin Barnes said the plan was clearly needed, given that the UK had one of the highest rates of drug-related deaths in Europe.

'While we welcome the additional funds announced today, we remain concerned about the £6m cut the government made in drug education and prevention work for young people,' Mr Barnes said.

## Policy change essential to reverse spread of BBVs, says Turning Point

**Government drug policy is failing miserably to address the spread of HIV, Hepatitis C and other blood-borne infections and needs to take a 'fresh look' at its policies, according to Turning Point.**

The national charity's attack on official policy comes just as the government unveiled a new drug harm reduction action plan. It also marks the start of the charity's new campaign, At the sharp end, designed to raise awareness of what is fast becoming a major public health issue.

Campaign research undertaken by the charity shows that one-half of the drug users surveyed share needles or other injecting equipment – making them more vulnerable to contracting blood-borne viruses. Drug users were also taking more risks with their health, with nearly one in five drug users speedballing (injecting heroin and crack at the same time) – a practice which puts them at higher risk of contracting infections.

However, the charity noted that less than one-quarter of drug users who did contract viruses were able to gain access to treatment and services.

'Twenty years ago, the government led the way in offering needle exchanges, which meant a lower level of HIV than other countries,' said Lord Victor Adebowale, Turning Point chief executive. 'The government needs to tackle the rise in blood-borne virus infections by making public health the key focus of the next drug strategy.'

## Support materials follow TOP

**Further to the announcement of TOP, the NTA's new Treatment Outcome Profile (see DDN, 21 May, page 10), boxes of training and resource materials are being distributed from 11 June.**

The 'TOP box' will include a training CD and supporting documents to deliver a half-day training session; service user and keyworker guides; an implementation guide for managers; forms, pens, and calendars to help clients with timeline questions.

The NTA said they wanted service providers and practitioners to take action when they received the materials.

Support training will be offered through regional training, starting in the South East on 4 June and culminating in the North East on 26 July, and is open to commissioners, performance managers, treatment providers, service users, carers and data managers.

*For details of regional events, contact your regional NTA office. (Regional team details are on the NTA website, www.nta.nhs.uk)*

**Baroness Massey throws herself into flapjack making with a 17-year-old on the Resettlement and Aftercare Provision (RAP) scheme. The chair of the NTA said visiting the programme, run by Westminster Youth Offending Team and funded by the Youth Justice Board had given her 'a real taste of how [it] could make a difference in helping young people move forward from offending and substance use'. Voluntary RAP worker Gemma Leeming said the scheme's success depended on the relationship between young people and staff. 'Sometimes it can be a slow process, but ultimately I continue to be motivated by the changes in the young people I work with,' she added. 'They have a great deal of potential and RAP is able to tap into that.'**

# Scottish survey reports decline in teenage drink and drug use

**Drinking and drug use has declined among Scottish teenagers, according to the most recent Scottish schools adolescent lifestyle and substance use survey.** More than 23,000 13- to 15-year-olds took part in the 2006 survey, which is conducted every two years to monitor the smoking, drinking and drug use patterns among young people.

When asked if they had consumed alcohol in the past week, 36 per cent of 15-year-olds said they had – a significant drop from the 43 per cent that answered yes in 2004. Similarly, the percentage of 13-year-olds consuming alcohol in the past week had also dropped from 20 per cent in 2004 to 14 per cent in 2006.

Overall however, the numbers of teenagers who said they had consumed alcohol were still high – 84 per cent of 15-year-olds and 57 per cent of 13-year-olds. Drinking to excess was not uncommon, more than 70 per cent of 15-year-olds and more than half of 13-year-olds reported being drunk. Many teenagers admitted that drinking to excess had led to arguments, fights, trouble with police and hospital admissions.

Interestingly, a significant minority of teenagers – 42 per cent of 15-year-olds and 32-per cent of 13-year-olds – reported their parents knew about their drinking, but did not mind.

In relation to drug use, a decrease was again recorded. When asked if they had used drugs in the past month, 14 per cent of 15-year-old boys reported they had, a considerable drop from the 21 per cent that answered yes in 2004. Drug use in the last month had also dropped among 15-year-old girls, from 20 per cent in 2004 to 12 per cent in 2006. The number of 13-year-olds consuming drugs also fell by 3 per cent over the two years.

Friends were the most common source of drugs, but not all teenagers felt it was easy to obtain drugs. Around one-third of 13-year-olds and one-fifth of 15-year-olds reported it was difficult or impossible to get drugs.

*The survey is online at www.drugmisuse.isdscotland.org/publications/abstracts/salsus_national06.htm*

# Housing authorities urged to remove barriers

**Stable housing is the best way to help homeless people address their drug problems,** yet restrictive housing authority policies and practices are effectively denying people this chance, delegates at the recent Shelter Housing and Drugs conference were told.

According to Lisa Barker, deputy director of homelessness and housing management at the Department of Communities and Local Government, drug misuse was an issue for around 80 per cent of single homeless people and about 50 per cent of homeless families. Stable housing could provide the much needed 'base' from which these people could begin to address their problem.

However, many housing authorities and arms-length management organisations were applying rules governing housing allocation far too strictly. The result was that many homeless people were effectively being entirely excluded from housing registers, said Natalie Pace, policy advisor for the Housing Corporation.

The public perception of drug users and homeless people did not help this situation, said Martin Barnes, chief executive of DrugScope. Fuelled by inaccurate media reports, the public often believed that drug use was far more widespread and problematic than actually was the case, meaning homeless drugs users – already a vulnerable group – were further stigmatised.

'No one wants to become a drug user. To address these problems we need a great sympathy for the plight of the drug user,' he said.

# Alliance thanks two departing activists

**The Alliance has asked DDN to extend a heartfelt thanks to two activists who, after many year's association with the organisation, have decided to move on to pastures new.**

Daren Garratt, the Alliance's executive director, says:

'Unfortunately, due to health issues, we have had to say an amicable goodbye to Alan Joyce. Alan has been a staunch and effective ambassador for the Alliance since its inception, and has contributed invaluably to the development of treatment specific advocacy as a recognised professional intervention.

'Alan has made many friends over the years and I'm sure all the readers of DDN who know Alan personally will join the Alliance staff and Board in acknowledging all he's achieved and wishing him all the best for the future.

'Secondly, we would also like to extend our thanks, congratulations and best wishes to Eliot Albert, who has also decided to end his long-standing relationship with the Alliance. Eliot's recent appointment as chair of the Board of NUN [the National Users Network] gives him an excellent opportunity to dedicate his skills to developing the network, and the staff and board of the Alliance would, again, like to acknowledge the contribution he has made to the charity since becoming involved.'

# Tackling Drugs Day

**May 23 was the Home Office's annual National Tackling Drugs Day, with events around the country.**

**Brighton & Hove:** The minister for crime reduction, Baroness Scotland QC opened an art and photography exhibition by recovering drug users. Many services in the area use art therapy as part of their treatment which, according to the DAAT's John Patience, is a way for clients to 'express themselves and for others to see them in a different light'. The exhibition will run until the end of August.

**Darlington:** The DAAT dressed up as characters from the Wizard of Oz to educate pupils on the dangers of substance misuse. An information bus toured three local secondary schools and a college to hand out leaflets. Each character represented a different message: Dorothy was 'get home safe' (after a night out); Tin Man said 'look after your heart'; Scarecrow said 'you have a brain' (use it to make choices) and Lion said 'have the courage to say no to drugs'.

**Redcar and Cleveland:** Ex-drug users, drug workers and councillors released 114 white balloons – one representing every five people that have been treated for drug addiction in the area. Among the balloon releasers was Alan Davis, founder member of the ReCovery Group, who hoped that the gesture would evoke public awareness of the good work services are doing in the area.

**West Yorkshire:** Police launched a new book, The Low Side of Getting High, at the Bradford Media Museum. More than 200 children who contributed poems, posters and short stories to the book attended the event, which included a performance by Tong School and a pop concert by NYK.

**Kent:** Eleven to 15-year-olds from Leigh City Technology College in Dartford discussed drug use in sport with former Chelsea and Charlton Athletic footballer, Paul Elliot MBE.

