DDN
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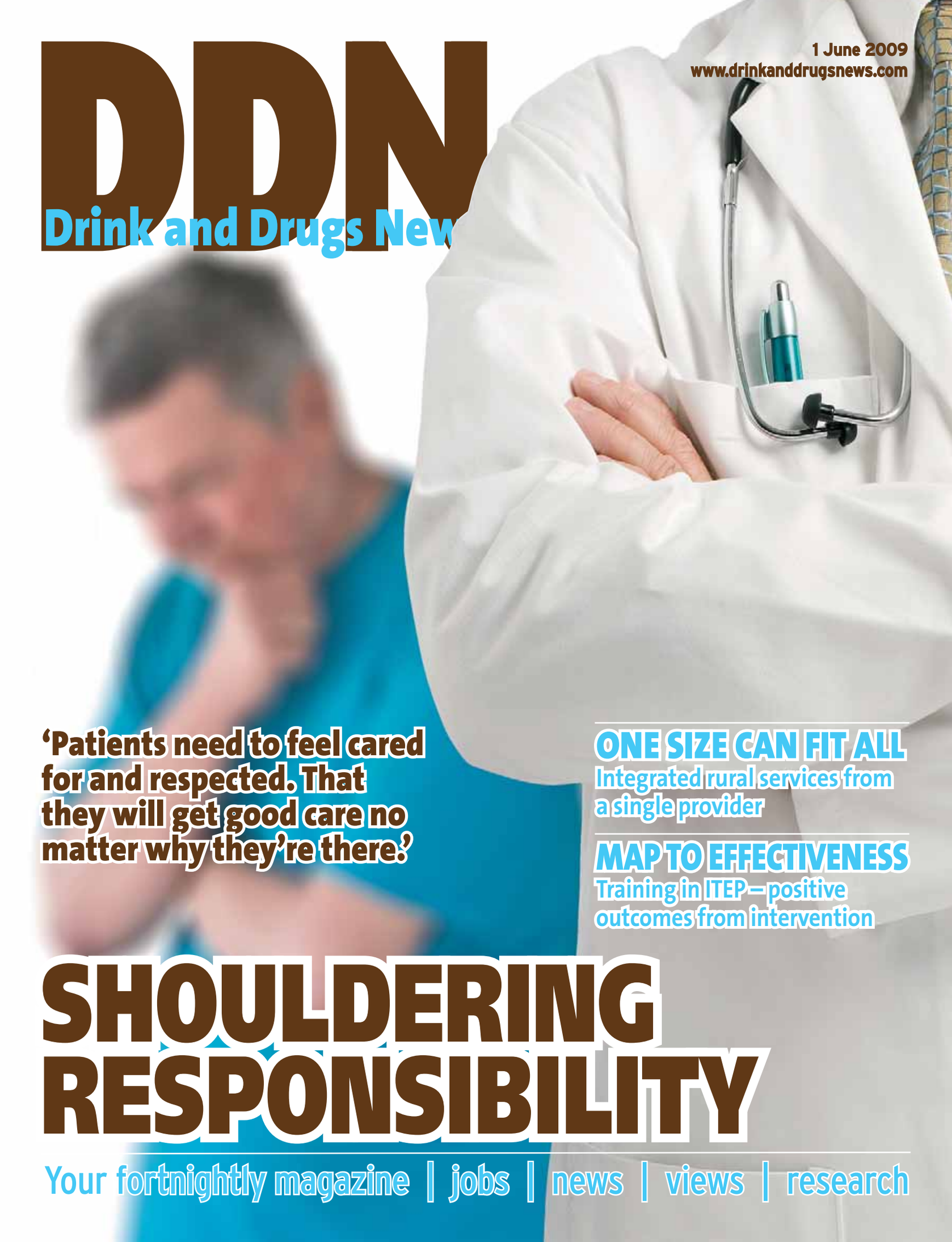
www.drinkanddrugsnews.com



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25 June 2009

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Delegate rate £145 (a free service user place is included with every three paid for places).

For more details and to book visit

www.conferenceconsortium.com

DDN Drink and Drugs News

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Editorial – Claire Brown

What's up doc?

Being an 'agent of change' is not the easiest job

The SMMGP conference – the event for Substance Misuse Management in General Practice – held in Liverpool this year was as positive an experience as ever. Alongside specialist sessions to fine-tune GPs' skills in all areas of drug and alcohol treatment, there was agreement in the main sessions that this was a special event for demonstrating how much participants genuinely cared about their clients.

But that's no particular surprise. GPs attended the event because they were already interested and engaged in making a difference. The challenge – which the conference recognised – was to make the experience more consistent for all patients, whatever their needs and wherever they might live – and that often meant a battle of wills with adjacent local services. GPs were recognised as having 'a unique situation as agents of change' – the challenge was to make sure this went beyond the people in the room and filtered into doctors' surgeries and out to their partner care services throughout the country.

Pressure on hospital doctors and nurses is highlighted in this issue's news story on drink-related hospital admissions (page 4) and I was interested to observe during a brief hospital visit this week (totally unrelated to alcohol) how the 'brief interventions' culture had been introduced to each stage of the admissions process. I was asked about my unit intake and regular drinking patterns by a doctor, a nurse and two anaesthetists – it was so thorough that I would have had ample opportunity to ask for help. It struck me as a real culture change since my previous contact with health services. As the news story highlights though, by the time hospitals are involved it is often too late to prevent long-term damage, and it is once again down to doctors to spot the early signs and intervene – not an easy job when the patient is visiting about something else – as Dr Chris Ford's column (page 8) demonstrates only too well.

This issue

FEATURES

REGULARS

News in Brief

The long road

Scotland needs to build on the 'significant progress' in the year since the launch of its national drugs strategy, according to community safety minister Fergus Ewing. The Scottish Government has published a new report setting out what has been achieved since the strategy was launched this time last year (*DDN*, 2 June 2008, page 4). 'The strategy is clear that through treatment and other services there must be a greater focus on recovery,' said Mr Ewing. *The road to recovery – one year on* available at www.scotland.gov.uk

Fourth pint 'not irresponsible'

Brewers Greene King have been cleared of encouraging irresponsible drinking following a complaint about a promotion that offered drinkers who bought three pints of their beer a fourth for free. The Portman Group's complaints panel ruled that the promotion allowed customers to take advantage of the offer over a number of visits to the pub. 'The panel decided that nothing in the promotional material encouraged consumers to drink four pints in one session,' said Portman Group chief executive David Poley. The government is currently consulting on its forthcoming mandatory code of practice for alcohol retailers, aimed at tackling the promotion of irresponsible drinking (*DDN*, 18 May, page 4).

High score

A recent campaign urging Scottish parents to talk to their children about drugs has led to a 41 per cent rise in calls to the *Know the score* helpline and an almost six-fold increase in visits to the website, according to the Scottish Government. Launched in March, the campaign included TV, radio, internet and newspaper advertising, as well as the distribution of leaflets and parents' guides (*DDN*, 23 March, page 4) – there were nearly 26,000 visits to the website during the campaign, compared to 4,365 in January and February. 'The message is that if parents don't discuss drugs with their children, someone else will, and very often they'll be getting the wrong advice' said community safety minister Fergus Ewing. www.knowthescore.info

Drink related hospital admissions up by two thirds

The number of alcohol related hospital admissions has risen by more than two thirds in the last five years, according to figures released by the NHS Information Centre. There were 863,300 alcohol related admissions in 2007/08 – where an alcohol related disease, condition or injury was the primary reason for admission or a secondary diagnosis – compared to 510,200 in 2002/03.

According to *Statistics on alcohol, England 2009*, which compiles figures from a number of sources, there were 6,541 deaths in England directly related to alcohol in 2007, a 19 per cent increase since 2001 – nearly 66 per cent of these were from alcoholic liver disease. In 2007, nearly a quarter of adults – 33 per cent of men and 16 per cent of women – were classed as hazardous drinkers, while 6 per cent of men and 2 per cent of women were estimated to be harmful drinkers. Nine per cent of men showed signs of alcohol dependence, although the figure had been 11.5 per cent in 2000, while 4 per cent of women showed signs of dependence, unchanged since 2000.

'Today's figures clearly show that alcohol misuse is one of the most serious public health problems facing the UK,' said chief executive of Alcohol Concern Don Shenker. 'The dramatic increase in admissions caused by alcohol consumption is a warning that unless action is taken, we face an escalating public health crisis and increasing pressure on the doctors and nurses working in our hospitals. The rise in deaths directly due to alcohol goes hand in hand with the increase in consumption over recent decades.

'As alcohol has become more affordable, fuelled by the growth of irresponsible low cost sales, the population as a whole is drinking more and this is having a massive impact on the nation's health,' he continued. 'Only one in 18 problem drinkers is receiving proper support. It is vital that the government starts investing more in alcohol treatment to help those with a drink problem tackle these issues before it's too late.'

Alcohol Concern is also backing the chief medical officer's recommendation for a minimum price per unit of alcohol sold to cut consumption among young, binge and heavy drinkers (*DDN*, 18 May, page 8).

Meanwhile the All Party Parliamentary Group on Alcohol Misuse has published its report on alcohol treatment services in England, which finds 'patchy levels of funding and inconsistencies in the way treatment services are being planned across the country'. The group wants to see cross-departmental leadership from the government, including measures to improve GPs' understanding of alcohol problems.

