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DDN
Drink and Drugs News

4 April 2005
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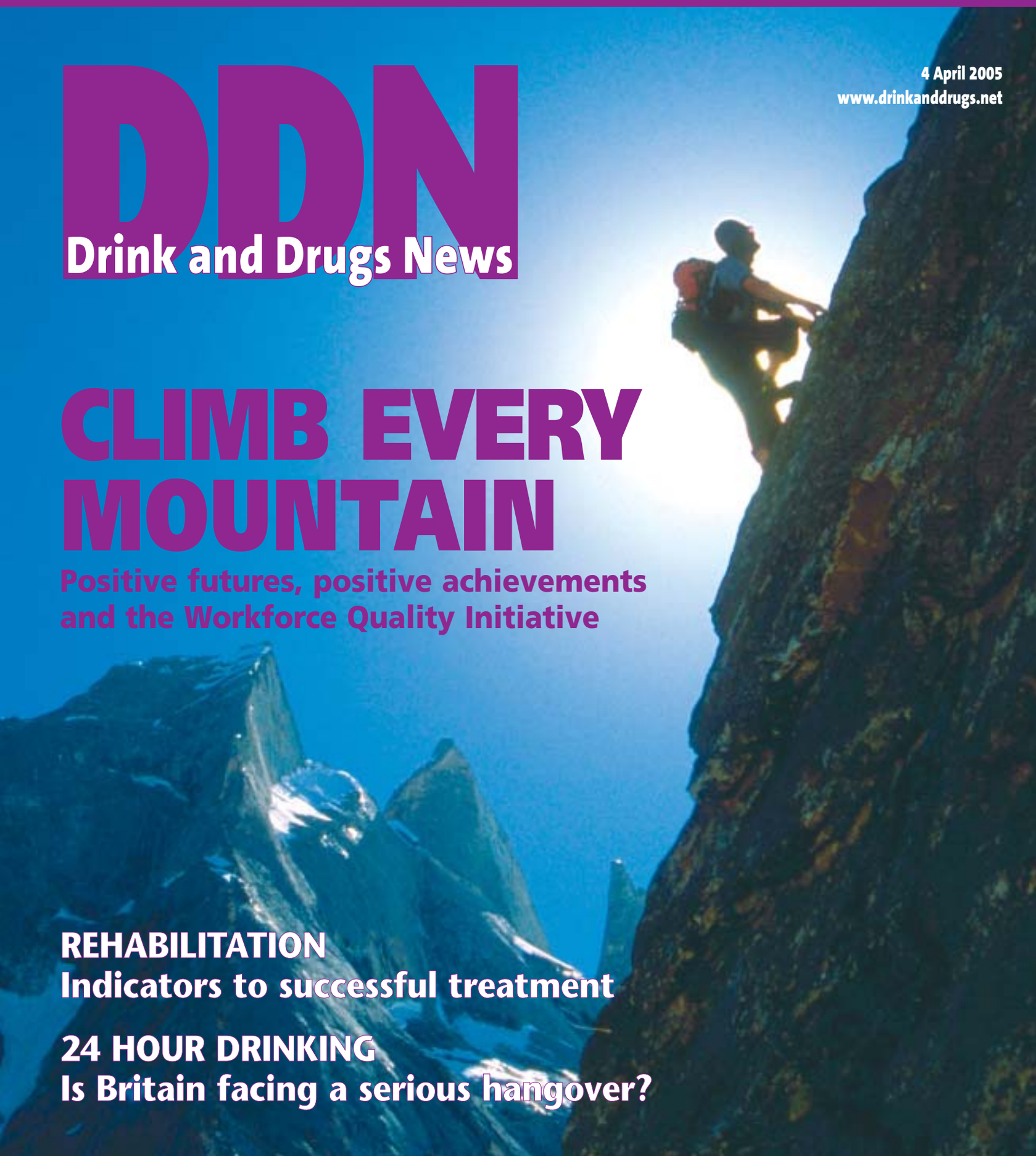

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The 21st Century approach to tackling substance misuse

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Drink and Drugs News

4 April 2005

Editor's letter

Going over to Chelmsford for an Essex Drug and Alcohol Service Users Conference last week, turned out to be an interesting experience. For starters, nobody was 'badged up', so we didn't know from the outset who was a service manager, who was a service user and who (heaven forbid) was from a publication. We were sat at round tables throughout the day, speakers took the floor with a microphone but no platform, and answered questions as they came up, and we were all involved in the charge for the chocolate cake at lunch.

I had seen Ron Pepponis from NIMHE (the National Institute for Mental Health in England) do the same speech at the National Drug Treatment Conference the other week – but how different it sounded from the floor, with interruptions, and adaptations, and responses to ad hoc questions and thoughts. The purpose of the day was to look at how user groups might be set up. What did we think might be the first stages? What would keep them from fizzling out? Lesley the organiser chivvied us gently, getting us into groups, coaxing some structured thought. The atmosphere at the conference spoke volumes about the best way to encourage participation.

Those who had been through the experience spoke up about how to get a group going – and there'll be more of that in the next issue of *DDN*. What the day demonstrated to me, was that getting a user group up and running is very much about the way you approach it: mutual respect mixed with a heavy dose of persistent organisation.

We're hearing about user groups starting up here and there, so next issue we'll take a look at what works, and hopefully come up with some useful advice. If you're in any way involved with a user group – getting one started, or keeping one going – please email as soon as you get a minute.

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In this issue

Media watch

Injecting crack cocaine is surprisingly common among US drug users, the first large study of the practice has revealed. The trend is worrying as its links with high-risk behaviour, such as sharing needles and having unprotected sex, are stronger than for other intravenous drugs.
New Scientist, 30 March

Thursday night in Sunderland is becoming known as 'nappy night' because of the number of children as young as 13 binge drinking in city centre pubs. Police are staking out off-licences, patrolling parks and seizing booze in a crackdown on under-age drinking and anti-social behaviour.
Sunderland Today, 24 March

Illicit valium is one of the most popular drugs in Scotland, ranking just behind cannabis and heroin, according to a survey by the Scottish Drugs Forum. SDF warns that the tablets slow down the body's reaction and increase risk of overdose on other, higher classification drugs.
Scottish Herald, 31 March

The Isle of Man has begun a survey of drinking habits, which will compare data with 30 other countries and involve 1,000 adults of all ages and social groups. Interviews by a team of volunteers will produce a picture of the island's attitudes to booze, by October.
Isle of Man Today, 19 March

Sniffer dogs have been used for the first time in a Scottish School. Specially trained police officers carried out random searches at Kingussie High School, to discover if staff or pupils were carrying drugs, following increasing seizures of heroin, cocaine and crack cocaine in the Highlands. Dogs have been used in English schools for nearly two years.
North Scotland Press, 31 March

Police and drugs workers in Plymouth have warned that crime may surge because of a chronic national shortage of diamorphine. DrugScope advised a bigger range of options to prevent drug addicts from dropping out of treatment.
Plymouth Evening Herald, 29 March

A fibreglass submarine that could smuggle 10 tonnes of cocaine has been found in Columbia. 'The ingenuity of traffickers is amazing,' said police chief, Eduardo Fernandez.
Sunday Mail, 27 March

Billie Piper, aged 22, scheduled a booze-up to avoid watching herself in the first episode of Dr Who. 'I'll do what I always do on transmission dates, which is go to the pub and get lashed,' she said. Come on Billie, you weren't that bad.
Daily Mirror, 21 March

Young people strategy gets regional focus in 'pioneering project'

'Initiative will target children who are using drugs themselves, or who are affected by someone else's drug use.'

Thirty local authorities have been selected by government to lead the way on a national drug strategy for young people.

The initiative will target children who are using drugs themselves, or who are affected by someone else's drug use. It follows on from *Every child matters*, a cross-government partnership between the Department of Health, Home Office and the Department for Education and Skills, which represents £2.8m investment in drug guidance for young people.

Home Office Minister, Caroline Flint, said the 30 local authorities would drive the strategy forward, 'testing what works best and sharing effective practice across the country'. They would act as 'leaders for the whole programme'.

Minister for Schools, Derek Twigg, said the 'pioneering project' would 'develop and test a best practice model of service, which [the government] would them disseminate nationally'.

The 30 'high focus area' local authorities are: Thurrock, Essex, Nottingham, Nottinghamshire, Westminster, Tower Hamlets, Hackney, Camden, Southwark, Lambeth, Newham, Redcar & Cleveland, Stockton on Tees, Middlesbrough, Bolton, Liverpool, Knowsley, Rochdale, Cumbria, Manchester, Milton Keynes, Southampton, Brighton & Hove, Bristol, Plymouth, Birmingham, Kingston upon Hull, Bradford, Barnsley and Calderdale.

'Every child matters' is online at www.everychildmatters.gov.uk/_content/documents/ECMYPD.pdf

Daily Dose attracts vital support

Daily Dose, the drugs and alcohol news portal, is celebrating the next stage in its development with the announcement of four commercial sponsors.

The news service is managed by a small team at Wired, the information network created and led by Professor David Clark, a professor of psychology at Swansea University.

For the last four years, Daily Dose has delivered to subscribers' email a summary of the day's news from around the world, with web links to the source documents. The service has a growing band of 3,000 subscribers, with others opting for the 'Weekly Dose' round up.

The new sponsors, Euromed, COBB, Blithe Computer Systems and DTL, backed Daily Dose as an 'important resource' and 'the most thoughtful selection of need-to-know news in the drink and drugs field'.

Prof Clark said the encouragement and support from subscribers and sponsors made 'getting out of bed for the pre-dawn news scan just that little bit easier'.

The sponsorship will enable Wired to put new initiatives in place for the tailored news service and expand the subscriber base.

Visit www.dailydose.net to browse and subscribe.

Your views needed on harm reduction

A consultation exercise is underway with key stakeholders on drug treatment and harm reduction, to see what action is needed to reduce blood borne viruses and overdose.

The survey by the UK Harm Reduction Alliance (UKHRA), funded by the National Treatment Agency, is seen as particularly crucial in light of US threats to harm reduction, and erosion to public health from the criminal justice agenda.

The online survey takes a few minutes to complete, and will be used to provide feedback to the NTA.

Log on to www.ukhra.org to contribute your views, by Monday 18 April.