**London:** Ministers from three government departments visited local projects addressing drug misuse in the city. Among them, Parmjit Dhanda, under secretary of state for children, young people and families, visited a young people's drug and alcohol service in Camden. The Camden police bus was in the town centre to provide information on drug services to the public. Hounslow Community Safety Partnership teamed with the Harlequins Rugby League club to discuss ways of getting young people and children off the streets and into playing rugby. In south London, Home Office minister, Vernon Coaker, teamed up with Alan Johnson, secretary of state for education and Andy Burnham, minister of state for the Department of Health to open the 2007 Tackling Drugs Changing Lives Awards, with a five-a-side football match.

The diamorphine shortage of 2004 resulted in disruption to many users' prescriptions and a switch to methadone and other alternatives. Two and a half years later Plymouth User Forum tell **DDN** about the real impact on those involved.

# When the **diamorphine dried up**

When the Department of Health warned of a supply problem with diamorphine in December 2004, doctors were told to conserve stocks for patients in greatest need of the opiate painkiller, and to use 'alternative medicines' wherever possible.

Patients in acute and chronic pain were obviously top priority for the dwindling supply. Which left the rest: those who had been prescribed diamorphine – pharmaceutical heroin – as a last resort for their opiate dependency, and who were now confronted with the prospect of adapting to an alternative.

Distraught feedback followed the prolonged uncertainty of the situation, with calls for a swift resolution from service users, their advocates, and from caring consultants who were faced with the unhappy task of separating patients from a drug that had given them back a measurable quality of life. An article written at the time by a service user representative, a consultant, a community psychiatric nurse and a specialist registrar (*DDN*, 25 July 2005, page 9) illustrated the impact the crisis was having on some of the most vulnerable people in the UK and their families.

Two and a half years on, Julie, Stuart and Jules of Plymouth User Forum (PUF) have gathered to talk about a survey they conducted at the height of the crisis. There are lessons to be learned from it they say, which go beyond problems with the supply factory. It adds up to a story of poor communication from the top, lack of trust in service users, and a misplaced faith in methadone as the only substitute.

Their call to arms began in the summer of diamorphine deprivation, July 2005. 'Originally we were just trying to get ammunition to get our scripts back,' says Stuart, who along with Julie has been maintained on diamorphine for more than a decade. Researching the situation on the internet and persistently phoning up the supply companies gave them the information that stocks were still available, despite the shortage – a totally different scenario to that presented to them by their consultant, who refused to consider maintaining their scripts.

With valuable support from their DAAT and PCT, they exercised their right as patients to a second opinion, and were transferred to a sympathetic consultant in neighbouring Cornwall, who reinstated their diamorphine scripts and placed them in the regular care of a prescribing GP.

For Julie and Stuart, life regained balance and normality. But the turmoil they had experienced, and the brick wall they had hit with their local consultant, compelled them to find out more about how the shortage had affected local service users. Just as important to them, they wanted to demonstrate the drug's life-transforming potential to consultants that they suspected saw diamorphine merely as an expensive option that they 'wanted to get rid of by the back door', and who were all too willing to substitute methadone.

With help from the local university and their 'brilliant, supportive DAAT', they drafted and redrafted their survey for local service users until the questions were open and unbiased. Then, with a cover sheet assuring confidentiality, they arranged

for it to be posted out to 28 affected service users and returned to the DAAT, so that all personal information was protected.

Their questions covered details of the respondent's previous diamorphine script; information about the substitute drug they had been prescribed and whether there were side effects. They asked about whether they had used other drugs on top of the new script; if they had had contact with drug dealers; been engaged in criminal activity; and spent money on illegal drugs – before and after the diamorphine script had stopped. They asked their respondents to compare a range of possible symptoms, up to overdose, before and after diamorphine; and asked them to also tick boxes relating to social, family, financial, housing, work or training problems. Having given a picture of life before and after the script was withdrawn, their respondents were asked about how supportive local treatment staff had been and whether they had been actively engaged in decisions.

The 12 respondents (a 46.5 per cent return rate) reported back that they were all now on methadone – nine by injection and three orally. PUF's summary report records that 11 out of 12 of them recorded side effects with their methadone, including headaches, back pains in the kidney area, severe constipation, and vein damage. One had stated: 'It makes me too drowsy for normal living and has generally made me feel unwell and unhealthy.'

Eleven respondents had used drugs or alcohol on top, and most had turned to heroin, benzodiazepines, or both. Eleven had increased their contact with drug dealers. All 12 reported spending daily on illicit drugs since losing their diamorphine – nine of whom had used no illicit drugs before the script had been stopped.

The chaotic picture continued to build through 22 reports of serious drug-related incidents, where there had been none on diamorphine; increased criminal activity; and escalating social and family problems. One respondent stated: 'This situation has caused financial chaos, three court orders, one of which relates to rent on our council property from which my husband, two children and myself were almost evicted. I am suffering from lumps and abscesses on my arms from street heroin.' All 12 who responded said they would have liked to have been offered alternatives to methadone.

Trying to distribute the survey revealed a climate of fear among patients that alarmed the members of PUF. 'When we were doing the survey, we had so many people say "we really want to fill it in, but we're worried about what'll happen and who'll know about it",' says Julie. 'We had to say several times, "don't put your name" and really reinforce that, because people were too scared. They were worried that they would never get their script back.'

The situation seems to have bred mistrust generally, they report, with many service users reluctant to raise problems with their treatment. 'People are very scared of upsetting the applecart, because it's so easy to retaliate against someone on a prescription,' says Stuart. 'You've got so much power when you're writing someone a prescription – their life's in your hands.'

**'It's one of the major hypocrisies we're trying to fight against. On the one hand they're saying we need to pull our lives back together, and that training, employment and housing are really really important. On the other hand they impose measures that prevent you from getting your training, employment and housing options together.'**

'Even when we told people they could come to us in person and we'd take their grievance anonymously back to whoever – the service provider, the DAAT or whoever needs to be approached about it – they're still nervous about speaking to us,' adds Jules.

The two diamorphine patients among them, Julie and Stuart, are grateful for a DAAT that encouraged them to stand up for their rights, and they are determined to persevere with helping others do the same. Diamorphine stocks are now rebuilding, but supplies are still short: there are people throughout the country waiting for the return of their prescriptions. Most clients in Plymouth have now had at least half of their diamorphine script reinstated.

Jules has a slightly different reason for 'believing vehemently' in the chance of a diamorphine script. On a methadone script for more than 20 years, he likes 'to make it [his] life's mission to campaign against the evils of methadone for anything other than a short-term intervention'.

'It's the most wonderful short-term intervention in the world for getting people off diamorphine,' he begins to explain. 'But once you've done it for years…' Stuart picks up where Jules tails off: 'There's supposed to be a choice. The NTA say there are these options and they're supposed to be available. And they're not. In effect, if you go in for treatment, you're going to get oral methadone, or Subutex possibly. For anything else, you've got to be at death's door for years.'

Having conducted the survey, the group admits that 'no-one took a lot of notice', and that 'it didn't make a difference locally'. But its purpose was greater than to make noise about the shortage.

'We hoped that by having it checked for independence and non bias by statisticians, we'd show consultants that it's not just people screaming about what's been done wrong to them, but that we're intelligent articulate people who can research something and put it in writing,' says Jules. 'All consultants should be challenged… it's a very old-fashioned way of looking at things if people are frightened to complain.'

Their manifesto has one main aim: to help service users back to a normal life – and that includes all the usual trappings of a home, job, money, family, friends. They are worried that the success of diamorphine will be judged on the new programme of trials, where the patient has to attend a clinic or chemist several times a day.

'How can you live a normal life, how can you try and get your life together under these rules?,' asks Julie, who just the other day had to assure a locum that her diamorphine was not dispensed under supervised consumption – 'he just assumed, as it's the norm now'.

Jules adds his concerns on supervised consumption: 'The whole point of a script is that it's supposed to improve people's stability and life, then if they want to come off it later they can. But if you're making people's life more difficult, no matter how good the medication is, it's self-defeating… "We'll get you on methadone and then we'll see if we can get you a job": it's self-defeating if you've got to go into a chemist's twice a day to drink your methadone.

'It's one of the major hypocrisies we're trying to fight against. On the one hand they're saying we need to pull our lives back together, and that training, employment and housing are really really important. On the other hand they impose measures that prevent you from getting your training, employment and housing options together.'

