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Drink and Drugs News

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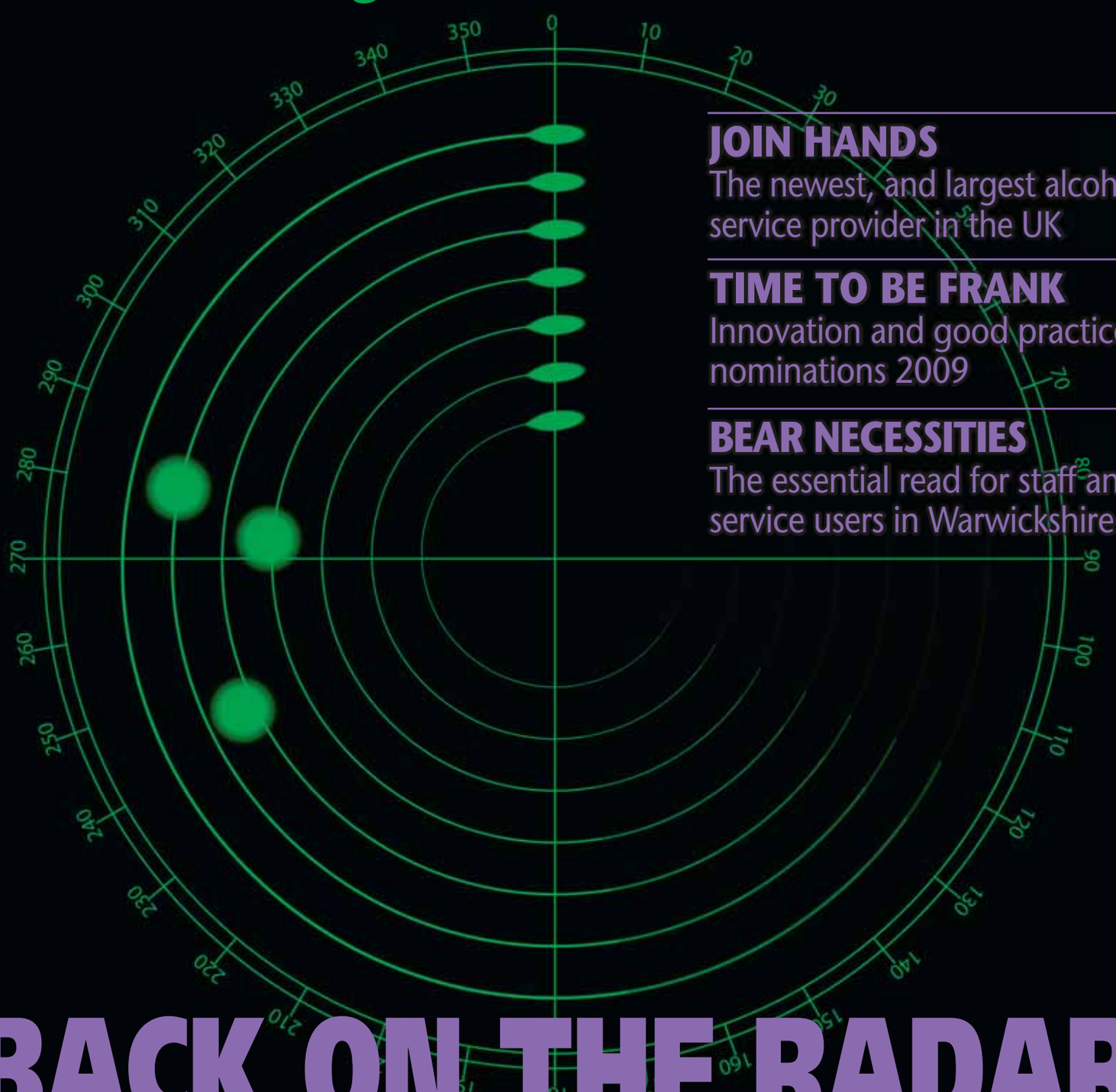

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Editorial – Claire Brown

Question time

What happens to all the vital Q&As from conferences?

Listening to the Public Health Minister at the injecting drug use conference this week (page 8) it was clear she cared about relating to the drug and alcohol field. She stayed for questions and was not hurried in and out of her slot by her minders before she had acclimatised to the conference room – unusual for ministers with a speaking engagement in this day and age. She took trouble to emphasise that government would not use welfare reforms punitively, and that treatment should be sympathetic and individualised. All the delegates tune in at question time, when in the few minutes available, they throw their burning missiles of concern at the platform. Would the government consider reforming legislation that banned aluminium foil being distributed in needle and syringe programmes? (See news, page 5 for explanation). How will new rules requiring those on benefits to declare their drug use not end up putting the welfare of society's most vulnerable at risk? Why aren't there clear and identifiable strategies on naloxone at DAT level, when it's proven to save lives?

Though the will is there to provide the answers that match delegates' expectations, evidence and experience, the minister's responses reflect the tangled layers of communication between government departments that constantly slow down the train of logic in this field. There is a long way between the Home Office and the Department of Health, and many stops in between; answers could be forthcoming, but not right now. The message to take away from this seemed to be: don't stop campaigning and pressing for what works. Despite the slow progress, initiatives do happen – as demonstrated by the progress and partnership working on getting drug users to adopt safer practices, celebrated at the event.

