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DDN
Drink and Drugs News

KNOWLEDGE IS KEY
More information needed to tackle alcohol-related offending

A STORY OF NALOXONE
Why aren't we heeding evidence and distributing this life-saver?

BACK IN THE PICTURE
Focusing on the families of substance misusers

DON'T LOOK BACK IN ANGER
DDN reflects on a year of fiercely contested debates and issues

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DDN Drink and Drugs News

29 January 2009
Holiday Inn, Birmingham

The Alliance
Taking treatment forward

DDN Drink and Drugs News

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Editorial – Claire Brown

That was the year...

It's been a tough one, but there's plenty to shout about!

How's your year been? Looking back over the last 12 months in this issue's cover story gives the usual feeling of disorientation (...was that 12 months ago or two?) but it also makes you realise the scale of professional challenges you've tackled. Against the background of a new drug strategy, the day-to-day hurdles for drug and alcohol workers have never been greater in doing this difficult job, without the necessary political and financial support.

No one's pretending the coming year will be easy or settled, but there's plenty to shout (positively!) about. This issue is a reminder of much of the 'can do' spirit and attitude that characterises this field. Academics and medical professionals have collaborated to give a convincing argument for naloxone distribution, a highly effective way of reversing overdose (page 12). Not only does the science make sense – it's also a reminder of the essential buy-in of service users in making this initiative a success.

Nick Barton makes the case for involving and supporting families, on page 14 – and it's been encouraging to see more services starting to build their clients' families into the treatment picture this year. Looking back to the start of the Families Plus service a decade ago, Nick remembers the emotion and relief that spilled out of family members when they first tentatively suggested that *they* had needs too.

Maybe in the new year Justice Minister David Hanson will grant a few wishes by investing in meaningful and appropriate interventions for the many prisoners with serious alcohol problems (page 10).

With this issue we're entering the Christmas publishing break, but look out for our new website this month. We're adding the finishing touches – and there will soon be many more ways to be in touch with us! Season's greetings, and sincere thanks for all the support you've given us over the year. We'll be back on 12 January!

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News in Brief

Homemade problems

The consumption of 'illicit or non-commercial' alcohol is widespread in many countries and contributing to the 'global burden of disease', according to a report by the International Center for Alcohol Policies. Noncommercial alcohol in three regions focused on counterfeit and unregistered products and alcohol produced for home use or 'limited local trade' in sub-Saharan Africa, southern Asia and central and eastern Europe. In Sri Lanka, illicit alcohol has more than three times the market share of legal alcohol, while in Belarus it accounts for nearly half (43 per cent) of all sales. Much of the alcohol can be contaminated and toxic, posing 'a serious threat to public health, particularly in developing and transition countries,' says the report. Available at *icap.org/Publication/ICAPReviews/tabid/158/Default.aspx*

High-risk environment

Drug use and HIV infection are more prevalent among women in prison worldwide than men, according to a new UNODC report. Many women who have never taken drugs begin to do so in prison, according to *Women and HIV in prison settings*, and the proportion of female prisoners is 'increasing rapidly, particularly in countries where levels of illicit substance misuse are high'. Despite making up just 5 per cent of the total prison population, women are also vulnerable to sexual violence, more likely to self-harm and at risk of HIV infection through unsafe tattooing, it says. *www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf*

Joined-up action

A new report mapping the strategic importance given to domestic violence and substance misuse across London has been launched by the Stella Project. Aimed at commissioners, DAAT policy staff and community safety teams, the report highlights good practice as well as listing learning points and recommendations. More than half of London boroughs have taken specific action to tackle the dual issues and have monitoring systems in place, it says. *Innovative responses: new pathways to address domestic violence and substance misuse across London* available at *www.gldvp.org.uk*

Residential places to grow

The number of available residential, abstinence-based treatment places will grow by 2,000 a year following £54m of government capital funding, according to the NTA. The places will be spread across 42 residential treatment and supported housing centres throughout England.

The capital funding programme aims to provide more than 500 extra beds for residential and inpatient drug treatment, which – with an average stay of three months – adds up to more than 2,000 places a year, says the NTA. Bids from residential providers were assessed by regional forums, with recommendations made to a national panel including members of both the NTA and Department of Health. Around £1.2m of funding is still available.

All residential treatment centres need to complete their capital development programmes by 2010. One of the first to do so, following funding of £1m, was the Burton Addiction Centre in Newcastle-Under-Lyme, whose new 21 bed residential rehab unit was opened by NTA chief executive Paul Hayes last week.

'The aim of all drug treatment is to help addicts become drug free, leave treatment and reintegrate into society,' said Paul Hayes. 'There is no one size fits all answer to every problem drug user and that is why the NTA advocates a balanced treatment system to allow individuals to access the treatment they need from a range of clinically appropriate services. Many drug users can make adequate changes to their behaviour and move towards abstinence through community treatment, but residential treatment must be available to the minority of drug users that need to enter hospital for detoxification or go into longer term residential treatment.'

The NTA recently issued guidance to help commissioners and service providers plan for and buy effective Tier 4 residential treatment, urging local drug action partnerships to review their arrangements to make sure they are commissioning services in the most efficient way (*DDN*, 6 October, page 5).

The agency is also inviting proposals for pilots to deliver an 'end-to-end', personalised approach to drug users with multiple needs as part of its commitment to look for new approaches to treatment. The outcome of the pilots, which will focus on better use of pooled funding and individual budgets, will help 'set the future direction of regional and local drug funding, commissioning and delivery systems,' says the NTA. To bid visit *www.nta.nhs.uk/areas/docs/drug_system_change_pilot_invitation_to_bid.pdf*

Treatment 'halves' crime

New research based on data from the Police National Computer has shown that drug users in treatment commit fewer crimes. Offences like theft fell by almost half when drug users were in treatment programmes, according to research carried out by the National Drug Evidence Centre at Manchester University.

The research team studied around 1,500 opiate and crack cocaine users who had recently offended and were receiving drug treatment in the community rather than serving a jail sentence, meaning they were technically able to commit further offences. The total number of crimes committed however fell from 4,381 to 2,348 – almost half – following the start of their treatment.

Theft offences fell from just over 1,200 to just over 600, while violence more than halved, as did crimes involving fraud and prostitution. Half of those in the study committed no further crimes and in a sub-sample of offenders charged with acquisition or drug-related offences that would lead to a drug test on arrest, follow-up crimes fell by almost two thirds.

The study marks the first time anonymised data from the Police National Computer has been matched to the National Drug Treatment Monitoring System – previous studies on drug treatment and criminality have relied on self-reporting by drug misusers. The findings 'did not prove the falls in crime were solely the result of prescribing', but that they did justify further research, says the report. The Association of Chief Police Officers (ACPO) lead on drugs, Tim Hollis, said however, it was 'objective evidence' that treatment contributed to a reduction in crime and harm to local neighbourhoods.

'While this research confirms that the value of using substitute prescribing as a first-line treatment to stabilise drug users, it also shows that crime is cut rather than being eradicated altogether,' said NTA chief executive Paul Hayes. 'This reinforces the need for drug workers to go further and do more to actively get users off drugs and reintegrated into society.'

Report available at *www.nta.nhs.uk/publications/documents/nta_changes_in_ offending_rb35.pdf*

Scots on target

Waiting time targets for drug treatment have been introduced in Scotland for the first time. Faster access to treatment for drug misusers is one of the new targets included in the latest NHS Scotland performance management targets.

The 29 HEAT (health improvement, efficiency, access, treatment) targets for 2009-10 are designed to set priorities and focus NHS boards and others on delivering better and more appropriate care, says the government. 'We know that treatment works – between a quarter and a third of drug users entering treatment reach long-term sustained abstinence,' said community safety minister Fergus Ewing. 'For many drug users access to treatment is an essential part of their road to recovery. Where drug users are motivated and wish to seek recovery, we must be on hand to help them do that as quickly as possible.'

The Scottish Drugs Forum, which has long expressed concerns about long waiting times in parts of the country, said the announcement was 'excellent news'. 'Setting a target will ensure that we move to greater consistency of service access across Scotland,' said director David Liddell. 'However, treatment agencies also need to be assisted in improving the quality of their services so that people are given the best help to enable to recover from drug dependency.'

TRUST HOUSE, 40: TV presenter Maggie Philbin helped The Swanswell Trust celebrate its 40th anniversary as a provider of community-based drug and alcohol services recently, along with trustees, service users and more than 130 staff. The Trust has also been named regional winner in the National Training Awards for the second year running, with its alcohol awareness training the West Midlands winner in the education category. 'We hope to reach out to more people with complex needs though building capacity with partner organisations, as well as offering our proven holistic approach through our own services,' said chief executive Debbie Brannigan.

Scientists attack cannabis reclassification

A group of leading scientists has written to the *Guardian* newspaper strongly criticising government plans to reclassify cannabis as a class B drug. However its aim to convince the House of Lords to block reclassification next year has failed.

Written to coincide with a Lords debate on reclassification, the letter states that 'the impact of parliament agreeing to the government's policy would be very damaging.'

The government's intention to reclassify the drug goes against the advice of the Advisory Council on the Misuse of Drugs (ACMD), which recommended that the drug remains a class C substance – 'after examining all the available and latest evidence on short- and long-term health risks, as well as social harms, public attitudes and policing priorities,' says the letter. To act against it would be a 'sad departure' from the trend of public policy following expert scientific advice, it says, and would mean that government has 'rejected the explicit advice of its appointed experts, the ACMD, for the first time in nearly 30 years.'

The letter is signed by two former chief scientists – Sir David King and Lord May – as well as former head of the Medical Research Council Professor Colin Blakemore, chair of the Academy Medical Science working group on addiction Professor Gabriel Horne, President of the Royal College of Physicians Professor Ian Gilmore and former ACMD chair Professor Sir Michael Rawlins, among others.

The letter points out that cannabis use has fallen since the drug was downgraded and that reclassification would put the entire credibility of the system at risk. '(It) would send out an ambiguous message about the dangers of current class B drugs,' it says. The letter urged peers to support an amendment by Baroness Meacher to postpone any reclassification until after a further ACMD review in 2010, a move that was rejected by 116 votes to 64.

Championing the fight against youth alcohol

The winners of this year's Mentor UK CHAMP awards for tackling alcohol misuse among young people have been announced at a ceremony in London.

The projects – selected by panels of children and young people – were presented with cheques for £10,000 and will also receive mentoring and consultancy support.

The winner in the schools category was Kirklees-based Adolescents Anonymous, which looks at the effects of alcohol misuse on three young people at different stages of their lives. A DVD designed and written by young people, which comes with lesson plans, has been shown to 11- to 14-year-olds across the region to promote sensible drinking.

In the communities section the winner was P.A.R.T.Y (Providing Alcohol Related Training for Youth) by Youth Alive in Dumfries, an interactive 12-week education programme designed to give young people entertaining alternatives to drinking. And in the young people's involvement category, the winner was LookOut Alcohol from Lancashire, a website that involved primary school pupils in every aspect of its production and features downloadable lesson plans, homework based activities and an information section for parents and carers.

The other shortlisted finalists in the communities category were Strengthening Families, Cardiff and Mitalee Summer School Project, Luton; in the schools section, Alcohol Workshops, Churches Action on Substance Misuse, Wirral, Take Risks? Take Care!, Durham and Ludlow Alcohol Project, and in the young people's involvement category, Truth Is: A Denton Alcohol Free Poster Campaign, Newcastle and Wasted, Space2, Leeds.