'The scale of the problems we set out to investigate is huge – of the 1.1m people dependent on alcohol, sadly only one in 18 access treatment,' said group chair Lynda Waltho MP. 'There is still a lot of work to be done to highlight alcohol as a public health concern, while breaking down the stigma and lack of understanding that surround problems with alcohol. Clear, joined up thinking is necessary from government, combined with adequate funding for treatment services so that they can meet the needs of all those affected by alcohol misuse.'

Statistics on alcohol: England, 2009 available at www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2009-%5Bns%5D

The future of alcohol treatment services available at www.alcoholconcern.org.uk/servlets/doc/1458

Firms using drug tests for 'cheap redundancies'

Recession-hit companies are using drug tests as a way to lay off employees without having to make expensive redundancy payments, according to drug law charity Release. The charity received a five-fold increase in calls about workplace drug testing to its helpline in the first quarter of this year compared to the same period in 2008.

Release says that where previously these calls tended to be from people in 'safety critical' roles, they are now more likely to be from people in the finance sector and other office jobs, and often from people who have been in the same job for years with exemplary employment records. Employees from organisations that had not previously used drug testing were now contacting the charity to say their employers were carrying out 'health assessments' – including drug tests – for those employees left after the announcement of voluntary redundancies.

'This is a worrying practice that may breach employees' human rights and their right to privacy' said Release executive director Sebastian Saville. 'Employers risk alienating staff by forcing them into intrusive tests and should instead be supporting any staff member who might be experiencing drug problems, not using it as an excuse to make cheap redundancies.'

Twenty-six per cent of calls to the Release helpline in the first quarter of 2009 were about drug testing at work, compared to just 6 per cent last year. The charity had also noticed a 'significant drop' in calls from employers seeking advice on how to help members of their staff with suspected drug problems.

Most callers were worried about traces of cannabis being found in their system, said the charity, as this can show up in drug tests for several weeks after use. Drug testing of employees – when it does not feature in their contract – is unjustified, says Release, and carrying out a test without consent could be a criminal offence. If an employer does not have a drug testing policy in place then the test can be refused.

Anyone tested for drugs at work should ensure that the correct procedure – as set out in their contract or staff handbook – has been followed, and request a copy of the results, and people taking medication that could affect the results should make sure they have the packaging or prescription available. Anyone concerned about these issues is advised to contact Release or ACAS for further information.

Contact details for Release are at www.release.org.uk

NTA refutes attack on harm reduction

The NTA has issued a statement refuting the conclusions of a new report from the Centre for Policy Studies (CPS), which states that the UK drug problem is the 'worst in Europe'. Britain has one of the highest levels of recreational drug use and among the 'most liberal drug policies in Europe' says the think tank's report, *The phoney war on drugs*.

Despite the £1.5bn annual spend on drugs policy, enforcement is 'weak and underfunded' while the treatment strategy is 'counter-productive', says the report, with the UK facing a 'widening and deepening crisis'. The publication is strongly critical of what it perceives as the shift towards a harm reduction approach introduced by the Labour government in 1997, particularly increased spending on methadone prescribing, and says there is little evidence of the effectiveness of the Drug Intervention Programme (DIP). Furthermore the FRANK campaign 'endorses, rather than seeks to prevent' young people's drug use, it says, as it is based on the premise that young people will continue to take drugs.

'The harm reduction approach has failed,' says the document. 'It has entrapped 147,000 people in state sponsored addiction. Despite the £10bn spent on the war on drugs, the numbers emerging from government treatment programmes are at the same level as if there had been no treatment programme at all.'

The CPS calls on the government to abandon harm reduction and focus instead on the 'illicit use of all drugs, not the harms caused by drug use'. It wants to see abstinence-based treatment and a 'tougher, better funded' programme of enforcement to reduce supply. Investment in recovery will be undermined as long as drugs are cheap and easily available, it says, citing the examples of Sweden and the Netherlands who spend most of their drugs budget on prevention and enforcement and as a result have drug problems 'half and a third of the size of the UK respectively'.

'It is the UK, not the Netherlands, that is in the vanguard of the liberal movement to normalise drug use,' says the report. 'Our attempt to target its harms alone has impinged on more than treatment and public health – it has shaped approaches to enforcement and prevention making for hopelessly confused policy and practice.'

The NTA, however, is dismissive of the report's claim that the system is not working and that an overall harm reduction policy was ushered in by Labour. 'No one is complacent about tackling drug dependency, but the drug treatment system in England has improved dramatically in the last few years,' says the agency's statement. 'Now anyone who needs drug treatment can get it quickly, and every year more and more people are successfully leaving treatment. The policy of harm reduction has been operating in this country under successive governments for more than 20 years in order to safeguard public health and continues to play a vital role in addressing the harmful consequences of drug misuse.'

The UK Drug Policy Commission, meanwhile, said the CPS report presented 'selected evidence to support a set of conclusions'.

'The report risks further politicising the drug policy debate, particularly in its call to abandon a "harm reduction" approach, which it erroneously describes as a Labour government invention and something which is incompatible with enforcement and prevention efforts,' said director of policy and research, Nicola Singleton.

'It fails to acknowledge that the UK has some of the toughest sentences for drug offences in Europe (even if the Sentencing Advisory Panel's current proposals are accepted [*DDN*, 4 May, page 4]) and both the number of people sentenced and the average length of sentences for drug offences have been rising.

'It is ironic that the CPS's call for tougher law enforcement comes at the same time as the US is reconsidering the evidence and calling for a different approach. Whatever policies are adopted by future governments, they must be underpinned by high quality and objective analysis of all the available evidence.'

Report available at www.cps.org.uk/cps_catalog/The_Phoney_War_on_Drugs.html

Director of quality Annette Dale-Perera leaves the NTA after seven years – see page 10.

Government turns to 'legal highs'

The government has launched two new consultations setting out its proposals for controlling a range of substances that fall under the category of 'legal highs'.

The measures are in response to the 'changing drugs market and emerging threats to public health', says the Home Office.

The proposals are intended to halt the misuse of gamma-butyrolactone (GBL), 1-benzylpiperazine (BZP) and 1,4 butanediol (1,4-BD). The first consultation sets out three different options for the control of GBL and 1,4-BD, while the second details the government's plans to control BZP as a class C substance, along with measures to control related compounds. GBL and 1,4-BD have legitimate uses as solvents so the Home Office is keen to hear the views of industry, it says. The second consultation also includes the government's plans to add 24 anabolic steroids to the list of class C drugs.

'I am determined that we respond to the dangers of these drugs and that is why I have committed to controlling them,' said home secretary Jacqui Smith. 'It is absolutely right that we continue to adapt our drug policy to the changing environment of substance misuse. This is the next step in tackling the unregulated market of so called "legal highs".'

Consultation documents available at www.homeoffice.gov.uk/about-us/haveyoursay/current-consultations/

UNODC praises Iranian drug tactics

Iran has been praised for 'holding back a flood of heroin' by executive director of the United Nations Office on Drugs and Crime (UNODC), Antonio Maria Costa.

Antonio Maria Costa: '...narcotics police in Iran are among the best in the world.'

Speaking on a visit to Tehran, Costa said the country was making a 'massive sacrifice' to stop the smuggling of heroin from Afghanistan to countries in the west and deserved 'both the gratitude and support of the international community.'

UNODC estimates that most Afghan opium trafficked to the west is smuggled via Iran. The Iranian government has erected more than 1,000km of embankments, canals, trenches and walls along its eastern border and seizes around 2,500 tons of opium crossing its border every year. 'Most of the world's opium is produced in one country, Afghanistan,' said Mr Costa. 'The more drugs that are seized near production areas, the less drugs will reach western streets.'

Iran has one of the highest rates of opiate dependence in the world, but is 'taking the right steps to deal with it' said Mr Costa. 'The anti narcotics police in Iran are among the best in the world.'

However a report from the International Harm Reduction Agency (IHRA) on the use of the death penalty for drugs offences found Iran was second only to China in terms of the numbers of people executed for drugs offences, executing five people on a single day in December 2007 (*DDN*, 11 February 2008, page 6), and Amnesty International continues to document human rights abuses carried out in the country, including the execution of children and people who were minors when their crimes were alleged to have taken place.

GPs still see themselves at the heart of family medicine – but are drug and alcohol users always kept in view? **DDN** reports on challenges highlighted at this year's SMMGP conference in Liverpool

AGENTS OF CHANGE

From cradle to grave?

GPs are uniquely placed to help clients at every step of their journey, as well as provide a clear pathway through the maze of services, SMMGP delegates heard

A 46-YEAR-OLD MAN was taken to A&E with a seizure. After being stabilised and put on a short stay observation ward, he was seen by an alcohol specialist nurse (ASN) who did a survey of alcohol dependency questionnaire and discharged him the next day on a reducing regime. On the third day he was back at 4.30am with a headache and vomiting and referred to ophthalmology. On day five he had a CT scan and was found to have a subarachnoid haemorrhage.