On another subject entirely, DDN is four years old this week... happy birthday to us!

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Sector rejects welfare reform proposals

Organisations from across the drug sector have been critical of government plans to withhold benefits from drug users who do not seek treatment and launch fraud investigations against claimants failing to declare their heroin or crack cocaine use.

Agencies have described the proposals set out in the Department of Work and Pensions' (DWP) green paper, *No one written off,* as 'punitive', 'unworkable' and 'discriminatory' in their consultation responses and expressed strong concern about the effects they will have on an already vulnerable population.

According to the green paper as many as 10,000 problem drug users claiming benefits are not in treatment (*DDN*, 28 July, page 4). Under its proposals, benefit claimants failing to declare their drug use could face investigation of benefit fraud as well as withdrawal of benefits for failing to attend compulsory treatment or specialist employment support. It also allows for information sharing between the criminal justice system and the DWP, but suggests the introduction of a 'treatment allowance' for those drug users stabilising their condition and wants to encourage employers to take on people with a history of problematic drug use. The consultation period has now closed.

'We find no convincing evidence that making benefits conditional upon engagement with treatment will be effective in improving outcomes,' said the UK Drug Policy Commission in its response. 'Drug dependence is a disorder, often chronic and relapsing in nature, not simply a lifestyle choice. Many problem drug users have multiple, long standing problems which will require long-term, multi-component solutions as part of a rehabilitation package.'

Threats of criminal investigation and drug testing for those failing to declare their drug use were examples of how 'the civil liberties of drug users are being continually eroded,' said Release, while the requirement of self declaration showed 'a failure to understand the fundamental nature of addiction. It is our experience that problematic drug users face discrimination and the risk of "labelling" when they disclose their drug use.'

The benefit system for problem drug users would only work if it recognised the 'significant barriers' to employment for problem drug users, said DrugScope, adding that while entry in mainstream employment was an appropriate long term aspiration it was often not 'a realistic short term goal.'

While agencies welcomed the focus on social reintegration, the Scottish Drugs Forum said it was 'greatly concerned' that the 'language and policy details are a deliberate and reprehensible effort to characterise people with drugs problems as feckless, who require to be dealt with by means of the threat and application of sanctions.'

Work and pensions secretary James Purnell said the proposals added up to 'more support in return for greater responsibility'.

Green paper available at www.dwp.gov.uk/welfarereform/noonewrittenoff/

One third of injectors suffer from abscesses

One third of injecting drug users have reported an abscess, sore or open wound at an injection site, according to the Health Protection Agency (HPA). However HIV infections among injecting drug users in the UK remain 'relatively rare', according to *Shooting up*, the HPA's annual report into infections among the injecting drug population.

Swift and effective community and public health responses are the likely reason for keeping HIV prevalence down, says the report, with 2007 levels remaining broadly the same as previous years at around one in 90 overall in England and Wales. Within London, however, this rises to one in 20.

People who inject crack cocaine were more likely to be infected with hepatitis C, as were people who injected into their groin, says the report. Crack cocaine users can inject several times a day at different sites, increasing the risk of many types of bacterial infection including Severe Group A streptococci, wound botulism, tetanus and Staphylococcus aureus (including MRSA) – the severity of these can range from minor skin infections to potentially fatal. The HPA estimates the annual cost to the NHS of these infections at around £47m per year.

The report found however that uptake of hepatitis B vaccine had risen to 66 per cent from just 25 per cent ten years ago, and that more than 90 per cent of injecting drug users in England, Wales and Northern Ireland reported making use of needle exchange facilities. The number of users who reported sharing needles in the previous four weeks was 23 per cent, compared to 34 per cent in 2002.

'Injecting drug users are vulnerable to a wide range of infections which can result in high levels of illness or death,' said consultant epidemiologist at the HPA and co-author of the report, Fortune Ncube. 'Further research needs to be done exploring the risk factors that impact on injecting risk behaviour, such as homelessness, groin injection and crack cocaine use, and how these interact with one another. The majority of these infections are preventable.'

Shooting up: infections among drug users in the United Kingdom 2007 available at www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1224833091685

More detail on page 8 of this issue

Government to widen drugs education in schools

Drug education is to become a compulsory part of the curriculum for 5- to 16-year-olds, the Department for Children, Schools and Families (DCSF) has announced. All Key Stage 1 to 4 state school pupils will receive personal, social and health education (PSHE) that includes lessons on drugs and alcohol as well as sex and relationships, nutrition and personal finance.

PSHE will be given designated space in the timetable, backed up by increased funding, more resources and more specific teacher training, says the DCSF. Possible drug and alcohol topics for primary school pupils will include how toxins can affect the body, while for secondary school pupils the lessons could focus on drug laws and social impacts, according to the department.

The announcement follows the findings of a report by the Advisory Group on Drug and Alcohol Education, which concluded that PSHE was an essential part of a rounded education, and is part of the governments plans to tackle drug and alcohol misuse among young people as set out in the Children's plan (*DDN*, 14 January, page 5). It is also hoped the lessons will help reduce teenage pregnancies and sexually transmitted infections, but the sex and relationship aspects, in particular, have led to a predictable backlash from the tabloid press.