'The media constantly bombards us with negative images of young people – especially around misuse of alcohol,' said Mentor UK CEO Eric Carlin. 'The Mentor UK CHAMP awards prove that there are alternatives and that there are great projects out there helping young people make sensible choices and live healthy lives.'

www.lookoutalcohol.co.uk/welcome.html

News in Brief

Professional help

Doctors and dentists with addictions are to receive treatment as part of a two-year NHS pilot scheme. The Practitioner Health Programme is a free, confidential service for London-based professionals who 'have mental or physical health concerns and/or addiction problems.' Patients will be seen at a specialist GP centre before being referred for onward treatment and care. 'It is absurd that it has taken so long for the country to invest in a programme that helps those who care for our health,' said Nick Barton, chief executive of Action on Addiction whose Clouds House centre will provide treatment. 'They are as much at risk as the rest of the population. This programme represents a huge step forward.' *www.php.nhs.uk*

Liver deaths rise

The number of deaths from alcoholic liver disease rose by nearly 7 per cent to 4,450 in 2006, according to figures released by the Office for National Statistics. Liver specialists are now 'regularly' seeing people who have developed alcohol-related liver cirrhosis in their 20s and 30s, according to the British Liver Trust. 'This is the progression of the epidemic we and the medical profession have been predicting for several years,' said the trust's Imogen Shillito. 'These figures reinforce our call for urgent work to improve early diagnosis and encourage prevention.' A new code of conduct to outlaw happy hours and irresponsible drinks promotions in bars and clubs is expected to be announced this week.

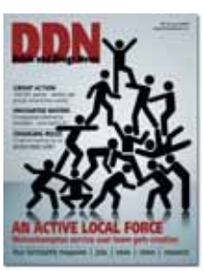
www.statistics.gov.uk/downloads/theme_health/DR-2006/DR_06Mort_Stats.pdf

Get Smart

A new service for steroid users in London has been launched by Turning Point, following the success of a pilot project run in partnership with Hungerford Drug Project (*DDN*, 22 October 2007, page 8). Smart Muscle has been launched in response to the increasing numbers of steroid users presenting at needle exchanges. 'We are seeing young guys in their early twenties who are injecting drugs they don't even know the names of,' said service manager Roy Jones.

Don't look back in anger

The new ten-year drug strategy finally saw the light of day, followed by punitive benefit reform proposals for drug misusers in the welfare green paper; the government at last appeared to be losing patience with ineffectual self regulation for alcohol, and there was fresh fighting on the traditional battlefields of harm reduction versus abstinence... and the BBC versus the NTA. DDN reflects on a combative year



JANUARY

The year began on a sobering note when a MORI poll revealed a depressing snapshot of public attitudes to drug use. Almost a third of people questioned could not identify sharing needles as a means of transmission for HIV but two thirds thought that those who had become infected through drug use 'had only themselves to blame', revealing a 'culture of blame that would never be associated with any other illness,' according to National Aids Trust chief executive Deborah Jack.

The International Harm Reduction Agency (IHRA) tackled stigma head on by calling for an end to the use of the death penalty for drugs offences – still on the statute books of more than 30 countries worldwide, and the government tried to do its bit to tackle ignorance by promising a renewed commitment to improving drug and alcohol education as part of its 'children's plan'. Ten months later this would bear fruit when the Department for Children, Schools and Families (DCSF) announced that personal, social and health education (PSHE) would become compulsory for all Key Stage 1 to 4 state school pupils.

And the first ever DDN/Alliance conference, *Nothing about us, without us*, saw more than 600 delegates – nearly three times the original projected figure, and two thirds of them service users – gather in Birmingham for a day of vibrant debate on the best way forward for user involvement.

FEBRUARY

Home Secretary Jacqui Smith's announcement of more powers for police to confiscate alcohol from those under age signalled the largely criminal justice-based approach to alcohol misuse that would characterise government policy throughout the year, although the Department of Health did also issue its first alcohol indicator for the NHS as part of its 2008/09 operating framework. Mental health charity Rethink meanwhile urged the government to 'stop wasting time and money' debating cannabis classification and focus on education instead.

The announcement that a series of events on whether abstinence should be the 'gold standard' treatment goal were to be called 'the great debate' was more than prescient in the light of the arguments that raged in these pages through much of the year.

MARCH

The new ten-year drug strategy was launched to a largely underwhelmed sector, despite prime minister Gordon Brown's assurances that individual responsibility would be rewarded with real support. Agencies expressed concern at 'headline grabbing' plans to 'incentivise' people to engage with services – a debate that continued with the government's controversial welfare reform Green Paper later in the year – and Transform called the strategy a 'miserable regurgitation of past mistakes'. A report from Addaction meanwhile estimated the cost of substance misuse related crime over the ten-year period of the previous strategy at a staggering £100bn.

The UN's International Narcotics Control Board (INCB) urged member states to improve access to treatment, while Neil McKeganey's opinion piece on professional standards in the sector led to a war of words on our letters page.

APRIL

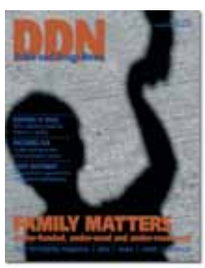
The Ministry of Justice and Department of Health announced extra cash to improve prison drug treatment, but Action for Prisoners' Families (APF) said more support was also needed on release to prevent relapse and a return to crime. The Centre for Policy Studies set up its own Prison and Addiction Unit (PandA) to challenge the government's 'fundamentally flawed' drugs policy, calling the NTA a 'monolithic treatment bureaucracy' and DATs 'expensive quangos'.

The government promised more funding to medical schools to incorporate alcohol training into the curriculum, as Alcohol Concern warned that the focus on binge drinking meant the NHS was failing to deliver adequate treatment to dependent drinkers, while National User Network (NUN) members were appalled at Merseyside Care NHS Trust's 'Get Clean' campaign using images of mocked-up household cleaning products.

MAY

The UN warned that the scale of Afghanistan's opium cultivation would lead to 'unmanageable problems' both in the region and worldwide, while the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) launched an international research project to improve the health of older drug users – the number of over 50s needing drug treatment could rise by up to 300 per cent by 2020, it warned. The Scottish Government said the country's annual alcohol bill now topped £2.25bn if all the health, criminal justice and social costs were taken into account.

Home Office minister Vernon Coaker spelled out the thinking behind the new drugs strategy in these very pages, while our 'Different paths' feature on maintenance versus abstinence ensured a bulging postbag for weeks to come. DDN produced daily magazines at IHRA's lively International Harm Reduction conference, which saw policymakers, treatment specialists, service user activists and representatives from the UN gather in Barcelona to debate the very best practice in the field.



JUNE

Our report on the UKDPC's attempts to come up with a new definition of recovery reignited the debate over abstinence versus harm reduction, while Scotland launched its new drugs strategy with an acknowledgement that it would need to be backed up with policies focusing on the underlying causes of drug misuse, like poverty. It 'rightly made clear' that housing, training, employment and family support played a huge

role in preventing people from developing drugs problems and helping them move away from them, said the Scottish Drugs Forum.

The Scots also consulted on raising the minimum age for alcohol off-sales to 21, setting a minimum price for a unit of alcohol and ending irresponsible drinks promotions, while south of the border new figures from the NHS Information Centre showed that alcohol-related hospital admissions in England had more than doubled since 1995. The government launched a £1m FRANK campaign to 'deglamourise' cocaine use in the eyes of young people as a UNODC report stated that coca cultivation in Columbia, Bolivia and Peru was at the highest level since the beginning of the decade.

JULY

Proposals that could see problem drug users lose benefits if they did not seek treatment and face fraud investigations for failing to declare heroin and crack use were included in the welfare reform green paper, *No one written off*. They were based on a deal of 'more support in return for greater responsibility' said work and pensions secretary James Purnell, echoing the drugs strategy, but many in the field felt them unnecessarily punitive and ill thought-through – 'talking tough for the sake of it,' said Turning Point.

A survey of police, councils and the NHS by the Local Government Association found that the main impact of the 2003 Licensing Act on incidences of drink-fuelled violence and disorder had simply been that they now occurred later at night, while a ruling by the Portman Group's independent complaints panel somehow found that cans of Special Brew and Tennent's Super did not encourage irresponsible drinking, following a complaint by homelessness charity Thames Reach. The government however warned that the industry's days of voluntary regulation 'could soon be over' as it launched a major consultation on retailing codes of practice.

AUGUST

Even large-scale drug seizures had little impact on the availability of drugs, according to a UKDPC review, which called instead for resources to be targeted on reducing the impact of drug markets on local communities. 'We were struck by just how little evidence there is to show that the hundreds of millions of pounds spent on UK enforcement every year has made a sustainable impact and represents value for money,' said co-author Tim McSweeney. Meanwhile the number of men dying from drug poisonings in England was it its highest for five years, according to the NHS Information Centre.

SEPTEMBER

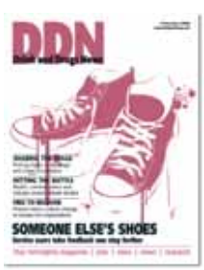
FRANK funding was money well spent, according to helpline advisor John McCulloch who told *DDN* about the challenging but rewarding work. 'We act as a filter,' he said. 'If every person that was concerned about drugs presented at their local addiction service then they would be more inundated than they already are.'

The ACMD debated the classification of ecstasy, while a UNODC report said the drug – along with other 'synthetic' drugs like amphetamine and methamphetamine – was becoming increasingly popular in the developing world. Countries were being targeted by organised crime groups drawn by inadequate resources and lack of regulation, it said.

OCTOBER

Not for the first time, BBC home affairs editor Mark Easton locked horns with the NTA, this time over its announcement of 'watershed' numbers of people successfully completing drug treatment when just 3.6 per cent were discharged free of illegal drugs. To claim the system was 'failing', however, was inaccurate, said DrugScope. 'Overcoming a drug dependency can take many years and unless the complex factors which contribute to drug use are addressed, relapse is a possibility,' said chief executive Martin Barnes.

The Home Office announced those caught carrying cannabis for a second time could face an instant £80 fine rather than a warning, while research findings published in the BMJ revealed that the UK death toll from smuggled tobacco was greater than all illegal drugs combined.



NOVEMBER

The extent of drug trafficking through West Africa had reached an extent that was threatening the security of the region, according to UNODC. The Gold Coast had become the 'coke coast', said executive director Antonio Maria Costa, estimating the value of drugs now passing through the region at $2bn per year.

The Department of Health announced it would 'fast track' help to 20 of the areas worst affected by alcohol misuse in the form of regional alcohol managers and increased access to treatment, while the Home Office launched nine new pilot arrest referral schemes for alcohol-related offences. Meanwhile, as the abstinence versus harm reduction debate continued to split the sector, Alliance policy officer Peter McDermott felt 'recovery' had become the 'most popular piece of jargon for state drugs apparatchiks'.

DECEMBER

DDN is launching its exciting new website for readers to keep abreast of the latest news, views, analysis and controversies from the field, and is putting the final arrangements in place for the second national service user conference, *Voices for choices*, in Birmingham next month. See you there!

Policy notes

DIRTY TRICKS

Using Baby P's death to fire a shot at parents who are prescribed methadone is not just inaccurate – it's a cynical ploy to discredit treatment services for political ends, says Sara McGrail

THE CENTRE FOR POLICY STUDIES Daily Blog on 13 November plumbed new depths of spin when it ran Kathy Gyngell's piece on the death of Baby P in Haringey. In it she talks at length about how 'liberal fascism' and a reliance on systems and structures rather than individual responsibility directly led to this child's death. In this the piece differs little from what's been written about this tragedy in a number of the national papers.