Uptake in cannabis contradicts Home Office panic

There is no evidence for claims of an explosion of cannabis use, according to the Independent Drugs Monitoring Unit, which has monitored any increase in cannabis use, year on year, over the last decade.

According to the IDMU, the findings directly contradict media claims of an explosion of cannabis use, following reclassification in January 2004 that prompted Home Secretary Charles Clarke to call for the Advisory Council on the Misuse of Drugs to review policy.

The survey reveals that the increase in regular use fell to 0.5 per cent in 2004, compared with 45 per cent in 1998. Matthew Atha, IDMU Director, said that 'far from leading to an explosion of use, declassification of cannabis appears to have had little or no effect on consumption levels of cannabis levels. If anything, the upward trend in cannabis use appears to have been halted.'

Campaigning groups for harm reduction were swift to condemn the Home Secretary's announcement as a pre-election gimmick.

Danny Kushlick, Director of the Transform Drug Policy Foundation, reiterated TDPF's call for cannabis to be legalised and regulated, to give some measure of control over availability and to allow information to be included on packaging about drug strength and safer use.

'Concerns over rising use are misplaced,' said Mr Kushlick. 'The Home Office, DrugScope and the EU European Drug Monitoring Centre all maintain that changes to enforcement policy do not have a significant effect on use.'

Homeless battle bus sets off on tour

A panel of homeless people has set out on a tour of England to make their views known to prospective parliamentary candidates.

The double decker bus will pick up homeless people in five cities to join the panel, who will invite local election candidates to debate election issues that will affect them, from housing to employment, education, health and crime.

Shaks Ghosh, chief executive Crisis, which organised the 'Big voice tour' with support from the Big Issue in the North, said the tour would give homeless people a voice.

'In the next few weeks, most of us will probably get a visit from one of the parliamentary candidates knocking on our doors canvassing our opinion. If you are part of that hidden group of homeless people, 380,000 people across the country, then there is a very good chance that your issues will not get heard.'

The bus, which was donated by the band Travis, set out from central London last week and will make the following stops:

- Birmingham, Monday 11 April
- Manchester, Tuesday 12 April
- Leeds, London 18 April
- Newcastle, Tuesday 19 April
- Bristol, Monday 25 April.

Crisis offers its own manifesto addressing key homelessness issues, at www.crisis.org.uk

Scots clubbers get smart advice

Young women in Scotland are being targeted with a pink handbag shaped leaflet, to warn them against the dangers of binge drinking. Advice folds out in comic strip format, giving useful advice and contact numbers.

The leaflet has been produced by West Lothian DAT in partnership with the Drug and Alcohol Service and Lothian and Borders Police, with £10,000 funding from the Scottish Executive. Hilary Smith, research and development officer at West Lothian DAT, said the initiative was a response to increased binge drinking and aimed to educate women on the potential dangers of alcohol use:

'We want people to have fun in a safe way by highlighting the potential health and personal safety risks associated with binge drinking.'

The campaign was launched at local clubs, where leaflets were distributed to women entering the venues.

Lancaster prison officers plan jailbreak!

A team of prison offers from HMP Lancaster will shortly be on the run – for a good cause.

The 'jailbreak' is to raise money for 'When you wish upon a star', a small charity for children with life threatening illnesses, that gives them the chance to meet a hero or take the trip of a lifetime. The charity receives referrals each day from all over the country.

Jan Nice and colleagues Bob and Kev, are taking the challenge to cover as many miles as possible during three days, and will visit as many other prisons as they can, to raise money. Their £15 a day subsistence cannot be used for travel or accommodation.

If you would like to sponsor them, email Jan at jannice204@aol.com

Research and guidance

Weblinks for these documents can be found in the research and guidance section of our website, www.drinkanddrugs.net

United Kingdom

Housing support options for people who misuse substances
Guidance for commissioners on meeting housing needs of substance misusers. Home Office, March 2005.

Government's response to Hidden Harm report on parental drug misuse
Response to ACMD 'Hidden Harm' report. DfES, March 2005.

Every Child Matters: change for children, young people and drugs
Strategic guidance on drugs and young people. Home Office, March 2005.

ICP guide 9: single shared assessment for drug users
ICP guide 8: problem substance use in pregnancy & reproductive health
Latest in series on Integrated Care Pathways (ICPs). EIU (Scotland), March 2005.

Nurse prescribing in substance misuse
Guidance for nurses on prescribing controlled drugs in treatment. NTA, February 2005.

Throughcare & aftercare – approaches & promising practice
Case-study based report on throughcare and aftercare. Home Office, February 2005.

The impact of mandatory drug testing in prisons
Review of evidence re MDT accuracy and effects. Home Office, January 2005.

Effective and cost-effective measures to reduce alcohol use in Scotland
Literature review of measures for reducing alcohol use. Scottish Exec, January 2005.

ICP guide 7: care of people with drug problems in general hospital settings
Seventh in series of guides on Integrated Care Pathways (ICPs). EIU (Scotland), January 2005.

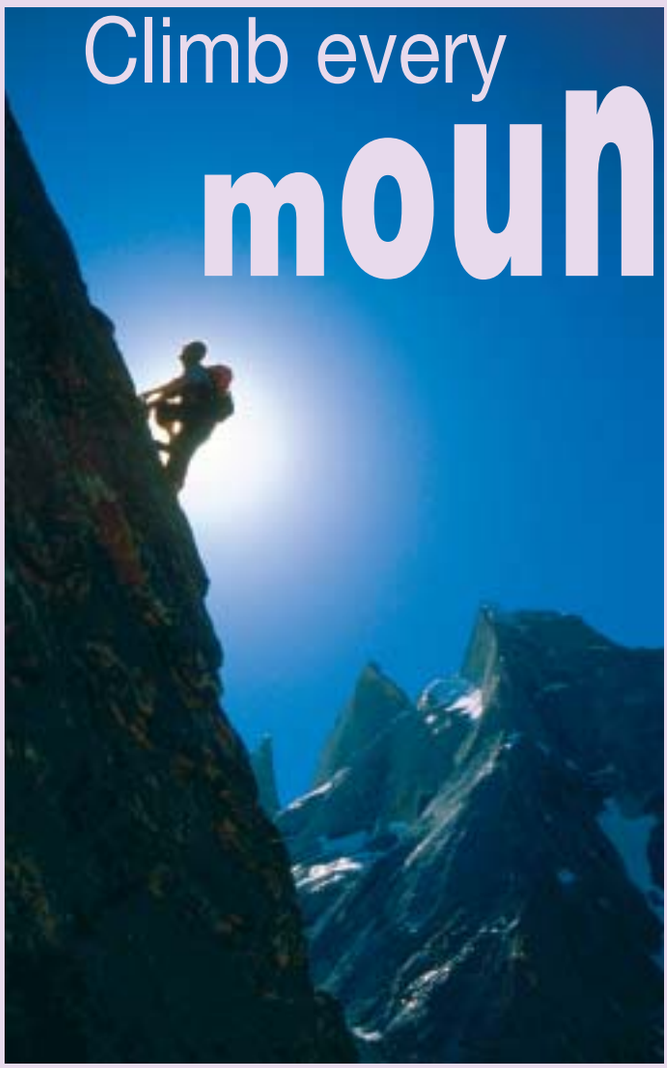
Overseas

Prevention of substance use, risk and harm in Australia
Review on prevention of substance use and harm. Dept of Health (Australia), June 2004.

Best practice guides from Health Canada:

- treatment interventions for drink drivers
- preventing substance use problems among young people
- treatment and rehabilitation for seniors with substance use problems
- methadone maintenance.
- concurrent mental health and substance use disorders: dealing with dual diagnosis
- fetal alcohol syndrome/effects of alcohol and substance use in pregnancy
- treatment and rehabilitation for women with substance use problems
- treatment and rehabilitation for youth with substance use problems
- substance abuse treatment and rehabilitation

Climb every mountain



Noelle O'Brien describes how the Workforce Quality Initiative recognises Positive Futures workers' natural strengths and builds on these to help them address the difficult issues of social exclusion, drugs and crime.

Positive Futures is a sports-based social inclusion programme managed within the Home Office Drug Strategy Directorate and delivered by 108 local partnership projects throughout England and Wales. Positive Futures workers need very special personal qualities to be able to empathise and engage with young people, involve them in sports activities and motivate them to build a better future for themselves and their communities.

However, Positive Futures has long recognised that personality and life experiences are not sufficient qualities for the delivery of a strategically-led, sports-based social inclusion programme. Consequently, it has sought to develop a comprehensive programme of training in line with the skills base identified in the strategy document, *Cul-de-sacs and gateways* (Home Office, June 2003). The strategy introduced the concept of the Positive Futures Workforce Quality Initiative, which has subsequently been designed to ensure that individuals working on projects have the knowledge, skills and personal qualities to perform their roles effectively.

The objectives of the programme are to:

- identify the National Occupational Standards (NOS) Positive Futures staff should be working to
- assess staff's performance, knowledge and skills to identify any training and development needs
- provide relevant and targeted training and activities
- evaluate the development of Positive Futures staff
- record and recognise the achievements of Positive Futures staff.

The Workforce Quality Initiative is managed by Management and Performance Solutions Ltd and is underpinned by the Performer software. The process has been refined through working with Positive Futures over the past two years. It follows the cycle of continuing personal and professional development. (See diagram.)

At the start of the cycle, Positive Futures workers and staff from other community sports projects attend a half-day workshop to introduce them to the Workforce Quality Initiative and provide them with a kick start.

At this highly interactive workshop, they use the Performer software to create and refine their role profile – the set of National Occupational Standards relevant to their work roles. Typically, these role profiles will include units from sport and recreation, youth work, youth justice and drugs and alcohol national occupational standards. For the managers and co-ordinators of Positive Futures projects, they also include management standards.

During the workshop, staff are asked to prioritise up to four units from their role profile to get them to focus on areas of their work that are really important, but about which they are not 100 per cent confident. All Positive Futures staff are required to include within their list of prioritised units, the Drugs and Alcohol National Occupational Standards (DANOS) unit AA1 Recognise indications of substance misuse and refer individuals to specialists – this core aspect of Positive Futures work has been found to be a blind spot for many workers.