For PUF, the diamorphine crisis demonstrated what happens when you pull the rug of a stable script from under someone's feet. While some service users were cautious about committing their negative experiences to paper, the death certificates of two other local patients spoke for them.

Having lost their diamorphine scripts, the couple went off the rails on internet Valium and alcohol. 'They came to one of our meetings and were asleep on the table,' says Julie. Two weeks later, according to the police who came to find out a bit about their backgrounds, one stabbed the other while they were 'out of their faces' on Valium and alcohol.

The couple appear as statistics in the carefully worded survey results, but PUF heeded the statistician's advice that they could not assume a link with the diamorphine shortage. 'You'd never get anybody to say that was because of the shortage,' says Julie. 'But it was – because he'd been stable for ten years.'

'These aren't just facts and figures, it's impacting on people's lives,' adds Jules. 'And when someone hasn't got a life to be impacted upon anymore, that's as serious as it gets really.' **DDN**

Alex Hinds

**"...what neither the NTA nor regional government offices want is intelligent, questioning, reflective, challenging workers and commissioners. What they actually want is political and technical compliance with centrally driven policy agendas – because that is how they, in turn, are performance managed."**

## Education or prevention?

Richard Ives writes about the difference between educating school children about drugs and trying to stop drug use altogether ('Don't do drugs... Drugs are bad...', *DDN*, 7 May, page 12) – an important and valuable distinction. The role of drugs educators is to equip young people with a solid foundation of information and empower them to make the right decisions, with the understanding of the real dangers of drug abuse and addiction.

Ives cites a *Druglink* article that commented on the irrelevance of some current drugs education. While this may be true in some cases, there are programme providers that offer a bespoke service and effectively reach their target audiences.

Drugsline's schools outreach team, made up of recovering addicts and those who work in frontline addiction services, is headed by Darren Gold, an ex heroin addict who has served time in prison, was homeless and estranged from his family and whose health suffered dramatically because of his addiction.

The team use their experience to inspire the trust and confidence of the young people they visit – 30,000 by the end of this academic year – and are honest and frank with the pupils, from the age of 8 to 18, neither sensationalising nor diluting their personal stories.

The team understand the pressures young people face on a daily basis, and are therefore well equipped and willing to answer the questions that young people are often too embarrassed or afraid to ask their parents and peers – questions that deserve and need adequate, appropriate responses if young people are to truly understand drugs and addiction.

In order to have a lasting, tangible effect on young people's attitudes to drugs, and raise their self-esteem and confidence, we must 'focus resources', as Ives suggests, on charities such as Drugsline and the services they offer.

**Christina Ball,**
**operations director, Drugsline (www.drugsline.org. Drugsline's free-phone crisis line number for drugs information, support, counselling and is 0808 1 606 606.)**

## Honesty doesn't pay

As one of the four letter writers who were anonymously published in the 23 April issue (page 8) I'd like to respond to Dr Joss Bray's letter (*DDN*, 7 May, page 10). Yes, we have reached the point where we cannot have an open honest debate – and still get paid.

Having spent the whole of last year as a builder and plumber because, after 15 years in the field, I could not get a job in a senior position because of 'previous press involvement', or a junior position because of being 'over experienced and over qualified', I can attest to the need to remain anonymous.

The principal reason is – as pointed out by Howard Parker (*DDN*, 7 May, page 8) and the newly formed Drug and Health Alliance (same issue, page 4) – that policy has become increasingly detached from the reality of the situation we are supposed to be addressing. Drug policy, under the criminal justice agenda, is now all about compliance not the development of healthy human potential – it actually confuses one with the other.

Models of care effectively removed any responsibility from the drug user and placed it firmly in the lap of the state – the belief being, that if you turn up on time and take your medicine politely, as directed on the tin, you will get better and the state will leave you alone. All service users are now expected to have treatment contracts, or care plans, that they sign up to and agree to comply with. You don't actually have to do any work on yourself – just follow the yellow brick care plan.

The same applies to workers in the field. If you unquestioningly complete your monitoring returns and align your activities strictly to DANOS competencies, the centre's belief is that you will work effectively and your clients will get better; therapy by numbers. The fact that the numbers get in the way of the therapy is completely irrelevant to bean counters and politicos. They have no idea what therapy is or what it does. To them it's like servicing a modern car: plug in the diagnostic software (assessment and monitoring), adjust the engine management system (treatment), and away you go (care plan).

I hear the laudable protestations from Toby Lloyd in Somerset (*DDN*, 7 May, page 11) that drug workers are first and foremost therapists, but the reality is that anyone now working in the field is, effectively, working primarily as an agent of social control – despite whatever compassionate or humanitarian grounds on which they originally entered the field. Toby rightly complains that workers are seen principally as data producers and not therapists, and that is what we have all become. And it gets in the way of forming helpful human relationships.

But what neither the NTA nor regional government offices want is intelligent, questioning, reflective, challenging workers and commissioners. What they actually want is political and technical compliance with centrally driven policy agendas – because that is how they, in turn, are performance managed. Anyone identified as openly criticising currently policy or practice (from within the field) is seen as a boat-rocking saboteur by those at the centre.

The increasing number of people gaining MSc's in addictions studies are in for a real shock when they try to apply any of the lessons learned. There is no freedom to deviate, innovate or protest; and one's job security in the field (including, I suspect, Paul Hayes') is directly related to one's willingness to shut up and do as one is told. As the NTA recently announced in a presentation on young people's services: 'We are the experts; resistance is futile'.

**Name and address withheld**

## Language is important

In his 'Notes from the Alliance' (*DDN*, 21 May, page 9), Daren Garratt appears to be issuing a cautiously worded endorsement for the use of addictive psycho-active drugs (APAD), while also making a plea for us to be more selective in our choice of words to avoid perpetuating 'negative stereotype images of drug users'.

Daren posits that 'words such as dependent, problematic, and chaotic have become interchangeable, and that is wrong'. I agree.

The words dependent and dependency in this context are the influence of politically correct thinking. They are considered less stigmatising than addiction. The fact that both words are hopelessly inaccurate and inadequate, to describe the mental disorder of addiction, does not seem to have concerned anyone other than the members of the American Psychiatric Association (APA).

After much debate, the word 'dependency' was elected by that body by just one vote to replace 'addiction' in DSM-1V. That decision did not alter the significant differences between these two contrasting conditions, one of which is that while dependency is reversible, addiction is irreversible. Unfortunately, it appears that some people are unaware of such differences; therefore it is not surprising that confusion, together with the use of superficial and unnecessary language, has arisen.

It may be this confusion that led to the claim by the RSA, and endorsed by Daren, that many people can use APAD without causing harm to themselves or others. Leaving aside the obvious contradiction in terms that the regular use of APAD does not cause harm; it is true that many people can use APAD, without becoming addicted. That is an entirely different matter. The RSA's claim is based on what is described as 'evidence' from the British Crime Survey, of a relatively small number of people. As such it is subjective, rather than factual or accurate. BCS reports are no more than a reflection of the opinions and views expressed by people from 'selected areas' responding to 'pre-constructed questions'. Their findings are not, and should not, be claimed as evidence.

The BCS report also claims that violent crime, which is closely related to alcohol and APAD misuse, remained stable during 2006. A scrutiny of the police recorded figures for London, which the Home Office concedes is where 50 per cent of the problem is, reveals, that with the exception of the years 2003-4 and 2004-5, (when Blair ordered a blitz on street crime, confirming that a highly visible police presence is an antidote to crime) there has been unrelenting increases in violent crime from 2000-1 to 2005-6 inclusive. The figures for 2005-6 show an eye watering increase in violent crime offences to 197,000 in 2005-6 from 17,000 in 2004-5.

It is these indisputable facts that confirm that BCS surveys could hardly be described as accurate, factual or 'evidence'. Therefore for the RSA, or anyone else, to claim it as such, is irresponsible and misleading. The subsequent claim, that one can regularly use alcohol or other APAD without harming oneself is a more than just a contradiction in terms; it is a denial of most of the universal medical, psychiatric and scientific evidence. It is equally unrealistic to claim that such harm does not impact on others. Regrettably it is distortions such as this that become almost inevitable, when we allow authoritative and influential sources to claim subjective views as 'evidence', instead of adhering to facts and empirical evidence.

Yes, language is important; it needs to be accurate and objective. The convenient, inaccurate, or subjective use of it for political expediency, or to promote the use and/or legislation of APAD is a distortion of the truth.