But then the piece moves into quite different territory. The focus shifts from events in Haringey, to the matter of drug dependent parents and specifically what is referred to as 'the state sponsored drugging of some 200,000 adults with the prescribed opiate substitute, methadone'. What relationship this has to the awful death of Baby P isn't explained. That's because there is no connection. As far as is known, neither of the parents was prescribed methadone or in touch with any drug service. Drug treatment was not an issue.

This is one of the oldest tricks in the book. The author seeks to create a connection between two otherwise unconnected issues in the reader's mind to support a political conclusion. In this case Gyngell set out to make people believe that there is a strong causative connection between child abuse and methadone prescribing. I guess she must believe that spinning such a tragic story is OK if it can shift policy away from harm reduction and prescribing, towards an approach that focuses primarily on encouraging abstinence and prioritising prevention. It's shabby, unpleasant and misleading – but it's nothing new.

Drug use and drug users have long been on the receiving end of this sort of treatment in the media and in society. People who've experienced problems with drugs who are trying to get back into the workforce or to access housing and support from mainstream services face immense problems as a result of the stigma associated with drug use. This stigma has increased over the past few years – but there can be no doubt that we need to tackle it head on if we're to maximise people's opportunities for recovery.

Lately there have been a number of commentators who have been very keen to push their own particular version of 'recovery' just by discrediting other forms of treatment. Like the Centre for Policy Studies, they seek not to reduce stigma or increase understanding but to condemn people in treatment, those who provide that treatment, and the treatment approach itself.

It's a dirty trick – and one that could cause real harm to communities, families and individuals.

It's said that the biggest divide in the drugs field is between those who believe in abstinence and those who believe in maintenance. I don't think that's true. To me, the real divide is between those who want to impose solutions on people and refuse support to those who don't fit into their narrow view of treatment – and who, like the Centre for Policy Studies will go to any lengths to make their case whatever the impact – and those who believe in putting the people, not the politics, first.

Sara McGrail will feature as a columnist for independent policy commentary in alternate issues of DDN. Her website is at www.saramcgrail.co.uk

'...do these people really believe that all of the doctors, all of the nurses, and all of the social workers employed in the drug treatment field are providing the people who use their services with a treatment that makes them worse rather than better?'

WAY OFF BEAM

Last week we were treated to a glimpse at the real face behind the 'abstinence at all costs' lobby, when Kathy Gyngell attributed the blame for Baby P's death not to the people who wielded the fatal blow, but to 'government apparatchiks, indoctrinated by the higher demand of process at the price of humanity.' *[See column, left – ed.]*

In a clumsy sleight of hand, Gyngell then switches her focus to her estimated 200,000 people who are the victims of 'state-sponsored drugging' in the UK, something she claims is 'catastrophic for the increasing numbers of children involved'.

People who weren't watching closely might be forgiven for thinking that Gyngell was suggesting that the parents of Baby P were problem drug users enrolled in drug treatment. There's been no evidence to suggest this, but why let the facts get in the way of a good rant – especially if we can stigmatise a whole population of service users and treatment providers into the bargain!

A recent story in the Observer *www.guardian.co.uk/society/2008/nov/16/drugs-methadone-rehab-heroin-addiction* provides one mum's account of the way that methadone maintenance enabled her to bring her chaotic drug use under control, and provide a decent life for her children. My own experience of methadone treatment was very similar. The youngest of my three children recently left the family home to follow her siblings and attend university. Despite my 'state-sponsored drugging', none of them have ever been in trouble. My guess is that their lives would have looked very different had I not had access to methadone maintenance.

Of course, not everybody is as responsive to methadone as the mum in the Observer story. Different things work for different people. But do these people really believe that all of the doctors, all of the nurses, and all of the social workers employed in the drug treatment field are providing the people who use their services with a treatment that makes them worse rather than better? Kathy Gyngell clearly does. What about the rest of her ideological cohort?

When the drugs field virtually abandoned maintenance treatment during the late 70s and early 80s, they did so believing exactly this. They came to accept it primarily on the basis of the overwhelming

evidence that it provides significant benefits in terms of health gains, offending gains and improvements in social functioning – all gains that the evidence shows to be markedly superior in terms of the number of people who can benefit – when compared with all of the other treatments out there.

Let's not forget that not everybody is responsive to residential rehab either. Go to any methadone clinic, or any drug dealer and you'll find no shortage of people who believe they got no benefit from abstinence-based treatment. The treatment system must provide people that have drug problems with maximum opportunities to stabilise and improve.

Unfortunately, choice is precisely what Gyngell and the rest of the anti-methadone lobby, oppose. They insist that only one form of recovery – the type that involves total abstinence – is valid. Anything less than this is woefully inferior, doesn't count as recovery at all, and invariably results in abusive parents who are wasted on a government-sponsored supply of drugs.

What Gyngell refers to as 'state sponsored drugging', is, in fact, a treatment that has been recommended for its effectiveness by the National Institute for Clinical Excellence (NICE), and the benefits of which have been replicated by robust research from all around the world. But this kind of stigmatising attack doesn't go unnoticed. It is spouted by people in the field, and picked up by the national media. Mothers read and hear these views expressed, and they decide that the last thing they want is to be thought of as being a bad mother.

But they don't dump their children with their nanny, and pop off to the Priory for a couple of months. What many will actually do is avoid treatment altogether, and struggle to maintain an illicit habit. In a context like this, children are much more likely to suffer than they are when their parents are actually in treatment, doing away with things like the need to go out and earn large sums of money to support their habit, or hanging around for hours on street corners, waiting for dealers to arrive. Such attacks are not only offensive, they're also grossly irresponsible. Kathy Gyngell and the others who parrot these moralistic attacks should hang their heads in shame.

Peter McDermott,
press and policy officer, The Alliance

STRANGE DLA DECISIONS

I thought I would write a wee letter to inform readers of changes that seem to be affecting the Disability Living Allowance (DLA).

Recently a close friend went for a DLA tribunal meeting. She fulfilled all the criteria to be entitled to DLA benefits.

The interview lasted the best part of an hour, and my friend spilled her guts about her illness. Medical evidence and documentation were also given to the panel.

She was then asked to leave the room and was later called back in to be told (and I quote) 'We do not believe you!' You may find this decision as strange as I do.

Since that happened, my friend has threatened suicide and now has a phychiatrist and two community psychiatric nurses visiting three times a week for the next month.

Surely treating those of us with mental health issues like this is totally unacceptable. This new way of dealing with DLA clients has been reported to me by several phychiatrists claiming their patients have been left traumatised, and other clients who have basically given up on their claims as they are confused about decisions.

I ask myself how this can be happening in our society, treating respectable ill people like this. Trauma is the word that I think of when I see these strange decisions – so come on benefit agency bosses, what is going on with DLA, and why has your new agenda not been publicised for the public to see?

Come out of the middle ages and get with the age we live in. Come out of the darkness and into the light of truth, and start treating your clients with respect, humility – and most of all honesty.

Bri, Cumbria Users Groups

'IN PURSUIT' RESPONSE

Simon's letter (*DDN*, 17 November, page 10) in response to my article 'In Pursuit of Truth' raises some key points to which I would like to respond.

First though I would like to say that I am in awe of the many professionals in the drugs field who work tirelessly for the health and wellbeing of their clients. As an ex-drugs worker I know the demands that the work places on them. Transform is keen to see drug workers involved with challenging the status quo and I would like to thank Simon for his support for our work. However, I would also suggest that prohibition is a big part of the reason why Simon and his colleagues are so overworked – firstly because prohibition creates so much harm and second because the collateral harm prohibition produces, has also led to a significant funding stream that pays the wages of many drug workers. There is nothing to stop drug workers speaking out openly as part of their work and at the least, (in their spare time) writing a letter to their MP. Anyone wanting to find out more about what they can do to push for reform can visit our website.

Second, not taking a position on prohibition *is* a position and, at the institutional level, the big treatment and harm reduction organisations have chosen this as their default stance. RAPt has even gone as far as suggesting on its website that: 'Prison is an ideal time for offenders to break the cycle of addiction, crime and imprisonment. Many use this as a reminder of the consequences of their addiction to make a determined effort to change their lifestyles.' Aside from asking how imprisonment breaks the cycle of prison, it begs the question, to what degree are these the consequences of addiction and to what degree are they attributable to prohibition?

Lastly, the question, again, for treatment providers and harm reduction organisations that choose the 'position of not taking a position on prohibition' is, whose interests are being served by failing to 'bring out the truth'?

Danny Kushlick, head of policy and communications, Transform Drug Policy Foundation, www.tdpf.org.uk

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.

Media Watch

A quarter of people surveyed said they were troubled by anti-social behaviour including drunkenness and drug dealing, according to the annual British Crime Survey published this week. Shadow Home Secretary Home Secretary Dominic Grieve said the findings 'betray ten years of failure by Labour', but Home Office minister Vernon Coaker wanted communities 'to know we are on their side'. 'That is why we have rolled out neighbourhood policing teams in every area,' he added.
The Independent, 28 November

Flip-flops are Torbay's latest weapon against binge drinking. Police and safety officials are gearing up to hand out plastic sandals to revellers who are spotted staggering home worse for wear in unstable high heels or bare feet, toppling over or 'dodging the broken glass or rubbish' in the seaside resort. The initiative will also give officers a chance to speak to young people about their overall safety as well as the immediate comfort of their feet, according to Superintendent Chris Singer. Matthew Elliott of the TaxPayers' Alliance called it an 'idiotic waste of money', adding: 'The police aren't there to be an emergency supplier of flat shoes'.
The Guardian, 28 November

The Scottish Government is under pressure to counter the 'escalating' use of methadone. Highlighting a rise in the annual methadone bill to £25.7 million, Scotland's Conservative leader Annabel Goldie has written to First Minister Alex Salmond to criticise the country's over-dependence on the heroin substitute. She welcomed the recognition of recovery and abstinence in the government's national drug strategy, but said the latest methadone bill showed 'the problem is escalating, not diminishing'.
The Herald, 16 November

'When I see a young patient with a heart attack, one of the first things I think of is cocaine,' says Dr Chris Baker, an interventional cardiologist in London. Coke-related heart attacks were more common in people who used cocaine a lot because they got furring of the arteries – but it could still happen to someone who had taken the drug as a one-off, said Dr Baker.
The Guardian, 16 November

A Cape Town addiction clinic is using surfing to give its clients 'new enthusiasm for life'. Catherine Pike is among the first-time surfers on the course at the Tabankulu Recovery Centre, and hopes to use the 'spiritual' activity to break her addiction to dysfunctional men. 'Being on the ocean gives you time to think and reflect,' she said. 'When you get out there it clears your mind.'
The Times, 28 November

The government has made it clear that tackling alcohol-related offending is a priority – what's not so clear is what works best in doing that. **David Gilliver** reports from the recent NOMS best practice conference on alcohol

Knowledge is key

'We all know that public expenditure is tight at the moment, and particularly tight in the Ministry of Justice. But that's no reason not to keep thinking about the development of good services and good quality interventions.'