Also as part of the workshop, staff assess themselves against their prioritised units to confirm their strengths and identify any gaps in their knowledge and skills, or ways in which they need to adapt their performance to bring it into line with the benchmarks of good practice as described in the National Occupational Standards.

Armed with this clearer understanding of the requirements of their role and their individual learning needs, staff are able to identify for themselves relevant training courses and other learning activities. Performer's learning resources database holds details and provides hyperlinks to over 300 learning resources throughout the UK that have been mapped to NOS; users can quickly find a local training course to meet their own particular needs.

However, anticipating staff's learning needs, Positive Futures offers a core training programme in each English region which covers:

- engaging with, working with, supporting and protecting young people (delivered by NACRO)
- preparing, leading, concluding and reviewing sports sessions (London Community Sports Network/Chartstage)
- raising awareness of substances and their effects and helping young people address their substance misuse (Crime Concern)
- dealing with abusive and aggressive behaviour (Eric Yates)
- managing projects and delivering quality to stakeholders' requirements (Human Performance Ltd).

Typically, a member of staff will participate in two or three of the core training sessions and also other training arranged by their own organisation, according their needs. The workshops are designed in such a way as to encourage staff to apply their new learning to their work and reflect on how this has improved their own performance and results.

Towards the end of the Workforce Quality Initiative cycle, staff return for a second half-day workshop using the Performer software. They reassess their performance in the units they prioritised for development and evaluate their improvement since their initial assessment. They reflect on their learning and record their achievements in their personal portfolio. They are also awarded certificates of attendance for the core training courses they went on.

The cycle continues with staff reviewing their role

profiles – How has my role changed during the last year? What new challenges are likely to confront me this year? – and prioritising new units on which to focus their learning and development in the coming period.

Challenges for 2005

2004 saw significant developments in the Workforce Quality Initiative, particularly the delivery of the core training programme and the invitation to other sports-based social inclusion programmes to participate. 2005 will offer new challenges around the issues of:

- further development of the core training programme
- accreditation of learning, achievement and competent performance
- future funding of the Workforce Quality Initiative.

Further development of the core training programme

The 2005 core training programme must take into account the learning needs of:

- existing Positive Futures staff, and the new priorities they will have for 2005, having already addressed the subjects covered by the 2004 training programme
- a smaller number of new Positive Futures staff, who will need training in the subjects covered by the 2004 training programme (and existing Positive Futures staff who did not avail themselves of these course in 2004)
- a growing number of non-Positive Futures staff who would like to participate in the programme.

The new priorities for 2005 will emerge as a result of the second round of half-day Performer workshops in April 2005. Once these results have been analysed, the priorities for new training courses will be clear.

Accreditation of learning, achievement and competent performance

This is an area that is underdeveloped in the Workforce Quality Initiative. Currently, participants are only provided with certificates of attendance at training courses.

Staff need to be encouraged to apply their new knowledge and skills and provide evidence of their competent performance in NOS units, which can then be independently assessed. The Performer software has facilities for recording evidence of competent performance in each member of staff's personal portfolio and for online assessment for NVQs and other competence-based awards.

NVQs may be an appropriate longer-term goal, but many Positive Futures staff are sessional workers and they need smaller, more manageable competence-based awards. Sector Skills Councils and awarding bodies are now looking at developing cluster awards, comprising three or four NOS units. Four cluster awards could meet Positive Futures' immediate needs, covering youth work, substance misuse, project management and sports leadership (this latter is already under development). These would be achievable by Positive Futures workers within a 12-month cycle, and would provide them with a nationally-recognised qualification, showing their transferable skills and providing parity of esteem with their colleagues in mainstream sports development or youth work contexts.

Future funding of the Workforce Quality Initiative

To date, all the direct costs of the Workforce Quality Initiative have been borne by Positive Futures and Sport England. Positive Futures will move out of the Home Office in 2006 and it is likely that a broader funding base will need to be found. Possible future funders include:

- European Social Fund project funding
- national organisations, such as the sports national governing bodies
- local Learning and Skills Councils, particularly for qualifications-based training and accreditation
- sponsors and commissioners of local Positive Futures and other community sports projects, through the grants they provide to the projects.

The Workforce Quality Initiative Model

'Since its inception in 2000, more than 70,000 young people have been involved in regular Positive Futures activities, offering them the opportunity to re-engage with their communities and develop a brighter future for themselves.'

Since its inception in 2000, more than 70,000 young people have been involved in regular Positive Futures activities, offering them the opportunity to re-engage with their communities and develop a brighter future for themselves. *Staying In touch* (Home Office, February 2005) analyses the impact of the Positive Futures programme on young people and the neighbourhoods in which they live. 72 per cent of partner agencies report reductions in anti-social behaviour, 63 per cent report a fall in local crime rates and 42 per cent identify reductions in substance misuse as a result of Positive Futures projects. In many places, Positive Futures has also contributed to neighbourhood renewal through a revival of interest and participation in sporting activities.

Over the next 12 months, Positive Futures will experience significant changes as its management moves out of the Home Office and it becomes part of mainstream community sports provision. The Workforce Quality Initiative will help to ensure that project workers have the required technical competencies as well as their natural flair for working with young people, and that project managers have the skills and abilities to navigate the transition.

Noelle O'Brien is project manager at Management and Performance Solutions Ltd

Fumbling towards democracy

Research into the attitude of treatment managers reveals that many still put stumbling blocks in the way of effective user involvement. Derek Bunce reveals the findings.

The NHS and Social Care Act (2001) established user involvement as part of the policy framework within substance misuse services. Despite this, the National Treatment Agency has yet to propose a formal model of how treatment providers and agencies should engage with service users.

From the 'consumer' perspective an increasingly vocal 'user movement' has emerged in the last five years and consistently called for increased representation at all levels of substance misuse service delivery.

However, the development of service user involvement may be hampered by a number of factors, including the type of relationship between drugs services and service users. Indeed one of the central concerns evident within 'user' magazines such as *Black Poppy*, *Monkey* and *Users Voice* is the nature of the relationship between user activists requiring ongoing methadone maintenance therapy (MMT) and treatment providers.

The question raised by these groups is how can users effectively challenge the 'system', when at the same time they are dependent upon it for their survival. Indeed, if managers and those in a position of authority are reluctant to share power there may be a number of hurdles to jump before a fully representative consultation process might emerge.

In order to investigate some of these issues a three-year project was established to identify factors that facilitate or hinder the development of user involvement. This study represents the first phase of the research and aims to access the views of treatment managers and those with a strategic responsibility within one UK region. This was achieved by interviewing 41 senior managers as well as accessing key policy documents such as treatment planning grids.

The treatment grid is a self-assessment exercise to gauge the quality of service provided within a DAT area. The results are then monitored and ultimately approved by the NTA regional office. The process utilises a 'traffic light' system according to the criteria in the box.

One of the assessment exercises encourages agencies to focus on the involvement of users and carers in the design of the local treatment system and their involvement throughout the implementation, monitoring, review and evaluation processes and the development of advocacy services.

In the submission for 2005/ 2006 only two DAT areas within the region managed to achieve an assessment level of green while four were assessed as red.

Interviews with key professionals established that 40 per cent remained dubious of any consultation process. Opinion about user involvement among professionals tended to be divided with only one professional speaking positively about engaging with active drug users.

One of the reasons offered was the fear that another task was going to be imposed upon already overstretched services. Other comments tended to assume that most service users actively engaged in user involvement are those who are either at the latter part of treatment or stable through a maintenance programme. Few felt there was any merit engaging with users prior to, or at the early stages of, treatment.

Many professionals were open to the idea of service users becoming involved in strategic planning and recruitment. However there was a significant decline in support for the idea of service users being engaged in both financial and budgetary issues or disciplinary matters relating to drug workers.

Only one respondent gave their reason for not including service users in disciplinary issues as being connected with staff/ trade union relations.

Many agencies indicated that they had experienced some difficulty establishing user groups and that once formed membership tended to fluctuate considerably. Engagement with service users in these areas had tended to be limited to a small number of focus groups during a 12-month period

It was also apparent that DAT areas employing someone with a responsibility for developing user involvement appear to have established small user groups. However, in order to engage with larger numbers of users, all were developing extensive outreach programmes.

There was also evidence that some respondents would have welcomed more support from the NTA in helping to develop user involvement in their area. Indeed, evidence obtained suggested that strategic organisations felt that the NTA commitment toward increased user involvement had lacked a cohesive plan.

Specifically, the absence of clear guidance and detailed key performance indicators, placed DATs in a position of having little control if providers refused or did little to engage with service users.

While this study helps to explain some of the underlying problems present in the current consultation process, what remains unclear is whether service users feel a need to engage in the policy process. Further research is required to explore the views of service users engaged in user groups as well as those who choose to not affiliate to this emerging 'user movement'. In addition, it is also important to seek the views of drug users who have yet to access treatment services. The next phase of the research will aim to address many of these issues.

Derek Bunce was lead researcher on the project. He has been involved in the substance misuse field since 1984 as a therapist and treatment manager and now works as a research fellow at the Policy Research Institute, University of Wolverhampton.

In the next issue of DDN, we'll be looking at how to set up user groups – and keep them going. If you're involved with a group, or have experiences relating to setting one up, please email the editor, claire@cjwellings.com, so we can build up a picture of national activity.

Grading: what the grade actually means

Red	No significant impact on the development of user involvement
Amber	Slight improvements to the consultation process
Green	Significant impact on processes to engage with service users

Getting started with user involvement projects

With a little money and imagination, user involvement can really take off and prove its worth, says Dawn Hart, Project Director at Centre for Public Innovation

There is no national strategy for drug user involvement – even the phrase means different things to different people. Terms such as 'participation', 'consultation' and 'empowerment' are used, but with no common agreement as to what they actually are.

As part of a Greater London Drug and Alcohol Alliance study, published earlier this year (1), the Centre for Public Innovation (CPI) looked at levels of involvement across the capital and found that they varied widely – from nothing in some areas, to well developed in others. The work also showed that a variety of different approaches were used (from user forums, to employing involvement coordinators) and at different levels (from users being consulted in questionnaires, to being invited to DAAT meetings).