**Peter O'Loughlin,**
**The Eden Lodge Practice**

## Hobson's choice

As the drug and alcohol workforce looks to up-skill, I have followed the debate about whether workers should be qualified to work in the field with some interest. While I understand it's important that recovering addicts have something to give back, I also wonder whether working in this field is the chosen option because it seems like the only option.

Certainly in terms of working in abstinence we have to be very careful, as our work is not about drugs, alcohol or any other way that addiction chooses to manifest itself, but about behaviour, and more specifically behaviour change, without which the risk of relapse is always there.

I think one of the dangers is that too many are coming into this field far too soon. All the best intentions in the world are simply not enough, and the journey from client to professional is a long and winding path in terms of changing one's attitude, outlook and behaviour. Wanting to help others can often be mistaken for being popular and can lead to appalling boundary violations, which only serve to reinforce clients' original dramas.

To think that you have to be in recovery in order to really understand addiction is neither here nor there; also, thinking from a client perspective – which can at best be described as unconsciously incompetent. Do clients really know what's best for them? Most of those I've worked with seem to think that having money, a relationship, full-time employment and a nice flat will automatically solve all their problems.

Some of the most effective practitioners have no personal experience of addiction whatsoever, but when it comes to modelling new behaviour they are exemplary, purely because they already have solid life skills. If all you've ever known in adult life is active addiction followed by detox, rehab, 90 meetings in 90 days, and then a course in substance misuse, what do you really know about life?

To my mind it all seems too incestuous. Go and do something different and get some normality in your life. Once you have learned to have meaningful and boundaried relationships in a variety of settings then perhaps think about coming into this field with the identity of an altogether better and well-rounded person.

Recovery is a process, which is subject to ups and downs, and to my mind the two-year rule is a misguided entity. If we want to be recognised as professionals then we need to behave like professionals. Five-year rule anyone?

**Whitey Singleton**

## Paper-free world

In the article 'Curing bad paperwork' (*DDN*, 21 May, page 13), the authors are advocating referral forms for GPs to use to refer people to the specialist drugs service. I do understand the rationale for this, but I would like to make a few observations on the practicalities involved.

GPs are increasingly being asked to use several different paper referral forms to refer to secondary care. In fact, the vast majority of GP consultations are paperless, as GP IT systems are generally well developed. The requirement for different forms becomes confusing and onerous, when time is short anyway. Is there a form for this speciality? Where are the forms? Do we need to do a letter as well? How do we refer urgently? These are some of the difficulties raised – and in some cases, this may mitigate against referral, as it is just too time-consuming.

The time-honoured way of sending a letter – now with the advantage of a summary printout from the computer record – is a lot more simple and straightforward. GPs can request urgent appointments – as they have always done – if needed, on the letter. While this may not provide all the information asked for, the secondary care service is likely to ask it all again anyway.

GPs are used to referring people and have to make their own clinical decisions. It is then up to secondary care to discuss with the particular referrer if they feel there are persistent problems with the process.

Education is good – personal relationship is better though. So visits to practices just to get to know each other will pay a lot more dividends than reminder letters alone. Who knows – services may actually become better for our patients as a result!

**Dr Joss Bray**

## Your views count!

**Please email your letters (up to 350 words) to Claire Brown, editor: claire@cjwellings.com or post them to the address on page 3.**

***Letters may be edited for reasons of clarity or space.***

The UK Drug Policy Commission launched with a fanfare of media coverage and high profile support in April. **DDN** visited new chief executive Roger Howard to find out why.

# Quest for evidence

In the run-up to a new drug strategy, there is a discernable thud of documents landing on the mat. Among them, 'An analysis of UK Drug Policy', from the newly formed UK Drug Policy Commission. Drawing on a wide range of expertise, the academic authors looked at what's working in drug policy, and what's not, with the conclusion that there had to be some fundamental changes in approach. The recommendations will underpin the work programme of the UKDPC.

So who are the UKDPC and what will they do with a £1.1m grant from the Esme Fairbairn Foundation over the next three years? What's their remit? And who's in charge?

In the heart of Mayfair, just behind The Ritz, chief executive Roger Howard is enjoying spacious offices before his newly appointed staff – a director of policy and research, and a head of communications – join the team. The offices, which are actually part of the Esme Fairbairn Foundation headquarters, feel as well connected as the new commission – a panel of eminent public figures and academics from diverse backgrounds and areas of expertise, chaired by Dame Ruth Runciman.

But there is an ambitious programme ahead for the next three years, with the first projects defined before the new staff are in their seats. Howard is keen to emphasise, from the word go, that his organisation is not about to replicate what other organisations are doing already.

'We are not a membership body, and we do not speak for a certain constituency,' he says. 'We're not a campaigning organisation either. I suppose the only thing we would campaign on is the need for more evidence and research.'

Neither does he see UKDPC as 'holders of knowledge'. They are, he says, uniquely placed to bring together existing evidence in a systematic way. 'We're going to support rigorous collection and analysis of evidence', he says – and make sure it gets to the media, politicians and the general public, to generate 'a more informed dialogue'.

Many people in the drugs and social care field know Roger Howard already. Until February this year he was chief executive of Crime Concern for three years. Before that, as head of the Standing Conference on Drug Abuse (Scoda), he steered the organisation through its merger with the Institute for the Study of Drug Dependency (ISDD) to lead the newly formed DrugScope for another three years. Further back, during a spell at Nacro in the early '80s, he became particularly interested in drug policy, using experience from a Winston Churchill Fellowship to bring ideas on US community based drugs programmes back home. His name soon became linked with drug and alcohol policy development, including setting up drug action teams in the '90s.

But while he has operated for years at a strategic level, as a consultant and in his senior executive roles, he describes his interest in drug and alcohol issues as a 'journey'. Back in 1975 he worked in corporate planning in Lewisham, 'doing a lot of stuff around corporate development, because it had places like Deptford and New Cross, which were going down the plughole at the time'.

'This was a time when the docks were closing and there was a huge amount of disadvantage,' he recalls. 'And there were major concerns about what we now know as Black and Minority Ethnic Communities and about the real difficulties they had.'

He was lucky that Lewisham was 'pretty advanced, with a very interesting political make-up', he says. Engaging community organisations as well as public services was high on the local agenda, so he worked with police, social services and the health department to build 'community responses to what were essentially major social problems'.

'Drugs didn't really figure in that day and age; they didn't really pop up on the radar in any significant way at all,' he reflects. Then came a spell working in an East London borough, where he led the local authority side in responding to the closure of two large psychiatric hospitals. It gave him as a crash course in 'health services on the ground – what we now see as community care' and an insight to people in mental health services that were using cannabis. Coupled with the memory of an old schoolmate who had died of a heroin overdose, he realised he cared about the issues and needed to pursue his interest.

While organising training on drugs, alcohol and homelessness for Nacro, Howard had chance to consider how communities could engage with crime prevention – 'the health and crime interface' that made up a vital part of his picture. 'I'd had this long interest in drug problems and how they connected,' he explains. 'I'd had a local authority perspective, worked closely with the health service and police for many years, managed treatment and prevention services, and been responsible through consultancy work for working with commissioners, while developing infrastructure around quality.'

Observing what worked and what didn't, underpinned Howard's work for the Department of Health on planning and commissioning, and laid the foundations for setting up drug action teams. It was also a valuable rehearsal for his new role at UKDPC. He has a magpie's eye for evidence – from the Effectiveness Review in 1996 to the Spending Review in 2000, and the trials and successes of the National Treatment Agency since it geared up to 'provide a service to a growing field of newly emerging commissioner, a whole raft of initiatives and a burgeoning treatment field', in 2001.

Over the next three years he will use this experience to direct the UKDPC towards evidence of what works and what doesn't, in the drugs field. He has made clear that he wishes to steer briskly through previously trampled territory, acknowledging the field's successes and addressing failures by looking at what's working in other areas of public health.

'I do think we are at great risk of polarising this dialogue,' he says. 'What people who argue that it's one or the other – it's a health problem or it's a crime problem – what they're at risk of doing is resorting to a very simplistic analysis of this major

complex social problem.'

With three years to redress the lack of evaluation and research in this country, the work programme swings into action this month, with the Commission's next quarterly meeting and the arrival of the new staff. The UKDPC's first major piece of work will be looking at interventions in the criminal justice system – a project 'that's going to hit fair and square on what are the lessons and sustainability of the Drug Interventions Programme'.