Rehabilitation of Addicted Prisoners Trust (RAPt) chief executive Mike Trace was addressing the *NOMS Same again? Break the cycle* conference in London last month, which looked at how best to reduce alcohol-related offending and strengthen delivery of services. Alcohol is a factor in half of all violent crime, and 63 per cent of sentenced males and 39 per cent of sentenced females report a hazardous drinking pattern before entering prison. Around 8 per cent of prisoners are physically dependent on alcohol, while 41 per cent of offenders assessed in the community have an alcohol problem linked to their offending.

One problem, Trace told delegates, was that there were simply not the same sort of studies on alcohol and offending as existed for drugs. With drugs there were three potential causal links with offending – law offences, raising money to buy the substance, and crimes committed under the influence. 'They're simplistic categories but they're helpful to think through the issue,' he explained.

Property crime had driven most drug treatment strategy, as people clearly needed money to support their habit, while alcohol was more complex – it was unlikely that someone would have a £500 week alcohol habit, for example. 'There might be a closer correlation than we generally accept, but we don't have the sort of studies that say "this is the extent to which people commit property crime to raise money to buy alcohol". There is a potential that the same sort of link is there, but at lower financial levels.'

But by far the most pressing issue in terms of crimes committed under the influence of alcohol was violence. His organisation believed in targeted interventions but with alcohol the question remained who to target. 'We can talk about a cohort of offenders who are hazardous or harmful or dependent drinkers, but it's not so easy to say "it's only this group we're worried about" when talking about offences committed under the influence of alcohol.' Having an impact on the violent crime associated with alcohol would mean interventions with a wide range of people from a wide range of backgrounds, he said.

Some methods of identifying target groups for drugs interventions were proving their feasibility with alcohol-related offenders – using point of arrest or court appearances to identify, assess and make arrangements for intervention, as well as effective projects using health and social services routes.

Overwhelmingly, however, the problem remained prioritisation. 'Where we are in the UK at the moment is identifying potentially how many people should receive some sort of intervention – through arrest and court case loads, GP case loads, A&E, social services and domestic violence circuits,' he told the conference. 'We are starting to identify the depth of the need, but at a time when there's no money around to meet that need.'

That did not mean there were no policy opportunities, he stressed, as alcohol was the government's main long-term strategic health issue, alongside obesity. 'But it's difficult to say "we've made the investment argument, let's create the budget" as we did in the late '90s with drugs. It's not the first term of a new government and it's not a good time to come up with new ideas for public expenditure.'

Instead now was the time for amassing the next stages of evidence and building the argument for greater investment, he said – improving research and information management and implementing pilot projects to demonstrate what would have an impact on crime and health. 'We've got to prove the impact in this sector,' he told delegates. 'So if there is any opportunity for increased investment – whether it comes from health or justice – then it's clear what sort of models are able to deliver the goods.'

One example was the intensive alcohol programme RAPt had been piloting in Bullingdon prison in Oxfordshire since early last year, he said, which had achieved an 89 per cent completion rate in its first year. 'There's a real resource problem – the key elements of what's needed for a very successful alcohol-related offending strategy are coming together – we need to keep our focus on developing our models and proving the case.'

Justice Minister David Hanson agreed that an inability to properly assess what worked and what needed to work in the future was a problem, but told delegates that NOMS had been working closely with the National Addiction Centre at King's College on screening interventions, and the findings would help develop a toolkit to put screening on a more professional basis.

NOMS had also improved the range and quality of alcohol interventions at different stages of an offender's contact with services, he said, making it a priority to increase its capacity to deliver brief interventions. Substance misuse services for 16- to 18-year-old prisoners now had a particular focus on alcohol, while the number of alcohol treatment requirements (ATRs) had increased from just over 2,000 in 2005 to more than 5,000 in 2007/08 and PCTs with a prison in their locality now had the responsibility for commissioning health services for prisoners based on need.

Professor of addiction psychiatry at the National Addiction Centre, Colin Drummond, told the conference that evidence for screening and brief interventions (SBI) from primary care showed it was both effective and cost-effective in reducing levels of alcohol consumption and re-admission.

Screening was most feasible in prisons, because of its – literally – captive audience, but brief interventions in that setting were more problematic. 'There's a very high prevalence of AUDs

(alcohol use disorders) across criminal justice settings, but probation is probably more feasible than other settings for SBI,' he said. But there were specialist training issues in criminal justice settings, as probation staff were less used to delivering this sort of work than healthcare workers, with the situation further exacerbated by heavy caseloads and high staff turnover.

'We are beginning to put the right tools with the right people to look at the right offenders at the right time,' David Hanson stressed. 'But I recognise that we need to do more to improve the way alcohol-related offenders are dealt with both in the community and in custody.'

Reducing re-offending was a key priority, he said, and rates of re-offending were falling. He acknowledged that availability of treatment had been patchy and inconsistent, with the National Audit Office critical of the amount of treatment available to the probation service to deliver ATRs. However a strategic review of provision was being carried out, he said, and his department had also introduced ATR completion targets for NOMS.

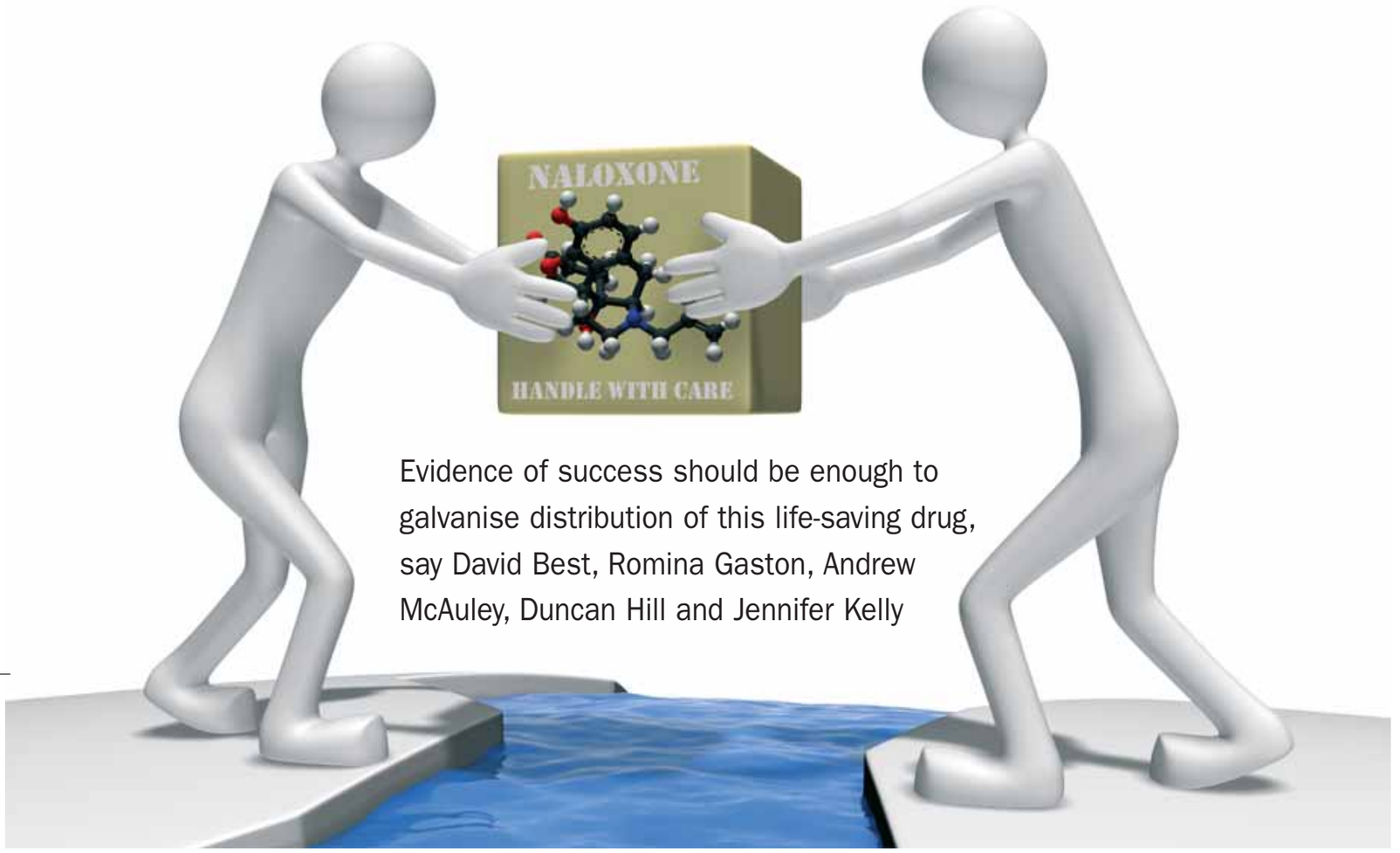
But increasing the availability of interventions was not sufficient in itself, he acknowledged. Offenders started their sentences with a range of problems, and effective treatment needed to take a holistic approach including the provision of background services. Continuity of care in terms of accommodation and employment was not at the extent he would like to see, and needed effective working partnerships between departments, agencies and providers to make sure offenders did not fall through the gaps.

Earlier in the day he had visited the Southwark offices of the London Probation service to see offenders on an ATR as part of their community sentence. Southwark's case load is a heavy 2,000 clients a year and it has been running an effective LIAP (Low Intensity Alcohol Programme) since 2006, as well as ASROs (Addressing Substance Relating Offending) for those with a serious alcohol problem.

'We're very committed to supporting community-based approaches, because alcohol is a major driver of low-level crime ' he told *DDN*. 'We need to challenge the behaviour that led to the crime in the first place.' The Southwark programmes were good examples of reducing re-offending, he said, as LIAP aimed to help offenders understand their drinking, set goals for controlling it and realise the links between drinking and other areas in their lives. 'We need to get people to realise the impact their drinking has on themselves, their communities and families. What we have to do is up our game on alcohol,' he said, acknowledging that drugs had been the primary focus up to now.

LIAP's project manager Phil McNerney told the conference that the programme had been launched to fill an identified gap in the market – drawing on a range of models, it is a 14 session programme that had been piloted over two years. 'We wanted to make sure we targeted a lower risk group,' he said. 'There's been good feedback from both staff and offenders, which is unusual for a pilot.'

'A lot has happened but I'm definitely not satisfied with where we are at the moment and what we need to do in the future,' David Hanson told the conference. 'There are real resource implications and there will be challenges, but we need to look at what works, what it costs and how it makes a difference to re-offending. Those are simple things that I need to look at all the time – not because I'm trying to make economies and cuts, but in terms of how we get best value. And that's about what changes people's lives, what reduces their offending behaviour and what we can get out of the investment to maximise the participation of voluntary sector agencies and prison and probation working together. I need to know what can make a difference – not just what the programmes cost, but what they achieve.'



Evidence of success should be enough to galvanise distribution of this life-saving drug, say David Best, Romina Gaston, Andrew McAuley, Duncan Hill and Jennifer Kelly

The stuttering story of naloxone distribution

In spite of a national target in the new drug strategy, a recent report from the Office for National Statistics (August, 2008) indicates that male deaths from drug poisonings are at their highest rate for five years – 1,914 male deaths from drug poisoning in England and Wales in 2007.

Yet this is not new. Between 1997 and 2002, opiates accounted for 6,194 deaths in England and Wales (ONS, 2004). In Scotland, the annual drug death figure in 2007 was 455 according to this year's figures from the General Register Office for Scotland (GROS) – up 8 per cent on the previous year and 103 per cent higher than the recorded number in 1996. Like England and Wales, most of these involve male opiate users between 25 and 44.