'This is a bold move and a necessary one,' said schools minister Jim Knight. 'Parents bring up children, not schools or governments, but schools can help guide them through the maze of issues and prepare them for the difficult transition from childhood through to adulthood.'

Chair of the Drug Education Forum Eric Carlin said the forum was 'delighted' at the announcement. 'The problems that drugs and alcohol cause are too important for drug education to be an optional subject for parents or schools,' he said.

The announcement was also welcomed by DrugScope, but the organisation said the government also needed to make sure young people with substance misuse problems had access to high quality local treatment. 'Sadly we cannot inoculate young people against using drugs with just a few hours of drug education in the classroom,' said chief executive Martin Barnes. 'Drug education needs to go hand in hand with better identification of potential problems and early intervention.'

NNEF launch consultation on foil

The National Needle Exchange Forum (NNEF) launched a consultation on the provision of foil in needle and syringe programmes at the National Conference on Injecting Drug Use last week.

The survey is open to all needle exchange workers, service users and commissioners, and it is hoped that the results will be presented to the Advisory Council on the Misuse of Drugs (ACMD) to inform their discussions on this topic later this month.

Many needle and syringe programmes across the UK are supplying specially designed packs of aluminium foil to encourage their clients to make the harm reducing transition from injecting to smoking – or even to engage with new clients before they even start injecting. However, these services are technically acting outside of the law according to the Misuse of Drugs Act, which allows for the supply of certain items in needle exchanges, of which foil is not one.

Although no needle exchange worker has ever been prosecuted for this offence (as it is widely accepted that such a prosecution would not be in the public interests), this legal technicality presents a major barrier for many programmes.

The NNEF consultation is being done through an anonymous, online survey which can be accessed at *www.nnef.org.uk/foil_survey08/index.html*, and should only take a few minutes to complete. The deadline for responses is 7 November 2008.

The NNEF holds regular free meetings around the country for its members and is free for needle exchange workers, users, advocates, managers and commissioners to join. The next meeting will be held in Liverpool next March; visit www.nnef.org.uk for more information.

More NCIDU reports on page 8.

NTA compiles new harm reduction guide

A new guide to help practitioners and commissioners improve their harm reduction services has been launched by the NTA. *Good practice in harm reduction* aims to demonstrate what works best on the ground, and is based on interviews with those partnership areas that scored highly on the joint improvement review of services carried out by the NTA and the Healthcare Commission.

The guide contains case studies showing how gaps in service provision in a range of different areas have been addressed, and demonstrates how the top ten per cent of best performing partnerships carried out the planning and delivery of their services. The key factors identifying good practice included prompt and flexible access, action to reduce death from overdoses, competent staff and harm reduction being embedded in the system. Examples of the latter included having a range of interventions, a variety of funding streams for harm reduction services and extensive user involvement.

The NTA is hosting a number of regional events between now and Christmas to support the publication. Contact NTA regional teams for details: www.nta.nhs.uk/areas/regions/default.aspx

Good practice in harm reduction available at www.nta.nhs.uk/publications/documents/nta_good_practice_in_harm_reduction_oct_2008.pdf

For more on the improvement review, see page 8.

Trafficking threatens regional security in West Africa's 'coke coast'

Drug trafficking through West Africa has now reached a level that is threatening the security of the region, according to a new report from the United Nations Office on Drugs and Crime (UNODC). More than 50 tons of cocaine from the Andean countries now pass through West Africa each year, according to *Drug trafficking as a security threat in West Africa*.

The area has never previously faced a drug problem and the trafficking is both unbalancing the weak economies of the region and criminalising its young people, says the report. Cocaine seizures have doubled every year for the last three years to almost 6,500 kilos in 2007, but the report estimates this as the 'tip of the iceberg' as most seizures are accidental – such as the 600 kilos of cocaine found in a plane with fake Red Cross markings at an airport in Sierra Leone earlier this year. Local police are ill-equipped to deal with the situation and corruption in the criminal justice is widespread, says UNODC.

Most of the cocaine from South America enters Africa at Guinea-Bissau or Ghana, and is then often shipped to Europe by drug mules on commercial flights, to be distributed by West African criminal networks. The majority of couriers are from Mali, Nigeria, Senegal and Guinea, says the report, and destined for Spain, France and the UK. UNODC estimates the value of cocaine passing through West Africa at $2bn per year.

'West Africa is at risk of becoming an epicentre for drug trafficking and the crime and corruption associated with it,' said UNODC executive director Antonio Maria Costa. 'The threat is spreading throughout the region, turning the Gold Coast into the coke coast. This is more than a drugs problem – it is a threat to public health and security in West Africa. Prosecutors and judges lack the evidence or the will to bring to justice powerful criminals with powerful friends.'

It was essential to promote development in these countries and tackle the corruption that was allowing criminals to infiltrate them, he said, and called for the creation of a West Africa intelligence sharing centre and the training of special police.

Meanwhile, a new report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has launched a briefing sheet, Monitoring the supply of cocaine to Europe looking in detail at trafficking routes and the destabilising effect on the countries involved.