The second piece will be around drugs and BME communities, tackling questions such as: 'When they are in treatment services, how do people in BME communities fare?'; 'Is it true that there seems to be disproportionate arrest and imprisonment?'; and 'Is there any truth in the belief that particular BME groups are more engaged in drug gangs?'

Is Howard worried about delivering within a three-year timescale? He brushes off the suggestion: 'A time span of three years can concentrate the mind to make sure there's a driving force behind us, to make sure we deliver,' he says.

Mentioning that the next three to five years will be 'so constrained in terms of resources, [with] this pressure, this constant pressure on value for money', he issues an open invitation, 'to commissioners, organisations, treatment organisations, police – whoever you are', to join the process of feeding in literature, service reviews, 'grey evidence' and internal reviews, to contribute to the data bank.

'If you can get enough of those, they build up into a systematic picture,' he says. 'They may not be the same quality as gold standard randomised trials, but they're absolutely invaluable.'

'You can't be stuck in the past, you've got to look forward,' he adds, warning to his theme for a final time. 'Let's acknowledge where we've come from, because this whole field has gone from strength to strength. Now's the time to start asking some critical questions as it goes into the next phase of development.' **DDN**

**To submit information or research to the UKDPC, email info@ukdpc.org.uk or call 020 7297 4750.**
**More information on the UKDPC's work and commissioners is on their website, www.ukdpc.org.uk**

# Q&A

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

## Flagrant disregard

Dear Amy
I read your letter in absolute despair, disgust and disbelief that anyone could be treated in the way you describe. Unfortunately, of course, I also totally accept and trust that this has happened and I know I should be shocked, but I am not.

Your confidentiality is paramount here and that is final. I am so fed up with listening to stories with this common thread of very poor keyworking and the flagrant disregard some workers have for their clients' basic human rights – let alone their right to an individual package of care which begins and ends with confidentiality and consent to share information.

Your treatment, therapy and recovery is what this person should be concentrating on, and how to best support you on this journey – to enable you to get back to work and continue to help the vulnerable, not wreck your career and the future lives of the people you will work with because of their lack of understanding of the protocols or guidelines that govern their work and protect you.
Best wishes to you,
**Ahmed, by email**

## Trust and rejection

Dear Amy
Firstly, I would like to congratulate you in accepting that you needed more support from your relapse and went into treatment to seek support and more understanding as to why this happened.

To me you write as a sound person and a giver, which is so common for us addicts. However, having yourself worked in a rehab, you know it can be very emotional, stressful and mentally painful sometimes when you're working with ill people just coming into treatment. Maybe something has been said, or you brought up issues from the past you had not dealt with, that were in your subconscious.

Amy, I can understand why you are horrified that your councillor feels she has a duty to protect future clients coming into treatment. You're not on your own: I know I cannot work in groups, rehabs etc as I feed into others' pain. But it is wonderful that you are determined to sort yourself out once and for all: go for it, lock stock and barrel! You are the most important person in this world and if you cannot sort yourself out or recover, then it's a fact – you are no good to anybody else at all.

Look after yourself. Yes, I can see you are horrified with your councillor, because it brings up trust and rejection and for you – maybe more; yet she sounds professionally wise. Please try not to beat yourself up over this. Ask yourself: would you want a user, addict member of staff supervising you? I feel you know the answer – yet addicts as we are, we sometimes need the final hurdle to jump from others understanding and supporting.

Sort all your issues out and look after yourself. Use all the past as a learning process, and you will become stronger, wiser and more able to cope.

I sincerely wish you the best, and that you can decide what is best for your wellbeing. Take care,
**Sean Rendell, by email.**

## Borderline case

Amy,
Are you worried that you might loose your job if your counsellor and employer communicate? Before getting into questions about the rules of confidentiality maybe you should look at your own position as a recovering addict from your position as a drugs worker. If you have worked in rehabs, you will have experienced the situation in groups where some clients focus too much on other people's problems thus ignoring their own. Such behaviour is called externalising, denial or deferment and needs to be challenged as a renowned predictor of relapse. So challenge yourself: Maybe you shouldn't be working to help others at this time? There's an old saying: 'You need to be able to help yourself before you can help others.'

As to your counsellor, empathise and think of what you would do in his/her position. It is a very tricky conundrum. I would hate to make such a decision. In my understanding of the rules of confidentiality, a counsellor/therapist is allowed (or is required) to break confidentiality if the client presents a threat to themselves or others. Your situation is a borderline case. From the comfort of home I might say: 'If nobody knows about your relapse, how much of a threat can you be?' and keep your secret while maintaining my faith in your ability to solve your personal problems. However, as a working counsellor I would have all sorts of worries and doubts about the ethics of your situation and would feel compelled to speak with your employer.

But how do you feel? Will you feel comfortable helping others towards a goal that you have failed to achieve? My advice would be to tell your employer face to face. In the light of mutual trust, your employer should react better hearing the news from you rather than second hand via your counsellor. If you open up, it will be beneficial to your own recovery (paramount) and those you work with (12 step style). If you hide the facts and live a lie, it will be detrimental all round and your counsellor may be forced to do that which all counsellors hate to do.
**Mike Richardson,**
**volunteer group worker**

## Reader's question

**I'm on a degree course, studying to become a counsellor and one of my friends, who I'm living with, is binge drinking to excess. When I try to speak to her about it she laughs and says she can handle it, but I can see it's starting to affect her life dramatically. She doesn't seem to think it's a problem – how can I convince her that it is?**
***Charlie, Manchester***

**Email your suggested answers to the editor by Tuesday 12 June for inclusion in the 18 June issue.**

# Want to be **a** better **manager?**

**Trevor Boutall recalls his shock at realising that the title of manager did not come with a set of skills attached – an experience that informed development of his new website, www.BeaBetterManager.com**

Ironically, my first proper job after I left university was working for an off-licence chain in their shop in Covent Garden. In those days, Covent Garden wasn't the posh quarter it is today. The fruit and vegetable market had recently moved out and we still did a roaring trade in Strongbow, Special Brew and 'British Sherry' for the rough sleepers under Waterloo Bridge, as well as half bottles of Gordon's and tonic for the local residents who dropped in on a daily basis. Covent Garden wasn't exactly the flagship store, languishing in the early 200s in the company's 250-store league table.

Then, all of a sudden, the covered market was refurbished, the fancy restaurants and designer shops moved in (forcing out most of the traditional trades people) and the upper floors were converted to offices to accommodate a new generation of designers and international advertising and 'marketing communications' executives. The ciders, super lagers and British wines made way for premium lagers, champagne and Tio Pepe, sales sky-rocketed and my store shot to number one position in the group.

It was a great time to be working in Covent Garden, with daily visits from a cross-section of creative types, actors and actresses working at the local theatres (who were happy to provide free tickets for the best seats in house in return for a little advice on a cheeky back-stage Chardonnay) and camaraderie with the barmen and waitresses from the neighbouring bars and restaurants. The bonuses, based on year-on-year increases in turnover, were interesting, too!

However, all good things come to an end. Recognising my sales achievement (which, in reality, amounted to little more than responding enthusiastically to the ever-growing tide of office workers and tourists passing the shop), at the tender age of 25 I was promoted to the grand position of area manager, responsible for all the stores in South East London, Kent and Sussex. At close of business on the Saturday evening, my boss handed me the keys to my company car (a turquoise Mark 3 Ford Cortina) and wished me success in my new role. 'Yeehaa! I'm a manager now!' I shouted as I drove home with a bottle of Augustus Barnett and Son's finest Champagne to celebrate with my wife.

The state of euphoria lasted the rest of the weekend and it wasn't until Monday morning that the new state of affairs began to sink in. I was a manager, yes, but that was about all I knew. I had no job description, no induction, no training or preparation for the role. I had a Ford Cortina, my wits and precious little experience. I was floundering in the deep end without any style or technique, a life jacket or even a pair of armbands. In my first week, I had to deal with a robbery in one store, dismiss a manager for theft and discipline another for poor time-keeping. I made a right hash of it, I'm sure, and I – and my wife – certainly suffered from the stress of being on 24-hour call.

