From FDAP in association with WIRED

# DDN

## Drink and Drugs News

27 June 2005
www.drinkanddrugs.net

**ENCOUNTER WITH 'DR E'**
A session with Alexander Shulgin

**DIAMORPHINE DESPAIR**
With a world glut of heroin why is there a UK shortage?

**A DAY WITH DAVE**
Support work through the eyes of a novice

# DAZED NEW WORLD

## What future for drugs and drug use?

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## Hair Analysis:

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- Provides a fuller picture of drug history – difficult to evade
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# Drink and Drugs News

27 June 2005

## Editor's letter

Sometimes the march of drug supplying and dealing seems unstoppable. Type any drug name into your Google browser and you will see thousands of companies offering to send you decreetly wrapped packages of this or that; no need to risk detection, your details can be encrypted online.

There's no doubt that if you want it, you can get it – which is where websites like 'the vaults of erowid' (www.erowid.org) come in. The two Americans who created this site now constantly update 30,000 documents covering 250 psychoactive substances, funded by donations and no advertising. Where many organisations, particularly in the US, have failed to get the kids to 'just say no', this pair have gone for the practical option of information provision – and a very impressive archive it is too. This surely comes close to an online harm reduction manual. Anyone with access to a computer can see exactly what a substance is made of, what it does, what it looks like, what to expect as it takes effect, and what the consequences will be. Erowid contributed to conference discussion on page 6.

These thoughts are taken further in the encounter with the Shulgins on page 12. You may be familiar with their work experimenting with psychedelic drugs (they tested them on themselves) or you may not; you may agree with what they do, or you may not. But whatever your view, it's a fascinating glimpse into two very original minds.

Articles in *DDN* reflect all kinds of views and positions, but it's probably timely to remind you that our job is to present what's out there and what's being talked about – whether it's criminal justice, harm reduction, abstinence, or original thought. The feedback must come from you.

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## In this issue

# Media watch

Parents have given their support to a secondary school's plans to introduce random drug testing of children. Colne Community School, in Brightlingsea, could now bring in the scheme in September after questionnaires were sent to parents last month. Principal Terry Creissen said more than 90 per cent of parents who responded were in favour of the proposed scheme, which would cost about £10,000 a year to run, with funding planned through sponsorship. Governors will make a final decision about whether to give the go-ahead later this month and, if so, the first drugs tests will be taken in September. Students will also be surveyed about the issue.
***East Anglican Daily Times, 23 June***

Children at playschool in Austria are having their toys taken away in the belief it will help them fight drug addiction and alcoholism later in life. Pilot tests have shown that taking away children's toys encourages them to think more about how to entertain themselves. They become more social and even those on the outside of the group find a positive role. The campaign comes after recent studies in Austria found more and more children are growing up in families in which one or both parents drink too much alcohol and the number of teenagers developing problems with alcohol and drugs is growing.
***Ananova, 24 June***

A Welsh assembly member who called for his colleagues to volunteer to try out a new drug detection machine has tested 'positive' for cannabis himself. Swabs taken from Conservative William Graham's hands at the Welsh assembly building revealed traces of the drug, probably from a door handle. The Ion Track drug detection system is so sensitive it can detect the equivalent in drugs of a grain of salt in an Olympic-sized swimming pool.
***BBC News, 15 June***

Problems with teenage girls binge drinking more than the recommended limit for adults have convinced Merton Council to apply for £90,000 to fund extra counselling. Youth workers hope the money, to be spread over three years, will step up counselling services available to young drinkers to make them aware of the dangers.
***Wimbledon Guardian, 23 June***

Cheeky Vimto anyone? Charlotte Church has revealed that her favourite tipple is double port and a bottle of WKD Blue (Vodka based alcopop) in the same glass. 'It tastes just like Vimto or Ribena. They're lethal,' she added. An average night sees this topped up with another 10 double vodkas 'I can sink 'em' said Church. A spokesman for Alcohol Concern said: 'We do not comment on individual cases, but drinking 10 double vodkas is a large amount'.
***Daily Telegraph, 22 June***

New research by scientists at Edinburgh University has found that young drug users can suffer brain damage similar to the early stages of Alzheimer's disease. The research claims that young injecting drug users are up to three times more likely to suffer brain damage than non-users. The studies suggest that intravenous use of heroin or methadone can be linked to premature ageing of the brain. It revealed that some drug users sustained a level of brain damage normally seen only seen in much older people and similar to the early stages of Alzheimer's disease.
***The Scotsman, 22 June***

# Protecting young people – more targeted action needed

More targeted action to protect young people has been recommended by the National Collaborating Centre for Drug Prevention. The centre, based at Liverpool John Moores University, is publishing its review on government-sponsored drug prevention evidence for vulnerable young people to coincide with the United Nations' International day against drug abuse and illicit trafficking, on 26 June.

Key findings acknowledged the importance of schools' role in delivering drug education as part of the curriculum. But there was a lack of robust evaluation that drug prevention messages were reaching vulnerable young people in the UK who had specific needs. These needs might relate to housing, education, health or employment. Furthermore, 'some young people from Black or Minority Ethnic groups have problems accessing services often because of language or cultural issues,' said Kimberley Edmonds, the report's lead author.

There needed to be more training for non-drug specialists working with vulnerable people, in line with national standards, according to the report. Behaviours not only needed to be identified, but young people should then be assessed regularly for ongoing needs relating to counselling or treatment. Resources for this should be on top of the £65m allocated to local young people's services by the young people's partnership grant.

Professor Mark Bellis, director of the National Collaborating Centre for Drug Prevention and for the Centre of Public Health, said: 'The case for good drug prevention in the UK is unequivocal… We must ensure that resources for prevention are used to fund programmes of proven effectiveness, especially for those most likely to become drug users.'

# Khat users' problems seen as very low priority

Drug support agencies are failing to engage with Khat users despite their increased risk of problems relating to mental health and social breakdown, according to social care charity Turning Point.

Traditionally used by communities in the UK originating from Somalia, Ethiopia and Yemen, the green leaved plant is chewed to create a similar stimulant effect to amphetamine.

Turning Point have raised concern that Khat use was seen as very low priority in local drug strategies, despite many of those surveyed displaying symptoms of depression, anxiety, appetite loss and sleep disturbance.

The social problems experienced by many members of these communities, such as unemployment, family breakdown and social exclusion gave a different setting for Khat use in Britain that was not being accounted for.

'What we found with Khat is that a substance that is used socially, maybe twice a week after work in Somalia, Ethiopia or Yemen becomes problematic in the UK when those using it are faced with unemployment and isolation.'

Despite 82 per cent of those surveyed saying they chewed Khat, none of them had had direct contact with drug treatment or mental health services.

Lord Adebowale called for a response from the wider social care field: 'It is a social care issue and it requires a social care response. We need to be looking at the whole range of people's needs from physical and mental health right through to employment and family support services.'

Children as young as 10 are regularly inhaling solvents, according to *Dangerous Highs*, a new report from the National Children's Bureau and Childline. Analysis of over 350 calls to Childline revealed that many children used volatile substances as a means of escape, not just to get high. The accessibility of glue, paint, correcting fluid, nail varnish and other common products found around the home, made it easy for volatile substance abuse to begin at a very early age. Many children are playing Russian roulette with their lives, says author Simon Blake.


Super athletes? Super soldiers? Super minds? Delegates at a London conference speculated on 'the shape of things to come' – a change from debating the current substance misuse agenda. Guests included Dr Alexander and Ann Shulgin, legends for those interested in the chemistry of psychedelic drugs.
See features on page 6 and 12.

# NTA produces new advice for child-focused services

Practical advice on making services child focused has been produced by the NTA. The 'essential elements' for treatment services have been developed in response to the joint strategy by the Department of Education and Skills and the Home Office, that linked *Every Child Matters* and the *National Drug Strategy for Young People*.

The guidance describes a comprehensive range of services that the NTA says all young people in every area of the country should be able to access, and aims to give practical advice and direction to service commissioners, co-ordinators and joint commissioning groups; children and young people's partnerships; and drug action teams.

It is designed to contribute to objectives in *Every Child Matters*, which state that children and young people have a right to being healthy, staying safe, enjoying and achieving, making a positive contribution, and economic wellbeing.

New key performance indicators are introduced in the document, which includes description of the features needed for good integrated service delivery.

The NTA has announced an increase in funding for young people's treatment services by a minimum of 55 per cent over the next three years, via the young people's partnership grant.

For the full document, visit www.nta.nhs.uk/programme/docs/Essential_elements_young%20people.pdf

# Addaction reports 30 per cent rise in treatment numbers

A rise of 30 per cent in the number of people seeking treatment for drug addiction has been reported by treatment charity Addaction.

A proportion of the data, which covers 70 services in 46 locations, will be fed into the National Data Monitoring System (NDTMS) to enable the government and National Treatment Agency to monitor new trends. More than 5,000 new clients made contact with services in 2004-5 than in the previous year – a total of 22,655 people seeking treatment.

Craig Moss, who manages the data programme, said the exercise revealed trends of drug use in different areas: 'We are seeing a rise in crack cocaine use in the Midlands, whereas earlier data showed concentrations of crack cocaine had principally been in London.

While reluctant to make assumptions, Mr Moss said there were indications that the national Drugs Intervention Programme had had an effect, as 'referral pathways are being cleared and responsiveness is improving'.

Analysis of groups accessing Addaction services showed that the main substance used by White British clients was heroin at 43 per cent, followed by alcohol at 31 per cent. Crack cocaine was the favoured drug of Black Caribbean clients at 37 per cent, followed by cannabis at 21 per cent. Bengali clients showed more heroin usage at 78 per cent, but a low level of alcohol use.