Drug trafficking as a security threat in West Africa available at www.unodc.org/documents/data-and-analysis/Studies/Drug-Trafficking-WestAfrica-English.pdf

Monitoring the supply of cocaine to Europe available at www.emcdda.europa.eu/html.cfm/index64214EN.html

News in Brief

Join the party

A new cross party group to inform the parliamentary debate on drugs issues has been launched by the Conference Consortium. Chaired by former chief inspector of prisons, Lord Ramsbotham, the aim of the Cross Party Group on Drug and Alcohol Treatment and Harm Reduction is to bring together politicians with those who work directly in the field. Members of the group will provide briefings for MPs, comment on legislation and organise seminars on key issues, and will look to good practice from the UK and abroad. 'We aim to supply members of both houses with accurate, pertinent briefings, to make the flow of information on best practice as smooth as possible,' said director of the Conference Consortium, Paddy Costall. More information on the group at www.conferenceconsortium.org

Coventry cuts

Work with substance misusers that has cut the crime rate in Coventry by more than a quarter in the last four years has been singled out for praise by the Home Office. Reducing drug-related crime has been a priority for Coventry CDT, which has retained 85 per cent of its clients in treatment for 12 weeks or more over the last 12 months. 'I have been extremely impressed by the success that Coventry has had over the last year in tackling drug-related crime,' said Home Office minister Alan Campbell. 'Drug treatment professionals have been working alongside the police and the health service to ensure that the right treatment is given to the right offenders. This approach, involving all agencies working together, ensures that enforcement is balanced alongside education, support and treatment.'

Kaleidoscopic copy

Newport-based charity Kaleidoscope, which celebrates its 40th anniversary this year (*DDN*, 20 October, page 12), has launched a free self-help book for people who think they may have a substance misuse problem but don't require formal treatment. The book, which includes self help exercises drawn from evidence-based approaches, will be given away free to Newport residents. The charity is now looking for sponsorship for a free book aimed at the family and friends of substance misusers. Available at www.kaleidoscopeproject.org.uk. Anyone interested in supporting the next publication should contact James Varty at james@kaleidoscopewales.org.uk

Back on the radar

With a high demand for young people's and older adults' services, Southampton drug and alcohol team were concerned that young adults seemed to be disappearing from view. **Russell Tullett** and **Annabel Hodgson** explain how a transitional service was set up to bring them back into their sights.

Three years ago Southampton Drug and Alcohol Team was concerned about how few 18 to 25-year-olds were presenting to adult services. The situation did not seem logical when the next age group (25s to 35s) remained the highest presenting age range in adult treatment services, so the DAT decided to commission a transitional service to close the gap in provision for young people and adults.

Anecdotally, the DAT knew that 60 per cent of young people over 18 years old were disappearing off the radar and failing to engage with the local community drug and alcohol team. They also realised that this was a critical time when most long-term substance misusing behaviours were developed – a time when it was essential to keep the young person engaged in treatment.

No Limits, a provider of tier 2 substance misuse services for under 18s in Southampton was commissioned to provide a transition service, and it was supervised by E's Up (pictured above), which is Portsmouth City Teaching PCT's provider of tier 3 services for young people.

'Just because a person reaches a certain age doesn't mean they are able to cope with life any more than before,' says E's Up clinical manager Russell Tullett. 'Quite the contrary in fact – children who start using drugs at the age 12 are emotionally stunted, and are more likely to require intensive specialised intervention.'

Transferring an 18-year-old client to an adult service was considered to be both inappropriate and ineffective for several reasons. Adult drug services require an agreed level of motivation and commitment from their clients. They are expected to take responsibility and attend regular appointments and other treatment interventions identified in the care plan – something that young people can be reluctant to sign up to. Another concern was that mixing entrenched drug users who have a long history of problematic drug use with young people that were still 'experimenting' was not the best solution to either issue, and gave rise

to the fear that young people could be introduced to a long-term drug career.

The transitional service aimed to create a relationship with each client based on respect, trust and self-empowerment, giving them the support to turn their lives around – a process that often involved overturning their previous negative experiences of authority. Using the five outcomes of *Every Child Matters* as a basis for designing the service was considered to be the best way of making sure the needs of young people were paramount. A consistent relationship would need to be maintained with Child and Adolescent mental Health Services (CAMHS), schools, police and voluntary groups, teaming up in new ways to share information and help young people to achieve their goals and have their say about issue that affect them.

Through a close collaborative partnership between E's Up, No Limits and the local adult DAT, the service has so far worked with 66 young people. Referrals come from a range of young people's services, such as accommodation providers, outreach services, mental health services and the drug intervention programme. Clients have also been referred from the adult prescribing services if their lifestyle has been recognised as chaotic. Others have migrated from the young person's service for continued care, following their nineteenth birthday.

The young people referred to the transition service have all displayed risk-taking behaviours around opiates, but they have diverse histories of drug use. Most have experienced problematic use of cannabis, ecstasy, alcohol, cocaine and crack cocaine, and they would not necessarily fit the criteria for attending an opiate-based adult service.

Looking at the differences in the primary substance of misuse among those attending different services shows how the transitional service covers the 'middle ground' between traditional adult and young people's services by answering the specific needs of young adults, which are often quite different from those in the other age groups.

Almost all of those attending adult services used class A drugs, compared to 36 per cent in the transitional service and just 5 per cent in young people's services. Conversely, almost half those in young people's services are attending because of their class C substance use, compared to 37 per cent in transitional services and 2 per cent in adult services. Half of the young people are also recorded as misusing alcohol and 14 per cent in the transitional service – compared to none of those attending the adult services.