The majority of opiate-related deaths result from accidental overdose, with at least 50 per cent of opiate users having experienced a non-fatal overdose (Coffin *et al*, 2003), and many overdoses occur in the presence of witnesses, most of whom are willing to intervene although not always skilled to do so effectively (Man *et al*, 2002). These factors combine to create a compelling case for the use of naloxone and indeed since 1996, there have been calls in the UK for increasing its dissemination (Strang *et al*, 1996). In 2005, the NTA funded a national training programme (described in Strang *et al,* 2008), in which 20 specialist drug services across England participated, resulting in the training of 219 clinicians and 239 services users. Of those 239 users, 186 were followed up an average of 2.5 months after the training. Of the 18 overdoses witnessed, naloxone was used on 12 occasions. On each occasion naloxone was given, the overdose was successfully reversed. Sadly in one of the six occasions when naloxone was not used, the overdose victim died.

Consistent with a growing range of international studies, the National Addiction Centre project 'identified high rates of personal and witnessed overdose among opiate users attending drug treatment services and high levels of support for widening the availability of take-home naloxone to prevent fatalities' (Strang *et al*, 2008, p94).

Where are we now?

Given this endorsement, shouldn't we expect a rolling out of naloxone with a national strategy, possibly a national harm reduction strategy? After all, it was the NTA who commissioned the study and the NTA who received the report endorsing its benefits.

It hasn't happened. Instead, we have groups of brave clinicians and user groups who plough a lone furrow without national guidance, support or coordination.

In contrast, the position in Scotland is more encouraging, and in 2008 the Scottish Government recommended the provision of take home naloxone pending the successful pilots in Glasgow and Lanarkshire.

So what is the current position? In several DAT areas in England, as well as in Glasgow and Lanarkshire, there have been major local commitments to both naloxone practice and policy as described here:

Birmingham: Following the national pilot, Birmingham DAAT supported a user-based dissemination model, based on increased user ownership of the scheme. At present, there is a 'rolling roadshow' of naloxone training in which one medic and two service users deliver a two-hour package of training in basic overdose awareness and use of naloxone. At the end of the session, the successful trainee is given a certificate to indicate that they have completed the training. In the absence of a prescribing doctor at the training, trainees receive a signed letter that they take to their GP – together with the certificate – to prescribe naloxone. The current programme covers specialist services, and in 2009, this will be extended to services accessing high-risk groups, such as bail and homeless hostels. The training includes a pre- and post-evaluation and a follow-up interview at three months, as part of an ongoing evaluation.

Blackfriars Road and Beresford Project (South London and Maudsley NHS Trust): In these services, there has been a more systematic linkage of naloxone prescribing to treatment induction, with key workers delivering the training and the prescription given as a standard part of the initial treatment package – even if the client is not believed to be an injector of heroin. A similar approach has been used in Salford in the North West, to attempt to link naloxone distribution to prescribing treatment services to ensure that a much wider coverage is achieved.

South Gloucestershire: Here a more ambitious project has attempted to extend distribution beyond specialist prescribing services. Outreach workers in association with the British Red Cross have been running regular sessions in overdose management with opiate-using females released from HMP Eastwood Park women's prison, where healthcare staff has also received training. In this area, naloxone is also available in the drop-in Harm Reduction Clinic where a Patient Group Direction (PGD) has been put in place for the use of nurse prescribers.

Lanarkshire: In an initial pilot, naloxone training and distribution was conducted on the basis of a 'buddy' scheme in which users were required to bring a friend or family member to the training. While this may have limited participation, it provided a safety net in the event of the users overdosing themselves. Clients were also asked to sign an 'agreement of trust' before being issued their naloxone which ensured they were aware of their responsibilities and the risks involved, should the naloxone be diverted to an untrained individual. The other critical component of the Lanarkshire study in developing an evidence base was that all reported overdoses were subjected to collateral verification with the ambulance service or police. This scheme is now being rolled out as standard practice within Lanarkshire, with monthly naloxone training courses for clients scheduled from November 2009.

Glasgow: In the initial pilot, which has been evaluated and extended, the benefits of the provision of naloxone and the associated training have been clear, with 15 successful reported uses from 450 naloxone kits issued. The pilot was developed through a multidisciplinary team involving Glasgow Addiction Services, NHS Greater Glasgow and Clyde, Glasgow City Council, Scottish Drug Forum, Strathclyde Police, Scottish Prison Service, Glasgow Association of Family Support Groups and HeartStart UK. The training consists of a two-hour session involving overdose awareness and life support skills, and is a mixture of short presentations and a practical session. Either pharmacists or nurses at the training supply naloxone through the use of a Patient Group Direction (PGD). HeartStart UK accredits the basic life support training, and participants are issued a certificate at the end to demonstrate competence. These sessions have been open to and attended by Crisis Centre (GDCC) residents, residential and day programme clients, family support groups and drug users.

Thus, we have a growing evidence base and significant local commitments to effective and safe distribution, sustained by positive evaluation and evidence of successful 'reversals'.

So what are the barriers to wider implementation?

Worker ambivalence: In the national study (Strang *et al*, 2008) and the Birmingham pilot (Gaston *et al*, submitted) there were many workers trained, who subsequently trained none of their clients. Perceived barriers included not seeing it as part of their duties, lacking the resources to deliver the training or the prescription, and the belief that clients were not suited or not interested. These issues will have to be overcome if the staff training route is to become the primary delivery mechanism.

Concerns about legislation: An amendment to the Medicines Act, which added naloxone to Schedule 7 in 2005, alleviated some concerns. This change allowed members of the public to administer naloxone for the purpose of saving a life. This is especially welcome given evidence of willingness by observers to intervene in overdoses. However the legislation change does not ease the practicalities of obtaining naloxone as it remains a 'Prescription Only Medicine' (POM), which means it can only be prescribed in an established relationship between doctor and patient, despite awareness that the person prescribed naloxone will not be able to use it on themselves! Anxieties remain about legal consequences (civic and criminal) for misuse or adverse outcomes, despite there having been no reported cases of misuse, nor of adverse health effects in the pilot sites.

Concerns about formulation: Legitimate concerns remain about the use of naloxone and potential consequences for those who administer it. For instance, intramuscular (IM) injections can result in needle-stick injuries and the reversal of the opioid effect can lead to agitation and violence following intense withdrawals. In addition, there are concerns that emergency services are not always contacted after peer use, resulting in the victim returning to an overdose state due to the short half-life of naloxone. These issues must be addressed in the training and distribution programmes. First, naloxone training must emphasise the importance of calling an ambulance and the need for ongoing care. Second, East Midlands Ambulance Service has started using naloxone nasal spray, which allows multiple applications, reduces the risk of injury and reduces the stigma of carrying needles. However, this formulation of naloxone has not yet been licensed in the UK and the lack of an available product remains a problem.

Lack of policy direction and prioritisation: In the world of NTA targets, if something is not a target, then commissioners, with all good intentions, will not prioritise it, particularly when time and resources are scarce. Naloxone training and distribution is a simple way of saving lives, yet the implementation of naloxone programmes is complex and the work from 'bottom to top' without commissioner involvement has been effective but slow, and reaches small numbers. Clear national guidance is essential to overcome some of these barriers.

Local variation in naloxone programmes: Currently there is marked variation in the content and length of training programmes. Standardisation of training would benefit future naloxone distribution schemes and reduce the potential to exclude the most chaotic and hard-to-reach users.

Where now for naloxone?

The agnosticism to these issues in the long-heralded NTA *Good Practice in Harm Reduction* guidance has been disappointing and appears to ignore the extensive evidence supporting the use of naloxone, and the major life-saving potential of a national naloxone programme. The current challenge is to implement what we know is effective and reach those who are best placed to address the unacceptable loss of life resulting from fatal opiate overdoses that could be prevented.

We desperately need a forum for discussion of best practice, evidence, and evaluations to challenge the anxieties of sceptical commissioners and prescribers, and then protocols to allow other areas to learn from the pilot sites and implement safe and effective programmes. We have an intervention that will save lives; we now need to show the commitment and clarity of thinking to ensure that this reaches the people whose lives it can save.

David Best is a senior lecturer in the Department of Psychiatry at Birmingham University and Birmingham DAAT lead on drug-related deaths. Duncan Hill and Jennifer Kelly are both pharmacists with Glasgow Addictions Services. Dr Romina Lopez-Gaston is a specialist registrar with Birmingham and Solihull Mental Health Foundation Trust. Andrew McAuley is information and research officer at the Lanarkshire Alcohol and Drug Action Team (ADAT).

Putting the family in the picture

As Families Plus celebrates ten years of supporting the families of substance misusers, Nick Barton **explains why the focus on families should be sharper than ever**

It's official! We can finally use the 'f' word. There, tucked into the title of the Drug Strategy launched earlier this year, was the word 'families'. We have come a long way – but not far enough. Not by any means. Families are by far the largest constituency directly affected by someone else's substance misuse. There are many millions of such people, including those children now identified with so-called hidden harm and yet, for decades, attention has remained narrowly fixed on the misuser.

In some respects it's understandable. After all, that person or individual so evidently causes harm to themselves and others. The family's focus – or, so often, obsession – is that they are losing to drugs or alcohol. But if the family excludes itself from the picture, how much harder does it become to convince the world that there is good reason for attending to families in their own right, whether as individuals or as a unit?

The family perspective is now at least being considered. It has turned up in recent public documents that are given national exposure, including the Drug Strategy and NICE guidelines. The National Treatment Agency's commissioning guidance on families and carers has finally emerged from the mysterious labyrinth of government bureaucracy and Hidden Harm is apparently weighing on the commissioning mind. Articles have been written and conferences organised. There are even oases of family-involving initiatives to be found across the hitherto family-free treatment landscape. Carers have been invited to contribute their views on policy and practice, although the funding to support the rhetoric is not yet apparent.

For Families Plus, established ten years ago with the specific purpose of serving the needs of families caught up in substance misuse and addiction, it is a time to look back for a moment and to celebrate achievements before recharging batteries for the great deal of work that is still to be done. Actually, the charity's work with such families goes back much further – 22 years to 1986. This was when Clouds established its first, brief (five days) residential programme for adult family members at a retreat centre in Warminster, Wiltshire. To this day the programme, which is offered several times a year, is attended by family members from across the country and abroad.

Standing out in my memory to this day is what happened at the very first meeting. To the assembled family members we said, 'We suspect that you have come here hoping to learn how to fix the addicted person in your life,' to which almost everyone in the room nodded. 'But,' we said quietly, 'We're not going to do that. We are instead going to ask you a question and that is: How are you?' We were a bit taken aback when half a dozen of the 16 people in the room broke down in tears. That very simple question had slipped past their overstretched defences, putting them in touch with their forgotten needs. It was a poignant moment.

Eventually we submitted this programme to independent evaluation. Two things were revealed by the battery of standardised tests administered. Firstly, quite how badly the participants were being affected by their relationship to addicted others and secondly, how a well-structured brief intervention could help significantly improve their wellbeing, also showing that this improvement could last for at least 12 months.

In the early days of Clouds, families had been seen by the treatment team as necessary only to dishing the dirt that would help break a patient's denial. But we have changed our approach over the years, moving to a position that recognises that everyone is caught up in a system infected by the dynamics of addiction. Family members are mostly just doing their best to manage and cope with what can feel like a living nightmare.

This approach led to us investing in family therapy training for one of our addictions counsellors, and then to the integration of specialist family counsellors into the addiction treatment team. As a result there is always someone on hand who is thinking beyond the individual and keeping hold of the family perspective. These family counsellors help patients with their relationships and assist in family conferences. They support visitors and point families in the direction of the specialist help of Families Plus.