# Methadone and beyond
## notes from the Alliance

**Alan Joyce, senior advocate at the Alliance, gives insight to the effect that the diamorphine drought is having on service users.**

It is sad at a time of many positive changes that the focus of the majority of the Alliance's advocacy cases is the 2005 diamorphine drought.

From the outset, clients have been poorly informed about the shortage. Most have had little idea of what is happening and why, and have been given no indication of how long the shortage will last and what will happen when it ends. This uncertainty has been compounded by a perceived lack of consultation with patients.

Several reports alleged that some services were insisting that all patients on IV diamorphine be switched to oral methadone, without choice, prior to assessment for IV Methadone. At a time when services are encouraged to embrace the holistic model of care, it is hard to square imposition of oral methadone with the needs of clients with a clinical history of poor response to oral methadone solution and entrenched IV use. Some fear the shortage is being used as a window of opportunity to test patients' response to treatment options they had previously resisted.

Some patients were advised that if they could find a pharmacy in their area that was able to fill a complete diamorphine script, there would be no problem issuing one. In response, clients spent time and money trying to find chemists holding sufficient stock to fill a script. While some were successful, many were later told that this option was no longer available. Clients, understandably, felt they had been led on a wild goose chase. A number of clients sought reassurance that scripts will be restored when the shortage had run its course. That some clients were unable to secure this promise only added to their distress at the situation.

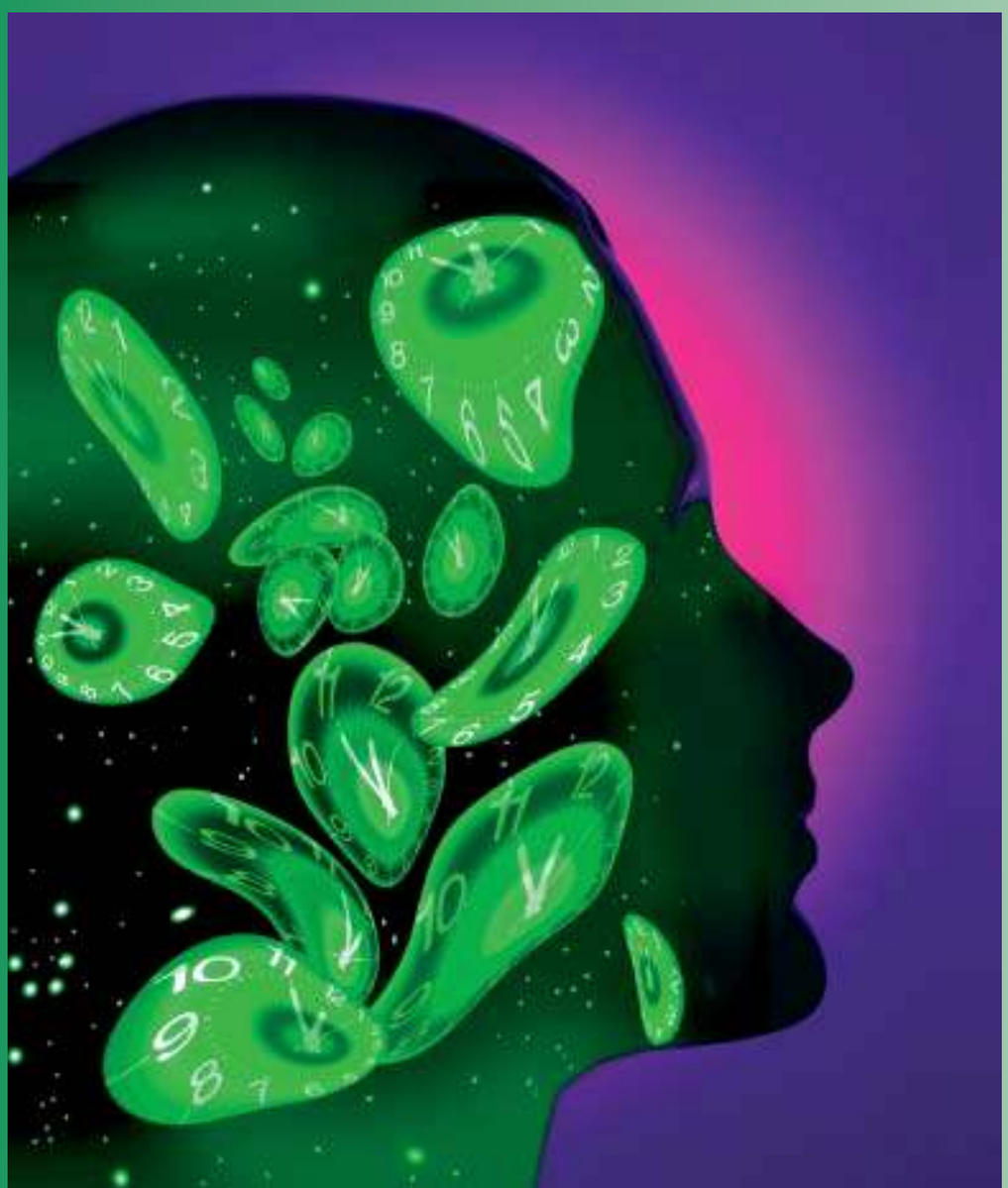
Patients scripted IV diamorphine often present extensive venous harm and the continued health of their remaining sites is a priority to ensure their stability and survival. The condition of viable IV sites was a source of anxiety for many clients. Reports of venous harm and distress reach me every day, along with reports of self-harm, hospital admission, infections requiring GP treatment and, most worryingly, self-treatment for infection.

Clients with a history of intolerance of IV methadone unsurprisingly remained intolerant. Some have opted for street H rather than lose what little IV access they had left. After years of not buying on the street, many clients found themselves vulnerable to exploitation and assault, both physical and sexual. Some returned to criminal behaviour to finance their use. Many reported losing what little self-esteem and worth they had. The accounts of self-punishment and emotional price paid by these clients were among the most harrowing I have heard. Exposure to a street market also led to increased use of other drugs.

Many clients reported that they had been told that dirty urine tests would be met with a punitive response. It is a situation in which the use of street gear can jeopardise continued treatment, while not using street gear while receiving inadequate or inappropriate care jeopardises treatment retention. Furthermore, temporary stabilisation on oral methadone for some clients may result in them not being allowed to return to IV diamorphine when the shortage is over. It is truly a Catch 22.

**See feature on page 9**

# Smart living?



**Drug dealers are already within reach at the touch of a button and you don't have to search too far to find magic pills to make you stronger, faster, calmer, more alert. So what's the drug landscape of the future? Speakers at last week's conference 'Drugs – the shape of things to come?' gave some thought-provoking insights on the direction we're heading.**

Hundreds of suppliers ready and waiting to take your order for every drug imaginable. No need to meet a dealer on a street corner; no effort to develop contacts for the next deal. Supplies arrive in discreet packaging, and an encryption site such as 'Hush Mail' enables you to order without leaving a paper trail. All you need is access to a computer.

Is it any wonder that the internet has become the first choice for drug trafficking?

As Dr Robert Forman of the University of Pennsylvania's Treatment Research Institute explains: 'Clandestine enterprises are particularly well suited to the internet. It's available to over a billion people at the moment, like no other media.'

With anonymity comes frenetic activity: 'information is rapidly deployed – and rapidly disappears'. The marketplace reflects the offerings of hundreds of suppliers. Some contribute to that plague of modern life, email spamming. Some pitch to chat rooms in an attempt at more targeted marketing. Others list their wares openly on the web, in the comfortable knowledge that the customer will happily seek them out.

There are of course legal protocols to skirt round. You may not find marijuana, but there are thousands of adverts for seeds. You may only find sites offering help for addiction if you search for heroin – but you can buy opium poppies with extraction instructions, complete with token warning that this should not be tried at home because it's illegal.

Such trafficking might involve a computer in Russia, a website registered in Mexico, a bank account in Tunisia, and a business run from Australia, but such is the freedom of the internet that it has become like a digitised version of Pierre Teilhard de Chardin's concept of a Noosphere – 'all interacting minds', according to Dr Forman.

The obvious concern is that anyone can visit such sites, whatever their age, whatever their physical condition – and whatever their knowledge of the likely side effects. Earth and Fire Erowid have devoted the past ten years to a practical means of countering the inevitable increased accessibility of drugs. Their website, 'The vaults of Erowid', now contains 30,000 public documents covering more than 250 psychoactive substances. Their site is entirely non-commercial, and its creators are driven by the wish to make full, honest, unbiased information freely available as part of an 'ongoing conversation to minimise harm'.

The medium has lent itself perfectly, enabling them to provide information and data that's bang up to date. 'Publishing and conversations become nearly indistinguishable' these days, they explain. What better way to promote harm reduction than offering really accessible and easy-to-understand information one click away, in a home setting?

To Earth and Fire – and to their 40,000 unique visitors each day – their reason for existing is very

# or dazed new world?

clear. The US authorities have been less comfortable with their passion for harm reduction. When Earth contacted the US Drug Enforcement Agency to point out an inaccuracy in a report, 'they informed me they were on the opposite sides of a very tall fence, and told me not to contact them again,' he says.

It can be a very strange business, this question of drug-related ethics. Talk about illegal drug taking, even in the context of 'well if you're going to do it, minimise the risks' and the condemnation from authorities can be swift.

Dr David Neil, a philosophy lecturer from Australia, describes an interesting scenario. In April 2002, a US pilot dropped a bomb on a Canadian unit, killing personnel. The defence offered was that the US airforce had given the pilot amphetamines, apparently a familiar practice for when pilots were doing long shifts without sleep. The drug's side effects were blamed for the error of judgement; and the verdict? The pilot was found solely responsible, fined and reprimanded, but not suspended from active service.