CPI's main effort was to pilot a quick and cost-effective way of getting good buy-in from users in two different parts of Lambeth in south London. We decided to use an approach called Real Time Community Change (RTCC), which encourages local people to take the lead in delivering change by giving them assistance, on-going help and small amounts of financial support to quickly start up short projects. Generally grants are for between £2000 and £5000, with projects running for three to six months.

Key to the RTCC process are 'sparkplugs' – people at grassroots level who are the catalysts for change that CPI believes exist in every community, even in groups of problematic drug or alcohol users. According to Sipho Mlambo, who led CPI's efforts in the borough:

'Sparkplugs know what the problems are and they usually have very good ideas on how they can be solved. RTCC provides them not only with funds to turn their ideas into reality, but also on-going and easily available vital support and mentoring, and does away with much of the energy-sapping strategic application and evaluation processes. This way, they get quick wins and soon see the results of their efforts. And what that means, is that they become more committed and find ways to sustain their work.'

After attending a Lambeth user forum, Sipho found two groups in the borough who were keen to try out the self-help tactics. Both had entrepreneurial ideas for projects they wanted to get off the ground and he worked with them to formulate these into simple presentations, which formed the basis of their funding bids. The funding 'applications' were made in person to a panel of stakeholders at a special workshop session. Decisions were made the same day, and funds made available just a few days later.

The Sanctuary Club

One group was made up of members of the local Alcohol Recovery Project, who knew that what they wanted most was a social club, where they could meet in a non-judgmental and temptation-free environment. Their target was 'anybody who feels they may have a drug or drink problem who needs a safe place to socialise outside treatment, where they could combat isolation and boredom'.

The organisers were tasked with finding suitable premises, carrying out all the business negotiations and logistical work to get the club up and running and then to publicise it to create a membership. This team had to overcome many problems and obstacles, but did manage to find a venue and sign a lease. They discovered new skills when liaising and negotiating with a host of local bodies and people, including councillors, police, banks and landlords. They also had to buy equipment for IT, a games room and a café – all on a grant of only £2,500.

The Club was officially opened by the Mayor of Lambeth and now runs one evening each week, with a steadily growing client base. It's so successful that Lambeth's enthusiastic DAAT Coordinator, Becca Walker has already promised further funding to make sure it continues and is confident that it will be a very good return on her investment.

Involvement in this innovative project has had other unexpected side benefits too. Not only are the founder members managing to running a thriving enterprise, but their confidence, language and self-esteem have grown tremendously.

Fear and Loathing

The second group, connected to the Stockwell Project, highlighted the lack of clear and simple information materials that would be read by drug users. They called their project Fear and Loathing and set out to use a grant of £2,500 to design, print and distribute two publications.

One was a card with information about local treatment services, the other on harm minimisation information. Both leaflets were professionally designed and several thousand copies have been distributed in the neighbourhood through their own network.

An immediate result was an increase in the number of people accessing services, which it is hoped will continue. The leaflets have also been well received by local professional agencies and the authors are likely to be commissioned to help in other information campaigns. And they are keen to put their new-found skills into action again.

> 'The work in Lambeth challenges the widely-held belief that users are unreliable and incapable of organising or managing resources.'

At the end of CPI's involvement in the two projects, a ceremony to publicly acknowledge and reward the efforts of the users was attended by the NTA's head, Paul Hayes. In welcoming the work as a practical example of how users can indeed be effectively involved in service development, he commended RTCC as an approach that allows change to be directed and led by community members, rather than by professionals.

The work in Lambeth challenges the widely-held belief that users are unreliable and incapable of organising or managing resources. We found that it needs more than money though. Couple it with the extra ingredients of sympathetic help, trust and belief, and great things become possible. Not only did the two groups meet their targets, they produced outcomes that far exceeded expectations and had a big impact on how the statutory services viewed their capabilities.

An account of the study is available in a GLADA booklet Lessons Learned, single copies are available free from the Centre for Public Innovation, tel 020 8675 5777 or email info@publicinnovation.org.uk.

You can learn more about CPI's Real Time Community Change approach to user involvement at a one-day specialist training course on 25 May in central London. Full details are available from laura.hollis-ryan@publicinnovation.org.uk or visit www.publicinnovation.org.uk.

Listening to what works in rehab

Over the last few weeks, DDN has carried articles emphasising the importance of listening to service users in treatment. This issue, Dr Roger Green shares results of a study involving residents at Vale House, which aims to highlight indicators of successful treatment.

Substance misuse services are increasingly being required by purchasers of services to demonstrate the effectiveness of the treatments they provide. However as *Models of Care* has noted, 'The literature on the effectiveness of residential rehabilitation programmes remains sparse, albeit growing'.

This small-scale, primarily qualitative study should be seen as part of this ongoing process, by examining the population of Vale House Residential Rehabilitation Unit over a five-year period from 1996 to 2000. It follows on from an initial pilot study, which mapped out the development of Vale House within the context of government policies and resources for the residential treatment of substance misusers.

This study was not an attempt to 'prove' that the rehab unit intervention had a direct impact on resident's addictive behaviour and subsequent post-rehab outcome. Its aim was to understand ex-residents and staff experiences of the unit, and highlight key performance indicators of success and 'good practice' that emerged.

Vale House Stabilisation Services opened its doors to clients in 1996. Based in Hertford, it treats people with problems of alcohol, illicit drug misuse, prescription drug misuse, eating disorders, anxieties, depression, and other related problems.

It provides a range of services including a residential rehabilitation unit, drug treatment and testing order service (DTTO), and a structured day centre. In addition satellite services offering one to one counselling and group therapy operate at Hatfield, Welwyn Garden City, Cheshunt, and Bishop's Stortford around the county of Hertfordshire.

The residential rehabilitation unit at Vale House is a Tier 4 specialist service, one of more than 100 units and projects in England.

The unit accommodates up to seven residents for a period of six months, has seven single bedrooms, a large kitchen area, dining room, lounge, and a library. Residents also have access to a garden at the rear of the house.

The treatment programme offered to clients is eclectic, and intensive based. It provides structured group work, one to one counselling, opportunities for voluntary work, and adult education courses, complementary therapies, and healthy living. This is supported by after-care programme and day care services.

A multi-method research strategy was used to study the work of the residential rehab unit. These included in depth interviews with ex-residents, key staff working at the unit, and ex-staff, the analysis of case records, and field notes made at meetings.

Ex-residents, staff and ex-staff identified a number of important areas that they felt contributed to a successful outcome.

For ex-residents these included: the composition of the resident group in terms of gender, age, and main drug of choice; residents' positive relationships with their key worker/counsellor; the importance of undertaking voluntary work and attending a college course whilst being in the unit; staff who had been residents in the rehab unit viewed as positive role models; and the on-going accessible after-care offered at Vale House.

Staff and ex-staff highlighted the following: that the Rehab Unit and Vale House was perceived as a welcoming environment; the assessment of individuals and care pathway being responsive to residents particular needs and chemical addiction; the usefulness of a balanced staff group which included some ex-residents as staff members; a high staff-resident ratio; the size and composition of the rehab unit residents group; residents motivation in wanting to successfully complete rehab; the importance of residents achieving measurable short-term goals during the six month rehab period; attendance at college and voluntary work seen as building residents self-esteem, confidence, and supporting the transition back into the community; and accessing after-care as an important and necessary part of the programme.

Other findings included evidence of a decrease in self-reported hospital and legal episodes post-rehab compared to pre-admission from a sample of 40 ex-residents from the Hertfordshire area.

In addition, an analysis of an internal Vale House audit of Hertfordshire funded residents, representing 83 per cent of residents admitted to the rehab unit during the study period, noted an average completion rate over the five year period of 71 per cent.

Whilst this latter study was based on ex-resident follow up and self-reporting their lives over periods ranging from seven to two years post-rehab, which raises the question of the reliability of such data, it is useful as a possible indication that they are doing well.

Similarly the 71 per cent completion rate for this group out performs local funders' expected rates of completion, although how these rates compare both regionally and nationally is unclear, as current figures were not available from government sources and national drug agencies at the time of this study.

A number of these findings are supported by EATA in their publication *Rehab – what works?*; for example, the role of residential care, after-care provided, the staff team, and the length of stay,

This study has highlighted the need for further longitudinal and time-limited research in this area particularly in relation to successful post-rehab outcomes. In addition given the paucity of such small-scale localised studies nationally of residential services, further research would contribute towards our understanding of the processes involved in successful residential rehabilitation.

Dr Roger Green is based at the Centre for Community Research, University of Hertfordshire.

Copies of the research report *Losing my best friend, The First Five Years (1996-2000). A Study of Vale House Residential Rehabilitation Unit* can be obtained from Chris Hannaby, Chief Executive, Vale House Stabilisation Services, 43, Cowbridge, Hertford, SG14 1PN, tel. 01992 553173

Dead drunk at happy hour

Behind the buzzwords for flexible drinking lies a far more serious hangover for Britain, says Norrie McKechnie.

Since the new licensing bill has appeared there have been a lot of buzzwords floating around – 24-hour opening, flexible hours, staggering hours, last orders.

The reality, of course, is not about 24 hour opening or flexible drinking. Very few high street pubs and clubs will open 24 hours as it would cost too much. Nor will there be flexible hours between pubs – they will all stay open as late as the last one to close, maybe 12.30am or 1.00am, and they will cream off the best hours.

You will still have the last orders drinking up regime and you will still have people hitting the street at the same time – only they will be drunker, as they will have had cheaper pub drinks available for longer. Clubs will stay open till 3.00am or 4.00am, with price wars to get drinkers in as early in the night as possible.

If you believe this is all in my imagination, look at Scotland. That's exactly what's happened up there, since extended hours came into place. In the big cities the focus and concentration of drinkers hitting the streets has not changed in numbers; only the times have changed – from around 1.00am in the past, to 35,000 drinkers now hitting the streets of Glasgow between 4.00am and 5.00am. The only staggering done up there is by the drinkers, not the pubs.

I often wonder why they call flooding your body with poison 'happy hour' – but this is of course one of the drinks industry's tricks of the trade. They know from experience that once you get people in the pub, half the battle is won. They also know that the people who are interested in happy hours in the first place are not the kind of people that are going to have a few drinks and then go home.