The following day when the ASN went back to see him, the patient said: 'I suppose it's my fault. They're very busy and I deserve what's happened.' As Dr Lyn Owens, nurse consultant and clinical lead for alcohol services at Liverpool PCT, who shared this story said: 'Someone should have picked up the alcohol problem.' But the other major point she was making was about dignity in patient care – how medical staff and patients relate to each other, which can become 'an issue of capacity with patients with drug or alcohol problems'.

'What patients want from nurses hasn't changed,' she said. 'They need to feel cared for and respected. They need to feel listened to and that the listening is unconditional and they're not making a judgement – that they will get good care no matter why they're there.'

'Our patients have the perception that health professionals value them less than other patients,' she added. 'But we need to realise that anyone can run into difficulties. The more positive the experiences of our patients, the more we'll be able to dispel these perceptions.'

'Old style patriarchal doctoring used to be from cradle to grave, and social cohesion went with those ideas,' commented Paula Byrne, lecturer in social health at Liverpool University. 'But unfortunately some things went very wrong... there is the idea of an underclass that are disaffected and disengaged. There are good reasons why people abuse alcohol and drugs – the gaps between rich and poor have got worse.'

However GPs were now becoming more political and making policy demands. 'This is the juncture where things have to change,' she said, drawing parallels with feminism in the early 70s, where shouting loud challenged the status quo.

'This conference is one of the last vestiges of radicalism – GPs have a unique situation as agents of change,' she said. 'The professional position is shifting – you need to be a patient advocate and a policy guru.'

Mark Gabbay, head of the division of primary care at Liverpool University warned against complacency. While there was plenty of evidence for methadone and buprenorphine maintenance, the means were 'not an end in itself'. 'Let's think about the root of the problem... the link between problem drug use and deprivation – poverty of opportunity,' he said.

'We need to be advocates of prevention, not on the treatment roll – "get 'em in, get 'em assessed and included in statistics and on a script with infrequent reviews, pile 'em high". We need to be active partners with our clients.'

'Some of it is common sense, giving them resources for stability,' he added.

'We need to be putting pressure on people like me to make sure there are real options,' said Paul Hayes, head of the National Treatment Agency. 'Our clients are entitled to access mainstream services, but we shouldn't shy away from the fact that it is often difficult... our challenge is to make the aspirations the actual experience of service users.'

Dr Chris Ford wanted to level the field of patient care at the outset: 'We need to stop talking about cannabis users, cocaine users, opiate uses... we need to start talking about people with a range of needs.' ■

Constantly fighting discrimination

Dr Deborah Noland, a GPwSI (GP with a special interest) in Liverpool, shares some of the day to day frustrations in trying to bring better care to her drug and alcohol patients

'MY JOB AS A GPWSI IS CONTINUING TO BE DIFFICULT. Our practice provides care for the homeless within Liverpool and we provide support, counselling and scripts when necessary for chaotic patients. We would love to be able to offer drugs counsellors, but we are unable to as these clients are seen as being too chaotic for shared care. This client group is being discriminated against. All other patients have choice – these patients are only allowed to go to the drug dependency unit if they want drug worker support.

The drug dependency service still has a poor reputation within the drug using community – although this is improving with the appointment of a new approachable consultant – so many of these vulnerable clients refuse to go. We have had to make the decision therefore to casework this difficult client group ourselves and transfer them to our drugs workers when they are deemed stable enough for shared care. This is far from ideal and these difficult clients should be a higher priority to see drugs workers.

My other problem is that the drugs and alcohol services work independently – I feel they should work together, as so many of our clients have both problems. The alcohol service is currently being reviewed, but at the moment there is no provision for home detoxes and very little support for primary care. I got funding approved for an alcohol worker to work with the homeless and students to prevent readmissions to hospitals, with funding for research, but the appointment has been blocked by the DAAT. Yet again I am waiting for a decision while people with alcohol problems have to wait. I have been assured that it is because they want to provide more, but I feel it would be good to start somewhere rather than continually waiting.

On a positive note, working closely with David Young – who is medical director of the Lighthouse Project providing shared care support in Liverpool – has been very positive and we feel supported as a practice. I am also looking forward to liaising with the new consultant Dr Mohammed at the drug dependency unit – closer working to support chaotic groups can only benefit our clients.' ■

Cradle to grave... or pillar to post?

Asking for help from several GPs has left **Doug** feeling disaffected and disengaged

WHEN I FIRST WENT TO SEEK HELP FOR MY DRUG USE I was working as a housing worker, so it was difficult to actually ask for help. I went to my GP because I felt unable to approach local drug services as I knew a lot of workers from previous jobs and from the organisation I worked for.

The GP was unhelpful from the start, stating that I really should have gone through local drug services. However she wouldn't refer me out of county either, but wouldn't give a reason why.

Eventually I managed to get started on a Subutex script but was then forced into going off sick from work. I had managed until that point to continue working and had kept my problems from work – I never scored locally and kept my use very discreet. But because the GP noticed my name on some minutes from a local forum and realised I worked with some of the patients from her practice, she threatened to inform my employer if I didn't, as she felt I was a risk to my clients – her colleagues were scripting some of them. So now I was off sick, getting a full-time wage still and with lots more time on my hands. As a consequence of this my crack use rocketed and my heroin use went up with it.

I informed the doctor of what was happening and she stated that this was all too much for her to deal with. She referred me to another doctor who was a psychiatrist and head of forensic medicine and had experience of dealing with fellow professionals. I didn't get on with this chap at all and eventually ended up lying about my use just to get away from him and to try and return to work. However none of this worked and eventually I left the city I was living in.

For the next two years I managed to keep going on meds (methadone) I was buying on the black market. So now my illicit drug use was under control but I was left with a methadone habit.

Again I decided to move towns and went to see local drug services where I had a very difficult time trying to explain to the doctor there that I didn't have a problem with any illicit drugs but was struggling to get off the methadone. They eventually did script me but every time I talked about reducing the methadone, I was discouraged and told that I was trying to do too much. So I reduced my methadone right down to a very low level on my own and went back to see the doctor to ask for a 'rattle pack', *ie* some meds to alleviate the symptoms of coming off the methadone, but I was told that they didn't do anything like this and never would.

I have just registered with a new GP and had to visit her to get my other meds sorted out (I am hypothyroid and suffer from migraines and high blood pressure). She unwillingly sorted these out, berating me for visiting a new surgery before my records had been transferred over and saying that she really didn't like giving me any medication without having seen my previous notes. So now I am dreading having to return to see her when she does have my notes, because I need to come clean about my previous drug problems and have no idea what sort of reaction I will get. ■

POST CARD FROM WALSALL

My name is Tracey Gibbs and during 2006 I was tasked with setting up Hi's 'n' Lows, a new user group covering Walsall.

And what a task! Firstly I've never been a user, so I was aware that I would struggle to be accepted but I had two things going for me – I had a wealth of life experience and understood life in a vulnerable community. I also had SR on my side, a respected local user. I spent hours at places with high activity, eventually starting to get nods and occasional chat. SR introduced me to lots of people and slowly I was accepted – I was always honest, never pretending to share their lifestyles.

I soon got a tiny office and began finding out what was wanted by the using communities and the gaps in services. Firstly, we started open access drop-ins at venues around the borough, although many of these failed due to the area/venue being wrong. One of these drop-ins worked after a little playing around with days and times, so I learned from it and we now operate four drop-ins, providing free food, drinks, clothing and bedding for rough sleepers at all of them.

Diversion is a tool that works, so it was decided to run activities like cinema trips, ice skating, a climbing club, and a yearly residential. These have been a tremendous success, addressing many issues along the way.

Clean-ups are also part of our work, going into shooting galleries and removing any discarded paraphernalia. We also engage with the guys using at these sites, offering harm minimisation, advice and information and a backpack needle exchange service.

I now manage five staff members and four volunteers, the majority of whom have been users. We receive funding from the local DAAT and also from Supporting People, allowing us to run a floating support service for the homeless and vulnerably housed.

So I guess what I'd say is never give up – even if no one turns up for your meeting, stay with it. I'm also honoured that the using communities have accepted and trusted me and I would also like to thank SR – I could never have done it without you.

Hi's 'n' Lows are at The Glebe Centre, Wednesbury Road, Walsall. Tel: 01922 627294

Post-its from Practice

Make no assumptions

Not asking the right questions can mask a serious problem, explains **Dr Chris Ford**

Tony came to visit me a couple of months ago complaining of palpitations. He explained to me that the worst episode had been following a long night of drinking after a family celebration. I had known Tony for over 25 years, delivered two of his four children at home, supported him and the family through his wife's diagnosis of – and recovery from – breast cancer and many other family events. Such are the joys and privilege of old fashioned general practice.

I knew he drank too much and we had had many discussions about it including talking about his increased risk of heart disease, which was heightened due to a strong family history. But I had never asked him about, and he had never volunteered information about, other drug use. Even when he presented with palpitations and 'heavy night drinking' I didn't think of asking him about cocaine.

Tony returned to see me immediately after his appointment with the cardiologist to whom I had referred him after his ECG at the surgery had shown a slight abnormality. He said he thought he had better explain before I got the letter from the hospital. He informed me that he had been snorting cocaine on and off for four years. He had started using it when going through a difficult period with his wife but had managed to stop with the help of a counsellor after one year.