The advantage of the transitional service to the service user is that it offers flexibility and accessibility. Positive engagement with the young people who are referred is obviously paramount, and it adopts an assertive approach to engaging them, recognising the need for rapid assessment and treatment to an unpredictable client group with fluctuating levels of motivation.

Because caseloads are small, normally around 15 young people, there is time for the key worker to form a trusting relationship with each of their clients, making sure they are at the forefront of everything that is planned for them. There is a culture of not giving up on the client, and the key worker will persist in contacting them if they fail to attend appointments, recognising such symptoms of chaotic substance use as needing further support, not exclusion from the service.

Outcomes from the service have been very positive. Of the 66 young people that accessed the transitional service, 56 (84 per cent) had positive discharge outcomes, with all of them achieving their care plan goals, 98 per cent reporting a reduction in their drug and alcohol use, and 94 per cent reporting improved relationships with their families.

Fran's case demonstrates how the transitional service can make a crucial difference. Fran grew up in Southampton living with her mother, brothers and stepfather. Her stepfather was violent and physically abused Fran, her mother and her brothers, and also sexually abused Fran as a child. Mum was a regular crack user and when Fran was ten years old, her stepfather left, and her mum also started to use heroin.

Because of her chaotic lifestyle at home, Fran rarely attended school and became a carer for her younger brothers. For around three years she lived with her aunt, and her younger brothers were put into care. At the age of 13, Fran returned to live with her mother, where she continued to be a carer and still rarely attended school.

Fran first tried drugs at the age of 11 in the form of cannabis, which she continued to use. At 13 she began using amphetamine, and at 14 she started taking cocaine and crack cocaine. She became pregnant, and soon after giving birth aged 15, she was introduced to heroin by her mother.

After her first child was born, Fran was given her own council flat, with social services being involved. During this time, she continued to use heroin (funded by shoplifting and selling stolen goods) and was using up to £40 of heroin daily, until she became pregnant with her second child at 18. She had previously been receiving 60ml methadone daily, but had failed to engage with the adult service.

At 20 years old, Fran was referred from the adult drug service to the transitional service. She had been receiving treatment for heroin use at the adult service, but was not engaging well with the clinic.

At the transitional service her series of interventions began. Following assessment, an appointment was made with the consultant for a substitute prescription to be picked up daily, with supervised consumption by the chemist. Alongside this, Fran was offered weekly appointments at home, to monitor her drug use and work with various other therapeutic interventions, such as relapse prevention and motivational interviewing.

For the first few weeks, Fran's attendance was sporadic. During this time E's Up liaised closely with her social worker and the chemist – close working that enabled the team to assess the risks between continuing her medical interventions or stopping her treatment. Gradually a rapport was building and Fran began attending appointments more regularly.

Some months into treatment, both her children were taken into care, with Fran having limited supervised contact. She found the situation incredibly hard to deal with, and for a while her drug use spiralled, and she began to use crack cocaine as well as heroin. Eventually, with continued support from E's Up, Fran managed to stop her illicit drug use and became fairly stable on her methadone prescription.

While beginning to learn to deal with life without heroin, Fran attended court for past offences and received a three-month custodial sentence. However this did not set her back; she completed her sentence and remained free of drugs, other than her prescription.

After being stable for a while, Fran suffered a relapse and returned to her previous lifestyle. As her periods of stability grew longer each time, there were a few minor lapses, but each time this occurred, she was able use what she had learnt to quickly identify the triggers and change them to a more positive outcome. Under the consultant's supervision, she also made the decision to reduce her methadone dosage.

Throughout Fran's treatment, E's Up has worked closely with her and other agencies, helping her to deal with her emotions and feelings, whether these were good or bad.

Fran now has regular contact with her children, and she has become a much stronger and more self-aware young woman. She continues to be seen and monitored by E's Up, but as she has not used illicit substances for a substantial period, it was agreed that Fran's prescription no longer needed to be supervised by the chemist and she was able to have weekly pick-up instead of daily – a move forward for Fran and the beginning of preparations for her to be transferred to adult services.

As Fran's case demonstrates, decisions made during the transitional stage of development are critical, and some of the most important and far-reaching ones taken at any time of life. Disadvantaged young adults can often be least equipped with the skills they need to make the choices that influence their futures, which is where the transitional service comes in, to take them beyond their late teens. We have seen that for a significant number of young people with complex needs, successful adjustment from adolescence to adulthood has not been made, and that the age cut-off at 18 years is too arbitrary.

It has been widely recognised and generally acknowledged that if a young person 'fails' in adult services they will disappear, only to re-emerge ten or 15 years later with severe and entrenched problematic chemical dependency.

The transitional service provides an opportunity for those service users who have chaotic lifestyles to focus on their complex and problematic psychosocial issues and address them, with continuity from a key worker with whom they've built a dynamic, trusting and therapeutic working relationship.

With the intensive treatment, good inter-agency working, and a person-centred approach, we can help young people make extraordinary changes and to make the impossible seem possible.

Russell Tullett is E's Up clinical manager and Annabel Hodgson is No Limits strategic manager. For further details on the transition service, contact Russell.tullett@ports.nhs.uk

Reports from the 2008 National Conference on Injecting Drug Use held last week in London

Treatment must be flexible and personalised, says Public Health Minister

'The primary objective of any treatment has to be abstinence and this drives our strategy,' Public Health Minister Dawn Primarolo told delegates.