**'The immense increase in technological complexity means the soldier is the weakest link. So enhancing soldiers' performance has become paramount – whatever the ethics.'**

This has become the nature of contemporary warfare, explains Dr Neil. 'The immense increase in technological complexity means the soldier is the weakest link'. So enhancing soldiers' performance has become paramount – whatever the ethics.

Organisations such as DARPA DSO – the American Defence Sciences Office – have a brief of achieving operational dominance. Their mission is to develop a capacity to respond to military capability throughout the world – and that means developing soldiers that have an unnatural resistance to tiredness, injury, pain and stress.

Preventing sleep deprivation is sought through ampakines, which act as a neurotransmitter to boost glutamate. Transcranial magnetic stimulation and experiments on flies to examine the Shaker gene aim to unlock the secret of the oft-quoted Maggie Thatcher style performance of needing just a few hours of sleep.

Once out on the battlefield, the soldier is being equipped with superpowers to enable him to continue fighting, even when wounded, according to Dr Neil. A self-care project is developing a pain vaccine 'so the war fighter is not distracted by performance degrading pain', and there will be accelerated wound healing with five times the healing power for flesh wounds. Forget the inconvenience of gushing wounds: an innate magnetic tourniquet will be injected into the bloodstream, controlling haemorrhaging by the magnetic field causing particles to gel.

Metabolic dominance will complete the picture of super soldier. He will be able to control energy metabolism on demand, operating 24 hours a day for three to five days, with any need for food.

It all sounds very futuristic. But when swimmers at the 1976 Montreal Olympics were beaten by the East German women's swimming team, who won 11 out of 13 events despite never having won a gold medal before, they must have wondered at the new breed of super athlete. The team was soon engulfed in scandal as it was revealed that coaches and trainers were deceiving the athletes into taking anabolic steroids.

Doping has dogged sport for many years. From beefed up weightlifters to amphetamine stoked cyclists, it's been more a case of catching them with drugs in their system than speculating whether it goes on, and the scale of the problem has provoked evangelical campaigning by athletes who compete under 'honest' conditions.

The question according to Michele Verroken, who designed drug testing standards during 18 years as director of ethics and anti-doping at UK Sport, is how do we untangle the confusion between substances permissible in normal life (just think of the recent controversy over caffeine) and substances that are judged to be out-of-bounds performance enhancers? 'We can't go on criminalising things when they're accepted in normal life,' she says.

Performance enhancement has turned into a long-term ethical debate, according to Verroken. 'Training regimes have become eat, sleep, train. Coaching consists of a manager, psychological counsellor, lifestyle advisor…' Athletes are nurtured for one purpose only: to win. Medical interventions such as 'spinning' can accelerate their recovery from injury. And this is the accepted and expected side of sport.

The line is crossed with drugs for designer traits: Human Growth Hormone (HGH) to make them stronger; erythropoietin (EPO) to make them run faster. But the problem is there's no guarantee that your body parts will grow in proportion to each other, so you'll never be sure how you'll turn out.

'We know that genomics can make some drugs operate more effectively and efficiently, says Verroken. 'But are the side effects worthwhile? We know that specific genes are linked to athletic performance… But do athletes know when to stop?'

Human beings will probably never know when to stop. As Dr John Marsden of King's College London's Institute of Psychiatry points out, performance-enhancing drugs have shared their evolution with mammals, and we've enjoyed experimenting since we discovered them.

Many outlawed drugs had respectable beginnings, he points out. Alphamethylphenylethylamine, better known as amphetamine, was advertised as a nasal decongestant in 1931. It was sold in three types, inhaler, tablet and powder – but how quickly we learnt to break open the inhaler and soak it in coffee or alcohol.

Drugs such as dexamphetamines, promoted as 'restoring mental alertness, cheerfulness and optimism' were commonplace after the Second World War, together with new appetite suppressants such as Syndrox 'for the patient who is all flesh and no willpower'.

The parade of artists, writers and musicians who have relied on drugs through the ages bears testament to the commonplace attitude towards drug taking in bygone eras.

So where does this take us for the future? For some, the vast array of drugs available on the internet has opened up a sweet shop of options: Dr Marsden refers to a documentary he made for the BBC on 'smart drugs' in which he interviewed an American couple who spent $600 a month on taking hundreds of pills of all kinds. The case was extreme, but it illustrated the modern obsession with enhancing memory and learning, and preventing physical and cognitive decline.

While commenting that chronic dosing is 'probably a waste of money as there is probably rapid tolerance', Dr Marsden says that in our ageing society, interest in improving mental life will become increasingly valued. Options are likely to become more sophisticated, with an expanding landscape of synthetic drugs being 'gene coded' for effects: forget the experimentation, you would be able to gauge how you would react to a drug by its suitability for your gene type.

If all this sounds quite logical, take a moment to consider how far we should go: 'suppose CVs of the future included smart drug testing to see if you have the right personality traits for a job,' suggests Dr Marsden. Or maybe your fiancée could check your traits for suitability?' Maybe there are some boxes better left unopened. **DDN**

*The DTL conference 'Drugs – the shape of things to come?' took place in London on 17 June and was chaired by Wrye Sententia, director of the Center for Cognitive Liberty and Ethics.*

### Harm minimisation is not a ticket to recovery

I read *DDN* regularly at work in a homeless hostel in Bristol and in my main job in a mental health support team specialising in dual diagnosis.

From reading your magazine it would appear that you support the harm minimisation model and feel that it is a form of recovery. Whilst at work we must work within a framework of giving the service user choices, I have yet to meet a substance misuser who when given the option of abstinence or 'controlled usage' will opt to stop completely. It would appear that the great obsession of all problematic substance misusers is that one day they will regain the control they once had five, ten, fifteen years ago, but it has been our experience that the vast majority of people who try controlled using have temporary success, closely followed by an even greater relapse. There are examples of people who seem to get their lives in order whilst still using class A drugs – and my hat is off to them – these examples however are rare. The vast majority cannot control their drug or drink use. I cannot subscribe to the theory that people given time and a methadone prescription will eventually sort themselves and the real danger here is that many service users die in 'in the contemplation mode'.

I feel, and I believe I speak for our staff team, that addiction needs to be challenged in a respectful manner. I have yet to meet a service user who automatically will be honest about his/her problems – in fact I have heard many say at later dates, 'I could not tell the truth because I was unaware myself'. They are in fact in pre contemplation/denial. This situation does not change by osmosis.

I hope you do not see this mail as an attack on your magazine as your article of 30 May and editor's letter were excellent, as are your updates on prison drug use and random drug testing.

**Roy Fisher, mental health (dual diagnosis) worker, Bristol**

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### Having a job is not key to successful rehab

Having worked within a welfare to work environment for the past four years I was concerned to see Mr. Mann's referral that getting people back into work was essential, and without 'they will not complete any successful rehab if they are not in work' (*DDN*, 13 June, page 5). Whilst I do think it is important for individuals that have completed rehabilitation to find sustainable employment, I do not feel that this is the key to them completing rehab – in fact in my experience it can often be the opposite.

Many individuals initially feel that moving into employment will bring a much-welcomed structure into their lives that will help them to remain clean. However, often the pressure that accompanies this change can in fact lead to relapse, especially when they suddenly have an expendable income.

Working nine to five often means that they are no longer able to attend their group sessions or counselling. They suddenly find themselves without their support network, and what should be a fresh start becomes a relapse.

Whilst I agree that it is important for addicts to move forward and establish a new life, I do not feel that Mr Mann's analysis would provide a solution for the service users. What is required is for agencies to work together to improve the facilities that service users can access to encourage employment opportunities when they feel ready for the work environment. This should be encouraged by inter-agency working through things like secondments, to ensure staff within welfare to work organisations are adequately adept at dealing with services users, and staff within rehabilitation centres can learn the skills to move individuals into employment.

**Kerry-Ann Homer, by email**

### 12 steps have many applications

Thank you for the inspirational article regarding RAPt's work (*DDN*, 13 June).

At the risk of appearing pedantic, I would like to point out the obvious, *ie* these are not 'RAPt's 12 steps' as suggested in the article, but the steps of AA, suitably amended.

Of even more importance, it is essential to understand that in themselves these are not the steps, simply their titles. To acquire a thorough understanding of the wisdom and effectiveness of the steps it is necessary to study them. To the best of my knowledge the only detailed explanation of the steps and what is required of the participant in recovery is contained in AA's publication *12 steps and 12 traditions*.

For anyone working in recovery who is seeking to be of ultimate service to their client, the knowledge to be gained from studying the above will prove invaluable in assisting with their clients' recovery. Applying that knowledge within the framework of Prochaski and DiClemente's *Process of change* creates a structured foundation for the recovery process.

In using such a foundation we need to remember that, as the authors of the latter point out, the time spent in each stage varies, and it is not unusual for people to remain in the contemplation or preparation stage for several years. Equally, a study of the 12 steps will not reveal any date by which any of the steps should be completed. What is important to remember, is that Prochaski and DiClemente stated quite categorically, that they successfully predict that anyone who leaps from the contemplation stage to abstinence will relapse.

Speaking for myself, I have yet to meet an alcoholic or addict who stopped until they had had enough. Equally I have yet to meet one who immersed themselves into the process of recovery and change until they were ready. The good news is that when that occurs, the recovery is lasting.

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

### Long history of support

The RAPt article was excellent. Can we just say that no one organisation or individual has personal ownership of the 12 steps – RAPt is a great organisation but the 12 steps as written for RAPt (DDN, 13 June) are word for word the same as the 12 steps for Narcotics Anonymous developed at their foundation some 56 years ago, who in turn took them on from AA, with whom NA is affiliated, who in turn had adapted and developed them from the six steps of the Oxford movement to make them relevant to alcoholics supporting each other.