I gradually learned from my mistakes, got some advice from colleagues and even signed up for a management course in the evenings at Southbank Poly. I eventually became a half-decent manager, and I even got further promotion before the company was sold to a brewery, after the tax-authorities seized the assets of the parent company in Spain. It was a tough, painful and exhausting experience, though not dissimilar from the experiences of the majority of managers I meet, who are thrown into management positions without the preparation or resources they need to make a success of it.

When I started working in training and development in the 1980s, I decided

## How to build a better team

**Identify the purpose of the team**
Be clear with yourself and others what the team has to achieve.

**Identify team requirements**
Be clear about the mix of expertise, knowledge and skills required to achieve the team purpose.

**Select team members**
Choose people with the required expertise, knowledge and skills and different personalities so they can play complementary roles.

**Establish ground rules**
Agree with team members the behaviours that are likely to help the achievement of the team purpose and those that are likely to hinder progress and should be avoided.

**Define team roles**
Help team members understand their unique contribution to the team purpose, the contributions expected of fellow team members and how these complement and support each other.

**Build team cohesion**
Provide opportunities for team members to get to know each others' strengths and weaknesses and build mutual respect and trust.

**Encourage team working**
Encourage team members to share problems with each other and solve these creatively together.

**Create a culture of frankness**
Encourage open communication between team members, including providing feedback to enhance performance.

**Support the team**
Allow time and provide support for the team to develop through its stages of growth.

**Celebrate and commiserate together**
Celebrate team and individual successes together and commiserate together when things go wrong, before refocusing the team's energy on achieving its purpose.

*More at www.BeaBetterManager.com*

**'I had no job description, no induction, no training or preparation for the role. I had a Ford Cortina, my wits and precious little experience. I was floundering in the deep end without any style or technique, a life jacket or even a pair of armbands.'**

that I would make it my mission to help people be happier and more successful in their work. I helped develop and promote the national Management Standards to provide a clear template that managers can use to do their jobs effectively, safely and without undue pressure. More recently, I have been involved in the drive for competence in the substance misuse field through the use of the Drugs and Alcohol National Occupational Standards.

Working with DAATs and service providers has reinforced for me, however, the importance of competent management in delivering quality services. If managers don't delegate responsibility clearly to people, ensure staff are capable of carrying out these responsibilities and hold individuals to account, then service standards are never going to be met. I appreciate that probably the majority of those in supervisory and management roles in services have risen through the ranks (that's a good thing) and have had little formal training or preparation for their roles (that's not so good), and are often not totally clear what their roles entail (that's even worse).

The Competence Group, of which I am a member, has as its goal 'a competent workforce to tackle substance misuse by 2010' and supports work towards this goal with training programmes for staff at all levels, but particularly for managers (http://www.fdap.org.uk/cog/training.htm). On 6 July, CoG will be facilitating a seminar in London for those responsible for workforce development to bring people up to date, exchange good practice and seek solutions to some of the tougher problems of developing staff and volunteers.

My own company, The Management Standards Consultancy, is making a more individual contribution to the competence of managers, not just in substance misuse but across all sectors in the UK, through the launch of a new website on 5 June. With just three clicks on www.BeaBettermanager.com, managers can find best practice checklists to help solve their immediate problems, grasp opportunities for personal and professional development and achieve immediate improvements in their results. Each checklist links directly through to relevant National Occupational Standards, to a vast array of resources available free on the web, to structured training courses, books, e-learning and to local and sector specific support from the best UK learning providers.

BeaBetterManager.com is free to use and available 24 hours a day. As well as tackling nasty things like budgets, discipline and dismissal, it also provides guidance on the more positive aspects of a manager's work, such as team building, delivering services people really need and making sure meetings are effective. Each checklist can be downloaded to help plan your work, monitor progress and review your achievements. It won't save the planet (although the checklists on environmental management could help!), but it will save managers – like myself in my days in the wine trade – from making elementary and costly mistakes. It may also help them sleep more peacefully at night.

*Trevor Boutall is director of Management Standards Consultancy and an occupational standards expert.*

## Post-its from Practice

# Holding back an emergency

**Slow progress in getting a relapsing patient the help he needed demonstrated to Dr Chris Ford the poor state of in-patient alcohol detoxification.**

**A few weeks ago** I had to admit John as an emergency to an acute medical bed. John who was in his early 50s and had suffered a haematemesis (vomiting of fresh blood). He was seriously unwell on admission and although improving remains very poorly.

John first came to see me about eight weeks ago. He informed me that after seven years of being abstinent from alcohol he had relapsed about eight months ago. He was drinking at least a bottle of vodka a day as well as several (four to six) cans of nine per cent lager (about 53 units a day). On examination he was already showing signs of liver damage and his liver function results were seriously alarming. He had managed to gain seven years of sobriety following an in-patient detoxification and he pleaded with me to arrange the same again. He declined individual and group counselling and explained that AA hadn't worked for him. He knew that it was in-patient detox that would. He also knew that he had no chance doing it in the community. I agreed and said I would do my best, but had to explain to him that 'urgent' and 'detox' weren't two words that go together in our area (and I know that it is far worse in other areas). On his next visit we completed the forms, faxed them off and got him on the urgent waiting list. His date for admission was four days after he presented as an emergency.

What I can't say for certain is whether John could have avoided this life threatening episode, if I had been able to get him a bed when he first presented. What I do know is that his chances of good recovery would have improved dramatically.

Where I work I am more fortunate than many of my colleagues who have no access to specialist in-patient detoxification beds. The service available to us did try to get John in as an emergency, but because of funding and waiting lists the first available bed was given to him several weeks after he first asked for it. Dr Ed Day in his *In-patient drug treatment survey* in December 2004 found that 41 per cent of detoxifications were for alcohol and only 29 per cent of all detoxifications were provided in specialist units. There were not enough beds, there was no consensus on management and there were poor links to aftercare.

I would suggest that, as with John, alcohol detoxification is often an emergency and we should be able to treat it as such. Additionally John was extremely motivated and personally I worry when motivation is almost used as a weapon to exclude people from services.

Perhaps we need to rethink our supply and entrance criteria for detoxification, both for alcohol and other drugs? The NTA said that access to in-patient detoxification should be within four weeks for 2002/03 and two weeks from 2003/04 onwards[1] – are we even close to achieving this? Plus I would have preferred to admit John as an emergency on the same or next day of presenting – do you agree?

**Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP**

*1. NTA In-patient drug (and alcohol) misuse treatment, March 2003*

# A licence to cure?

## Would buying from Afghan opium farmers under licence be a solution to the shortage of opiate medication, or a bad strategy of no return? **Professor Neil McKeganey** considers the risks.

The Senlis drug policy group have recently recommended that the UK government and other governments change their policy in tackling the world's heroin problem by buying up supplies of the drug and using these within the legitimate drug economy to plug a global shortage of opiate medication. If you can't beat them then maybe you should join them and in the process turn a negative into a positive.

But what would be the impact of a policy that involved the UK and US government negotiating with those who are currently supplying 90 per cent of the world's heroin? If we were to start buying up the Afghan heroin crop we would effectively be embarking on a process from which there was no easy return.

Each and every year you would have to agree the same thing no matter what the increase in price. 'If you don't pay, I sell to the drugs trade' would be the simple message underlying those negotiations. And what would the price be that you had to pay for each year's opium harvest? Would it be the meagre price currently paid to the farmer, or the price obtained by those criminal gangs involved in international supply of the drug? If it were the former, then those selfsame crime gangs would put the farmers under enormous and possibly violent pressure to continue to sell their crops in the way they have for years. If it were the latter, our government would effectively be putting large amounts of money directly into the hands of some of the world's most affluent – and in their own terms influential – criminals.

In agreeing to that deal you would be sending out a powerful message to each and every country in the region that if they wanted a guaranteed income from the West then all they need to do is start farming opium. Far from stemming the drugs trade you could find yourself actually stimulating its growth. Those countries in particular who had already stemmed their opium production on the basis of international pressure might feel mightily irked by such a change in policy and decide themselves that it was no longer in their interests to so assiduously police their own opium trade.

If you succeeded in persuading a local farmer to sell you his opium crop you would be placing them at enormous risk, because the gangs who currently run drug production are not going to sit around and watch their market disappear. Instead they are going to use whatever force is necessary to ensure that no matter who buys the drugs the money goes into their pockets. Such a policy then would require the capacity of the West not simply to buy the drugs from the farmers at source, but to provide the level of security that those farmers are going to require as a result of their decision to switch the sale of their product.