This current episode had started nine months ago and he had been using about two grams per day. He had realised that he needed help again so after seeing me he had booked himself an appointment to go back and see the same counsellor. Three weeks into counselling he was cocaine free and was motivated to stay that way.

People using cocaine risk a number of health problems including heart problems. Blood pressure can be increased and needs to be checked regularly. Cocaine use can lead to rhythm changes and/or arrhythmias, which if untreated can be fatal. The risk of arrhythmias increases greatly during binges, but reduces again during periods of low use/abstinence. Cannabis and cigarette smoking can increase these arrhythmias. Angina, myocardial infarct and congestive heart failure can result from reduced heart muscle function, increased heart size and arteriosclerosis of the arteries.

Cocaethylene, formed by combination of cocaine and alcohol, greatly increases the risk of heart problems, as well as sudden death, and increases the risk of suicide, accidents and the incidence of violence. Cocaine and alcohol can also both acts as disinhibiters and patients can find themselves in risky situations. When seeing patients with a combination problem, both must be addressed.

After apologising for not asking him about drug use, I was interested to know and enquired why he had not previously told me about his cocaine use. For Tony it was all due to his shame and fear of what I might think of him, even though he knew I had an interest in working with people who have drug problems. From my side I was questioning whether I had made assumptions about his class and colour – or had I just forgotten to think outside the box? Anyhow it was a good lesson for me to be reminded of, especially in the sex and drugs field – 'make no assumptions'!

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP.

'In AA we have a saying that we don't shoot our wounded, and in my experience those still struggling to stay sober are accepted with compassion – after all, with a relapsing illness like alcoholism it could be any one of us.'

AA advocacy

Well done, Richard Shrubb (*Drastic measures*, DDN, 16 May, p12) – sober four years plus, thanks to Antabuse.

It's a shame if, as he claims, he was ostracised by the AA group he attended and that they refused to renew contact as he struggled on alone. Of course, it would be interesting to hear their side of the story.

In AA we have a saying that we don't shoot our wounded, and in my experience those still struggling to stay sober are accepted with compassion – after all, with a relapsing illness like alcoholism it could be any one of us. The only requirement for AA membership is a desire to stop drinking, so no one should feel ostracised.

Of course, with over 3,000 AA groups in Britain and 30,000 plus members, not all AAs will behave as well as we should. But if anyone does not feel welcome in one group they could always move to another one – or start one of their own. Richard points out that, 'Studies show that Antabuse only works if the patient wants it to.' The same principle applies to AA, of course.

AA member (sobriety date 10.8.84)
Name and address supplied

Dangerous words

While it was great to read about the progress Richard Shrubb has made in managing his alcoholism by using Antabuse, I do feel that he has given out unsafe information in his account by suggesting that it is safe to drink three days after stopping taking the tablet. Further, drinking while taking the tablet will not only make you violently ill – it can kill.

How did he reach this conclusion? There is not a clinician in the world that would agree that his words are safe.

Like Richard I have taken Antabuse for several years, but now at low levels – two tablets per week, which is all I need to deter me from drinking alcohol. Until fairly recently I was under the impression that seven days would need to pass before it would be safe for me to drink, but I have seen evidence from America that it can be up to 13 days before being able to do so.

I agree with studies that Antabuse can only work if the person wants it to, but I consider it a 'wonder drug' as it saved my life!

Kevan Martin, chief executive, NERAF

Conference rage

I am generally pretty angry, but I'm more angry than usual. I have just been to the 6th UK/European Symposium on Addictive Disorders organised by UKESAD. Over the past two years I have attended the National Conference on Injecting Drug Use, now organised by Exchange Supplies and the national Needle Exchange Forum. Although both 'international' conferences appear to provide a balanced and independent view of the substance use field there is an obvious political undercurrent.

It appears that either the conferences and/or the audience has been infiltrated by extremists. I became gradually aware during discussions with delegates at coffee, and by the occasional heckling, that the audiences have a vested interest. The National Drug Treatment Conference is attended by a large number of service users who, in private, clearly want all illicit drugs legalised. The conference is generally sympathetic to methadone maintenance treatment and opposed to any suggestion that the criminal justice agenda be used to justify drug treatment.

By contrast the UKESAD conference seems to have a predominance of men in smart suits who are often CEOs of private or 'independent' residential rehab facilities. Abstinence orientated approaches appear to be the fashion amongst of this group.

One lecturer gave a shamefully biased and one sided view of drug treatment in Scotland which completely neglected any positive reference to medication. Indeed he clearly told us that drug treatment in Scotland had failed which is patently untrue. My patience finally snapped when one of the audience (who was wearing a suit) suggested that methadone was being prescribed as part of a conspiracy between doctors and the pharmaceutical industry to keep people addicted and therefore maintain their profits – the patent for methadone expired decades ago, exposing this sort of conspiracy theory as delusional nonsense.

After a few other members of the audience walked out in protest, I began looking at the conference timetable more closely and realised that there was not one lecture or meeting concerning substitute medication. This is clearly negligent as all reasonable authorities now, reluctantly, acknowledge that there is overwhelming evidence for the benefits of methadone (and other substitutes) in treatment of heroin addiction.

I have a shameful double life in that as well as being an addiction psychiatrist I am also an amateur politician and sit on Southend Borough Council. What amazes me is the political naivety of many of the conference audience and the way the speakers often pander to this. While I completely agree that the dangers of cannabis are exaggerated, if heroin were legalised historical evidence suggests there would be an epidemic of addiction with the prevalence approaching that of alcoholism.

However, regardless of this, we must be realistic. Policy is decided by public prejudice, not 'scientific' evidence. Extreme policies, such as the blanket legalisation of illicit drugs will never happen in my political lifetime. Attempts to re-classify cannabis as a less dangerous drug are being reversed under extreme political pressure and anyone suggesting other forms of legalisation would have politicians from all parties diving for cover. Equally deranged is the view that complete abstinence is the universal panacea. Any balanced reviewer knows that residential treatment is expensive and the medium term effectiveness of abstinence orientated treatments is very poor.

The idea that there is a dispute between maintenance and abstinence orientated approaches is clinically irrelevant to me. Patients at drug treatment services are usually entirely familiar with the varied options and spontaneously ask for rehab, detox, methadone or buprenorphine.

I long since recognised the futility of arguing about this – their enthusiasm is more than sufficient indication to prescribe whichever treatment they request. However there has to be limits – more heroin addicts died of methadone than heroin in the late 1990s due to liberal prescribing and, whether we like it or not, the rules regarding supervised consumption and dosing are rigorously enforced when something goes wrong.

So what is to be done with the infiltrators and extremists at the conferences? Nothing! In the current economic and political climate we will be lucky to have any NHS illicit drug treatment at all in five years regardless of whether we are 'harm reduction' or 'abstinence orientated' enthusiasts. Let the extremists rant – whether they be crackpots or crusaders. Their 'demands' will fall on increasingly deaf and poverty stricken ears.

Jason Luty, councillor, Southend Borough Council and consultant in addictions psychiatry, South Essex Partnership NHS Trust

We welcome your letters...
Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity.

Moving on

The National Treatment Agency's director of quality, Annette Dale-Perera, moves on to a new role at the Central and North West London Foundation Trust this month. She tells **DDN** about seven momentous years at the NTA.

'EVERYONE WHO CAME TO WORK AT THE NTA in the early days was given a three year contract – at times we really didn't think we'd last that long,' says Annette Dale-Perera. Seven years on, however, she's about to step down as the NTA's director of quality, while the agency itself has gone from strength to strength.

'We hit the ground running,' she says. 'The first three years were really tough. Expectations about the NTA were high, we were ambitious and we drove ourselves, and the field, quite hard. However, we did manage to rally people around the framework of *Models of care*, we got waiting times down and we managed to build the government's confidence in the sector, which meant they kept increasing funding.'

During those seven years by far the biggest change has been in terms of access to treatment and treatment coverage, she says. 'The early wins around reducing waiting times from an average of nine weeks to two weeks were phenomenal, and the treatment penetration we have now – both in the community and in prisons – is unrivalled in the world. We forget sometimes how easy it is for people in this country to get free drug treatment especially for heroin and crack cocaine problems – that's really rare internationally.'

All of this is the result of a huge collaborative effort by providers, commissioners, the NTA and service users, she stresses, backed by 'hefty' government funding. Last year saw her take on the role of UK expert delegate to the UN, which, she says, brought home the extent of the achievements made in England in those years.

'I had to give the UK statement on what we'd achieved,' she says. 'When you compare us to other countries, yes our prevalence of drug use is quite high and we don't do so well on drug related deaths, but in terms of treatment penetration, waiting times and local areas having systems with the basic building blocks of harm reduction, opiate substitute therapy and access to drug-free psycho-social treatments, inpatient or rehab facilities, we do very well. And, unlike a lot of other places, we can demonstrate what we do because we've got the best monitoring system in the world – I know everybody thinks NDTMS and TOP are a pain, but people around the world look at us with envy. I'm really proud of what we've achieved.'

Her involvement in addiction treatment stretches back to the 1980s – she enjoyed a placement at Leeds Addiction Unit while a student but had no plans to work in the sector. 'I was working in an adolescent unit but it closed down and I ended up working in drug rehab and took to it like a duck to water,' she says. 'I also lost a brother to an overdose in the '80s. He had severe mental health and substance misuse problems and the services then were pretty under developed – particularly in the North East and particularly for people with schizophrenia. That motivated me to do something about it.'