Families Plus was awarded a substantial three-year grant from the Home Office to roll out a low threshold Carer Support Group that we had designed. Again, independent evaluation revealed positive benefits resulting even from a group-based intervention lasting no more than three hours once a week.

Families Plus's most recent initiative has been to develop a structured intervention to support children living with parents with alcohol and drug problems – a programme called Moving Parents and Children Together (M-PACT). We are presently working to ensure that the M-PACT programme, which has been evaluated by MHRDU, a collaboration of the University of Bath and the Avon and Wiltshire NHS Partnership Trust, becomes available to as many children as possible across the UK.

Having built a considerable body of knowledge and expertise in working with families affected by substance misuse, we decided that we needed to accelerate the spread of a family inclusive approach to treating addiction and its effects, by passing on our knowledge and skills. So we developed training courses that now draw students from across this country and beyond, including Italy, Portugal, Holland and Malaysia. One course is incorporated into the Addictions Counselling training, taught at our Centre for Addiction Treatment Studies that results in a Foundation or Honours degree awarded by the University of Bath. The other is a standalone module taught by Families Plus, also accredited by the University of Bath, designed for health and social care professionals.

Why is the ten years' work of the Families Plus division of our charity needed now more than ever? At its simplest, families affect, and are affected by, their members and by the system in which they all live. It makes no sense to treat people for a largely psychosocial condition without reference to the context of their most important relationships. The closer the tie, the more powerfully affecting the relationships are. Families may be the breeding ground of addiction, they may play only a minor role in initiating or sustaining the condition, or they may contribute very positively to recovery. They may do none of these things – but should that prevent them from receiving help and support in their own right?

It is not just the harm to children that is hidden. A thorough trawl through the research literature clearly reveals that addiction has a measurable effect on non-addicted family members. This shows up in the array of mental and physical symptoms that have been traced to a relationship to addicted others. Mostly these are stress related symptoms, such as physical impairment on the one hand, to types of depression and anxiety on the other. If we take all those symptoms and multiply them by the number of people presenting with them, we arrive at a total in the several millions. From this we must surely conclude that this country has a significant public health issue on its hands. It is one that has major economic as well as human consequences. The cost of visits to the doctor, psychiatrist, hospital or the prescriptions that result and the diminished productivity or the time off work all mounts up.

We can hold on to our blinkers and keep our focus exclusively on the substance misuser or we can be bolder and more creative and, I venture, be more successful at disarming addiction by taking a family-encompassing approach whenever we can.

Nick Barton is chief executive of Action on Addiction, of which Families Plus is a division. www.actiononaddiction.org.uk

TEN POINTS FOR TEN YEARS

1. Involve families in treatment planning.
2. Involve families in treatment interventions and processes.
3. Do not always assume that families are the passive victims of addiction and necessarily interested in the recovery of their family member.
4. Ensure there are specialists in addiction and the family and that addiction treatment practitioners have family-related knowledge and skills.
5. Support families in their own right both as individuals and collectively, and respond to their specific needs.
6. Do not try to exploit them as a cheap mechanism for the control and treatment of the substance misuser.
7. Doctors or other health professionals: When people present with stress-related symptoms, ask whether someone in the home abuses alcohol or drugs.
8. Government and its agencies: Recognise the public health issue, identify and invest in cost effective interventions that result in a reduction of symptoms among family members.
9. Research the effect on substance misusers of supporting their families.
10. Above all, think beyond the individual.

Post-its from Practice

Cruel to be kind

Getting cross can be constructive!, says Dr Chris Ford

SITTING BEFORE ME YESTERDAY WAS MARK, who was really pleased with himself as he had now completed five weeks with no alcohol. Mark is only 32 years old but already has severe medical problems, including chronic pancreatitis and liver damage resulting from his 14 years of dependent drinking. Five weeks is the longest time he had been alcohol free in those 14 years and as from yesterday he hopes to continue to be alcohol free one day at a time.

He has been a patient of the practice for about two years, coming back to live with his mother after his wife threw him out because of his drinking. In those two years he had not seen his two daughters now aged three and four years. His mother in her late 70s welcomed the company and in the beginning enabled his drinking. The transfer letter from Mark's previous GP was helpful and asked us to continue his diazepam prescription. However it added that he had despaired with his drinking as he had had endless detoxifications, both in-patient and out-patient, yet he had never managed to stay off drink for more than one day.

I remember the first time Mark came to see me two years ago. As his mother, a complete teetotaler, was a patient of mine she had asked me to see him. I admit he nearly drove me to drink the first time I met him (and many times since!). If left, he can talk for hours telling complicated stories about nothing when you ask him a simple question like 'what have you drunk today?'

During the past two years he has had endless 'emergency' detoxifications, usually on acute medical wards during admissions for one of his medical problems. But at his request we have been able to arrange two in-patient detoxifications in our local specialist detox unit. Both times he went in with great promise, received support, but declined rehabilitation and relapsed on discharge. We have also undertaken three community detoxes and again he drank immediately on completion.

But were all these episodes a waste of time and resources? I think not. One of the many papers we have written over the years, which has not been published, was how lessons are always learnt from a drugs or alcohol detoxification, whether completed or not. Also evidence and opinion vary over time as to whether frequent detoxifications from alcohol help or damage the brain.

During Mark's last medical admission about two months ago, he was again told if he did not stop drinking he would be dead before he was 40. He came saying he wanted to have another go at community detoxification and proceeded to list the reasons why the previous ones had failed. I said I would discuss it with the team and that he should present at 3pm the next day after the team meeting. We discussed it and agreed that if we didn't try again, then death was going to be the inevitable outcome.

'...he did come back, but he was more drunk than I had ever seen him before. As he stumbled into my room he denied it and rambled on about everything and nothing. I was so cross I broke all therapeutic boundaries telling him he was a waster, a drunk, and that I was not coming to his funeral.'

So he did come back, but he was more drunk than I had ever seen him before. As he stumbled into my room he denied it and rambled on about everything and nothing. I was so cross I broke all therapeutic boundaries telling him he was a waster, a drunk, and that I was not coming to his funeral. He looked terrified as I shouted at him to leave the room and not to return until he had decided he wanted to continue living!

A week later, Mel the specialist counsellor entered my room with a large envelope containing a beautiful thank you card and a lovely pink (my favourite colour) cyclamen from Mark. Mel informed me that Mark wanted to say thank you and say that he was now ready to try and save his life, but that he was too frightened to come back in my room in case I shouted at him again. When he did, he told me that he had really heard me this time and even though he was drunk he could see that I was really worried about him.

Of the 39 per cent of men and 23 per cent of women drinking above safe levels in the UK, 5 per cent of the population, like Mark, are dependent. A detoxification is only needed in someone who has developed a state of alcohol dependency which is manifest by symptoms of alcohol withdrawal *eg* sweats, sleep problems, anxiety. They cannot usually manage 24 hours without a drink. The drug of choice is usually chlordiazepoxide (Librium) although diazepam can be used as an alternative.

Occasionally people make community detoxification too restricted and complicated, but the main point for this kind of detoxification is to be flexible. There needs to be some titration against the amount of alcohol the patient is using, and the severity of the withdrawals they are experiencing. The regime needs to fit with individual need and symptoms. It is important to discuss the procedure with the patient and carer, and it is helpful if the carer can give out the medication on a daily basis. If that's impossible we get the patient to attend daily and give out the medication. Plus don't forget to treat any nutritional/vitamin deficiency and commence thiamine 100mg daily for two weeks.

Since that day Mark has not drunk any alcohol. He has already improved physically and with counselling twice a week he is beginning to work on his mental wellbeing.

It may be that now is the right time for him, or that he is using all the lessons learnt from previous attempts, or that his mother has changed (thanks to Al-ANON), or maybe that he saw his GP lose her rag. Most likely it is a combination of all of these, but while it may still be early days, there is definitely something different about things this time.

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

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Sixth Annual Drug & Alcohol Professionals Conference

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Drugs Alcohol & Criminal Justice

Drugs, Alcohol and Criminal Justice

Interventions – how do we make a difference?

The Conference Consortium in partnership with DDN, CNWL Health Trust and Coventry and Warwickshire Partnership Trust announces the above conference on:

Thursday 25th June 2009 (10.30 to 4.30)

Venue: Friends House, Euston Road. London

The aim of the conference

The Conference will focus attention on Criminal Justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, looking at both 'what is working' and the 'pinch points' in the delivery of services.

Who should attend

The conference will be aimed primarily at DIP and Service Managers, Practitioners and Staff from arrest referral, courts teams, Probation Officers who manage the DRR's and those who run the programmes. Health Workers and Doctors who deliver rapid prescribing and triage interventions, Police Officers and Magistrates.

The cost – £145 inclusive of VAT

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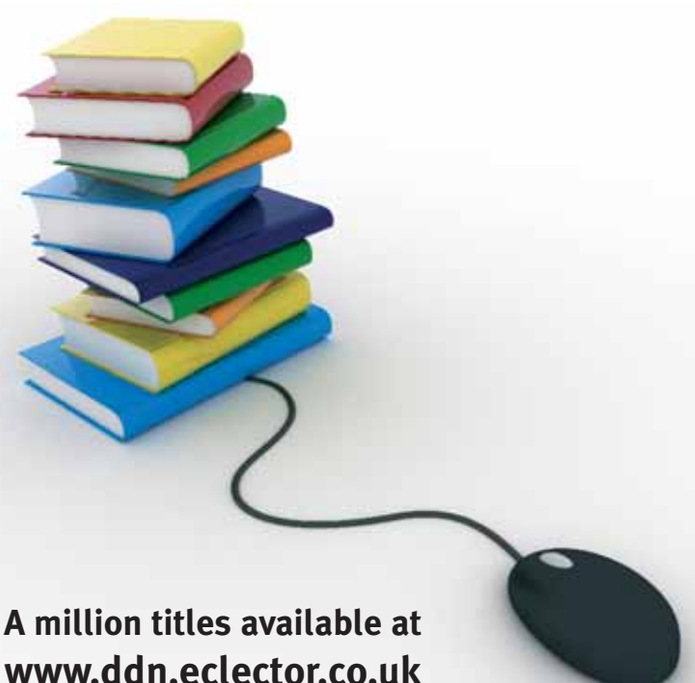

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CONFERENCE FIRST NOTICE

Families, drugs and alcohol: innovations in practice, new insights from research

Wednesday, 11th February 2009
Cavendish Conference Centre,
22 Duchess Mews, London, W1G 9DT

The conference aims to:

- ☐ Update participants on relevant research and good practice;
- ☐ Support an evidence-based approach to an expanding and innovative area of practice;
- ☐ Provide a cross-disciplinary forum in which the range of people with an interest in the well-being of substance misusing parents and their children can network and exchange ideas.

Adfam
Families, drugs and alcohol

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K·C·A
Training and Professional Development

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

HAVE YOU THE ENERGY?

HAVE YOU THE COMMITMENT?

Inclusion has a reputation for quality, innovation and commitment to providing excellent drug/alcohol treatment and psychological therapy services in community and custodial settings. Come and work with us.

Inclusion aims to combine the public service values, which drive the most progressive elements within the NHS with the commitment to tackling social exclusion shown by the best of the voluntary sector. Our approach is increasingly being recognised as being successful in delivering respectful services for drug/alcohol users and their families.