According to the new bill, happy hours are going to be a thing of the past soon. Well not according to the edition of *The Publican* on the internet in February. It reports: The Office of Fair Trading has dismissed reports that licensing authorities will have the power to ban happy hours. Mark Hastings, Director of the British Beer and Pub Association says: 'The bottom line is that the local authorities cannot ban happy hours in their area. They have no power to do so.' He then goes on to tell them who to contact if they have trouble.

So the good old drinks industry is already getting into the spirit of things and trying to help cut down on binge drinking (some hope). Money is their one and only motivator, absolutely nothing else, and they will fight to keep it rolling in.

Mr Blair talks of the 'few', relating to the few drinkers that spoil it for everyone else. These small groups of men (usually about six in number) terrorise our towns and cities, making them no-go areas in the evenings. Well, there are a few all right – but it is more like a few million.

I have worked on an alcohol referral scheme in the south west for seven years. The stream of alcohol related offenders being brought in is relentless. I could say without a shadow of a doubt that custody would be 90 per cent empty were it not for alcohol related offences, especially at the weekend, when it could be as high as 95 per cent. If you counted all the alcohol related offenders that come through all of Britain's custodies, they must run to millions. For every person that gets arrested for an alcohol offence on the street or pub, there must be another 10 that do not get apprehended or arrested. If you added all these up, the caught and the uncaught, I honestly don't think it would be appropriate to call them 'the few'. So another theory bites the dust.

It would take a massive change in consciousness to snap people out of this illusion about alcohol and be able to change habits, and a culture that's been going on for centuries. The government would also have to start putting people's lives before revenue. Why would a government deliberately under-fund alcohol projects and let them fold, when an estimated 33,000 people die each year from direct and indirect alcohol related deaths? I estimate that figure is more like 50,000, as does a research team at Oxford University, that discovered that GPs often leave out the words 'alcohol related' on death certificates, to save families embarrassment. I have seen this for myself in Scotland, in the past.

So if it was 50,000 deaths a year, that would be half a million in a decade. That means by the year 2025, 1 million people will have died from alcohol related illness.

Prices are deliberately kept low, even when a report in The Lancet says: 'We estimate that a 10 per cent rise in British alcohol prices would produce a drop in cirrhosis mortality of 7.0 per cent in men and 8.3 per cent in women, and a fall of 28.8 per cent and 37.4 per cent in women in deaths from explicitly alcohol-involved causes.' They go on to say that raising the price of alcoholic beverages is an effective way to reduce rates of alcohol-related problems everywhere.

These licence reforms are a political bribe, a bribe to the binge drinkers, and a bribe to the drinks industry that has got away scot-free with most of this, and will make a fortune. And again, no-one will refuse it; these pubs and clubs will be packed. And the chancellor will make a killing in increased revenue – not bad going eh?

Norrie McKechnie is an alcohol counsellor in the south west.

This week in *The Scotsman*...

'City gets tough on its breakfast booze bars: Bars which currently open as early as 5am will have to produce robust evidence for the city's licensing board if they are to continue to serve alcohol at breakfast time. About 200 now have permission for breakfast opening, with around 20 of them serving alcohol from 5am or 6am.'

'Fears as girls of 11 found drunk on streets: Girls as young as 11 are regularly being found drunk and incapable on the streets of the capital amid fears about the effects of "ladette" culture. Police and youth workers are finding that hundreds of them are getting drunk, usually after buying alcohol from grocery stores.'

'There's plenty of larks at dawn bars: It's incredibly surreal to be drinking at 6am on a Thursday morning. I'd already been told that this place is an infamous early morning drinking den, but walking through he doors to its upstairs lounge, I couldn't believe how busy the place was.'

Clarity missing from coercion debate: what's really happening?

In response to the 'This house believes...', debate in *DDN*, 21 March: I sense another dialogue of the deaf amongst substance misuse professionals. The semantics and emotion surrounding the use of 'coercive' in the debate on DTTOs and what might follow in terms of treatment, clouded rather than clarified the issue.

What was missing for me in the reported debate, was a sense of what is actually happening in terms of the 'treatment plan' attached to individual DTTOs.

When I first heard about the massive investment (£500m) in the CJIP, aka DIP, initiative I hightailed it to a friendly senior probation manager I knew and asked what this was likely to look like in practice. The answer I got surprised me.

First, there would be an assessment against an offender profile to identify clients who were likely to stick with the order. Broadly these were defined as 'drug addicts who have fallen into crime', as opposed to 'career criminals who have fallen into drugs'. The latter group were seen to be more intractable and the former more likely to be facing a turning point and thus more likely to be seeking a successful outcome.

Second, the treatment plan 'could be as much as 20 hours per week'. Such treatment was non-residential and unlikely to move the client from their place of risk (neighbourhood where drug abuse and their crimes took place). Any therapeutic process was unit-cost managed.

Subsequent to that meeting, I learned from another contact that 20 hours was wildly optimistic and would more likely be three hours per week for a drug test and 'how's it going?' chat with the client manager.

Thus the business case for the treatment side of the DTTO is reduced to the unit cost difference between prison and DTTO. This distorts the real business case – the difference in life-of-crime costs associated with an individual and the costs of an effective programme of treatment leading to their recovery and rehabilitation.

If this is widespread, then it is no wonder that 'coercive' testing and treatment fails at even its most basic level – 'retention in treatment'. This in turn undermines the intent of the initiative, which is to get the 'drug addict referred by the criminal justice system' both out of their addiction and criminality. I am told that getting such addicts to address both their addiction and criminality is intensive, a '24/7 regime of therapy, diversion and support for three to six months, with a further six to nine months of regular ongoing contact and relapse prevention – all conducted away from their place of risk'.

It would be helpful to know just how much of the £500m is spent on treatment and how much is CJIP admin costs – one figure from the NTA suggests that just over £100m of this new money is being earmarked for treatment for criminal justice referred clients. I am happy to be proved wrong.

The problem is further compounded by the divide in thinking between service providers who seek abstinence focused outcomes and those who are content to just stabilise addicts through long term substitution prescribing. (Substitution prescribing in this context seems little else but a chemical prison.)

The issue is also marred by too flabby a definition of 'treatment'. (The NTA lumps six differing things together in terms of treatment places.) I appreciate 'client centric plans' make it difficult to generalise, but patterns do emerge and some standardisation is necessary to measure the effectiveness of approaches. For the criminal justice referred clients, there is a dual jeopardy at work; the bias of practitioners and the postcode lottery created by commissioning managers' prejudice.

What I would have liked to have seen in the debate, was a discussion of what an effective treatment plan and its outcome should look like, for people referred into treatment through the criminal justice and offender management system.

To help such clients agree the intensity and duration of their care plans, they should also be informed about the underpinning philosophy and success rate of the service providers they end up with.

It will however require the managers of the CJIP/DIP process to be more honest, or even informed, about the time needed to recover from addiction and the costs involved.

B. Heywood, Loughborough

What constitutes 'risk' when employing former drug users?

Responding to your cover story: 'The two-year rule', *DDN*, 7 March: I work for the Shaw Trust offering employment related services to clients with addiction problems. The project is funded by the Essex DAT and Social Services.

I take each client as an individual case; I encourage further training and a life skills course for those who need it as part of their rehabilitation and to put some distance between their using and their criminal records – also to put something on their CVs. We offer host-client ongoing mediation and retention services. Substance use is dealt with as an occupational health issue and information is exchanged on a 'need to know' basis. No information is given without the informed explicit consent of the client. The client can withdraw consent at any point, in the course of our work together.

I have found small host companies more willing to employ. Bigger organisations are more reluctant, but employees benefit from superior employment policies and procedures. I have placed people in voluntary work in the addiction field as early as six months.

The Shaw Trust is currently working on creating a consistent policy across the Trust. The first questions to come up are:

A Disclosure Policy, *ie* when we present a client to host companies, should we encourage the client to disclose that they are in recovery? If so, how long in recovery before we do not encourage disclosure at all? Six months? One year?

Many Clients want to leave our service on the point of going into work so as to avoid prejudicing their employment chances. If we know that they are putting themselves or others at significant risk how much onus is there on the Shaw Trust Officer to breach their confidentiality? We are mindful that the boundaries of confidentiality have been explained to them on initial contact with the Trust and repeated during their time with the Trust, and that we are no longer in a professional relationship with them.

How do we establish what constitutes significant risk?

These will be the first of many such questions, and I would much appreciate any thoughts your readers may have on these matters.

Cathy Chabo, Shaw Trust

'Many Clients want to leave our service on the point of going into work so as to avoid prejudicing their employment chances. If we know that they are putting themselves or others at significant risk how much onus is there on the Shaw Trust Officer to breach their confidentiality?'

Can we protect young people from being stereotyped?

In *DDN*, 24 January issue (page 5), you printed a request by documentary filmmakers, to interview a young person, aged 11 to 14 years, who has a chronic problem with alcohol use over several years.

On hearing that such a documentary was to be made I became concerned that such public exposure could be damaging to a young person. This could be in terms of how others may come to view the young person within the school environment and in the future, possibly potential employers, as well as other young people or friends and family. I would also question whether someone as young as 11 could assess the impact of taking part in such a programme upon their own sense of self and the effect of public exposure in the future.

Secondly, where a young person is involved, I think thought should be given about how the substance use is described. The programme could be seen to label that young person as an 'addicted' substance misuser or problematic user – these are familiar terms to use with adults, but how useful are they for young people?

My concern is that by focusing on the individual child and their relationship to a particular substance, other issues will be overlooked – for example, the social environment, effects of poverty or the type of parenting the young person has received.

The label of 'substance user' or 'alcohol user' can be unhelpful for younger children. This is happening increasingly in the media. This drive to label children as 'suffering' from different conditions is occurring a lot earlier in their development than previously.

It may be more helpful to examine the following:

- Attitudes conveyed in parenting, for example the behaviour that is modelled by parents in relation to drugs and alcohol. If alcohol is made readily available to children how is it that this is happening? And who is responsible. Parents? Off licences? The wider community?
- Alerting behaviours: children who do not receive clear boundaries or love or comfort, and who are emotionally impoverished, will develop alternative coping mechanisms in the drive to get their needs met. These mechanisms or behaviours, however dysfunctional, are often a response to the lack of love and effective parenting. To give the child a label at this early stage based on the dysfunctional behaviour takes the focus away from the causal factors.
- Understanding the pressures young people are under. At the same time that young people are being seen as a marginalised group with unmet needs and pressures upon them, they are also being criminalised or burdened with labels inappropriate to their age and development. It is widely recognised that young people are frequently the victims of crime and often do not have a voice to speak out about what is happening to them.