The field has changed almost beyond recognition since then. Alongside changing drug trends and the challenges associated with much more widespread drug use, the sector has become much more professional, she says. 'We have a massive suite of guidance on evidence based practice and drug treatment is now also one of the most performance managed and monitored areas in health. This has very big strengths and has allowed the expansion, but it can be tough on providers and commissioners, because there is a real pressure to constantly prove your worth.'

Clearly, the sector also has its fair share of infighting, as any glance through *DDN*'s letters pages will show, but she believes that is a testament to its passion and commitment. 'What I love about working in the field is that generally people are very committed, whether they're providers, commissioners, policy people, researchers or service users. We have some very robust arguments – but you don't have those unless people have a belief in what they're doing and are trying to make the world a better place.'

Having worked in west London rehabs and community detox projects in the 1980s, her new post as strategic director of addiction and offender care for the Central and North West London (CNWL) Foundation Trust feels like a homecoming, she says. 'I live in west London and I'm very keen to try and improve services in my home area. I'll have more than 40 services covering drugs, alcohol, gambling and offender care and I'm very pleased to be going back into provider land, which is where I started. I really want to consolidate and improve those services and improve the interface between good quality clinical drug treatment, research and the recovery agenda.

'As far as services go, we shouldn't see service users in isolation,' she continues. 'We need to see them as part of an ecology that includes their families and communities, including employers. If treatment services can provide good quality clinical treatment and work to try and improve that ecological system – help the families and children of drug users, help service users build non drug using networks and have real job opportunities – this should improve service users' long term outcomes.'

Stopping the home fires burning

Sarah Hardman became drug and alcohol community advocate (DACA) for Trafford after six fatalities in home fires in a year were found to be linked to alcohol consumption. Here she tells **DDN** why service providers should include fire safety as an integral part of their clients' care plans.

THE LINK BETWEEN SUBSTANCE MISUSE AND FIRE DEATHS and injuries is well established. Fire investigations have identified that a substantial proportion of Greater Manchester fire victims have perished in a room where fire has started, possibly unaware of its existence as a result of contributory factors including drugs and alcohol.

The alcohol link is particularly visible to us as a fire and rescue service. In 2006 we launched a poster and beer mat campaign, featuring a blazing pint of lager and the alarming statistic that one in three fire-related deaths happen when people have been drinking. The most obvious dangers if you've had a drink, or been using drugs, are posed by smoking, cooking, or burning candles. However, I've found that when substance misuse is dependent or chaotic, the risk to fire safety can be more complex and people can be harder to reach. It's vital to Greater Manchester Fire and Rescue Service that our approach to community fire safety is inclusive. That means making sure that we go the extra mile to engage hard to reach populations and that's where specialist roles like mine fit in.

Working at ground level with local DAAT treatment services helps to ensure that service users have easy access to fire safety advice and interventions. I deliver fire safety workshops and drop-in sessions at various places where service users can get advice and take away leaflets. They can also book a 'home fire risk assessment' – a home visit to analyse home fire safety and eliminate or minimise any identified risk. Critical to the assessment is making sure every property has working smoke alarms and a household escape plan. Additionally those who smoke might be eligible for fire retardant bedding and sofa throws, and we run a scheme that replaces chip pans with new deep fat fryers.

When clients are referred to me, I undertake the risk assessment and then work long term with them to build a relationship and help them to maintain a good level of fire safety in the home. Often, it's about combining management of substance misuse with good household maintenance and housekeeping. For example, if internal doors are missing then fire can spread easily; if there's a build up of grease and crumbs in the kitchen fire can start more readily, and if exit routes are blocked it can impede escape. Depending on the client's needs, and with their agreement, a home visit might result in getting other organisations on board such as tenancy support, housing association repair teams, or health professionals.

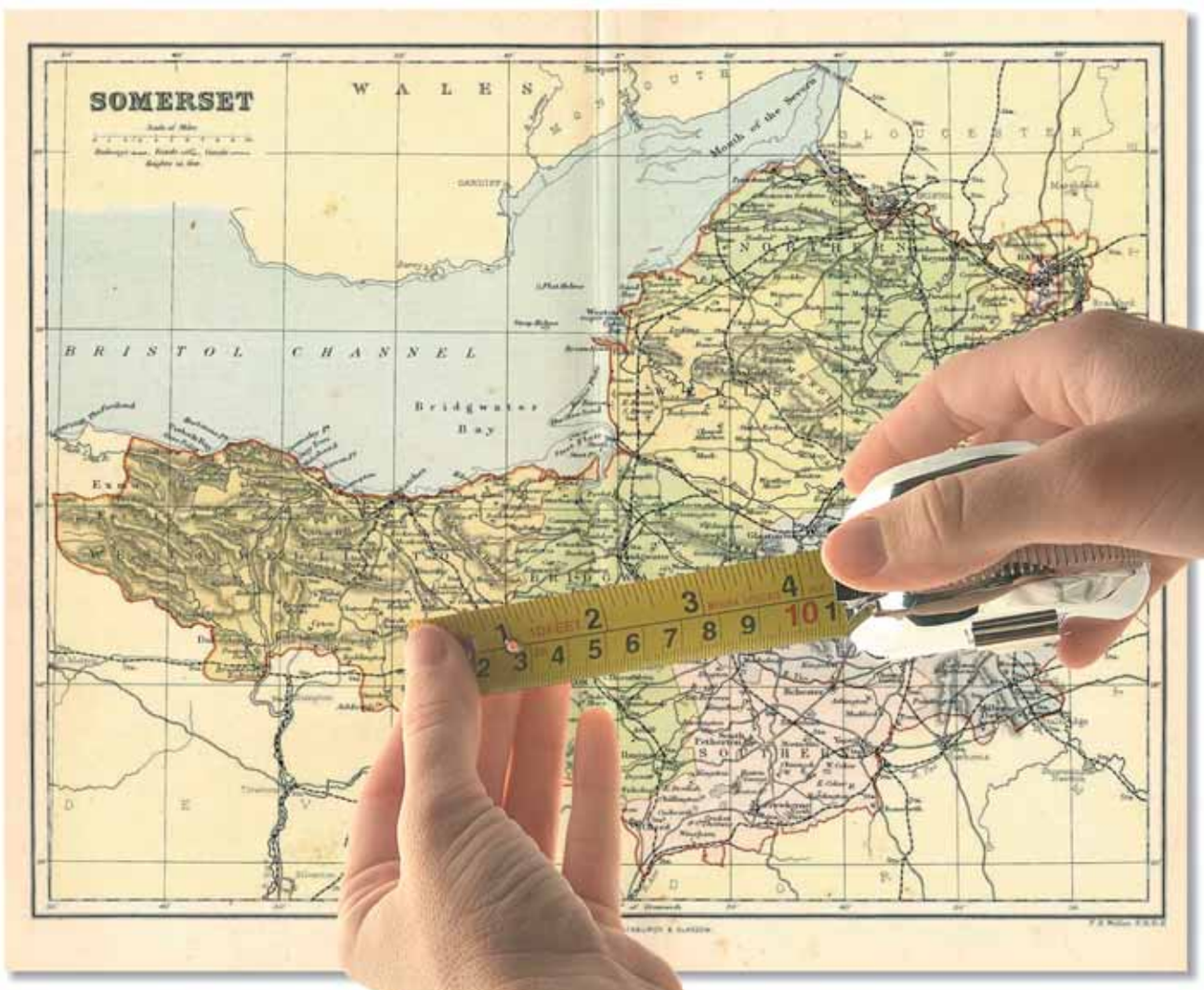
To date there have been 180 referrals to the DACA and I am pleased with the way that fire safety has been integrated with treatment services in Trafford. I am also working with other agencies and organisations across the borough.

Clients can be referred to me through a variety of pathways including housing associations, police, probation, GPs and, crucially, internally from operational fire fighting crews. If someone has already had a fire and falls into a high-risk category, we want to do everything possible to prevent a further incident, injury or even death. In cases where a new client isn't already engaged in treatment, my role is to provide brief interventions or referrals to treatment as appropriate. The key aim for the GMFRS is to make a household safe from fire and one route to achieving this is to help them to address underlying issues that are compromising their fire safety and wellbeing.

Successful partnership working has enabled us to put fire safety on the agenda alongside treatment and support services. It has to be a joined-up approach for it to infiltrate the community safety agenda. All treatment services carry posters and leaflets on drug and alcohol related fire, and other agencies such as probation and A&E are also making these available to service users. My long-term aim now is to develop further local partnerships so that everybody who uses drugs or alcohol harmfully, hazardously or dependently, understands the link with fire safety and benefits from the service we offer.

One size can fit all

Service users in rural districts often have to contend with services spread across large areas. In Somerset, however, a single organisation is providing integrated services across the county, with cost savings to boot. **David Gilliver** reports



The popular image of drugs and deprivation is one of inner city streets and estates. But, as several reports have highlighted in recent years, rural areas also face significant problems – with the added barrier of distance to access often fractured and fragmented services, where they exist.