Our services include tier 2,3 and 4 drug/alcohol intervention programmes. They span a spectrum from needle exchange through psychological therapy services to residential stabilisation, detoxification and rehabilitation programmes.

If you are energised by our vision and feel that you can contribute to our development we would like to hear from you.

HEAD OF OPERATIONS – SOUTH (Base Negotiable)

NHS Agenda for Change Band 8B up to £54,000

Ref: 301-JS377

You will have a passion for ensuring that we continue to deliver respectful services characterised by full service user involvement and commitment to evidence based practice.

You will also have the capacity to contribute to shaping our strategic direction and service development.

HEAD OF SERVICE DEVELOPMENT (Base Negotiable)

NHS Agenda for Change Band 8B up to £54,000

Ref: 301-JS378

You will have a strong entrepreneurial spirit and a high level of writing ability with the drive to use these qualities to grow services, which engage those who are easy to avoid – offenders, those experiencing mental health difficulties, members of BRM communities and homeless people.

Inclusion is part of South Staffordshire and Shropshire Healthcare NHS Foundation Trust a first wave Mental Health Foundation Trust and recipient of the Trust of The Year award for 2008. We are committed to achieving equality of opportunity in employment.

For an informal discussion please contact Edith Brown on 01730 300684 or Alistair Sutherland on 01276 501222.

Closing date: 22 December 2008.

The Trust is committed to equality, diversity and improving the working lives of our staff.

inclusion
breaking the link between drug use and imprisonment

INVESTOR IN PEOPLE

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

The outlook's great

If you're looking for a brighter future, the forecast's good at our Trust: one of the largest and most innovative in the UK.

Specialist Drug & Alcohol Services
HMP Erlestoke

12 Step Treatment Worker *Job Ref:* 342-DA851-1108

Salary: Band 5 £20,225 - £26,123 pa
Hours: 37.5 pw

Working with People – Working with Change
Do you like a challenge?

AWP is a major provider of prison drug services in the South West. This includes both CARATS (counselling, assessment, referral, advice and throughcare), rehabilitation programmes and community-based drug work within the criminal justice system. We require skilled and committed people to join our dynamic team and welcome applications from people who have a history of problematic substance misuse.

The successful candidate will be part of a team providing a prison-based treatment programme within the 12 Step philosophy. You will encourage prisoners to address offending behaviour and respect others. Applicants should have good groupwork and 1:1 skills. Applicants will attend an assessment centre and be asked to prepare a presentation.

For an informal chat about this post, please contact: Juliet Fenne, Treatment Manager at HMP Erlestoke on 01380 814393/4490.

Apply online at www.recruitment-awp.nhs.uk

Closing date: 14 December 2008

The Trust is committed to improving working lives and there are opportunities for flexible working

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Newcastle City Council

Crisis Intervention Worker/Therapist

Ref: CSD/147(e)
£31,348 - £34,107 per annum
37 hours per week
Fixed term until March 2011

The project provides a service to families where substance misuse is causing difficulties in relation to the care of their children. The aim of the service is to create positive change in families functioning to enable children to remain safely at home wherever possible. It is based on the Option 2 model pioneered in Cardiff, www.option2.org. You will work in partnership with families, enabling them to reflect on values and beliefs, explore their skills and strengths and set goals so that parenting can be improved and children can remain safely at home.

You will be an enthusiastic and experienced practitioner with high levels of personal and professional skills to support parents with substance misuse problems to contemplate, initiate and maintain change. You will have a professional qualification in social work (adult/children) psychiatric nursing, counselling, clinical psychology or equivalent. High levels of flexibility will be required and a willingness to work outside office hours. The post would be open to a secondment opportunity, you must gain your managers approval prior to application.

For an application pack please contact the Resourcing Section on (0191) 211 6359 (answerphone). For further information or an informal discussion please contact Joanna Noon on (0191) 278 8151 or email: joanna.noon@newcastle.gov.uk.

Closing Date: 11 December 2008

Newcastle City Council

Phoenix Futures
Ending dependency, transforming lives

INVESTOR IN PEOPLE

TRANSFORMING LIVES

Helping people overcome their dependence on drugs and alcohol is both challenging and rewarding. Our pioneering work with individuals, families and communities has made us one of the UK's leading providers of social care services in this complex area. We also deliver extensive prison based drug treatment in the UK – and with your help we aim to become even more effective in the future.

HMP BRIXTON

HMP Brixton consists of male offenders whose sentences do not exceed two years, those sentenced in the first division and for debtors and prisoners on remand.

TREATMENT MANAGER

£27,390 - £31,043 PA including London Weighting

You will lead a dynamic and committed team delivering a five-week accredited Prisons Addressing Substance Related Offending (PASRO) programme to substance misusers. Working closely with our prison management team and senior prison staff, you will be responsible for ensuring the programme is correctly delivered and identified targets are met. You will be a highly motivated and forward thinking individual with previous experience in facilitating accredited drug treatment programmes.

We offer a generous range of benefits including a final salary pension scheme and ongoing training to support your personal and professional development.

For an application pack please visit **www.phoenix-futures.org.uk** email **recruit@phoenix-futures.org.uk** or telephone 020 7234 9772 quoting ref: 08/11/534. Closing date: 12 December 2008. Interview date: TBA.

Registered charity in England & Wales 284880 and Scotland SC039008.
Committed to a policy of equality and diversity.

HMP LEICESTER >

EXTRAORDINARY JOBS.
EXTRAORDINARY WORKPLACE.

SUBSTANCE MISUSE MANAGER
£26,280 - £38,082 PER ANNUM

If you are ambitious, pro-active, able to adapt to constantly changing circumstances and comfortable working in a busy, high pressured environment, this post presents an excellent opportunity for you. It is essential that you have previous experience working in substance misuse, and a clinical background is preferred. These posts are also open to part-time/job share applicants.

For an application pack please contact Roberta Birden, Recruitment Co-Ordinator, HR Field Based Team, HMP Ranby, Retford, Nottinghamshire DN22 8EU, phone 01777 862247 or email: roberta.birden@hmps.gsi.gov.uk

Applicants will be required to declare whether they are a member of an organisation which the Prison Service considers to be racist.

Closing date: Friday 19 December 2008.

The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age (subject to being within the normal age of retirement for the grade), sexual orientation, disability or any other irrelevant factor.

We are committed to promoting the benefits of a diverse workforce.

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"an essential aid for everyone working with substance misuse"

- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
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Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom. Introductory price £19.95 + P&P

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KCC and KDAAT invite expressions of interest from providers of Residential Rehabilitation Care Services for People with Substance Misuse Problems.

KCC Communities Directorate and KDAAT are seeking provision of a preferred provider list for residential rehabilitation care services for drug and/or alcohol users who are seeking recovery and are over 18 years old. Only service users who have completed a successful detoxification programme will access a placement within a residential rehabilitation unit.

Those providers who are selected will cover the full range of approaches to manage alcohol or drug misuse. For individual placements providers will be selected based on the identified need of each service user. Only in exceptional circumstances, where individual service user needs cannot be meet from the preferred provider list, will packages of care be purchased outside of this list.

All providers will be registered appropriately with CSCI and compliant with NDTMS and NTA data collection and recording requirements. KCC has determined that all service providers appointed will be no more than 200 miles from the Council's headquarters to enable effective contract management, coordination and support for service users from professional staff and carers.

The contract for these services will commence in April 2009 and last for five years.

Expressions of interest should be made ONLY by visiting www.southeastiep.gov.uk and following the link to the South East Business Portal.

The closing date for registering expressions of interest on the Business Portal is 21 December 2008. Tenders will be issued on the22 December 2008 and the closing date for the receipt of tenders is 23 January 2009.

Kent Drug & Alcohol Action Team

Kent County Council

Nottingham City Council is proud to present

➜ Family Intervention Project Practitioners (6 Posts)

£26,706 - £28,270 pa

Arboretum

Temporary funded contract until 31 March 2011

This is an exciting opportunity to join Nottingham Family Intervention Project, which is a well-established FIP sitting within Children's Specialist Services and is recognised nationally as a model of excellence. The FIP has secured funding to expand its core work with anti-social families at risk of eviction to working with the following additional groups; families suffering child poverty, families of prolific and persistent adult offenders and families surviving domestic violence.

Engaging challenging and 'hard to reach' families, you will work persistently and intensively with targeted families who face particularly complex and multiple issues using a holistic 'think family' approach. Acting as a Lead Professional and holding a small case-load, you will undertake a comprehensive family assessment and co-ordinate a multi-agency response towards the delivery of an intensive intervention programme, promoting sanctions when necessary to motivate a change in behaviour.

Experienced in working with hard to reach children and families who present challenging behaviour using an 'outcomes focussed' approach you should have proven assessment skills, a thorough understanding of the government agenda to tackle anti-social behaviour and child poverty with the ability to recognise and promote enforcement measures. The ability to chair multi-agency meetings and manage family attendance is also essential.

A professional qualification in one of the following areas is desirable; social work, housing, youth work, domestic violence, drugs and alcohol, mental health, probation and youth justice.

For informal enquiries only, please contact Paul Martin on (0115) 915 1965.

CRB and NPPV checks required.

For an application form please visit www.nottinghamcity.gov.uk/jobs, email jobs@nottinghamcity.gov.uk or ring the Recruitment Team on (0115) 915 6509.

Please note that the Authority is in the process of reviewing its pay and grading structure. Therefore the salary advertised cannot be guaranteed and may be subject to change.

We are committed to safeguarding and promoting the welfare of children and young people and expect all staff to share this commitment.

Closing date: 22 December 2008 (noon). Interview date: 8 & 9 January 2009.

We are committed to caring for our employees both inside and outside the workplace. We provide a competitive final salary pension scheme, excellent training opportunities and a culture of diversity and equal opportunities for everyone. Moreover, we have created a variety of options to help our employees achieve a healthy work life balance. This includes generous leave entitlements, flexitime for many posts and a smoke free environment.

Nottingham City Council

bridge
a way forward

Director of Operations

Full Time: 37.5 hours per week
Salary: £41,083 (NJC Scale 49)

It's an exciting time for Bridge; we're an expanding charity providing quality substance misuse services across Bradford and are looking for a talented and ambitious leader to fill this newly created role.

The successful candidate will work closely with the Chief Executive to implement the strategic aims of the organisation, with lead responsibility for operations, performance management, HR and third party relationships.

You will have at least 3 years management experience and significant experience and record of achievement in substance misuse or a related field.

For an informal discussion contact
Jon Royle, Chief Executive on 07887 563058.

For an application pack and form please visit, *www.bridge-bradford.org.uk* or email *beverley.bray@bradford.nhs.uk*

Should you require assistance with the application process please call Beverley Bray on 01274 723863

Latest time and date for receipt of applications is 12 noon on Friday 12th December 2008.

Interviews will be held on 22nd December 2008

Brighton and Hove City NHS
Teaching Primary Care Trust

Tender

Alcohol Brief Interventions Service

Brighton and Hove City Teaching PCT invite expressions of interest for the provision of Alcohol Brief Interventions Service for Harmful and Hazardous drinkers

Contract duration – 2 years with option for 1 year extention
Planned date for service commencement – 1 April 2009

The purpose of this service is to provide advice and brief interventions intended to reduce alcohol related harm including:

- Reducing alcohol related hospital admissions;
- Reducing alcohol related A&E attendances;
- Reducing alcohol related domestic violence;
- Reducing alcohol related violent crime;
- Reducing alcohol related offending.