The 12 steps have many wide applications as a framework for living, and, in a more secular age, are open to individual interpretations of what constitutes a higher power – one idea being that the self-help group is a better source of support than the alcohol or the drug to which some people had surrendered control and therefore their 'power'.

**Peter Martin, CEO, Addaction**

**Please email your letters to the editor, claire@cjwellings.com or write to the address on page 3. Letters may be edited for reasons of clarity or space. Read more reader correspondence in our Q&A feature on page 14.**

# Yes, We Have No Diamorphine

IN LATE DECEMBER 2004, the Department of Health circulated a message to UK clinicians warning of an impending critical shortage in supplies of diamorphine (heroin). Though the drug's use has been discontinued in many countries since it became the object of a US-driven anti-addiction crusade in the first decades of the twentieth century, British medicine has traditionally used the drug quite widely.

In addition to its dwindling application in the maintenance of opiate dependence, heroin is the painkiller of choice for many clinicians working in the treatment of cancer, palliative care, and is increasingly replacing pethidine as the most widely used analgesic in child delivery. Exponents of the drug insist that it remains the most effective means of treating acute and chronic pain. According to Department of Health figures, the UK uses some 640,000 ampoules monthly.

While the immediate origins of the shortfall are linked to unforeseen natural events, they highlight the dissatisfactory nature of present arrangements for ensuring supplies of this essential tool in the therapeutic armoury.

The sole licensed processor of opium in the UK is the Edinburgh based company Macfarlan Smith, a company with origins in the halcyon days of the Anglo-Indian opium trade. Macfarlan Smith supplies opium or morphine-base to two further corporations, who between them monopolise the provision of diamorphine to the NHS. The first is Chiron, which manufactures the drug at its plant at Speke, Liverpool, and takes the lion's share of the market at some 70 per cent. The second is Wockhardt, a Mumbai-based company which took control of CP Pharmaceuticals in 2003.

The immediate cause of the shortfall lies in technical problems at Chiron's factory at Speke. Possibly due to flooding and subsequent contamination, the manufacturing process of the company's flu vaccine was stopped and its licence suspended. Resources were shifted to remedying this situation, with the consequence being a slowdown in diamorphine production. It seems that the UK authorities were given scant notice of impending difficulties. Wockhardt was then approached in an attempt to make good the shortfall, and was soon issuing denials that its own stocks were compromised as a result of unusually high demands placed upon it as a result of military conflict in Iraq.

Regardless of the localised causes of this failure in provision, it is clearly rooted in a restrictive duopoly from which the Health Service is compelled to source its requirements of injectable heroin. The value for money for the British taxpayer is doubtful. The NHS pays some £41.36 per gram for diamorphine, as opposed to the £6.30 (9.45 Euro) paid by the Dutch health service. A further factor that contributes to the inordinately high cost differential between UK and Dutch or Swiss diamorphine lies in the difference in production method used. The only licensed form in which diamorphine can be sold in the UK is the most expensive one – namely, freeze-dried amps; in both Holland and Switzerland, however, diamorphine is provided as powder, which can be dissolved for injection as required.

Both companies have promised to devote all available resources to increasing supplies, yet anticipated dates for a return to normal levels have repeatedly come and gone. Meanwhile patients in severe pain have been told by clinicians that stocks remain critically short, and opiate dependent clients have been moved onto alternative medications, often at considerable cost to their hard-won health and psychosocial stability.

The government response thus far has been less than effective. From initial predictions of March, then May 2005, it now seems that the issue will not be resolved before the autumn. In its first alert, the government stated that 'The Department of Health and the NHS Purchasing and Supply Agency are urgently exploring alternative international sources of diamorphine injection', an urgent exploration which has, nonetheless, demonstrated no tangible progress in the intervening six months. The problem that the government is experiencing in locating these mysterious and elusive sources is itself rather baffling given current market conditions. Internationally, the licit opiate industry is experiencing a glut in production, with increased crops in Turkey and India forcing opium farmers in Tasmania to cut back on cultivation, and driving down prices by 12 per cent.

In February, Health Minister Rosie Winterton told parliament that, while UK officials are 'in close contact with manufacturers of diamorphine' regarding UK supply, 'the details are commercially confidential'. It is surely time that the imperatives of public health were prioritised; that the skirts of commercial confidentiality were lifted and the goings-on beneath them revealed. We need to know why it is that in a global market awash with both licit and illicit diamorphine, the UK is unable to restore provision following half a year of equivocation.

*By Dr Eliot R Albert, freelance researcher, UKHRA Exec member and Alliance volunteer; and Christopher Hallam, independent researcher working regularly for the Alliance and Release.*

***'This is to alert you that stocks of diamorphine injection may reach a critical level in the next two weeks and to provide advice on how to manage the potential shortfall.'***

**Department of Health, 23.12.04**

'The problem that the government is experiencing in locating these mysterious and elusive sources is itself rather baffling given current market conditions. Internationally, the licit opiate industry is experiencing a glut in production, with increased crops in Turkey and India forcing opium farmers in Tasmania to cut back on cultivation, and driving down prices by 12 per cent.'

# A day with Dave

Nine o'clock on a Thursday morning and Dave is already hard to pin down. Rushing around dealing with telephone calls, clients and staff, he is unnaturally energetic for the early hour, and in my bleary eyed state I start regretting volunteering to follow him around for a day. At this rate, I'm bound to lose him and get left somewhere, undoubtedly with some unsavoury drug dealers or the like.

My fears are compounded by the ominous warnings I receive from people around the agency, along with advice not to enter his office in case I get lost amongst the clutter (despite the clutter management course!). This is a man whose reputation as a 'superman' precedes him, and I, a naïve medical student from a sheltered background, am going to have to do my best to help and not hinder him in his duties.

Yes, I am undoubtedly extremely naïve to the world Dave works in. I may live in Scotland, the home of *Trainspotting* and legal street drinking, but I've never actually seen or met (at least knowingly) anyone with an active addiction. What I will learn today however is that I probably have seen people suffering from a drug or alcohol addiction. I just haven't realised it because they mostly look like normal people and don't fit into my stereotypical view of what an addict looks like.

Sitting in on an interview where Dave describes his role, I start to get a real understanding of what he does: absolutely everything and anything. From arranging housing, to dealing with debts, to working on the agency's allotments. He talks of the importance of his network of contacts, which I am to see in person later – he seems to know everyone, from receptionists to magistrates.

What starts to sink in is the fact that Dave hardly ever refers to the person's drug habit. Not what I would have expected from a drug worker. It dawns on me that Dave's role is not to just treat the addiction, but to provide the resources an individual needs to support them in beating the addiction and preventing them from being pushed back into it. It's no wonder that someone living on the streets needs a bottle of cider before going to sleep – they need something to warm them up. And there's no point in helping them to recover from their addiction if they are going to face the same circumstances tempting them to drink when they get out of rehab.

The first person we see is a homeless man who is a recovering alcoholic. He had experienced a relapse a few days previously and was feeling hopelessly guilty about it. Moreover, he was desperate to find a flat, because living with his brother was putting a lot of pressure on him. Dave goes to get his big book of contacts, and I face my first challenge of the day: talking to my first client. Until this point, I had been following him around like a lost soul, feeling hopelessly awkward and unnecessary. And as the seconds tick by, and we sit in silence, that awkwardness increases and increases.

I have no idea what to talk about: whether he feels comfortable talking about his addiction, whether he wants to talk about his addiction or whether I should just make desperate small talk until Dave's welcome return. Finally summoning up the courage to talk, I find that we are united in our mutual love of our mobile phones and Playstations. What strikes me is his complete normality – he is nowhere near what I had imagined an alcoholic to be like – and his unprompted openness about his addiction, even to a stranger.

Our next stop is Singleton hospital, to visit an alcoholic suffering from pancreatitis. When we arrive, the Sister informs us that he is ready to leave, and that he can't stay the weekend because they need the bed. Approaching the bed however, I get a different impression. The man is sobbing and sobbing, due to the pain he is experiencing. Apparently he is not allowed any pain relief because he is a drug user as well. He tells us that he is depressed and cannot even hold water down. I immediately feel immensely sorry for him, blaming the hospital staff for being uncaring and insensitive.

Dave, on the other hand, knows the client far better than me. He has seen this behaviour again and again and seen the client turn down numerous rehab places, just to return to drinking on the streets. He says he finds this incredibly frustrating, but nonetheless, he makes a number of phone calls, eventually finding a place in a rehab in Weston Super Mare. A few days later he already has him installed. I am hugely impressed by this dedication – Dave makes the effort to give the man another chance, despite the fact that it has been thrown back in his face again and again.

Back at the centre a gorgeous, smiling woman asks for Dave's help. I am shocked to hear that only seven years earlier Dave had literally picked her out of the gutter, helping her to overcome her addiction to amphetamines. Her husband has been convicted of aggravated bodily harm, under hugely unfair circumstances, and she came to the centre hoping someone could help. There is clearly little Dave can do however, but this seems to me to be a prime example of people's faith in the centre, and what they can do to help them – even to the extent of influencing Crown Court proceedings!

It is now that I get to experience the first of many of Dave's magic tricks. He had talked about his 'magic trick meeting' earlier in the day but in my naïvety, I thought it must be a key word for some sort of rehab or detox. But no, he actually meant real magic tricks – and very impressive ones too. Dave explains to me the importance of gaining the trust and confidence of clients, by engaging them, or their children, by performing a magic trick. And from what I see, it really does the trick.