But, she added, the debate had become distorted. 'Cold turkey is viewed as tough love by the outside world and people can't understand anything else. Maintenance is seen as a soft option, as failure.'

This argument did a disservice to those working in drug treatment, said Ms Primarolo, who said the two elements should be 'twin paths of our approach'. 'Your work means more users are getting help to beat their addiction,' she added.

While personal stories brought the importance of maintenance treatment home, recalling them was 'not to say we shouldn't be more ambitious'. 'Some providers are too cautious about moving people through the system quickly,' she said.

Deaths had fallen since 2000 and 1,600 lives were being saved every year, said the Minister. There was progress on crime and infection rates and hepatitis C rates fell 2 percentage points in the last 12 months, she said, 'but we've got a long way to go'.

'The high levels of users in treatment give us a platform to improve,' said Ms Primarolo, who said government had to continue concentrating on the 'basics' of 'getting the right services in the right places'. Stronger data and better data-sharing would give better information to commissioners and 'shine a light on local need'.

Work between the NTA regional teams and local partnerships was yielding positive results, the Minister said. There was now particular need to help prisoners and ex-prisoners, who were 37 times more likely to die from drug overdose, she said. Adequate clinical standards would be in place by 2011, she said, and the Department of Health had committed to quadrupling prison investment in the next four years.

Successful treatment needed to be personalised, with drug users getting treatment for their individual needs, said Ms Primarolo. This needed to be underpinned by 'flexibility and understanding of the deeper causes of people's addiction'.

'We've got to do more to ensure services unite around users and give them a clear path to recovery,' she added. 'It's not enough to expect vulnerable people to negotiate a complicated web.'

'More coverage needed on needle exchanges'

'We want to develop good quality needle exchanges with good coverage,' said Vivian Hope, discussing the main recommendations of the new 'Shooting Up' report (see news, page 4). As senior lecturer at the Centre for Research on Drugs and Health Behaviour and the London School of Hygiene and Tropical Medicine, he had co-ordinated the report team.

Research for the report had found that while needle and syringe sharing had declined, certain behaviours had become more common. Injecting into the groin and injecting crack cocaine – behaviours associated with higher levels of infection – had increased. Rates of HIV and hepatitis C infection through drug use were now higher than in the late 1990s; almost half of injecting drug users were infected with hep C and about one in 90 with HIV.

Needle exchanges needed to be accessible and open when needed, included evenings and weekends,' said Dr Hope. 'Well-trained staff must be able to respond rapidly to evolving patterns of drug use and referral pathways must be good.'

Good partnership working, such as with homelessness agencies, was essential support for those who want to stop using drugs, he emphasised. But more needle exchanges were an obvious way forward: 'We need coverage, coverage, coverage,' he said.

'Responses positive' to NICE guidance

Consultation on NICE guidance on needle and syringe programmes had produced a good range of responses and comments, with stakeholders 'generally happy with the direction of recommendations,' said Mike Kelly, director of the Centre for Public Health Excellence.

The referral from government to produce independent guidance had been driven by the need to prevent bloodborne viruses: 'It wasn't about whether needle exchanges are effective or not, but about the best ways of making this provision,' he said.

Main concerns centred on the accessibility and distribution of services, and making sure they related to local need. Stakeholders were keen that services should cover a 24-hour cycle, and that commissioners made sure a range of services were available with properly trained staff, including pharmacy-based needle and syringe programmes as well as agency-based services.

Consultation with communities was felt to be important, and an opportunity to provide local people with information on the purpose of local services – though there was acknowledgement that this would have to be handled carefully to avoid NIMBYism (Not In My Back Yard).

Alongside recommending that needle and syringe equipment should be more widely available, stakeholders said there should be more specific guidance on what this actually meant.

Mr Kelly said that interpreting evidence relating to interventions meant looking at their likelihood of success – and this meant including evidence from practice involving their use. Recommendations, to be published next February, would be provisional he said, and would be reviewed in five years' time on the basis of fieldwork and feedback.

TOP progress encouraging, says NTA

One year on from the launch of TOP – the Treatment Outcomes Profile – the National Treatment Agency was very encouraged by the response of the field, said NTA treatment delivery manager Colin Bradbury.

'It was a world first – no one had tried to measure the ongoing change to people in drug treatment's behaviour. It's been a complicated and challenging endeavour,' he told a workshop at the conference.

Workers, clinicians and service users had contributed to making the system a success and it was important to acknowledge the progress made in a short time, he said, but added that the NTA agreed with the field 'that we need to move away from proxy indicators, to how and where people gain benefit'.

'What's important to people is "how long do I have to wait before I get help, and what happens when I get there",' Mr Bradbury added.

Developed with the help of 70 agencies and more than 1,000 clients, the NTA wanted TOP to replace existing systems with a 'standardised, validated instrument' that would not go over one side of A4. It would be a clinical tool as part of the care planning process and would inform local commissioners and providers by tracking improvements and effectiveness, said Mr Bradbury. Furthermore, it provided evidence of client experience that was 'more relevant than ever' in light of media criticism over the past year.

With further work in progress to tune TOP to client treatment reviews, an outcomes report on the system was not expected until 2010. 'In time TOP will enable us to map systems and agencies against efficiency and effectiveness,' said Mr Bradbury.