There is increasing awareness of the anti-social behaviour of young people, but what about the causes? Often these are too painful to be revealed and, for adults, buried deep within our own childhoods. Often the causal factors are so ingrained in our society that we can only catch glimpses of the dysfunction of the system or the culture that perpetuates it. As adults, and as a society, we have learnt to internalise our distress whilst children enact or externalise their distress in more obvious ways.

This debate is relevant to many conditions and their accompanying labels which now are being used for younger and younger children; for example labels such as 'self-harmer' or 'anorexic' are being given to children as young as six or seven. This is not to say they don't exhibit characteristics of those conditions, but that they may be being burdened with unhelpful diagnoses too early on.

Possibly an approach could be to examine what intervention could have helped each time the behaviour occurred. Our attention should be drawn to the environmental or familial factors at play that allowed the behaviour in the child to take place. This would be relevant for any self-damaging behaviour a child engages in, from self-harm to substance misuse. I believe that paradoxically it would be more helpful to take the focus away from the child as a way to keep the 'adult style labelling' from them.

This is exactly the process we would use with a toddler that strayed to close to a fireplace – we wouldn't analyse whether the child is a risk-taker or addicted to danger; we would intervene in a protective manner and examine or change the environment. I believe this approach becomes subtly more complex as they get older but in essence the responsibility to provide safety remains the same.

At Brighton Oasis Project we use harm minimisation techniques and assess the young person's ability to access or make use of mechanisms that keep them safe. We also explore whether negative beliefs and patterns of familial substance use can be challenged internally and externally.

Often the aim of such interventions is to enable young people to feel they have a right to access mainstream young people's services and support in the same way as any young person, rather than feeling that they are an outsider because of the problematic substance use. Minimising the negative stereotyping and stigma of being a substance user becomes integral to the intervention.

Many of us who work in the substance misuse field recognise the damaging effects of the stigma and negative labelling upon adult service users – what then is our responsibility to young people?

How do we focus on the problematic substance use without reinforcing the negative stereotyping this could lead to?

Could it be possible for drug and alcohol practitioners and the FDAP to take a united stand on this in order to protect young people from sensationalised stereotyping?

We are, after all, the professionals that day in, day out, work with the complex range of issues that young people present with and understand better than anyone how simplistic labels like 'addict' are unhelpful and damaging to the self-esteem of children and young people.

I would like to open up a debate and encourage other practitioners to respond via the pages of *DDN* and share their experiences of dealing with these issues.

Tania Soley, Young People's Services Co-ordinator, Brighton Oasis Project

'There is increasing awareness of the anti-social behaviour of young people, but what about the causes? Often these are too painful to be revealed and, for adults, buried deep within our own childhoods... As adults, and as a society, we have learnt to internalise our distress whilst children enact or externalise their distress in more obvious ways.'

Diary of a heroin addict

In the second part of his story, David Wright realises he is addicted – to heroin, to an increasingly chaotic lifestyle, and to the adrenaline rush of risking freedom for drugs. Life is all about the next fix.

My heroin career had started, and I began to feel bad when I did not have any opiates. But the first time I experienced cold turkey, that was something a bit more than feeling a bit shit. I had been hitting up meth tablets. We had a good cheap supply, an endless supply – until your money runs out. I had my last hit on the Friday morning.

Saturday I just spent the day in the pub (on my tab) getting pissed. Around 5am Sunday I woke up with a start. Something was wrong. I felt agitated, wide-awake, looking at people on the telly, thinking how could they be happy. It was the direct opposite of contentment. I knew I had to get to my friend's house, a 15 minute walk when well. It took me nearly two hours to get dressed. Putting on a sock was such an ordeal I had to lay recovering for 10 minutes after.

By the time I got out of the house, it was around 9am Sunday morning. I felt like a being full of negative atoms in a positive air environment. I was out of sync, off beat, swimming against a tide that people took for granted. The pulse of the very essence of life continued, but I had fallen in between the pulses; when I should have been going up, I was going down. And people could see it as they cleaned their cars, humming with the harmony of life. I was an alien breathing poison. I staggered down the road as if I had been shot, vomit was coming out of my mouth. People were stopping what they were doing just to look at this misfit. I had heard cold turkey was bad, but this was unbearable. I had to get better. So my next hit of smack was high on the agenda – and I needed it fast.

As I staggered my way to Scott's on that sunny Sunday morning, in the full throes of cold turkey, I was scared. And for all the days to happen on, I picked the worst – Sunday. If you live the life of an addict, Sundays are by far the worst. No-one has any money, as who gets their benefit at the weekend? The opiate addicts I knew had a little bit of linctus to see them through to Monday if they were lucky, when the world wakes up again. Dealers switch their phones off to go and have Sunday dinner – it's a nightmare. So as I arrived at my friend's house, I knew my chances of getting anything was slim. He told me he had nothing as I expected, but as he rushed to get a bowl for me, I could see he was looking at me hard.

Scott disappeared upstairs and I could hear muffled voices of him talking to his long-term partner Ann. When he came back downstairs, he told me he had managed to get a few methadone tablets off her. He had to prepare the hit, which involved a 5ml barrel. Take the plunger out, crush the tablets, tip them into the barrel, remembering to put you finger over the end. Add cooled down boiled water, give it a good shake, put the plunger back in and you finish up with this milky liquid to inject.

As the plunger went in, it felt like I was a rusty robot, joints aching. The methadone was like oil, lubricating all the joints of my body with a warming sensation, my spirits soured and ten seconds later I was on top of the world. I was back in sync with the pulse of life, but deep down I knew this had a time limit and tomorrow was another day.

As time passed, a group of us heroin dependents moved into a big house. It was a heroin commune, which had the major advantage of giros coming in every few days. Scott was in charge and was an expert at wheeling and dealing – we were never without a car. He was in charge of our cannabis business; we also sold speed, which was easy for us because 99 per cent of heroin addicts hate speed, so there was no dipping in. I was the cook, and we ate every day.

We bought our heroin in bulk and we had a good contact in Moss Side Manchester – a place where you did not want to hang around. There were a lot of stabbings and shootings, but that was part of the buzz, the danger. It was usually Scott and me who went to score – which was a buzz on its own. It used to take us two hours to get to Moss Side, then straight to the house. Money was given over, and usually within 20 minutes she came back with the smack.

It was then straight in the kitchen and we would have our hits – only half of what we would normally use, as the most dangerous time of the operation was about to unfold, the drive back. Scott drove, and I had the bag of gear in my hand. This is when the adrenaline buzz started, knowing if we got caught with the amount of gear on us, we would be looking at a good few years in jail. On occasion we would get a police car behind us, that's when the adrenaline would start to pump. Are they tailing us? Is the drug squad waiting for us at the lights? Because if they were, you would not have a chance. You see the drug squad would be controlling the lights, so as you approached, the lights would go to red and they would attack from both sides, smashing the cars windows and you would have one of their telescopic truncheons against your throat. No chance.

But we were lucky. It was really safety in numbers because there were hundreds of people scoring from Moss Side a day. Scoring in Birmingham, which was only a 45 minute drive, was a wild experience. We used to score round the back of Birmingham City football ground, by the big main Mosque. There was a row of phone boxes where Scott would phone one of our dealers, all Asian, and we would wait for them in the car. There were always three or four other cars doing exactly the same as us. Sometimes the prayer call would ring out and you had a scene of addicts opening their car doors to be sick, or blatantly having a fix in the front seat while these devout Muslims shuffled past on their way to the Mosque. What a contrast.

Getting back to the house was always a relief, and as their gear was shared out, the mood of the house was at its highest. Everybody chattering away. Things were ticking over, until my heart stopped ticking as I went over.

Part 3 in the next issue of DDN

Psychoactive drugs: From absorption to elimination

Professor David Clark describes factors that can influence indirectly the way that psychoactive drugs impact on the brain and influence behaviour. He describes examples of individual differences in drug response that can arise from these factors.

Last issue, we considered how psychoactive drugs exert their effects in the brain to influence behaviour. However, there are other events and factors not directly concerning the brain that can influence drug effects. A psychoactive drug must travel from the site of administration to reach its target organ or site of action in the brain. This process can be influenced by absorption, distribution, metabolism and elimination of the drug.

The absorption of a drug is in part dependent upon its route of administration. Drugs can be applied topically for a localised response, *eg* cream for an abrasion. Drugs administered in this manner are not normally absorbed into the body as well as other forms of administration.

Since psychoactive drugs must enter the bloodstream to reach their site of action, the most common route of administration for this purpose is orally, in either liquid or tablet form. When a drug is required to act more rapidly, or is known to be broken down in the gastrointestinal tract, the preferred route of administration is by injection. Drugs of misuse, such as heroin, are often administered intravenously, *ie* directly into a vein.

Certain drugs are smoked, *eg* cannabis, crack cocaine, heroin, with absorption occurring through the lining of the lungs. This is a route of administration that is more socially acceptable, requires less paraphernalia, and is a less of a risk than intravenous injections, where sharing of needles may occur (possibly resulting in HIV/AIDS). Some psychoactive drugs, for example cocaine and amphetamine, are also taken by the intranasal route.

When a drug is administered a significant proportion of it reaches the bloodstream. Most drugs are dissolved in the water phase of blood plasma. Within this phase, some of the drug molecules will be bound to proteins and may therefore not freely diffuse out of the plasma. The drug is then transported around the body and can cross capillary walls to reach its target tissue(s). Psychoactive drugs must also pass the blood-brain barrier, a specialised barrier to protect cells in the brain.

If we look at the different routes of administration of cocaine, the pharmacological effects of the drug are the same regardless of route.

However, the rate of onset, intensity and duration of effects are dependent on the route of administration. Oral ingestion, not usually used for illicit purposes, achieves maximal plasma levels the most slowly, followed by the intranasal route. Intravenous and smoked cocaine achieve maximal blood (and therefore brain) concentrations most rapidly. Maximal plasma levels occur in seconds.