Running late, because Dave's scheduling encompasses all the problems he encounters regardless of how insignificant, we arrive at Cefn Coed – Swansea's psychiatric hospital. I am immediately intimidated by the red brick building, which is like something out of a film, and this feeling is far from alleviated when Dave explains that half of the front door is boarded up because someone drove a car through it the previous day.

Inside, the hospital is dark and dreary – some wards are locked all the time and doors are boarded up where people have forced entrance. Despite obvious efforts to improve the atmosphere of the hospital, I feel overwhelmingly uneasy in it – it really doesn't inspire the most positive mental attitude. On the secure detox ward, Dave chats about a number of patients who are in, or have been in, the ward. His detailed knowledge of a client's history regarding their addiction and treatment is amazing, especially considering the sheer number of people with which he deals. We meet a client who has obviously been self-harming – Dave addresses the subject in a

**When student Annalie Clark arranged to spend a day with real-life drug and alcohol worker Dave Watkins, she braced herself for an 'us and them' battle with addicts. Her experience was an eye-opener of a quite different sort, as she describes.**

direct yet positive manner, emphasising that it wasn't as bad as last time. His unfailing ability to say the right things in the right manner and tone is remarkable – he knows exactly how to pitch advice for each individual client, whatever their state of mind, and never seems to put his foot in it.

The next woman we see at the hospital is undoubtedly the most striking case I see all day. She is an alcoholic. If she is let out, she will be on the streets, drink again, be picked up by the police and brought straight back. So she has been sectioned for an indefinite length of time because, Dave says, 'no one wants her'. She hasn't got any friends with whom she can live. Her family don't want to know her and so she will probably be in the hospital, in a secure ward, for who knows how long. The fact that even Dave says that nothing can be done for her emphasises to me the gravity of her situation – Dave, the 'superman', who does everything and anything he can to help people, even if they don't want that help. Nonetheless, even though he can't do anything to help her situation, he continues to visit her. Amazing really.

Next, a quick call to check-up on a client whose friends are worrying about her. We get no answer on the intercom, so proceed up to the flat. At the door, still showing the signs of the last time Dave had to break in, we bang and shout through the letterbox to no avail. She is either out, drunk or dead. Reassured by a neighbour that she wasn't drunk earlier we leave, although I remain worried.

Our final call of the day and we're visiting an alcoholic with an eating disorder. She is so painfully thin she looks like she could be broken at the touch of a finger. She moves slowly, as if in a dream, and her speech is confused. From my lack of experience, I assume this is the normal effect of chronic alcohol abuse, but Dave later tells me he suspects she is taking another type of drug. This perceptiveness amazes me – it hadn't even crossed my mind. As we sit down, she brings out piles and piles of unopened letters, mostly all from creditors.

This is another aspect of the job that I had no comprehension of, but I can now see how quickly financial situations can spiral out of control – a number of deadlines had been missed because she had been burying her head in the sand and not opening her mail. Despite the daunting size of the task, Dave gets to work, reading, sorting and making phone calls – a hugely complicated job, but another of his talents. Within an hour the mail has been sorted, Dave has been in contact with her solicitor and has arranged a medical appointment to ensure that she doesn't lose her benefits.

So I reach the end of my day with Dave, and to my surprise I've survived! My brain is only slightly frazzled and all my previous misconceptions about drug and alcohol addicts have been pretty much thrown out the window.

Despite having heard numerous stories and news reports about drug and alcohol addiction, I was completely unable to comprehend the reality of the situation, because I couldn't relate it to actual people. But meeting clients today has enabled me to relate real experiences with real people, people who are just as normal as you or me.

*Dave Watkins works at the Swansea branch of West Glamorgan Council on Alcohol and Drug Abuse (WGCADA). More can be found out about the agency at wgcada.org.*

**'The first person we see is a homeless man who is a recovering alcoholic. He had experienced a relapse a few days previously and was feeling hopelessly guilty about it... I have no idea what to talk about: whether he feels comfortable talking about his addiction, whether he wants to talk about his addiction or whether I should just make desperate small talk until Dave's welcome return. Finally summoning up the courage to talk, I find that we are united in our mutual love of our mobile phones and Playstations. What strikes me is his complete normality – he is nowhere near what I had imagined an alcoholic to be like – and his unprompted openness about his addiction, even to a stranger.'**

# Encounter with 'Dr E'

**Dr Alexander Shulgin is a pharmacologist and chemist who has devoted the last 45 years to creating new psychoactive chemicals – and testing them on himself. In 1976 he experimented with a new synthesis process for MDMA, introducing it to therapists – so is often referred to as 'Dr Ecstasy' and 'the godfather of ecstasy'. With his wife Ann, a researcher and writer who worked with psychedelics such as MDMA and 2C-B as a lay-therapist while they were still legal, he wrote *PiHKAL* and *TiHKAL* about their experimental relationship with drugs. Last week on his 80th birthday, Dr Shulgin (known as Sasha) and his wife Ann answered questions about their life and work from delegates at a London conference.**

**Have you thought of the downside of experimenting with drugs for information? Have too many genies been let out of the bottle?**

***Sasha:*** There's growth of psychedelics – there will be so many more by 2050. We need to have growth of knowledge of new drugs.

***Ann:*** If people can maximise the setting for pleasurable experience, they should set it up that way. There should be as much reading as possible before anyone tries anything. Reading, practice, learning before you test the wheels. They are not materials to mess around with.

**People have used drugs and alcohol to get closer to God. Is the effect God – or just god in a pill?**

***Sasha:*** I straddle the line between atheism and agnosticism.

***Ann:*** Everything we experience isn't physical or spiritual – it's both. Most people take drugs because they want to touch something, whether or not they call it God. All psychedelic experiences are spiritual experiences – whether they go into it for that reason or not.

**I've seen people overdosing on ecstasy in Ibiza at a rate of two a day. Same here with Ketamine – people passing out in clubs. What's your reaction?**

***Ann:*** To a great extent problems and damage are done by illegality. You add a jail sentence to an overdose – and you have ruination of a whole life. If materials are legal, at least you have a chance of harm reduction. Taking drugs should be dependent on real education, not propaganda. Whether a drug affects you depends on the individual. We consider Ketamine very dangerous – but it's good in hospitals. You should try things out to know what it does to you.

***Sasha:*** You should get drugs from a pharmacy – then you know what you're taking and exactly how much.

***Ann:*** You also need a babysitter – someone who's been there – with you. You can hit the sorrow or death place, and if you're alone when you hit them you can be in real trouble.

**Do you take drugs for pleasure – or pure research?**

***Sasha:*** We've had clues that these drugs can be used as research – diagnostic and therapeutic tools.

***Ann:*** However, there are certain materials that are more delightful to experiment with than others. We have a rule that if the material does not lend itself to lovemaking, our interest in it is limited.

**I'm interested in the regulatory framework. Have you been raided by the authorities back home?**

***Ann:*** We've been raided twice. The second time was completely unexpected. We'd reported a prowler; he had bare feet in the snow and was going to freeze to death. The sheriff came and suggested he look all over the property. I'd assumed the lab was known to them – but I didn't know the personnel changed every couple of years. So the sheriff discovered the lab, and the next thing I knew, my husband and two journalists who were in the process of interviewing him were being escorted by the police. They kept them confined in the kitchen and dining room and got chance to examine the lab and house without a warrant. The first raid had happened after they'd phoned. This one was with no warning. But they found nothing illegal. Having a lab in itself is not against the law. As long as what you're doing in the lab doesn't involve Schedule A drugs, there's nothing they can do Sasha for (though they would love to).

***Sasha:*** I don't make illegal drugs – I make new drugs. It's the authorities' job to make them illegal.

**I would like ecstasy tests for safer clubbing, but I'm not allowed to test ecstasy pills in England. What's you opinion on harm minimisation?**

***Ann:*** 'Dance Safe' is an excellent idea. Don't use 'ecstasy' as a term, use MDMA. Ecstasy is a meaningless term – you don't know what you're getting. You have to know the laws of your own country. In the US they've tried to put the dance industry out of business.

**What have been life's most defining moments for you?**

***Sasha:*** One of the most fascinating ones was playing with my chemistry set as a child – the discovery of different chemicals and creating new things. People think of chemistry as a science, but it's not, it's an art. This mixed with that. The second one was discovering mescaline.

**What are the psychotherapeutic benefits of drugs?**

***Ann:*** I spent about two and a half years as a lay therapist. I was not trained to do it – you have to learn as you go. The reason why MDMA works is that it's an insight drug. It takes away self-hatred and negative judgement and lets you be a treasured being. It lets you have thoughts and problems but doesn't take away the value you have.

The MDMA experience allows people to look upon themselves with real love. It's one of the most treasured and effective drugs that's ever been used. I was involved in treating post-traumatic stress disorder, including torture victims. This is where MDMA should be able to help. I feel very sad that it's been made illegal.

**Do drugs increase the chance of a long life?**

***Sasha:*** I don't know, I'm not old yet! The whole concept of brain damage, brought in by governmental bodies, is a tragic misuse of the term damage. You have brain change – like college education.

**What ways can you suggest to record being under the influence – your experience and impressions?**

***Sasha:*** When I find new materials, I record them in notebooks in the passive voice.

Etienne Sauret – Turn of the Century Pictures

***Ann:*** I like to write it all on a computer keyboard and record the experience as I go along. Or use a tape recorder or make notes of what's going on. But do make notes or you will forget. It will be really important to you.

**Will we ever have a long-term handle on implications of MDMA, particularly with poly drug use?**

***Sasha:*** I'm not a chronic user of any drug. But I have used MDMA several times. But after the twelfth time it lost the magic of the first or second time.