Harm reduction 'should be more integrated'

An insight to gathering information for the Healthcare Commission/NTA substance misuse service review (see news, page 5) was given by Peter Burkinshaw, national programme lead for standards and inspection at the NTA.

It was difficult to gain a picture of national deficits, but much easier locally 'to provide a mirror to that locality', he revealed. Assessing harm reduction involved looking at whether initiatives were embedded in treatment systems and whether staff were competent. Scoring regions on their performance had revealed best progress on reducing drug-related deaths and worst progress relating to bloodborne viruses.

Many local partnerships had effective plans in place and community prescribing services mainly had a good range of harm reduction interventions in place, reported Mr Burkinshaw. But some partnerships were not making the most of their networks – paramedics might be trained in the use of naloxone for overdose, for instance, but others in the partnership might not know about these initiatives, missing the opportunity for full effectiveness.

Key messages from the review were that hepatitis B vaccination and hepatitis testing were not provided widely enough in treatment partnerships. Most partnerships had less than half of their service users with a recorded test date for hep C. HIV testing was also inadequate, with insufficient integrated counselling on offer.

'We found whole pockets where harm reduction wasn't integrated into the drug treatment system,' said Mr Burkinshaw. 'Nearly half of service users thought harm reduction services weren't comprehensive enough.'

Money's too tight...

I felt that I had to write a small letter for the Cumbria service users' group. I have personally been part of this project for about two years and I have several things that I would like to express.

Firstly are we accepted as a group of people who can add something to the treatment providers in this county? If the answer is yes, then I ask why do I feel as if I am going through the motions of committing time, expense and a great deal of travelling to still be in limbo when there are folk out there that need our advocacy, support, friendship and – the most important – to know that we care.

The core group are all committed, and are passionate about why we are involved in the Cumbria Users Project, but yet again I feel that the money that is given by the DAAT is not enough to sustain a vibrant group.

We are now confronted with the dilemma that our financial situation is so tight that we many not be able to go to events that are run for users' groups all over the country. We need to network with other groups – this is essential for us to be effective.

So once again I am asking the DAAT to please stop giving us such a meagre amount of finance that causes us extreme hardship and some difficult decisions, because we have not enough money to involve core members in attending important events.

Bri Edwards, Cumbria

Lost on tour

Regarding your 'Life Cycles' article (*DDN*, 20 October, page 6), I am writing to let you know that the project Wheels of Recovery and HAGA are both based in north London – Haringey – and while this is close to east London, it is actually postcoded and referred to as north London. Also Finsbury Park is most definitely in north London.

Souad Akbur,
communities co-ordinator, Haringey DAAT

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

Comment

By any means necessary?

If prejudice and dogma are entrenched within our treatment services, what effect is this having on our clients? John Lowes looks at how his own experience could easily have threatened to influence his judgement

The 'differences' between harm reduction and abstinence have historically created barriers between those involved in the treatment setting at all levels.

Having used a harm reduction approach to deal effectively with my own substance misuse, I have developed barriers to the abstinence-based approach, albeit subtle. My subsequent employment as a needle exchange worker somewhat re-enforced these barriers as I could not see any common ground between abstinence and needle exchange.

My own enthusiasm for needle exchange and harm reduction prevented me from fully accepting the abstinence model of treatment, and I feared a 'diluting' of my core harm reduction beliefs if I accepted a different way of doing things as also being right. Inevitably I got caught up in the mechanisms of treatment rather than allowing myself to simply look at the outcomes.

The personal belief of both abstinence and harm reduction staff in their respective treatments has always been evident, and it's this belief and the passion that underpins it that allows us to do what we do effectively. But we all need to be mindful that belief and passion can, if we allow it, cause us to become absolute and dogmatic. We can run the risk of becoming 'single minded', 'one way', or 'one treatment'. We can sometimes miss the simple reality – treatment is not about abstinence, it is not about harm reduction. It is about improving and saving lives.

Abstinence, harm reduction, relapse prevention and needle exchange, to name but a few, are simply the tools to allow us to do this. We do not need to distinguish between one way and another, this way or that, but simply achieve our aims, using the words of John Paul Sartre, 'by any means necessary'.

The provision of a number of effective differing methods can surely only add to the enhancement of services. It is up to us as workers, service providers, commissioners and policymakers as to how effective this enhancement is.

Is it possible that in our own passion we can often make the error of assuming that because we see or do things a certain way, other individuals are automatically going to accept it? Do we have the misconception that others understand what we do just because we understand it? Do we make the error of not considering others' lack of knowledge about the treatment approaches that we ourselves are very familiar and comfortable with?

It would be of benefit to all of us if we took the time to encourage each other into our own areas of treatment provision, to show others the full potential of what we can do. We need to remember that simply providing knowledge is not enough – attitudes cannot be taught, they must be caught! We need to be infectious in our own enthusiasm, not demanding in our expectations. When our treatment methods are questioned (which they will be, and should be), do we view it as an opportunity to share the knowledge of what we know? Are we mindful not to promote a way of doing things, but to encourage it instead?

Abstinence in particular is understood poorly among professionals who would benefit from a knowledge that may encourage greater openness and understanding of its use.