Providing the necessary level of security to the farmers and their families however, would be no easy feat. In the face of only a small number of high profile murders or kidnappings of farmers who had agreed to sell their opium to a legitimate representative of the UK or US government, many others would think twice about the wisdom of such a decision.

The Afghan government has resisted aerial crop spraying for a number of years with the reassurance that as ground level security increases, opium production will diminish. Nobody now accepts those reassurances and patience is running very thin. There is no question that we need to invest more in encouraging local farmers to produce non opium harvests and to support the development of a governmental infrastructure within Afghanistan. However local forces will have to show that they have both the capacity and the will to tackle drug production within their own country, or the inclination will inevitably be to impose a solution from outside the country.

In the face of the continued failure to reduce the scale of opium production in Afghanistan, then aerial spraying may well come to be seen as the last but now needed option in tackling opium production. There is also a need, however, to show those who are dedicated to opium production that their choices in this respect are going to cost them dearly, whether in seized assets or further military intervention. Putting money into the hands of those who are involved in organised drug production is about as far from that strategy as it is possible to get.

I recently attended an international seminar addressed by some of those who are involved in the Afghan counter-narcotics effort. Sitting next to me was a senior UK police officer who turned and said that part of the problem in tackling drugs production in countries like Afghanistan was the fact that you never knew whether the person you were speaking to was part of the problem or part of the solution: 'We are expected to share our intelligence but you never know when you take out a group involved in opium production whether you have reduced supply or simply lowered the level of competition in the market.' In a situation in which it is hard to tell whose side people are on, it is a risky strategy dolling out large amounts of government money.

*Neil McKeganey is professor of drug misuse research at the University of Glasgow*

# What the science shows, and what we should do about it (Part 4)

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

**Leading US addiction scientists met in 2004 at a 'think-tank' conference to share research findings in their respective areas and discuss possible implications for treatment and prevention interventions.** They proposed a set of ten cross-cutting principles, which I have considered in recent Briefings.

These principles suggest particular directions 'in designing programs, systems, and social policy to reduce drug and associated suffering, societal harms and costs'. I will now look at the first six recommendations.

**Recommendation 1:** Intervention is not a specialist problem but a broad social responsibility that should be shared by many public and private sectors.

Treatment should be integrated as much as possible in one-stop health and social service settings that connect people with other services they need. As with other chronic health problems, the successful resolution of substance use problems depends heavily on long-term behavioural self-management.

The value of screening and prevention services should not be under-emphasised and they need to be integrated in the same health and social service setting. There is legitimate concern that substance use issues may get lost in chaos and be given low priority in this system. This must not be allowed to happen.

**Recommendation 2:** Screen for and address the full range of substance problems, not just the most severe.

There needs to be an integrated continuum of care that addresses the full range of problems, rather than a focus of attention and resources on the most severe substance use problems.

The concept of stepped care is a sensible, although relatively untested, approach. There needs to be a menu and spectrum of services to allow people to find levels and types of service that they find appropriate and attractive.

A reasonable and under-utilised approach is to offer brief motivational counselling as a first-line intervention, followed by more expensive and intensive services to people who do not respond to this brief intervention.

**Recommendation 3:** Understand substance use and problems in a larger life context, and provide comprehensive care.

Substance use problems rarely occur in isolation. Since substance use may be just one component of a matrix of problems and issues – psychological, medical, family, social – disrupting only one of these components is unlikely to disrupt this complex self-organising system.

**'Substance use problems must be understood and addressed in the larger context of personal and social issues.'**

Substance use problems must be understood and addressed in the larger context of personal and social issues. Practitioners and the system must screen and provide adequate care for common concomitant concerns, such as depression and family problems.

Prevention efforts should look beyond substance use, making use of scientific knowledge about modifiable risk and preventive factors. Particularly at-risk groups and families should be identified for early intervention.

**Recommendation 4:** Look beyond the individual for the causes and solutions to drug use and problems.

Many interventions for substance use problems 'have been designed to address and to focus on personal pathology, implying that the locus of the problem is within the individual or family'. This misses the reality that substance use problems are part of a broader self-organising social system.

We need to take into consideration the impact of contextual, family and societal factors in promoting and decreasing substance use problems.

A societal response to illicit drug problems that focuses on deprivation and punishment is unlikely to be successful. Attempts to prevent people from using illicit drugs are ill-fated without providing access to alternative natural sources of positive reinforcement.

For example, people experiencing social deprivation will find it much more difficult to give up drugs than those living in areas providing access to a variety of alternative sources of reinforcement.

**Recommendation 5:** Enhancing motivation for and commitment to change should be an early goal and key component of intervention.

Drug use is a choice among alternatives. Prevention and treatment efforts are essentially competing with an inherently rewarding behaviour.

Change begins with motivation to change. 'How to' interventions are unlikely to succeed in the absence of motivation.

Approaches that in effect tip the balance of motivation away from problem substance use are effective in changing behaviour. These include brief motivational interventions, positive reinforcement for non-use, substitute agonist medication, and enhancing access to natural sources of positive reinforcement.

Much is known about how to impact upon human motivation and commitment to change that goes beyond simplistic advice to 'just say no'. This science needs to be used to craft effective interventions.

**Recommendation 6:** Changing a well-established pattern of drug use begins by interrupting the pattern to produce an initial period of abstinence.

Once addiction or dependence is established, it becomes self-perpetuating. A period of abstinence helps to destabilise this self-organising pattern and can trigger change.

An initial period of abstinence can be brought about by, for example, residential care, medication, or contingency management. The longer the abstinence, the more stable it becomes.

Choice and motivation are important components in helping people to interrupt substance use and experience a period of sobriety. External enforced abstinence tends to be less effective than periods of abstinence where the individual has choice.

*[to be continued]*

*Rethinking Substance Abuse: What the Science Show, and what we should do about it, edited by William R. Miller and Kathleen M. Carroll, Guilford Press, 2006*

UNIVERSITY OF KENT

# Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

## Programmes from 2007/08

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

### **Certificate in Substance Misuse Management** (Stage 1)

This access level Certificate provides a broad introduction for people currently working with problem substance users, or expect to be in the near future. The programme is delivered in Canterbury & across the UK where there is a cohort of 10 or more students. It is a recognised benchmark for those who seek an accredited qualification. The programme also benefits social, health and education professionals in all sectors whose work includes significant contact with problem substance users

**18 month programme from September 2007 or by negotiation**

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

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

**18 month programme from September 2007 or by negotiation**

### **Diploma in Substance Misuse Management** (Stage 2)

The Diploma provides a framework for understanding the nature of substance misuse and addiction processes from biological, psychological and social perspectives, and focuses on the settings and approaches within which treatment is provided. The Diploma is appropriate for practitioners working in Tiers 2, 3 and 4a services for drug users or people with alcohol problems.

**2 year programme from October 2007**

### **BSc in Substance Misuse Management** (Stage 3)

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

**2 year (top-up of Diploma) or 4 year programme from November 2007**

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

## Other positions

**Shared Care Workers – Bristol**
BDP - £16,216 - £24,377
Closing date: 12.06.07
*www.drinkanddrugs.net/jobs*

**Drug Using Parents Service Worker – Bristol**
BDP - £16,216 - £24,377
Closing date: 12.06.07
*www.drinkanddrugs.net/jobs*

**Volunteer Counsellors – London**
Drug and Alcohol Foundation – (travel expenses covered)
Closing date: 1/7/2007
*www.ldan.org.uk*

**Admin Volunteer – London**
EATA
Closing date: 1/7/2007
*www.drinkanddrugs.net/jobs*

**Staff Grade Substance Misuse Services**
£32,020 to £45,598
Sussex Partnership NHS Trust
Closing date: 17.06.07
*www.jobs.nhs.uk*


At Bridgend County Council we never stand still. We're always looking for ways to improve our service and our new leadership team has put change at the top of our agenda. We're looking for people who'll embrace the challenge and unlock our potential. So join us and be part of the transformation.

**Evaluated Early Parental Intervention Programme Project Worker**

£26,187 - £28,221 Ref: 01191

This post is subject to Job Evaluation.