***Ann:*** Before we knew about tolerance, we spent two years using it once a week – it was my writing drug. I wrote the first book under the influence. I stopped using it, then two to three years later used again, but to my sorrow it had the opposite effect. It became a depressant. I realised I had lost MDMA for me personally. No-one at the time knew that using it weekly or monthly would lose effect; I tell people now, don't use it more than four times a year. We're all of us losing the memory for people's names, over the age of 35. Some careful research should be done – but it's difficult to do that when it's illegal.

**Is there any experience you wish you hadn't had?**

***Sasha:*** I tried a drug for psychedelic experience – but it was also toxic... [there followed a detailed description of food poisoning symptoms].

**I'm very interested in links between depression and MDMA. I do research on chronic MDMA users and depression. In the future, can you imagine having drugs gene coded, for those who are susceptible to depression? Can you imagine a time when people's dose is calibrated?**

***Sasha:*** Yes, there are moves being made to understand genetic structure. There's response to new materials – but as it's progressing we're finding it more difficult to assess this response to new materials.

**After a period of extensive use of ecstasy, it lost effect for me. Then I got involved in dance therapy. What do you think about neurotransmitters in the brain enhancing experiences?**

***Sasha:*** People can see things and solve things more easily under psychedelic drugs.

***Ann:*** Using psychedelic drugs and envisionary plants are used as a way of envisioning, but they're not for everybody. There are other things that can take you into altered states – painting, writing poetry, falling in love. Music is one of the greatest psychedelic materials. Drugs can be very useful. Using these materials to enhance oneself as an adult is a basic human right.

**By 2050 there will be many new users. Who's going to take over your work... how unique is the Shulgin mind?**

***Sasha:*** I have no apprentice. But I get feedback from around the world – and have taken clues from this and that. The growth will continue. **DDN**

*Questions came from delegates at last week's DTL conference in London, 'Drugs – the shape of things to come?'*

**'The MDMA experience allows people to look upon themselves with real love. It's one of the most treasured and effective drugs that's ever been used. I was involved in treating post-traumatic stress disorder, including torture victims. This is where MDMA should be able to help. I feel very sad that it's been made illegal.'**

**I'm in contact with a client who has a long history of drug and alcohol use. He has been through rehab three times and is utterly discouraged and demoralised. He's lost his house and his marriage and his children have disowned him. He thinks there's no point in bothering anymore and is only just managing to keep his place at a hostel. This man is 41 years old and used to be an architect. Now he has no intention of working again – or even rejoining society. How can I convince him to give it one more go?**

*Kerry, drug and alcohol worker, West Midlands*

Dear Kerry
Your current job is to deal with the fact that your client doesn't want to change right now. I would suggest exploring in supervision and elsewhere your understandable but misguided desire to get your client to do what you want him to. Then perhaps you can build a relationship with him based on his needs rather than yours.
**Danny Kushlick, Director, Transform Drug Policy Foundation**

Dear Kerry
If your client is to make the most of the opportunities he is being offered, he must be open to the idea of many lifestyle changes. However, in spite of the fact that he has already been through rehab three times, his problem may lie in the fact that he hasn't yet found the right kind of treatment.

It is important that treatment is tailored to suit individual needs, as this can be the key to engaging people and sustaining their interest and motivation in their rehab programme. Phoenix House offers a range of treatment options, from single person and family orientated residential treatment to structured day care centres, prison based programmes and community outreach schemes. Our programmes are designed to be responsive to the clients needs offering flexibility but we also encourage service users to focus on new activities, skills and qualifications that will enable them to start developing the building blocks they need to live a full life after rehab.

The Phoenix House Access to Skills and Education scheme has helped many services users to access work and complete college accredited education courses; whilst our English Nature conservation project gives clients the chance to take part in environmental restoration work such as dry stone walling and river clearance, at National Nature Reserves in the Peak District and County Durham. We have seen a 20 per cent increase in retention rates for clients taking part in conservation projects and as your client already has a professional history and existing skills, something similar may encourage him to see past his addictions and help him engage with a treatment programme.
**Jaine Barry, Phoenix House.**

Dear Kerry
The first question I would ask him is why he attended rehab the first three times – was it because he himself wanted to give up, or because he was issued with an ultimatum from family members?

Having been brought up surrounded by people with substance misuse problems my experience had led me to the belief that enforced rehabilitation is rarely successful. Individuals will only truly engage in rehab when they are empowered to do so, and it is their decision.

Whilst I empathise with his current situation I would encourage him to make changes that in the future would allow him to build bridges with his family. In his current situation they have removed themselves to protect themselves from further pain. It is difficult not only for the person in rehab but those close to them, and I feel that currently funding from the government provides for the service user but not his family and loved ones, which can prevent rehabilitation. All involved need support to establish clear boundaries on what is acceptable behaviour (family constantly asking if individuals have used or drunk today can be an extreme pressure on the person in treatment) and receive counselling to move forward together and individually at their own pace.

I would encourage him to look forward at how he can reconnect with his family – is this going to be possible if he continues in the same vein as he is at present? The answer is probably no, but if he can move towards rehabilitation in small steps, then his chance will increase. Although his family may never forgive him, he will need to work out a way to forgive himself and accept that he can not change what he has done in the past, but that he can change his future.

It may be overwhelming for him to look at giving up drink and drugs and then return to work. I would empower him to complete an alcohol detox and then look at stabilising his drug misuse before discussing work.

If it is possible to contact his family and try to engage them in counselling, this may be a way to establish contact and rebuild their relationship if his children are willing to do so.

I wish both you and him every success in the future. I lost my father two years ago after 35 years of irrepairable damage caused to his body through heroin addiction. His illness destroyed him and his relationship with his family. As his only child I had maintained constant contact with him and we had a good and honest relationship. He was a bright and compassionate man and although I had forgiven him a long time ago, he never forgave himself for the distress he had caused love ones. His choice was to surrender to his addiction, but if the family support had been present in the 1970s maybe he would have chosen a different path.
**Kerry-Anne Homer, by email**

Dear Kerry
A good question! Unfortunately this scenario is not uncommon and presents the field with its biggest challenge: how to motivate the unmotivated.

There was a time when this man would be seen as in need of some serious 'denial bashing', where the consequences of his drug and alcohol use could be presented to him as 'evidence' that would force him to surrender to the idea that the 'game was up'. For some this approach did appear to work, but it also could be argued that at some level they had already made some commitment to change. In addition, someone in his position may feel seriously attacked and threatened by any suggestion that he let go of his dependence and do things differently. It is understandable that he will rely on the defences he has developed over many years, however ineffective they may be. These kind of entrenched positions often reinforce beliefs of helplessness and demoralisation.

As the 'helper' who may be working furiously and passionately, we can unknowingly be invited into a position that reinforces the idea that this person is beyond help.

So what's to be done?

For Kerry's client a different approach could be useful, that allows him to explore what is important to him and what he really wants from his life. The reality of change is that it has to have personal meaning for the client otherwise they will not be motivated.

The principles of Motivational Interviewing are that we facilitate a process where the client can identify what it is that they want to change, based on their own analysis of their current situation.

Forgive me if I'm stating the obvious, but many have found this approach helpful. Of course, when clients remain stuck it often leaves us with feelings of helplessness and frustration. As professionals we have to ensure that we utilise our support systems to understand the process and remain in a position to help others.
**Kirby Gregory**
**Head of Client Services, Clouds.**

Dear Kerry
Perhaps working again and rejoining society are large and daunting prospects. I might begin by encouraging the client to find an interest, something he could enjoy doing – from a game of golf to a music event. Perhaps simply going to look at buildings could be a way in which he could share some knowledge to improve his self-esteem.

If you could then facilitate the development of his interest, his general outlook could become more positive. I think it is about starting at the bottom and setting achievable goals.
**Steve Roden, Project support worker, Birkenhead.**

## Reader's question

**I'm a project worker and want to hold an event for young people on drug safety. I'd like to do something different that doesn't involve a lecture – does anyone have any fresh ideas for engaging not preaching? And does anyone have any tips on funding..?**

*Rob, community project worker, Lancashire*

**Email your suggested answers to the editor by Wednesday 6 July, for inclusion in the 11 July issue of DDN.**

# The regulation and control of drugs: Part 2

**In the second part of this briefing, Professor David Clark continues to look at the development of laws regulating recreational drug use, in particular in America which has influenced world drug policy so strongly.**

American drug law eventually reached a point that seemed to many people incompatible with American ideals of individual freedom. Arnold Trebach argued that 'the essential nature of the U.S. drug enforcement has an alien tinge to it, more suited to an intrusive totalitarian society than to the democratic... culture that evolved... here in the United States'.

Congress repealed almost all of the mandatory sentences for drug offences in 1970, but these were re-introduced by the mid-1980s.

The Nixon administration introduced a new 'no-knock law' in the 1970s that, for the first time, allowed narcotic agents to legally break into premises without warning.

Under the Reagan administration of the 1980s, the US Supreme Court upheld the right of US customs officials to detain anyone who enters the US until they defecated into a container, allowed their faeces to be examined, and thereby demonstrated their innocence of drug trafficking.

Other laws made it possible to compel attorneys to testify against their own clients in drug cases and to seize fees paid to defence attorneys if the money was thought to come from drug trafficking.

The Clinton administration passed the Violent Crime Control and Law Enforcement Act (1994) which allows the death penalty for being a 'drug kingpin'.

Other legislation and judicial decisions introduced or increased mandatory sentences for various drug sentences, eliminated the possibility of physicians prescribing marijuana to the medically ill, and failed to change the existing federal embargo on funding for needle exchange schemes.

The Bush administration has been linking drug use with supporting terrorists.