Somerset, however, is breaking the mould – for a year now a single provider has managed all aspects of drug and alcohol treatment, from prescribing and needle exchange to inpatient detox and residential rehab, with single points of access. And what's more that provider is a charity, Turning Point.

Somerset is a large rural county with a few main towns and large areas of deprivation. 'For years there'd been three distinct drug and alcohol services in Somerset so those areas would have two or sometimes three offices – a Turning Point office, an NHS office and a DIP office,' says manager for Turning Point, Darren Woodward. 'Plus a couple of staff who did a bit of alcohol work.'

Throw lack of adequate public transport into the mix and it adds up to a serious problem. 'In the main towns like Bridgewater it's not so bad but travel five miles outside and you're talking about literally two buses a day,' he says. 'It's a massive issue for clients. Then factor in childcare and other responsibilities – it can be hard to get to one appointment in a rural county, but more than that and it starts to look like a spider's web.'

Clearly things needed a shake up so the DAAT undertook a long consultation process with the PCT, *Waits and measures*, to decide what new a service provision model should look like. Service users favoured an integrated drug and alcohol service and Turning Point, with input from Drug Treatment Ltd, put in a bid.

Integration was a key word from the start, he says, not just in terms of drugs and alcohol but having all services under one roof. 'That way people don't have to travel around on buses that run about once a week. All the partners, providers and services users were clear that what needed to be commissioned was a one-stop shop. The commissioners had already devolved responsibility to existing providers, so when they re-commissioned the service they said "if you do integrate we expect you to make efficiencies".'

However, make efficiencies they did. While the average wait in March 2008 was almost three weeks, the service now sees 50 per cent more people with no wait. 'It's not only quicker and more accessible for service users, it's cheaper,' he says. 'But that's just tier 3 prescribing alone, and we've got a range of new services.'

So how did they do it? 'Before, you had criminal justice drugs workers who worked in a custody suite, and that's what they did. You had a specialist nurse in a prescribing clinic, and that's what she did. You had a tier 2 drop-in worker, and that's what they did. Combine all of them and forget the titles – they're now project workers – so they do a bit of arrest referral, a bit of core prescribing, a bit of group work, a bit of everything. It's meant huge efficiencies.'

Perhaps unsurprisingly, however, the commissioners needed some convincing that this was the right path. 'Having a third sector provider, a charity, doing specialist prescribing always raises eyebrows,' he says. 'People say "can they do that – surely it's got to be the PCT or someone like that?" We said "no, we're going to provide all the doctors, the nurses and we've got the governance arrangements to do it."

The most resistance came from clinicians and others who felt threatened, he says. 'You've no idea. We had a press and communications strategy with the council and the PCT, but we completely underestimated the scale of the ferocity we'd come up against. It was "is this safe? What does national guidance say? What policy is there that says they can't do this?" The strategic health authority, the NTA, the DAAT, all the local MPs were written to by people saying "this is outrageous and terrible." They were very disparaging about Turning Point's capacity.'

The NTA, however, were supportive of the model and backed the DAAT, and were rewarded with a successful service and praise from service users. "They played a very fair hand,' he says. 'The best answer to all of it is to do well, and the numbers speak for themselves.'

From 406 in 2008 the number of people being prescribed to has risen to 644 this year, with 12-week retention in tier 3 rising to nearly 90 per cent. 'There's no new money in this – that's the key thing,' he says. 'We met our target for the number of problematic drug users in treatment by the end of the first quarter, and we met our third year target by the end of the year. We're far exceeding the number of people we used to support, we're getting more referrals for alcohol than drugs and we've got blood borne virus nurse services, community detox nurse services, a five-day group work programme across the county. These things weren't there before.'

The service now gets between 5 and 10 per cent more referrals for people with a primary alcohol problem than a drug problem, people who previously would have had nowhere to go for help. 'With a service structure that didn't support people with alcohol problems, it was difficult to know categorically what the unmet need was,' he says. 'With a service that's commissioned to support those people we can now unequivocally demonstrate that unmet need.'

Doubts and resistance aside, the main hurdle in achieving integration was the sheer practical issue of bringing all the practitioners together, he says. 'Probably the biggest challenge is how to harmonise teams when you transfer them' he says. 'People might have been working in the NHS or Turning Point or the probation service for ten or 15 years – very different ways of working, different performance management processes and different policies. It's the challenge of having everyone skilled, trained and aware – some people hadn't worked with alcohol, for example, or methadone, so we had to try to get everyone to the same level. That's a tough job, and there are huge HR implications that take the management team away from what they need to be doing. But we've got big plans.'

'All the local MPs were written to by people saying "this is outrageous and terrible". They were very disparaging about Turning Point's capacity.'

These include the development of psychosocial interventions, with an in-house counselling service about to be launched, along with more family-focused work and two new A&E alcohol liaison posts. How does Turning Point see the service developing from here on?

'I'd like to present the picture that – ad infinitum – we can carry on seeing more people and having no wait, but there comes a point when you reach capacity and we've probably got to that point. Our services are now beginning to get waiting lists, largely because of people with alcohol problems who need our support. Alcohol is the elephant in the room. In Somerset there are five times more people with alcohol problems that need treatment than with drug problems. We need to be able to mobilise funding to meet that need we're now demonstrating.'

However, the services are moving in the right direction, he believes. 'We've exceeded all the targets in the first year when we didn't even expect to meet them. We thought all the responsibility of the HR issues would eat into our ability to do that, but we have.'

If another area was thinking of attempting something along these lines, what would be the best advice? 'It's not always right for everywhere, and I don't think that's down to the rural/urban question – I think there's always good enough reasons to have a one-stop shop,' he says. 'I think the issue is consultation – you need adequate time for everyone to agree this is what they want. If the public or service users or providers don't expect it, it won't work.'

Anyone considering a combined a drug and alcohol service also needs to be aware of the long-term funding implications, he stresses. 'You're going to demonstrate unmet need for a service that the PCT or council will commission, which means they're going to have to find more money. But by doing it, by taking a punt, you can demonstrate that efficiencies naturally come out of it. But you need a future proof management structure. It's obvious, but you can't have too many silos – if there's a change of government or local or national policies then you need a structure that can withstand that.'

At the moment it's one service with one manager and five offices across the districts of Somerset, but the ultimate aim is a single phone number for everything. 'We will get to that stage,' he says. 'I don't know of any other service as big that's run by the third sector. There are things that are close, but it's a new model.'

And other areas have definitely started to take notice, with commissioners asking to see the service with a view to potentially designing their own new model. Could it be a future template for services across the country? 'I don't see why not. One of the questions we're asked is whether we'd now exclude partnerships. My response is that if people – despite the evidence and assurances we give them – still don't want to put all their eggs in one basket then you have to listen to that. It's very important to go with what the local area's about. But you've got a very fractured, disparate approach at the moment, across the country. I believe this makes sense.'

A map to effectiveness

John Jolly and **Jo Palmieri** explain why Blenheim CDP decided to put ITEP – the International Treatment Effectiveness Project – at the core of its psycho-social treatment interventions

The International Treatment Effectiveness Project (ITEP) uses a care planning approach – referred to as 'mapping' – in the form of a manual used by trained keyworkers with their clients. Research has shown that these psychosocial interventions have a number of positive outcomes in terms of clients' treatment experiences and reducing illicit drug use.

Through its international treatment effectiveness project on implementing psychosocial interventions for adult drug misusers, conducted two years ago, the NTA found that ITEP interventions resulted in clients having better rapport with their keyworkers, improved levels of client participation in treatment and gave them the benefit of better peer support.

The report found that staff were extremely positive about ITEP training and use of the ITEP manual, reporting that it led to positive changes in their normal practices. Ninety-five per cent of staff agreed that the ITEP manual was relevant to their needs and found it useful.

Blenheim CDP, one of London's largest drug treatment providers, has put ITEP at the core of its psycho-social interventions in all of its structured treatment services, following the organisation's involvement in piloting its use. Its workers now use ITEP extensively in both one-to-one and group work settings.

With three years' experience of implementing it across a wide range of treatment modalities, Blenheim CDP has now established a dedicated ITEP training and consultancy programme – both to keep ITEP at the forefront of the organisation's own treatment interventions and to promote it to other health and social care services. The programme has already trained over 500 workers from a wide range of providers.

According to John Jolly, Blenheim CDP's chief executive: 'It is crucially important to ensure that staff have effective training and supervision, and that the organisation champions ITEP use at a senior level.'

Some of the ways in which Blenheim CDP ensures that ITEP is high up the organisations agenda are:

- Service managers support the delivery and promotion of the ITEP tool in their own projects, and discuss with their teams as to how best it can be integrated. Treatment rooms are 'ITEP friendly' by having whiteboards, maps, pens, flipchart and paper available so they are quick and easy to access.

  The manager of Blenheim CDP Rise Day Programme says: 'We use ITEP in some groups (particularly gender groups) and in key work sessions. ITEP is on our standard agenda for our weekly team meetings and every week a staff member presents a map they have done with their client and discusses how this went and if the client found it useful. Completed maps are kept in client's files and a copy given to them to take away.'
- All staff are trained as to how to use ITEP as part of their induction process and are encouraged to take evidence of their maps to clinical supervision, team meetings and their own supervisions. Maps are used creatively in key work sessions and group work.