To request a job pack please telephone 01656 643203 (24-hour recruitment line) or e-mail humanresources@bridgend.gov.uk

Closing Date: Friday 22nd June 2007

*Positive about people*

BRIDGEND

## We're Changing People's Views

COMMUNITY WELL-BEING

**Substance Misuse Joint Commissioning & Strategy Manager**

THURROCK COUNCIL

**£33,432 - £43,602 pa inc.**

*Post No: N01001*

In this role, you'll operationally manage the joint planning and commissioning of Health and Social Care for substance misuse services. Establishing the strategic direction for our local drug and alcohol services, you'll make sure they meet national expectations and local needs – it will be up to you to make the best possible use of resources, and maintain robust outcome and quality-based contract management.

With considerable expertise in the field of substance misuse, you'll work effectively across professional, organisational and partnership boundaries. Self-motivated and proactive, you'll be able to juggle your own workload and cope under pressure – it's also important that you can manage devolved budgets in line with financial and grant conditions, and present information both verbally and in spreadsheets.

A Criminal Records Bureau Disclosure at Standard level will be required for this post.

**Closing date: 2 July 2007**

For full details on this and other vacancies in the Thurrock area and to apply online please go to:

**www.thurrock.gov.uk/jobs**

If you do not have Internet access, please call 0870 787 1176 (Mon-Fri, 8am-7pm or Sat, 9am - 2pm)

Thurrock Council is committed to equal opportunities and welcomes applications from all sections of the community. Disabled people will be offered an interview where they meet all essential criteria on the Person Specification. Job share applications are also welcome. Most Departments operate a flexible working hour's system.

*In the Thames Gateway*

Apply on-line at www.thurrock.gov.uk

cambridgeshire drugandalcohol action:team

## Expressions Of Interest

### for the Provision of Adult Drug Treatment services in the Cambridgeshire DAAT area

Expressions of interest are invited from suitably experienced and competent organisations to tender for a contract(s) to deliver a variety of services for adult drug users in Cambridgeshire DAAT area.

The expected term of the contract(s) will be 1st April 2008 to 31st March 2009 with possible extension to 31st March 2011 subject to recurrent funding and satisfactory performance.

Expressions of interest are invited for all or for specific phases, from individual organisations or from agencies acting in partnership. Applicants are asked to note that multi agency applications are favorable and applicants will be required to evidence how they will work across the whole adult drug treatment system if only applying for specific phases.

- Induction phase
- Intensive phase
- Move on Phase

Prospective tenders should take into account the implications of TUPE arrangements with the existing provider of elements in all phases. Prospective tenders applying for components of phases or identified locality services are required to clearly identify and outline how they will work with other providers of the system in delivering a complete package of care. Multi agency applications are welcomed by CDAAT.

*Written expressions of interest and requests for tender documentation should be made to: Cambridgeshire DAAT, 18-20 Signet Court, Swann's Rd, Cambridge, CB5 8LA or email jessica.bendon@cambridgeshire.gov.uk*

**The closing date for submission of pre qualification questionnaires is 13 July 2007**

ARA addiction recovery agency

**PRINCIPAL COUNSELLOR** Job Ref: AP011
**Salary: £23,500 - £26,000 per annum.**
*Initially seconded to the Structured Day Programme you will need three year's experience of Abstinence based treatment.*

**COUNSELLOR** Job Ref: AP010
**Salary: £21,000 - £23,500 per annum.**
*Initially seconded to the Residential Rehabilitation Programme you will need two year's experience of Abstinence based treatment.*

Both posts include £800 On-Call and opportunities working with 3rd Stage Housing, Aftercare and Relapse Prevention. You will be Diploma qualified.

**Closing date: 9.00 am, 25 June 2007.**
To apply visit www.addictionrecovery.org.uk or call 0117 934 0844. Benefits include: 25 days leave, 35 hour week, pension, training.

ARA welcomes applications from all sections of the community.
Registered Charity No 1002224

# ACTION

**TWO PART-TIME TUTORS**
Centre for Addiction Treatment Studies Wiltshire
£26,332 per annum (pro-rated)

We wish to recruit two part-time Tutors to teach on our groundbreaking Foundation Degree and BSc Programmes in Addictions Counselling designed and delivered by the Centre for Addiction Treatment Studies (formerly Clouds Professional Education) and awarded by the University of Bath.
The ideal candidates will be involved in teaching, programme development, tutorial support and assessment of coursework.
We are particularly looking for Tutors able to teach confidently in at least one of the following areas: CBT and Relapse Prevention; Harm Reduction and Group Therapy.

**Academic qualification**
A first degree (class 2:2 or better) or equivalent.
Relevant post-graduate professional qualifications are also acceptable.

**Professional experience**
Excellent counselling knowledge and ability.
You will probably hold a Diploma in a relevant model of counselling or psychotherapy.
Experience with alcohol or drug using clients.
Some experience and knowledge of teaching.

**Professional knowledge**
You will need to be competent to teach and assess a range of the following at undergraduate level: counselling skills, motivational interviewing, 12 step facilitation, interpersonal group therapy, cognitive-behavioural approaches, relapse prevention, dual diagnosis, harm reduction models, ethics, supervision, diversity issues and family work.

UNIVERSITY OF BATH

**SENIOR ADDICTIONS COUNSELLOR / CO-ORDINATOR**
from £23,069 to £24,480 per annum (depending on experience)

SHARP (Bournemouth and Poole) based in Boscombe, Bournemouth, provides a range of addiction treatment services from pre-treatment through to aftercare and work based training. We are currently looking to appoint a Senior Addictions Counsellor/Coordinator to provide a full range of counselling services within the Structured Day Treatment Programme Team and as part of the Community Services multi-disciplinary team.

For more information and to receive the application pack for any of the above roles, please contact Mardeen Willows in the HR Office on 01747 830733. Alternatively, please email your interest (providing a postal address) to mardeen.willows@actiononaddiction.org.uk

Closing Date: 22 June 2007

Clouds has merged with Action on Addiction and the Chemical Dependency Centre. The new organisation is called Action on Addiction.
www.actiononaddiction.org.uk

Action on Addiction



# winthrop hall

SUCCESS IN RECOVERY

## RMN or RGN Nurses
## Salary c.£35K – We may be prepared to pay more for exceptional candidates

Success in Recovery Ltd's facility, Winthrop Hall, is a purpose-built 25 bed residential drug and alcohol treatment centre. It is situated in 27 acres of Kentish countryside, south of Maidstone, providing accommodation of a four star hotel-type quality to treat people with alcohol and drug addictions, who have the ability to fund their own treatment.

Success in Recovery Ltd was formed for the purpose of delivering cutting edge treatment of drug and alcohol addiction in the UK. Its fundamental guiding principle will be in research based and outcome driven client centred care pathways, delivered in a supportive and interactive environment. Our goal is to establish a centre of excellence in the field providing discreet private residential and follow-up treatment. Clients will stay for up to six weeks in our in-patient programme, which will combine a traditional 12-Step addiction recovery philosophy, married with a cognitive and behavioural treatment programme, supported by family work and delivered in group and one-to-one settings. Treatment will also provide medically supervised detoxification, social and community activities and alternative therapies.

We are seeking to recruit outstanding Substance Misuse Nurses, to work day or night shifts, with the motivation and skills to deliver our programme, achieving successful outcomes for our patients. The successful candidates must be innovative, articulate, dynamic and passionate about delivering excellent client care.

You will be a registered nurse with either RMN or RGN experience in the addictions field and preferably further training in addiction or supporting areas.

In particulate to:

- Play a key role in the client's medical detoxification
- Be involved in assessment, planning, implementation and evaluation of client care
- To utilise other supporting skills or training within this field, as nurses will be expected to play an important role in therapeutic activities within the centre
- To be valued member of the multi-disciplinary team

The successful candidates need to be exceptional individuals, committed to working within a government framework to deliver safe, effective, evidenced based care.

This post offers a high level of job satisfaction and an extremely attractive package and we are committed to your ongoing personal development.

For an informal discussion regarding this position please contact
**Julie Shannon 07970 914960**

If you are interested in this opportunity in the first instance please email a brief summary of your background and experience and a covering letter to
**julieshannon@successinrecovery.co.uk**

Closing date for application is: Closing date 15th June 2007

These posts require an Enhanced Disclosure under the Care Standards Act 2000