This service will make a significant contribution to shifting the culture towards sensible drinking in the city and to the vital sign target of reducing alcohol related hospital admissions, including the targeting of alcohol related domestic violence and prolific offending.

For further information about this contract and the procurement process see ***www.brightonhovecitypct.nhs.uk/healthprofessionals/tenderscontracts/index.asp***

Those wishing to submit an Expression of Interest in tendering are required to do so by 8th December 2008

To register your interest and obtain a copy of the PQQ please contact: ***maryjayne.bosley@bhcpct.nhs.uk***

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

THE REHABILITATION FOR ADDICTED PRISONERS TRUST

RAPt is the UK's leading provider of prison-based addiction treatment programmes and also manages a range of services in the community that aim to move drug using offenders away from a life of addiction and crime. We have almost 300 staff working in projects across the country.

Alcohol Treatment Manager

Starting Salary £29,075 - HMP Bullingdon, Oxfordshire, OX25

We are looking for an Alcohol Treatment Manager for our alcohol rehabilitation programme at HMP Bullingdon. For this position, you will need experience of working in a primary addiction programme and a thorough knowledge of, and commitment to 12-step treatment. A recognised counselling qualification and experience of clinical supervision of others is essential. You will need to be highly motivated, efficient and determined to work in the challenging and environment of a prison.

Senior Alcohol Counsellor

Starting Salary £25,845 - HMP Bullingdon, Oxfordshire, OX25

Alcohol Counsellor

Starting Salary £22,614 - HMP Bullingdon, Oxfordshire, OX25

We are looking to recruit a Senior Alcohol Counsellor and an Alcohol Counsellor. To be successful, you would need to have a thorough knowledge of, and commitment to 12-Step. Counselling qualifications are essential as well as experience of providing counselling services (people with alcohol problems). You will also need experience of facilitating therapeutic groups.
For the senior position, in addition to the above specifications we are looking for candidates with the ability and skill to deputise for the Treatment Manager when necessary. Experience of providing line management to a minimum of two other staff and substantial experience of providing a counselling service to this or a similar client group is also essential.

If you are interested in applying for these positions please download an application pack from www.rapt.org.uk or e-mail: recruitment@rapt.org.uk or telephone 0207 582 4677.

Closing date for completed applications: 19th December 2008

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

Registered Charity No. 1001701

NO AGENCIES PLEASE **www.rapt.org.uk**

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

The outlook's great

If you're looking for a brighter future, the forecast's good at our Trust: one of the largest and most innovative in the UK.

Specialist Drug & Alcohol Services
HMP Erlestoke, CARAT Team

CARAT Worker

Job Ref: 342-DA858-1108
Salary: Band 5 £20,225 - £26,123 pa
Hours: f/t 37.5 pw

Working with people – Working with change
Do you like a challenge?

We are a major provider of prison drug services in the South West. This includes CARATs (Counselling, Assessment, Referral, Advice and Throughcare), we also deliver rehabilitation programmes and community-based drug work within the criminal justice system.
We pride ourselves on recruiting skilled and committed people to our dynamic team. We welcome applications from people who have a history of problematic substance misuse.
Our multi-disciplinary team provides assessment, one-to-one support, group work and referral for prisoners with a history of problematic drug use.

For further information about this post please contact Suzanne Greatwood, Treatment Manager, email: Sue.L.Greatwood@hmps.gsi.gov.uk

Closing date: 16 December 2008

Apply online at www.recruitment-awp.nhs.uk

The Trust is committed to improving working lives and there are opportunities for flexible working

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paradigm housing

DRUG & ALCOHOL PRACTITIONER

Salary : £25.00ph – self-employed basis
Location: Welwyn Hatfield Foyer, Hertfordshire
Hours: 6 hours per week, working from 6pm onwards
Contract: 6 months

The Welwyn Hatfield Foyer supports young people between 16 -25 with housing, education, emotional & welfare needs.

As a qualified Drug & Alcohol Practitioner you will be responsible for developing and launching this exciting new project. You will have an understanding of issues affecting homeless people and drug/ alcohol users. Through a holistic approach to treatment you will provide skilled assessments, treatment and on going care of clients with dependency problems. Ideally you will be qualified in Auricular Puncture and Electro Stimulation.

For an application pack, please visit our website at www.paradigmhousing.co.uk or alternatively email humanresources@paradigmhousing.co.uk or phone 01494 588292.

Closing date: 15th December
Interviews will be held on 6th of January

Go on... make a difference!!

South Staffordshire and Shropshire Healthcare NHS

NHS Foundation Trust

Liverpool Primary Care Psychological Therapies Service with Focus on Alcohol

Access to Psychological Therapies for those experiencing alcohol related difficulties has been limited. In many cases the presence of alcohol difficulties has been a reason for exclusion from therapy. In Liverpool this is about to change. The new IAPT compliant programme, covering the whole of Liverpool, will target alcohol users as well as those with common mental health problems. We anticipate sixty percent of service users will have an alcohol problem often alongside mental health difficulties. If you are a Clinical/Counselling Psychologist or Psychotherapist and the opportunity to be part of this radical new programme energises you, we would be very interested to hear from you.

Inclusion and our partners Mental Health Matters are both agencies with a strong ethos of service user involvement and a commitment to working with the social, psychological and health components of dependency and mental health.

As over half of service users will be experiencing alcohol related difficulties, you must be committed to integrating evidence based alcohol specific therapies alongside the IAPT stepped care approach: preferably you will be experienced in delivering therapies for problem alcohol use. While the therapeutic core of the service will be delivered through CBT and Person Centred Counselling we are also looking for clinicians who have expertise in other evidence based therapeutic approaches.

CLINICAL LEAD PRIMARY CARE PSYCHOLOGY SERVICES LIVERPOOL

Band 8c £52,000 - £64,118

Ref: 301-JS324

You will be an inspirational leader prepared to champion the cause of accessible primary care psychology services across Liverpool. You will be an experienced Clinical Psychologist, who has held previous leadership positions, with a strong track record of service delivery and be an expert practitioner of CBT. Experience in managing and providing clinical supervision to senior staff essential.

CLINICAL/COUNSELLING PSYCHOLOGIST (2 POSTS)

Band 8a £37,106 - £44,527

Ref: 301-JS323

You will be an experienced Clinical/Counselling Psychologist or Psychotherapist with a substantial track record of service delivery and be a practitioner of CBT. You will also be able to demonstrate competency in leading therapeutic staff.

CLINICAL/COUNSELLING PSYCHOLOGIST (2 POSTS)

Band 7 £29,091- £38,352

Ref: 301-JS325

You will be a Clinical/Counselling Psychologist or Psychotherapist with a sound track record of service delivery and be a practitioner of CBT. You will be able to work in a variety of settings and within a multi disciplinary team.

Inclusion is part of South Staffordshire and Shropshire Healthcare NHS Foundation Trust a first wave Mental Health Foundation Trust and recipient of the Trust of The Year award for 2008.

For an informal discussion please contact Alistair Sutherland on 01276 501222.

Please apply for this post by visiting www.jobs.nhs.uk
If you experience any difficulties with the application process only please contact Jenny Smit on 01785 221485.

Closing date: 22 December 2008

The Trust is committed to equality, diversity and improving the working lives of our staff.

inclusion
breaking the link between drug use and imprisonment

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABILITY

South West London and St George's NHS

Mental Health NHS Trust

These are exciting times for Wandsworth Substance Misuse Services; along with being assessed as having 'Excellent' services and serving one of the largest and most diverse Boroughs in London, we have received significant additional funding from Wandsworth PCT to invest further in our range of service provision. We now want to put our strategy into action and rapidly recruit to our Primary Care Liaison Team, Liaison Psychiatry Service and establish a new Dual Diagnosis Service. We are looking for motivated individuals who can work effectively with our partner agencies such as the Wandsworth Drug Action Team and our Substance Misuse Commissioning Team in order to contribute to a borough wide treatment system for substance and alcohol misuse.

Primary Care Liaison Team

Alcohol Nurse Specialist .

Band 6 £24,103-£32,653 plus Inner London Allowance 20%

Drug/Generic Nurse Specialist

Band 6 £24,103-£32,653 plus Inner London Allowance 20%

Working at the heart of Primary Care you will lead on supporting GPs in the management of patients with drug & alcohol problems within a defined locality of Practices in Wandsworth.

We are looking for motivated individuals who understand the importance of building successful relationships with Primary Care. You will need experience in substance misuse services or transferable skills, an understanding of Health Promotion and Harm Reduction and an ability to mange complex care scenarios.

For further information on the posts please contact Claire Bown on: 07958 712 508

Liaison Psychiatry Service

Alcohol & Drug Misuse Nurse Specialist (A&E)

Band 7 £29,091-£38,352 plus Inner London Allowance 20%

Working in our excellent and highly regarded Liaison Psychiatry Team based at St Georges Hospital you will be responsible for developing and implementing an operational framework designed to improve the identification and management of drug & alcohol misuse within the hospital environment. You will need experience in substance misuse and/or mental health services or equivalent, experience in identifying training needs for Multi Disciplinary Teams in relation to alcohol & drug misuse and project management skills. You will also need to possess excellent communication skills and be able to work in a highly pressured environment.

Alcohol Nurse Specialist for Brief Interventions in A&E

Band 6 £24,103-£32,653 plus Inner London Allowance 20%

You will be responsible for assessing all clients referred from A&E and inpatient wards and provide expert advice and referral on to existing services within Wandsworth. You will also contribute to the development of a screening and brief alcohol intervention service for clients who are identified as drinking at a level that is harmful to their health.

You will need experience in substance misuse or mental health services or equivalent, an understanding of Harm Reduction and Health Promotion and excellent communication skills.

For further information on both posts please contact Dru Cherry on: 020 8725 3795

Dual Diagnosis Service

Team Leader Dual Diagnosis Service

Band 7 £29,091-£38,352 plus Inner London Allowance 20%

You will have the exciting opportunity to develop and manage our Dual Diagnosis Service across the Borough. You will be responsible for providing expert dual diagnosis consultation across the Borough (including non-statutory drug services & Wandsworth prison) to ensure that high standards of care and treatment are provided to people with co-existing mental health and substance misuse problems. You must have direct experience of developing services and managing change and experience of substance misuse and/or dual diagnosis working.

Dual Diagnosis Practitioner x2

Band 6 £24,103-£32,653 plus Inner London Allowance 20%

You will be one of three practitioners' providing specialist expertise, consultancy and training on Dual Diagnosis across the Borough. You will develop sound working relationships with our CMHT staff to enable them to work more effectively with clients who have co-existing mental health & substance misuse problems through collaborative casework. You will need experience of substance misuse or Dual Diagnosis working, the ability to work effectively as a clinician and educator and be skilled at delivering short term interventions.

For further information on all the posts please contact Tom Clarke on: 020 8682 6542.

Closing date for all posts: Wednesday 10th December 2008 at Midday.

Interviews for all posts: Week beginning 15th December 2008.

Please note that we reserve the right to impose an earlier closing date for this advertisement on NHS Jobs should we receive an excessive amount of applications. Hard copies will still be accepted until the stated closing date by calling 020 8682 6446 or by emailing recruitment@swlstg-tr.nhs.uk, stating the job reference number and your full contact details.

If you wish to apply for these positions please visit our website www.swlstg-tr.nhs.uk and follow the link for NHS Jobs.

The Trust is an equal opportunities employer and welcomes applications from people who have experienced mental health problems. South West London and St George's Mental Health NHS Trust is a smoke-free Trust.

www.swlstg-tr.nhs.uk