  'The maps are very straightforward and the clients like to take part and take it away with them. I feel that it simplifies things for the client,' says the project worker at Blenheim CDP, Linx, Greenwich. I have used a lot of different maps but I do like the exploring self maps as these also give me that chance to build rapport with the client and allow him or her to be in control of their recovery,'
- Service users and service user coordinators are informed about ITEP. To stimulate interest, posters and leaflets are displayed in reception/drop-in areas.
- The volunteer programme uses 'information maps' to help present facts and information on accredited training programmes for volunteers.
- Education, training, employment – maps are used to encourage motivation and goal setting. ITEP is used extensively through accredited training to support the learning process.

  'We use the free maps for a number of free-thinking sessions and particularly use the structured maps for anger and conflict, self esteem and boundaries,' says the manager of Blenheim CDP's learning and development Programme. 'The clients like to use the maps as it gives them a creative, visual communication tool and a way of getting thoughts and feelings down without using too many words. This is especially good for those with low literacy levels and dyslexia.'
- Other staff training involves using maps in core sessions including care planning and crack cocaine awareness.

In February this year the NTA formally endorsed ITEP as 'a pioneering new tool for drug workers and clinicians to promote behaviour change in drug-dependent clients.'

They added: 'Extensive research has shown that this easy to use and innovative technique – which enables drug workers to visually represent their clients' thinking in a series of personal maps – improves the engagement and motivation of drug misusers.'

The NTA is now asking that all service providers and commissioners consider implementing and using ITEP, and investing in training and supervision to use the ITEP manuals across local systems.

John Jolly is CEO and Jo Palmieri is director of learning and development at Blenheim CDP. For further information about ITEP training and consultancy email Sharon Burke at s.burke@blenheimcdp.org.uk or call 020 7582 2200.

How maps helped regain control

Stephen (not his real name) is 19 years old and uses cocaine and cannabis. When he combines these with alcohol he can become very aggressive. At one stage he was facing three different sets of criminal proceedings for offences ranging from drink driving to criminal damage.

His father brought him to the service but Stephen was reluctant to engage. He wanted his drug taking to cease and to find a job and settle down, but felt unable to help himself. Motivational interviewing revealed that for Stephen, the perceived advantages of his drug taking far outweighed the disadvantages even though he clearly wanted to reduce, then stop his drug use.

His worker introduced Stephen to a map that helps people identify their strengths. Stephen found it very encouraging as he was able to identify a number of positive attributes about himself. Previously he had often referred to himself as stupid or a waste of space – but by using the ITEP map he could see himself instead as good-looking and fit. He also recognised that although he could not read or write very well, he was good with problem-solving and figures. His family are extremely important to him and it was important to Stephen find a job.

Over the next few sessions his key worker continued with the ITEP maps, moving onto maps looking at 'what challenges are you facing' and 'running into the brick wall' – which was the one Stephen could relate to the most, as that had kept happening to him. From this map he saw that he put himself into situations purposely by instigating arguments, knowing that he would use this as an excuse to go and use drugs.

The ITEP material looking at the thinking and behavioural cycle was also very useful as he grasped the concept very quickly and managed to control his thoughts. His keyworker is clear that ITEP mapping helped with Stephen's confidence and after ten sessions Stephen had stopped cocaine altogether and cut down on drink and cannabis. He is now attending a course and completing his community service. Stephen found the maps useful and takes them out sometimes for reassurance when he gets a craving.

Partners in criminal justice

COMMUNICATION IS KEY

In the fifth of our series, DIP/PPO co-ordinator for Swindon, Sue D'amico, describes how her team engages with clients from arrest to court and beyond.

I'VE BEEN DIP/PPO (PROLIFIC AND OTHER PRIORITY OFFENDER) CO-ORDINATOR FOR SWINDON for about three and a half years now. I have an office at the police station where I liaise with the three DIP workers and direct the daily work. I make sure there's full coverage of police cells – of which we have 40 – as well as the magistrate and crown courts, where there are cells managed by the Reliance security group.

When someone is arrested and brought to the police station, the DIP worker will see them. The client might then be transferred over to the magistrate's court to go through the court process for whatever they've been charged with, and a DIP worker will follow that journey – that means engaging with them in the cells and possibly going into court with them. The DIP worker will be looking at recommendations like a DRR requirement or substitute prescribing – the usual stuff – as well as issues like housing, because a lot of people either don't have any or else their housing is pretty insecure. With that lifestyle it's usually the case.

In court the DIP worker will engage with the probation service, the defence solicitors, the Reliance staff and, obviously, the client. To be able to talk to all of those different people we have to get the client's consent first, which is usually forthcoming. We have to fill in a 20 page Home Office form called the drug intervention record, at the back of which is a consent form. Sometimes they'll say 'I don't want you to talk to my probation officer' but we encourage them to allow us to talk to people, purely because it will help them in the long run – we're not there to give misleading information, we're there to give them the facts and to try and move them into the treatment system.

In a typical month we probably see around 50-plus clients – some interventions might be very brief and others are quite in-depth, where we go on to case manage them. It's fairly full on – people never stop getting arrested.

Joint working is very good. There's been a re-commissioning process in Swindon, and we now have an agency called Inclusion that deals with prescribing, as well as a stimulant service – which not many places have – called the Drugs and Homelessness Initiative, which deals with cocaine. Relationships with all of them are excellent – we are often able to get people into treatment quite quickly. It wasn't always like that, but since the new providers have come in it's been really effective. Over the past 18 months things have changed massively for the better – we've got more people in treatment now than we've ever had, and there are no waiting times. If it's a normal route into treatment, where someone walks in off the street and goes to assessment, it can be up to two weeks. If it's through us – someone's arrested and is sitting in a cell – we get them in within a few days at most.

We're also involved in a joint outreach initiative with Wiltshire Police, working with sex workers, which was launched last October. Wiltshire Police recruited a vice liaison officer which means that somebody can coordinate the operations, and it's a really good way for DIP staff to reach a really difficult to engage client group. We've had really good feedback from the sex workers themselves, because they feel a lot safer, as well as from the local community. There have been community tensions in the past so it's about keeping the community safe as well – we'll regularly attend residents meetings.

There's effective information sharing between all the agencies and we have an excellent relationship with Wiltshire Police. Being based in the police station really helps, and we have access to their computer system. There was a bit of a culture clash originally – I've worked in different areas and certain police will always test your patience – but now we have a brilliant relationship and they respect us, whereas originally I think they wondered what on earth we were doing in here.

By far the biggest obstacle we face is lack of housing – it's not resources. Within DIP we have enough staff – three staff plus me – and morale is excellent. We always communicate really effectively, and everyone has a sense of humour, which you need in this job. I'm very optimistic about the future of the service – we're a good little team, hard working and passionate about the client group.

Understanding what is working and the 'pinch points' in the criminal justice system relating to drugs and alcohol is the aim of the Conference Consortium's forthcoming event, 'Somebody else's shoes', on 25 June in London. Paul Flynn MP, David Burrowes MP, Lord Ramsbotham and Jonathan Aitken will be on the parliamentary panel. Visit www.conferenceconsortium.org for details. In the run-up to the conference DDN will be interviewing a selection of people within the system, to give insight to different roles and how they relate to each other.

INVITATION TO TENDER

Haringey Council

FOR THE PROVISION OF THE HARINGEY OFFENDER MANAGEMENT SCHEME –

incorporating DIP and PPO programmes

OPEN TENDER

Expressions of interest are invited from experienced companies to tender for the provision of the Haringey Offender Management Scheme, incorporating the Drug Interventions Programme (DIP) and Prolific and other Priority Offenders Programme (PPO).

Offender Management Scheme contract(s) should commence in April 2010 and will be awarded for 3 years with an option to extend for a further 2 years. The money available for all lots is approximately £1.2m.

Contractors will be appointed based on the most economically advantageous tenders received by the Authority, as assessed according to the criteria to be listed in the instructions to tenderers.

Bids are invited for all or specific lots, from individual organisations or from agencies acting in partnership. We especially welcome stand-alone bids for the Resettlement service of appropriately 12% of the total contract cost.

Lot 1 Criminal Justice Integrated Team Provision of end-to-end engagement and management of substance misusing offenders (including PPOs) as they pass through the criminal justice system

Lot 2 Rapid Access Prescribing Provision of low threshold prescribing to CJIT and DRR clients

Lot 3 DRR Programme Provision of a creative, flexible programme for people on a DRR Orders that effectively addresses recidivism

Lot 4 Resettlement Service Provision of a comprehensive Resettlement Service for stable/clean clients

The process is under Open Tender regulations; suitably qualified and experienced organisations are invited to request documentation from:

Andrew James, DAAT Performance Manager,
3rd Floor, Alexandra House, 10 Station Road, Wood Green, London N22 7TR

Whose fax number is 020 8489 2992
(email andy.jamesdaat@haringey.gov.uk)

Properly completed tenders must be returned to the address on the tender label by: 13.00hrs 19 August 2009.

Haringey Council is committed to maximising diversity and welcomes applications from all sectors of the community.

THE RECOVERY CENTRE

The Recovery Centre requires experienced

Sessional Counsellors

for our established daycare programme in Chelsea, Central London, treating addictive behaviour, eating disorders, depression, anxiety and dual-diagnosis.