These differences in absorption of cocaine (and other drugs) impact at a behavioural level in several ways, one of which concerns long-term behavioural change. The learning of a habit – which is the psychological process underlying dependence – is influenced by the time interval between the act of drug-taking and the drug's rewarding impact on the brain. The shorter the interval, the greater the likelihood of the drug-taking habit developing.

Metabolism is a process whereby enzyme systems in the body transform drugs into safer molecules which can then be excreted by various routes of elimination. These enzyme systems are primarily located in cells in the liver, but can be found in other cells. There are a number of consequences of metabolism, the main one being that an active drug is converted into an inactive form. This is largely responsible for termination of drug action. Other forms of metabolism involve an active drug being metabolised into another active drug, which may or may not have the same pharmacological action of the parent drug, or even being converted into a toxic compound.

The most common route for drug excretion is through the kidneys into the urine. Drugs and their metabolites are filtered out from the plasma through the capillaries within the glomeruli of the kidneys. Drugs and metabolites can also be eliminated by the body in other ways, *eg* salivary glands, sweat glands.

'The learning of a habit is influenced by the time interval between the act of drug-taking and the drug's rewarding impact on the brain. The shorter the interval, the greater the likelihood of the drug-taking habit developing.'

There are genetically determined individual differences in pharmacokinetics through individual variations in the amount and characteristics of enzymes involved in metabolism and the amount of binding protein. These individual differences result in individual differences in drug response. One important factor influencing drug pharmacokinetics is age. Growing older is associated with a reduction in total drug clearance for many drugs, in particular central nervous system depressants.

Pronounced individuals differences are noted in the metabolism of alcohol. Over 90 per cent of alcohol is metabolised in the liver. The major metabolic pathway is oxidation by alcohol dehydrogenase (ADH) to acetaldehyde, which in turn is oxidised by aldehyde dehydrogenase (ALDH) to acetate, which is metabolised into carbon dioxide and water. Acetaldehyde is highly toxic. Women have less ADH then men are therefore likely to have higher blood alcohol concentrations when they drink because less alcohol is metabolised before it is distributed around the body in the blood. This difference in metabolism helps explain why, in general, women become intoxicated at lower levels of alcohol than men.

There are at least four isoenzymes of ALDH in humans. ALDH2, the isoenzyme largely responsible for the oxidation of acetaldehyde exists in two forms, one of which is virtually inactive. As many as 50 per cent Orientals (Japanese, Chinese and Korean men and women) have a low activity of ALDH2 and this results in a flush reaction when these people drink. This reaction is unpleasant, and individuals with low activity ALDH2 are less inclined to drink and are less vulnerable to developing alcohol dependence.

Are you buying just a drug test or knowledge, accuracy & trust?

With pressure on drug workers time increasing as more people seek treatment for drug addiction, it is important that the bond of trust is maintained between drug worker and client. Altrix looks at how an oral fluid drug testing programme will save time, but may become a false economy if results are not accurate and reliable.

Whatever the result of this year's general election, it is the intention of both major political parties to increase the numbers of people receiving treatment for drug addiction.

With a greater workload about to be placed on an already stretched resource and a shortage of skilled workers to fill new posts, it is vital that treatment centres get the tools they need to remain as efficient as possible.

Ingrid Fife, Commercial Director of Altrix Healthcare, suggests one of the major areas where drug workers' lives can be made easier is in drug testing, but only if the solution provided is simple to use, cost-effective and (most of all) reliable & accurate.

"We know from talking to drug workers that, although testing forms a crucial part of their day-to-day activities, there is no standard best practice on how this should be implemented. As a result drug workers are left to find their own way through a confusing array of testing types. Failure to choose the right solution can be costly in more ways than one, with reduced reliability being the ultimate price.

Many centres still use urine tests as the tried and tested method, while an increasing number use one of the array of oral tests on the market. Oral testing is growing in popularity as it promises the same level of accuracy, but makes an enormous difference to efficiency thanks to the fact it can be used anytime, anyplace and by an person. In addition, it avoids many of the problems of urine testing such as the possibility of cheating, same sex observation and the storage and transportation of samples.

Urine testing is also losing favour as it can be seen as compromising the dignity of the donor and, in many instances, it can take a long time to obtain a sample due to shy blader (sometimes up to an hour). This can lead to overcrowding in the treatment centre and can disrupt the working patterns of drug workers.

So can oral testing provide efficiency accuracy and trust?

If the right test is chosen, we believe so. We have many clients who have found the introduction of our Intercept® test has managed to reduce the burden on key workers. The time to obtain a sample is just two minutes, allowing more clients to be processed in a shorter time. What's more, over 99% of results are returned the day they are received in the lab meaning that any necessary action can be taken quickly and therefore with greater effect.

However, not all oral tests offer the same benefits. There are a number of oral tests that are not efficient at collecting samples for analysis. Dry mouth from smoking or drug taking is a common problem and this leads to difficult sample collection.

In a busy treatment centre it is important to choose a drug testing method that, time after time, can quickly & painlessly collect an oral fluid sample in under 5 minutes (without the need to suck tablets or stones).

This added efficiency is important, but the real issue at the heart of successful drug testing is accuracy. Testing has a vital role in maintaining the bond of trust between drug workers and their clients. If a test is easy to cheat or presents false positive or negative results, how can testing serve as a means to assess progress or determine future actions?

Yet we hear of many examples where other oral tests have failed in this important area. Either people have experienced difficulties in using the equipment, collecting a sample or in interpreting the result. Whatever the reason the effect has been the same – to undermine the respect for drug testing and the relationship between drug worker and client."

So where do you turn to to improve the efficiency and reliability of your drug testing?

Altrix has a network of specialists, some of whom are ex-drug workers with experience of the issues you face. They can help you to evaluate your drug testing programme free of charge, working with you to find your way through a growing choice of possible solutions and helping you become more efficient without undermining accuracy and trust and without leading to false economies.

"The real issue at the heart of successful drug testing is accuracy. Yet we hear of many examples where other oral tests have failed in this important area. Whatever the reason the effect has been the same – to create a false economy, to undermine the respect for drug testing and damage the relationship between drug worker and client."

adapt

Adapt is a national charity providing drug services to the community and the prison system. Committed to quality, our staff of community workers, nurses, counsellors, doctors and prison drug workers have established a reputation for success in delivering care to drug users from all parts of the community.

Based on its success, Adapt has recently been awarded a number of new contracts from HM Prison Service to provide CARAT services within the following establishments: -

HM PRISON SERVICE

Eastern Area	East Midlands Area
HMP Bedford, HMP Blundeston,	HMP Foston Hall, HMP Leicester,
HMP Bullwood Hall, HMP Chelmsford,	HMP Lincoln, HMP Morton Hall,
HMP Edmunds Hill, HMP Highpoint,	HMP North Sea Camp,
HMP Hollesley Bay, HMP Littlehey,	HMP Nottingham,
HMP The Mount, HMP Norwich,	HMP Ranby, HMP Stocken,
HMP Wayland, HMP Whitemoor	HMP Sudbury, HMP Whatton

The CARAT Service (Counselling, Assessment, Referral, Advice & Throughcare) is a fundamental part of the prison service's drug strategy. CARATs offer services to those with Drug & Alcohol issues whilst within prison and continuity of care for prisoners on release.

CARAT workers' primary task is to provide in-depth assessments to prisoners of their substance abuse issues, and to develop appropriate packages of care. CARAT staff also offer low threshold interventions including brief counselling, relapse prevention and groupwork.

We are looking to appoint suitably qualified and committed staff to the following posts:

CARAT PROJECT WORKERS (ALL LOCATIONS)

Custodial Drug Services, Salary Scale (£18,000 - £24,000)

AREA MANAGER (NOTTINGHAM)

Custodial Drug Services , Salary Scale (£28,000 - £30,000)

ADMINISTRATION ASSISTANT (NOTTINGHAM)

Custodial Drug Services , Salary Scale (£12,000 - £13,000)

All posts are subject to CRB Disclosures and Home Office clearance.

Closing date for applications 22nd April 2005
Adapt welcome applicants regardless of race, colour, nationality, ethnic origin, gender, sexual orientation, marital status, disability or age.

For an application pack please contact:

Adapt, Eastern Regional Office, 32a Tolhouse Street, Great Yarmouth, Norfolk, NR30 2SQ. Tel: 01493 854370 (out of hours answerphone) Fax: 01493 857697 Email: adapt.ltd@btconnect.com

ADAPT is a registered charity, no. 803110

Alcohol and Drug Addiction Prevention and Treatment

Cheltenham & Tewkesbury NHS
Primary Care Trust

www.chelttewkpct.org.uk

Young People's Substance Misuse Service Manager

£35,000 pa

Based in Gloucester

An exciting and challenging full-time opportunity exists for a highly motivated manager to lead an established specialist substance misuse service for children and young people. This service comprises two teams; an outreach drug worker team and a consultant-led medical team, working from a newly renovated service centre. The service is fully integrated with the multi-disciplinary approach advocated by the National Drugs Strategy.

You will lead a service of dedicated professionals who are currently delivering substance misuse early intervention and treatment to children and young people. Your good level of knowledge on national policy, and of substance misuse interventions and treatment, will be supplemented by a demonstrable knowledge of budget management. Your sound leadership skills will include staff supervision experience and an understanding of case management. You will have experience of partnership working and will have a commitment to closely involving young people in the development of services.

You will hold a professional qualification in social work, youth work, nursing or teaching.

A further qualification relating to substance misuse would be helpful.

For an informal discussion please contact Colin Hassall, DAAT Manager on 01242 548837.

As part of our ongoing commitment to the continued safety of our patients, visitors and staff you will be required to undergo a Criminal Records Bureau check.

Our application pack includes information and an application form. To obtain a pack please phone 01452 891088 (24 hour answerphone) or email: Recruit@glospart.nhs.uk quoting Ref: CHTK/4/3129. Closing date: 12 noon, 12 April 2005. Interview dates: 25/26 April 2005.

LOWER RATES

DDN
Drink and Drugs News

Drink and Drugs News and www.drinkanddrugs.net
The winning double for all your substance misuse posts.

Step up to the oche and contact the sales team for a no obligation quotation.