The total population in jails in the US has surpassed two million – more than triple the number of 1980. Nearly one in four prisoners behind bars are there for a non-violent drug offence.

A study by the Leadership Conference on Civil Rights in 2000 noted that blacks represent 12 per cent of the US population and an estimated 13 per cent of drug users. Despite the fact that equal arrest rates for minorities and whites are yielded by traffic stops and similar enforcement, 38 per cent of individuals arrested for drug offences and 59 per cent of those convicted are black.

In their book *Crack in America*, Craig Reinarman and Harry Levine point out the politics that surrounded crack in the US during the 1980s and 90s. Crack first appeared in late 1984 and 1985, primarily in impoverished African-American and Latino inner city neighbourhoods in New York, Los Angeles and Miami.

Crack never became a popular of widely used drug, being used by the poorest, most marginalised people in American society. This was not the way that the media and politicians talked about crack from 1986 to 1992. In 1986, President and Nancy Reagan led a string of politicians in asserting that drugs, especially cocaine, were 'tearing our country apart' and 'killing... a whole generation [of]... our children'. A 1988 ABC News special report termed crack a 'plague' that was 'eating away at the fabric of America'. In 1988-89, the Washington Post ran 1,565 stories about the drug crisis.

**In 1986, the editor in chief of Newsweek began a full-page editorial with the assertion that 'an epidemic [of illicit drugs] abroad in America, as pervasive and dangerous in its way as the plagues of medieval times'. In the 14th century, the 'Black Death' killed about 75 million people in a few years.**

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At the start of the crusade to save 'a whole generation' of children from death by crack in 1986, the latest official data showed a national total of eight 'cocaine-related deaths' of young people aged 18 and under in the preceding year.

In 1986, the national prevalence of high school seniors having tried crack in the past year was 4.1 per cent. This declined steadily to 1.5 per cent by 1993. Amongst 18 to 34-year-olds in 1992, only 3 per cent had ever used crack, whilst only 0.4 per cent had used it in the past month. Therefore, prevalence was low. Despite claims that the drug was instantly addicting, most people who used it did not continue.

When he became President, Reagan attempted to restructure public policy according to radical conservative ideology. Programs directed at social problems were systematically de-funded and taken apart.

Unemployment, poverty, urban decay, crime and other social problems were treated as if they were the result of individual immorality or deviance. Arguments against these ideas were classed as left-wing.

For the New Right, people did not abuse drugs because they were jobless, homeless, poor, depressed or alienated. They were jobless, homeless, poor and depressed because they were weak, immoral or foolish enough to take drugs. Business productivity was flagging because many workers were taking drugs. US education was in trouble because a generation of students were on drugs and teachers did not get tough enough with them.

Crack was a godsend to the New Right. 'They used it and the drug issue as an ideological fig leaf to place over the unsightly urban ills that had increased markedly under the Reagan administration social and economic policies.'

The drug problem provided an all-purpose scapegoat. Politicians could blame an array of problems on the deviant individuals and then expand the nets of social control to imprison those people for causing the problems.

And Nancy Reagan could have a highly visible 'Just Say No' campaign showing her social consciousness and demonstrating that she was caring and not frivolous.


# Only one partner can pull together all the elements of a harm reduction service

For further information and samples phone Jane on : 01495 235800

FRONTIER MEDICAL PRODUCTS
Newbridge Road Industrial Estate,
Blackwood, South Wales, NP12 2YN.
T : 01495 235800
F : 01495 235808
E : info@frontier-group.co.uk

Sharpsafe®
exchange™
www.harmreduction.co.uk

## Appointment of contractors for the Gwent Drug Intervention Programme/Local Criminal Justice Integrated Teams

The Council of the City of Newport, on behalf of the Gwent Drug Intervention Programme and Welsh Assembly Government/Home Office seek to appoint 2 contracts with service providers whom it may call upon to contribute to service delivery in the following packages:

**PART 1** **The provision of Criminal Justice Integrated Teams (CJIT) as part of the Drugs Intervention Programme throughout the Gwent region.**

**PART 2** **The provision of a rapid access prescribing service for CJIT/DIP service users.**

It is anticipated that the total value of PART 1 will be approximately £748,000.Funding is secured until March 2007, with the possibility of extension dependant on Central Government funding through the Drugs Intervention Programme.

PART 2 will be approximately £200,000 to March 2007, with the possibility of extension dependant on Central Government funding through the Drugs Intervention Programme.

*The contractor(s) will be able to demonstrate:*

PART 1 (only) The ability to develop and deliver Level 2 substance misuse service, to people with substance misuse problems for those in the criminal justice system.

PART 1&2 Best practice and evidence of past success in relation to a reduction of drug related offending, reduction in the number of drug related deaths and improvement in the well being of service users.

Applicants will be required to complete a Pre Qualification Questionnaire including financial status, organisational structure, Health and Safety Record and a commitment to delivering of services in accordance with good practice in issues of diversity.

Applicants will be asked to provide details of similar schemes undertaken together with their proposed method statement.

References may be sought from bankers and relevant clients at this stage.

**The closing date for both applications will be 2nd August 2005.**

**Return of questionnaire by 4th August 12 noon at the latest.**

**Applicants should apply at this stage to:**
**Sarah Andrews, Substance Misuse Lead Officer,**
**Newport City Council, Newport, South Wales. NP20 4UR.**
**Tel: (01633) 232296**
**Fax: (01633) 232286**
**Email: sarah.andrews@newport.gov.uk**

Newport City Council
Cyngor Dinas Casnewydd

# The Training Exchange

## The Training Exchange Drug & Alcohol Training Programme Autumn/Winter 2005/6

**One day courses (£95 + VAT)**

| | |
|---|---|
| Introduction to Drugs Work | 13th October |
| Alcohol & Poly Drug Use | 3rd November |
| Difficult & Aggressive Behaviour | 21st November |
| Working with Diversity | 30th November |
| Drugs & Housing | 1st December |
| Personality Disorders | 13th December |
| Crack Awareness & Users' Needs | 14th December |
| Service User Involvement | 17th January 2006 |
| Women & Drugs | 25th January 2006 |
| Steroids & Steroid Users | 31st January 2006 |

**Two day courses (£180 + VAT)**

| | |
|---|---|
| Motivational Interviewing | 19th & 20th October |
| Brief Solution Focussed Therapy | 10th & 11th November |
| Relapse Prevention | 6th & 7th December |
| Dual Diagnosis | 19th & 20th January 2006 |
| Young People - Mental Health& Emotional Support Needs | 1 & 2 February 2006 |

the TRAINING exchange

**All the courses in this programme are mapped to DANOS.**

All courses take place in Bristol.

For further details and full course outlines contact
The Training Exchange,
Easton Business Centre,
Bristol BS5 0HE
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
www. trainingexchange.org.uk

***The Training Exchange is an independent training and consultancy service. We focus on issues that affect health, young people and communities.***

# drugtrain

## Working collaboratively to promote excellence in drug & alcohol work through training

Sheffield Hallam University

### Certificate in Drug and Alcohol Counselling – recruiting now for October 2005 start, deadline for applications 27th July 2005

This 2 year part-time course offered in partnership with Sheffield Hallam University provides comprehensive therapeutic training in the Cognitive-Behavioural model of substance use for current drug / alcohol workers and those new to the field who wish to pursue a career in Drug and Alcohol Counselling. The course includes supervised work experience in Year 1 and supervised counselling practice with drug / alcohol clients in Year 2. Attendance is 1 day per week (Thursdays) for Year 1, plus a residential weekend, reducing to 1 day per fortnight in Year 2.

**Modules:**

- Studying Substance Use
- Personal Awareness
- Introduction to Cognitive Behavioural Counselling Skills
- Drugs Worker Skills
- Specialist Counselling for Substance Misuse
- Supervised Counselling Practice
- Developing as a Counsellor
- CBT for Common Problems

**Qualification:**
Certificate in Higher Education consisting of 120 credits at Level 4. Successful completion of the course will provide participants with the main skills and knowledge required by the Drug and Alcohol National Occupational Standards (DANOS).

### Short courses
**(OCN accredited and non-accredited)**

- Drug/Alcohol Awareness e.g. *Alcohol Facts*; *Drugs Awareness Levels 1,2,3*
- Skills Development e.g. *Motivational Interviewing*; *Relapse Prevention*
- Professional Development e.g. *Introduction to Cognitive Behavioural Therapy for Drug Workers; Mental Health and Substance Use; Parental Substance Use and Child Protection*

### NOCN

Coming soon – new NOCN suite of Level 3 qualifications in *Tackling Substance Misuse* with 5 endorsed routes:

- Commissioning and Planning Services (aimed at service commissioners and others involved in managing local strategies)
- Practitioners (aimed at Drug Workers)
- Drugs Education
- Managers (aimed at senior practitioners and team leaders in drug treatment services)
- Generalist Worker (aimed at those with another specialism but taking a special interest in working with drug users).

In order to achieve this DANOS mapped qualification, a learner must complete a total of 15 unit credits at Level 3 made up of:

- One mandatory unit at 6 unit credits
- A choice of optional units at 9 unit credits

### In-house bespoke training

We are also keen to bring our training to you. All courses can be run within your organisation and the **drugtrain** team can offer bespoke training to meet your exact needs. We are experienced in designing and facilitating effective team building and planning events.