- £80-£100 per hour
- Up to 5 hours per week
- Monday to Friday 10am – 6pm

Please send your CV to info@therecoverycentre.com

supportive, fair, effective

COMMUNITY SAFETY DEPARTMENT

Information Systems Analyst

Ref: COM0028 Salary: SCP 39-44 £32,475 - £36,838

This post is fixed term until 31st December 2010 subject to further funding.

Substance Misuse Service User & Carer Involvement Co-ordinator

Ref: COM0027 Salary: SCP 23-30 £19,998 - £25,220

Closing date: Friday, 26th June 2009

Application forms and further details are also available from www.torfaen.gov.uk or e-mail job.vacancies@torfaen.gov.uk Tel: 01495 742560 quoting the reference.

Bournemouth Borough Council

St Paul's Lane

Commissioning and Contracts Assistant

Ref: 4097, £21,306 - £24,402, 37 hours per week

Bournemouth Drug and Alcohol Action Team (DAAT) has developed a comprehensive range of harm reduction, treatment and support services aimed at reducing the harm caused to individuals, their families and the wider community.

The DAAT is a partnership of statutory organisations hosted by Bournemouth Borough Council and is the lead commissioner for substance misuse services within the Bournemouth area. Services are procured from both statutory and non statutory providers, and contract and performance are monitored on a regular basis against Government targets.

You will be involved in all aspects of this process, together with the Joint Commissioning Manager, from working with the specialist data recording system to leading on small specific projects within our small and friendly team.

For an informal discussion, please contact Karen Wood, Joint Commissioning Manager on 01202 458740.

To apply online visit http://jobs.bournemouth.gov.uk

Alternatively, an application pack may be obtained via:
e. recruitment@bournemouth.gov.uk
t. 01202 454775 or 01202 458838 (24-hour answerphone)

This post is subject to a pay and grading review.

Closing date: 19 June 2009.

The Council is committed to achieving equal opportunities and a work life balance. Bournemouth Borough Council does not accept CVs without an application form.

Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Understanding mental health, understanding people

Senior Substance Misuse Practitioner - Alcohol

Peterborough and Cambridgeshire
Band 6: £24,831 - £33,436 p.a.
Full-time, 37.5 hours per week - Job ref: CPFT30555

We require highly motivated Senior Substance Misuse Practitioners to work within the alcohol field. You will be part of an interagency and multidisciplinary team working with clients with substance misuse problems and often highly complex needs.

We welcome applications from both experienced CPN's and those more recently qualified wishing to develop their skills within this field. Full training and support will be given.

As part of the selection process, you will be required to undergo a Criminal Records Bureau check.

We are genuinely committed to Improving Working Lives and our commitment to training and development is second to none.

FOR MORE INFORMATION:

Informal contact: Maggie Lawrence, Team Manager on 01733 898385 or 07983 342666 (mobile).
Email: maggie.lawrence@cpft.nhs.uk

For full details on this and all other vacancies in the Cambridgeshire and Peterborough region and to apply online, please go to:

www.jobs.cambs.nhs.uk

If you do not have access to the internet, please call 01480 398652 (24 hour answerphone).

Closing date: 12 June 2009. Interview date: 26 June 2009.

We are an equal opportunities employer.

In partnership with the University of Cambridge

PCP
a new beginning

Chelmsford – immediate start!

PCP are looking for a dynamic, enthusiastic and qualified counsellor to be part of our new exciting set-up in Chelmsford. You must have:

- 12 step experience
- group work & 1-2-1 counselling experience
- minimum, diploma-masters qualifications
- 2/3 years' experience working in a treatment centre setting
- report writing experience
- ability to support our senior counsellor

Salary negotiable. Please email cvs to : darren@pcpluton.com

Invitation to Tender

ISLE of WIGHT COUNCIL

SUPPORTED ACCOMODATION

The Isle of Wight Council on behalf of the Community Safety Service (formerly known as the Safer Neighbourhoods Partnership) invites Tenders from suitably qualified contractors for the provision and development of units of accommodation for service users in local drug treatment. The contract is to run from March 2010, subject to full community consultation and statutory approvals.

The closing date for receipt of Tenders is 14.00 on 15th June 2009.

Persons proposing to submit a Tender are advised to read the Invitation to Tender carefully to ensure that they are fully familiar with the nature and extent of the obligations to be accepted by them if their Tender is accepted.

The Council's Authorised Officer for the purposes of this Invitation to Tender is
Ms Mandy Sellers, Commissioning Manager, Drug Action Team,
Community Safety Service, Charter House,
14 St Thomas' Square, Newport, Isle of Wight PO30 1SL

Telephone 01983 550980
Email: mandy.sellers@iow.gov.uk

the care forum

Based in Fishponds, Bristol The Care Forum is the lead voluntary sector infrastructure organisation working in health and social care in Bristol, Bath & NE Somerset, North Somerset and South Gloucestershire. We also provide advocacy and information services. We now seek a

Drugs advocate

18.5hrs pw, £19, 427 – £25,220 pa pro rata

To provide advocacy casework for people using Bristol Drugs Treatment Services. You will have experience of providing advocacy, excellent communication and organizational skills, and a good understanding of the drugs and alcohol sector and the issues that drug misusers face.

We welcome applications for this post from ex substance misusers. *Applicants will be assessed against relevant units from the Drug and Alcohol National Occupational Standards.*

Closing date 17 June. Interviews 3 July.

We welcome applications from all sectors of the community. Our offices in Fishponds, Bristol are free from barriers and fully accessible for disabled people. For a job pack visit our website, email: admin@thecareforum.org.uk or tel: 0117 965 4444.

www.thecareforum.org

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"

- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how.
Available on CD Rom. Introductory price £19.95 + P&P

NEW – NOW AVAILABLE TO DOWNLOAD

To order your copy contact Charlotte Middleton:
e: charlotte@cjwellings.com t: 020 7463 2085

Northern Health and Social Care Trust

This new position in Northern Ireland offers you the opportunity to join a dynamic and highly motivated team of professionals who are committed to improving the lives of individuals suffering from opiate dependence. Applicants will have a professional qualification in Nursing, Social Work or an Allied Health Profession.

Shared Care Co-ordinator Band 7

(Substitute Prescribing)
Addictions Service, Ballymena
SALARY: £29,789 - £39,273 pa
It is intended to hold interviews on Tuesday, 14 July 2009.

Application forms and further information about the requirements of the posts **(including details of waiting lists some of which may be Trustwide)** can be obtained by visiting www.hpssjobs.com or by writing to the HR Department at the address below, quoting the title of the post and enclosing an A4 SAE to the value of 55p:

Human Resources Department, Bush House,
45 Bush Road, Antrim BT41 2QB.

Forms to be returned by **Wednesday 17 June 2009 at 4.00pm.**

An Equal Opportunity Employer.

www.hpssjobs.com

Swanswell has over 40 years' experience of offering the prospect of change to people affected by drug and alcohol misuse. Working in partnership with primary care trusts, criminal justice services and local authorities, we actively involve our service users to improve and develop our services.

We help people change their lives for the better, so they can feel well, do well and be happy.

We are looking to recruit:

work

well

together

Substance Misuse Workers

37 hours per week, based in Birmingham
Salary from £22,001 subject to qualifications and experience

The postholders will be responsible for:

- Managing a caseload within a defined health action area
- Providing treatment and support services to directly referred clients
- Participating in supervision, continuous professional development and support activities

Our staff are our greatest asset, so we want to recruit talented people who can help us to make a real and lasting difference.

If you would like an application pack, please visit our website: www.swanswell.org or email: jobs@swanswell.org

Applicants with a disability who meet the essential criteria for the post are guaranteed an interview.

Closing date for applications: Friday 12th June 2009 at 12 noon.

Proposed interview dates: week commencing 29th June 2009.

swanswell

Tackling the harm and impact caused by drugs and alcohol

Cranstoun Drug Services is a non-profit, independent charity and leading provider of specialist services to those affected by drug and alcohol use.

Service Manager — Dudley DIP

£26,784 - £31,439

A new and exciting opportunity has arisen for a Service Manager to lead the way with Dudley DIP, a new service becoming part of Cranstoun as of 1st July 2009.

Reporting to the Area Manager, you will be responsible for the day-to-day management of the service. You will be responsible for ensuring the highest standards of practice and providing motivation and leadership to the team of staff.

You will have a relevant track record in service provision and a proven background of managing a team. A working knowledge of strategic and organisational development would be desirable. **Ref: 515**

We are looking to appoint to this role as soon as possible to allow a smooth transfer of service with a commencement date of 1st July 2009.

To download an application pack, visit www.cranstoun.org
Unfortunately we are unable to accept CVs.

Closing date: Wednesday, 10th June 2009.

We welcome applications from all sections of the community. Working towards equality.

Registered Charity No. 1061582

Cranstoun drug services | 1969-2009 40TH ANNIVERSARY

STILL NO.1 FOR RECRUITMENT AND CONSULTANCY

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SUBSTANCE MISUSE PERSONNEL

PERMANENT - TEMPORARY - CONSULTANCY

Supplying experienced, trained staff:

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

NOW REGISTERING AND SUPPLYING NURSES

Register online www.SamRecruitment.org.uk

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

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