Ian Ralph: ian@cjwellings.com
020 7463 2081

The Nour Al-Shorouk Centre

is a pioneering program established in Beirut, Lebanon to provide first class treatment for substance abuse & addiction, and counselling programs to individuals whose lives have become unmanageable as a result of addiction, while introducing them to a new and better way of life. Treatment is provided by an expert staff of counsellors, therapists, and professionals in the field of substance abuse treatment and includes counselling, education, and training in the tools of recovery and how these tools will apply to a new lifestyle free from drugs.

The centre is currently seeking to appoint experienced Chemical Dependency Counsellors and Clinical Psychologists. A highly attractive remuneration package will be offered to the right candidates.

Counsellors

must have at least 4 to 5 years experience in counselling clients/patients utilizing a 12-step approach to therapy. Candidates should be stable, emotionally mature, with a recovery background and a thorough understanding of the value of an anonymous support group. Candidates should also have a Masters degree in counselling or mental health. Candidates must be either certified as a counsellor under the US or UK certification process or studying to qualify for international recognition.

Clinical Psychologists

should have at least 5 to 6 years experience in testing, assessments, and evaluations of clients/patients with an array of dual disorders. Candidates must have a thorough knowledge of various approaches utilized in treating chemically dependent/substance abusing clients and an understanding of differential diagnosis. Candidates must have at least a Masters degree in psychology and significant counselling experience.

Interested candidates who meet the above requirements are invited to submit an application, with a detailed resume/curriculum vitae in English to, email: alshorouk@btinternet.com

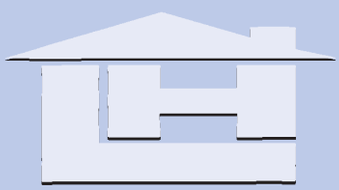
Deadline for submission is April 29th, 2005.

We thank all candidates for applying, but can only acknowledge those under consideration.

THRESHOLD HOUSING LINK

(Registered Charity No. 1017599)

A resettlement agency working with single homeless people in Swindon



Substance Misuse Worker - 38hrs p/w *(averaged over a 4 week period)*

An innovative service will be based at Threshold's new resettlement accommodation project, for single homeless people with substance misuse issues. Working closely with residents and staff the post holder will provide advice and support regarding substance misuse issues.

A successful applicant will have current knowledge of drug and alcohol issues, risk and needs assessments, treatment and rehabilitation processes, together with experience of making referrals to treatment groups and working in a residential or day–care setting: facilitating group and individual sessions and experience of staff supervision and appraisal. An ability to develop, implement and evaluate strategies to reduce risk and harm to the individual and others is essential, as is the ability to collaborate effectively with external specialist agencies and primary health care providers. An integral part of the resettlement process is excellent team working skills, therefore the willingness to share information and support co-workers is essential to the success of this project and client care.

The salary commences at £23,520pa with 25 days annual leave plus public holidays. On successful completion of the probationary period an increment of 2.5% will be applied to the annual salary plus employer stakeholder pension contributions of to 5%. In addition to this a performance related bonus benefit of up to 2.5% is also available. Shift work is required with a sleep in allowance of £30 per night.

This post also brings with it qualification of low cost key-worker accommodation within Swindon.

For an application form or an informal discussion, please phone Cher Sawyer on 01793 524661

Newcastle City Council

SOCIAL SERVICES

Childrens Services - Youth Offending Team

DRUGS WORKER

£19,053 - £27,411 pa

Fixed term until 31 March 2006 - Ref. S/405(e)

Based within the Youth Offending Team and responsible to the YOT Manager you will be part of a successful and highly motivated multi-agency team working to reduce offending by children and young people. Your role will include supporting young people with substance misuse issues in both the community and the secure estate, direct work with young people and families, and co-ordinating referrals to outside agencies.

You will be experienced in direct work with vulnerable young people, delivering training programmes up to at least tier 2, and have the proven ability of group work and case management. You will have a good knowledge of intervention approaches for various forms of substance misuse. The post will entail working closely with the D.A.T./Partners and contributing to the young people's substance misuse plan within the City.

For an informal discussion, please contact Paul Brownlee, ISSP Manager on (0191) 265 7259.

An application form and information pack can be obtained by ringing (0191) 211 6359 or apply online at: www.newcastle.gov.uk/jobs

Closing date: 21 April 2005.

Working Towards Equal Opportunities

PROVIDENCE PROJECTS

Helping you find the way

The Providence Projects

Based in Bournemouth The Providence Projects are providers of Quasi-Residential Treatment and supported Sober Living Houses offering detoxification and a full time 7 day week therapeutic treatment programme.

Due to expansion we are currently looking to recruit

- an experienced full time counsellor
- a part time counsellor and
- a trainee counsellor

The ideal candidates will be looking for a challenging and rewarding career in the field working with the chemically dependent in a 12 Step abstinent based setting.

Salary will be based upon experience and qualifications.

For information please telephone Carole Spiegel on 01202 555000 or email info@providenceproject.org

The Providence Projects are an equal opportunities employer

TOWER HAMLETS

Lifeline Project

Helping Drug Users Since 1971

YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICE

The Lifeline Project has a national and international reputation for providing effective interventions with substance misusers. We have services throughout England including Young People, Treatment, Criminal Justice, Research Projects, and services for minority ethnic communities.

The Young People's Substance Misuse Service is an exciting new service for children and young people under the age of 19. The service will be provided across the London borough of Tower Hamlets, and will operate as two teams; the Early Intervention and Outreach Team and the Care Management Team from brand new premises in South Quay. The service will aim to offer a range of holistic interventions and diversionary activities to meet presenting needs. We are therefore seeking a number of people to establish a new team who are open to a new challenge.

SERVICE MANAGER (REF: TH 001)
Salary: (scp 45-48) £34,746 - £37,212 (Plus £3,012 Inner London Weighting)
The Service Manager will be supported by a Senior Manager and will be responsible for the operational development and delivery of the Young People's Substance Misuse service which will encompass two teams, whilst supporting the Team Leader and practitioners to deliver consistent and high quality interventions, this will be done in line with national and local strategy. At least two years experience in a senior post in a related discipline is required.

TEAM LEADER (REF: TH 002)
Salary: (scp 40-43) £30,747 - £33,168 (Plus £3,012 Inner London Weighting)
The Team Leader will primarily be responsible for the day-today management of the Early Intervention Outreach Team and the Care Management Team. Experience of project management and staff supervision is essential with at least two year's experience of working with vulnerable young people.

OFFICE MANAGER (REF: TH 003)
Salary: (scp 24-29) £19,053 - £22,512 (Plus £3,012 Inner London Weighting)
The postholder will work under the general direction of the management team to provide a comprehensive administrative support service to all staff and act as the first point of contact on reception. They will assist and support the implementation and maintenance of central administrative systems required for the smooth running of the services. Effective communication skills and knowledge of the Microsoft package is essential.

EARLY INTERVENTION AND OUTREACH TEAM

The team will provide a range of interventions including: outreach, diversionary activities, targeted prevention work and Initial Level 1 Assessments, working closely with a range of statutory and voluntary agencies including; Schools, Pupil Referral Units, the Youth Offending Team and Social Services.

TRAINING AND DEVELOPMENT OFFICER (REF: TH 004)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
To co-ordinate the delivery of the Early Identification and Assessment Framework for local services working with children and young people across Tower Hamlets. The postholder will also be responsible for the recruitment and support of key members from the local community to enable them to become Interacters and peer educators to help deliver seminars, advice surgeries and training sessions, working closely across both teams.

GROUPWORK/ DIVERSIONARY PRACTITIONER (REF: TH 005)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
To develop and provide groupwork and diversionary activities to vulnerable young people across Tower Hamlets which are appropriate, be innovative and meet local need.

YOUNG PEOPLE'S ENGAGEMENT PRACTITIONER (REF: TH 006)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
To provide targeted prevention programmes which will include appropriate education, advice, information and support to young people, from diverse and hard to reach groups (in particular BME communities and young women), identified as being vulnerable to substance misuse, both in and out of school settings.

EARLY INTERVENTION AND OUTREACH TEAM PRACTITIONERS
(2 posts REF: TH 007a and 007b)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
To use the Early Identification and Assessment Framework with young people referred from other agencies, to ensure early identification of need and deliver appropriate interventions such as education, advice, information and support to young people identified as being vulnerable to substance misuse, both in and out of school settings. Each postholder will have a specific lead in: Education (formal and informal), Social Services and Youth Offending.

CARE MANAGEMENT TEAM

The team will provide comprehensive assessments and develop care and/or treatment plans for children and young people, across Tower Hamlets, who misuse substances. The team will work closely with the CAMHS ASATs team.

SUBSTANCE INTERVENTION PRACTITIONER (3 posts REF: TH 008a and 008b)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
The Substance Intervention Practitioners will assess the substance related needs of children and young people and provide care and/or treatment programmes to meet identified need.

PARENT AND FAMILY WORKER (REF: TH 009)
Salary: (scp 31 – 36) £24,000 - £27,411 (Plus £3,012 Inner London Weighting)
To work as part of the Care Management Team to deliver a range of services and resources for parents and families in relation to drug use in the family.

All successful applicants will have an understanding of drugs and drug related issues within diverse communities along with a proven ability to work effectively with these communities. A recognised community work/ social work qualification (or equivalent) is desirable for all posts except for the administrative worker. Knowledge and ability to speak a local community language will be an added bonus.

To find out more about the project and posts come along to an open evening to be held in Tower Hamlets Tuesday 19th April and Tuesday 26th April 2005, 6.00 – 8.00pm. For an informal chat about any of the posts or the new service contact: Kate Buchanan on 0161 8392054. For further information and an application pack, please send an A4 SAE with 2 x 1st class stamps to: Samantha Moses at Lifeline Project, 2nd Floor, 4 Railway Street, Huddersfield, HD1 1JP (Tel. 01484-537511) or email samantha.moses@lifelinekirklees.org.uk The closing date for receipt of completed application forms is Monday 9th May at 12.00pm, applications received after this date will not be considered.

Lifeline Project is an Equal Opportunities Employer and invites applications from all regardless of race, colour, nationality, ethnic or national origin, religion, marital status, sex, sexual orientation, age or disability.

www.lifeline.org.uk

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