**For a prospectus, application pack and further information contact:**
**Steph Windle,**
**Training Administrator,**
**drugtrain,**
**Sheffield Alcohol Advisory Service,**
**646 Abbeydale Road,**
**Sheffield S7 2BB**
**0114 258 7553 ext212**
**steph.windle@sheffieldaas.org.uk**

*drugtrain is a collaboration of community based drug and alcohol treatment agencies which have a proven track record for high quality vocational training, comprising:*

- *Sheffield Alcohol Advisory Service (SAAS)*
- *Barnsley Alcohol & Drug Advisory Service (BADAS)*
- *Rotherham Community Alcohol Service (RCAS)*

**Our aim is to promote excellence in drug and alcohol work through innovative training which cultivates the development of a committed, high-quality workforce**

We're Addaction, a leading UK charity working solely in the field of drug and alcohol treatment. With over 70 solution focused services, we work within communities and individually with clients from all backgrounds, helping to reduce substance misuse and to combat the harm it causes. Now we want you to help us evolve our services further and in the process find far-reaching solutions to one of the major social issues of our day.

**For an application pack, please contact Judith Boateng, London Area Administrator, on 020 7017 2723 or email j.boateng@addaction.org.uk quoting the appropriate reference and where you saw the advertisement.**

**Closing date: 13 July 2005.**

**www.addaction.org.uk**

*The leading drug and alcohol charity. Helping individuals and communities to manage the effects of drug and alcohol misuse.*

Elizabeth Fry Centre

established 1967

addaction

## Addaction Hackney Community Drug Team

If people with drug problems need help, where's the best place to provide it? As one of the country's leading deliverers of frontline treatment, offering effective interventions for drug dependency, where should we focus our efforts? The answer is where it's needed most. And for the vast majority of the people we help, that means locally, in the community where it's easy to access. That is why we are proud to be a key partner alongside the DAT in the Hackney Substance Misuse Service, one that is committed to providing the response the community requires.

### PROJECT MANAGER Ref: ADDLR32

**Up to £38,500 dependent on skills and experience**

We are seeking to recruit a dynamic and experienced Project Manager to continue to develop our Hackney service. Taking a strategic lead, you'll be responsible for developing partnerships with key stakeholders and the community. Managing the practical work, you'll guide clinical practice, report on its progress and ensure that we keep the needs of the service users at the forefront of what we do. You should have demonstrable experience of effective management in Adult Services in the drug and alcohol or social care field. You will be an excellent communicator and team player, with a track record of delivering high performance services in a continuously developing environment. You will require strong leadership skills and a vision to continue the excellent services that this project currently provides.

### OPERATIONAL MANAGER Ref: ADDLR33

**Up to £32,000 dependent on skills and experience**

We are looking to recruit an experienced manager who, in conjunction with the Project Manager, will oversee the day-to-day management, clinical governance and accountability of the project to the highest standard. In your role you'll direct the activities of your team and be responsible for ensuring that they are supported and developed appropriately. Ensuring that the service upholds the core policies and care standards as agreed by Addaction and commissioners, you will take the lead in respect of the service's legal and ethical obligations for health and safety, QuADS etc. With your excellent communication skills, you will promote good working relationships within the service, and externally with other services and the community. You will already have experience of working within a multi-disciplinary team within a drug and alcohol, or other related social care background.

West Sussex Health and Social Care NHS

NHS Trust

## Senior Social Work Practitioner

**(Substance Misuse)**
**£30,000 – £32,400 pro rata**
**18.5 (job share)**
**Horsham & Crawley**

You will be responsible for the care and management of a caseload of individual and complex substance misuse problems within our well-established multi-disciplinary Substance Misuse team. You will supervise social care and other employees to ensure the promotion of our best practice social care values and principles.

*Applications are welcome from Social workers with 4 years post qualifying experience*

You will be employed by West Sussex County Council and then seconded to West Sussex Health and Social Care Trust.

*This post is subject to Criminal Records Bureau checks*

For an informal chat or further information please contact Paul Savage 01293 600340

**For an application pack please go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 777503 (24 hour hotline), quoting the reference number.**

**Closing date: 15 July 2005**
**Interview date: 15 August 2005**

# www.drinkanddrugs.net

## BSc (Hons) Substance Use Studies

**University of Wales degree available full or part-time**

***Do you want to help others overcome drug problems?***

This course is aimed at people wishing to enter a career in social care or who already specialise in addressing drugs and alcohol issues within the youth and community, education or health related fields. The course is signposted to the Drug and Alcohol National Occupational Standards (DANOS) and will be fully aligned by 2006.

Modules include Drug Use and Society; Treatment and Prevention; Drugs and the Family; Difference and Diversity; Models of Care in Service Planning; Managing Services; Drugs and Crime; Drugs in Sport and Recreation; and National and International Policy. Those with existing relevant qualifications are able to join the course at levels 2 or 3.

Applications from those with personal experience of drug problems are particularly welcomed.

Contact Dr Paul Burlison for further details: **01978 293407** (p.burlison@newi.ac.uk) or Sian Walters: **01978 293380** (s.walters@newi.ac.uk)

**NEWI** – member of the University of Wales

www.newi.ac.uk

NEWI North East Wales Institute of Higher Education

*Athrofa Addysg Uwch Gogledd Ddwyrain Cymru*

## Are You Looking For Staff?

**We have a comprehensive database of specialist substance misuse personnel**

*DAT Co-ordinators ● RoB Co-ordinators*
*DIP Workers Counsellors ● Project Workers*
*Commissioning Managers ● PPO workers*
*TCAC workers ● Case Managers*

**Consultancy, Permanent, Temporary**

Solutions Action Management Recruitment & Consultancy

*"We have found Solutions Action Management to be a focussed professional and responsive provider of both Consultancy and interim management support as well as helping with our permanent DAT coordinator/ recruitment. They have been able to target our own specific needs and have provided high calibre candidates for us."*
**Chief Executive- Slough PCT**

**Contact the Director to discuss your recruitment needs:**
**Samantha Morris**
**Tel/Fax 020 8995 0919**

**www.SamRecruitment.org.uk**

# LIFE WORKS

## TRANSFORMING LIVES

## Clinical Manager, Counsellors & Support Staff

Life Works is a progressive and dynamic residential treatment centre in Surrey, providing high quality, individual-specific treatment for addictions, compulsive behaviours and related mental health issues. We are now expanding our service to include a new Day Centre on Duke Street, London, W1.

**A chance to be part of something exceptional...**

Due to unprecedented growth and demand for our services, we are currently recruiting passionate and high quality individuals in London and Surrey for the following positions:

- Clinical Manager (London)
- Primary Counsellors
- Clinical Psychologist
- Bank & Part-Time Counsellors, Trainee Counsellors, Student Placements & Care Workers

A recovering background is a plus but the passion and commitment to make a real difference and be part of an innovative organisation is a must. To apply for any of the above positions, please send your CV with salary history to dserratt@lifeworkscommunity.com

For further information please visit

**www.lifeworkscommunity.com**

## Scottish Addiction Studies, University of Stirling

### On-line Courses in Drug & Alcohol Studies

Scottish Addiction Studies at the University of Stirling, Scotland has been offering on-line courses in the addictions for over ten years. We have a strong reputation for academic excellence and innovation. In 2005/2006 we will be offering three validated short courses:

*University Certificate in Drug and Alcohol Studies* (UG) - 44 Credits - Level 10 (SCQF). Module 1: Policy and Practice (DA01). Module 2: Understanding Drug Treatment (DA02). Fees: £760.00. (£380.00 per module).
CLOSING DATE - 31st AUGUST 2005.

Drugs, Alcohol and Nursing (UG) – 44 Credits - Level 9 (SCQF). Module 1: Society and Health (NUR179). Module 2: Policy and Implementation (NUR180). Fees: £440.00 ( £220.00 per module) if taken as part of the degree programme or £640.00 (£320.00 per module) if taken as a "stand-alone" course.
CLOSING DATE - 13th SEPTEMBER 2005.

*Postgraduate Certificate in European Studies in Substance Abuse* - This course is offered in collaboration Universiteit Gent (Belgium), University of Aarhus (Denmark) and University of Maastricht (the Netherlands). 60 Credits - Level 11 (SCQF). Module 1: On-line Taught Section (ESS1). Module 2: Practice Placement and Dissertation (ESS2). Fees: 1040 Euro.
CLOSING DATE - 31st AUGUST 2005.

All courses are taught on-line and may be studied part-time over one or two years. In all courses, completion of Module 1 is a prerequisite for Module 2. Further details, including enrolment, downloadable flyers, provisional timetabling etc., are available on-line at:

**www.dass.stir.ac.uk/sections/scot-ad/sascourses.php**

**Or contact: Rowdy Yates at Scottish Addiction Studies, Dept. of Applied Social Science, University of Stirling, Stirling FK9 4LA. E-mail: p.r.yates@stir.ac.uk**

## RIGT: The Responsibility in Gambling Trust

### Interested in helping to tackle problem gambling?

**RIGT's aim is to make it less likely that people will become problem gamblers and more likely that those who do will be able to seek and secure effective help.**

We are inviting applications for two new posts

- Research and evaluation officer
- Treatment development worker

**c. £25k + 6% pension**
**Full time**

These are exciting opportunities to be in at the start of a new era in tackling problem gambling. Based in central London, RIGT is the national commissioning body for services for problem gamblers. We also commission research, disseminate research findings, and commission prevention and education activity.

These new posts are central to enabling RIGT to commission high quality and effective treatment and research. For the treatment post you will need to have treatment practice, policy or commissioning experience, ideally in a related addiction or social care background. For research, you will need to have skills in research findings acquisition and dissemination, and in commissioning research projects and working with researchers.

Both posts offer exciting development opportunity working in a small, motivated and energetic team. If you have relevant skills, lots of enthusiasm, and interest in gambling problems, we will be interested in you.

**To apply look at www.rigt.org.uk, which details the application process. If you have any difficulties with this, give us a ring on 0207 824 9222. Closing date for applications will be 11th July 2005.**

*RIGT is an equal opportunities employer*