While harm reduction treatment is readily available and widely accessed across the UK with high caseloads and long waiting lists, I would suggest that abstinence treatment by comparison does not appear to be as readily available, and where it is available does not appear to be 'bursting at the seams' with service users.

Each of us needs to look at ourselves with honesty as to why this is. Abstinence may not be suitable or needed for everyone, but are people being missed who would undoubtedly benefit from it? Is there scope for some of the philosophies and principles of abstinence to be made available to those who may not be ready to undertake the full expectation and commitment required, but who would never the less benefit from some of the aspects of this approach?

Surely it makes no difference as to how or by which means a person addresses their problems with substance misuse, as long as they do it. For each person the method may be different, but isn't the desired outcome the same – the realising of a better quality of life? Are we using all the tools available to us, to help individuals achieve this?

My main concern is that if prejudice and dogma exist within the substance misuse treatment setting, are they resulting in the restriction of access to effective treatment models? We can only answer these questions if we look at ourselves with honesty.

John Lowes is a needle exchange worker at West Glamorgan Council on Alcohol and Drug Abuse (WGCADA)

Media watch

The National Audit Office has claimed NHS local health managers do not have a clear understanding of the scale of alcohol problems in England. The number of alcohol-related deaths has doubled to nearly 9,000 a year and the cost of treating conditions such as liver disease has risen to £2.7bn a year. The report found that a quarter of PCTs had not carried out assessments of the problem locally and four in 10 did not have a strategy in place. In particular, the report called on GPs to take more responsibility as the NHS was struggling to reach those at the early stages of alcohol misuse. A Department of Health spokesman said the government was doing 'more than ever' to tackle alcohol-related problems, while Dr Hamish Meldrum, chairman of the British Medical Association, said more brief interventions were being encouraged.
BBC News, 29 October 2008

The vast majority of 24-hour alcohol licences are still held by hotels and supermarkets, according to latest government figures. Pubs and clubs account for just ten per cent of the 640 24-hour licences, the vast majority of which are held by hotels which always had the right to serve residents around the clock. Licensing Minister Gerry Sutcliffe commented, 'So again the predicted explosion in 24-hour drinking has failed to materialise.'
The Publican, 31 October 2008

The former Home Secretary, David Blunkett, who was responsible for the original decision to downgrade cannabis from a class B to class C drug, said yesterday that the government's recent decision to reclassify the drug was based on public opinion, rather than hard evidence. Speaking to MPs, at the Commons Public Administration Select Committee, Mr Blunkett said while he felt his original decision to downgrade the drug was right at the time, he understood why people respond in a democracy to general feeling.
The Daily Mail, 23 October 2008

Police in West Yorkshire have seen an increase in the smuggling of raw opium into the area – the reason, officers believe, is that dealers are finding it easier to import opium than heroin. Iraqi and Iranian communities see the use of opium as part of their social life and police suspect this allows dealers to see them as a target. Information about the dangers posed by opium and the legal risks is to be distributed to these ethnic groups via briefing statements translated into Farsi, Arabic and Kurdish.
The Yorkshire Post, 30 October 2008

While the price of cocaine has decreased over the past five years, so too has its purity, according to information from the Forensic Science Service which tests much of the cocaine in the UK. 'Five years ago, most of the street cocaine we seized had a purity of around 50 per cent,' explained Rob Wainwright, international director of SOCA. 'But we're now finding a lot that is of far lower quality – some barely 10 per cent pure.' Much of the seized cocaine is cut with phenacetin – a pharmaceutical drug banned some years ago in Britain for causing kidney failure and cancer. Other drugs used for cutting cocaine include lignocaine (a dental painkiller), tetramisole (used for de-worming pets) and boric acid (used to kill cockroaches). Dean Ames, lead drug scientist at the Forensic Science Service, commented: 'It's impossible for someone buying a wrap of cocaine on the street to tell, just from looking at it, what it's been cut with.'
BBC News, 28 October 2008

Post-its from Practice

Catching them young

General practice is the place to work with young people, says **Dr Chris Ford**

I was really touched yesterday when Leo came to see us, his GP and counsellor, bringing us both a packet of 'Love Hearts' as a thank you. I loved them as a child but didn't know that they still existed! Leo is 17 years old and had been referred a few weeks ago by the local Addaction. He had been sent there from the Youth Offending Service as he had been arrested in possession of Class A drugs. Leo had been assessed by Addaction's young persons' worker and sent to us for treatment. He engaged well with us and settled on substitute prescribing. His goals were to avoid a prison sentence and to eventually become drug free. He had not been able to tell his family because he feared he would be thrown out, as had happened to his brother.

Leo was the last in a trickle of young people we have been sent recently. All have been referred by Addaction, with whom we are jointly working. None of the others has yet been in trouble but all were on the cusp. They were sent to general practice because, as in so many other areas, there is no specific service for young people and our local CAMS, by their own admission, have no experience or competence in working with young people who use drugs.

The other four young people we have been sent are all 15 or 16 years old and come from one community. They got into heroin when there was no cannabis to be found, enjoyed it and became dependent. They come and see us once a week after school in their uniforms. They have no mental health issues and we are able to be flexible with times and appointments. We have experience of dealing with young people of all types so why should drug use be any different? And what better place for these young people to be seen than in general practice? They appear in the waiting room like any other patient.

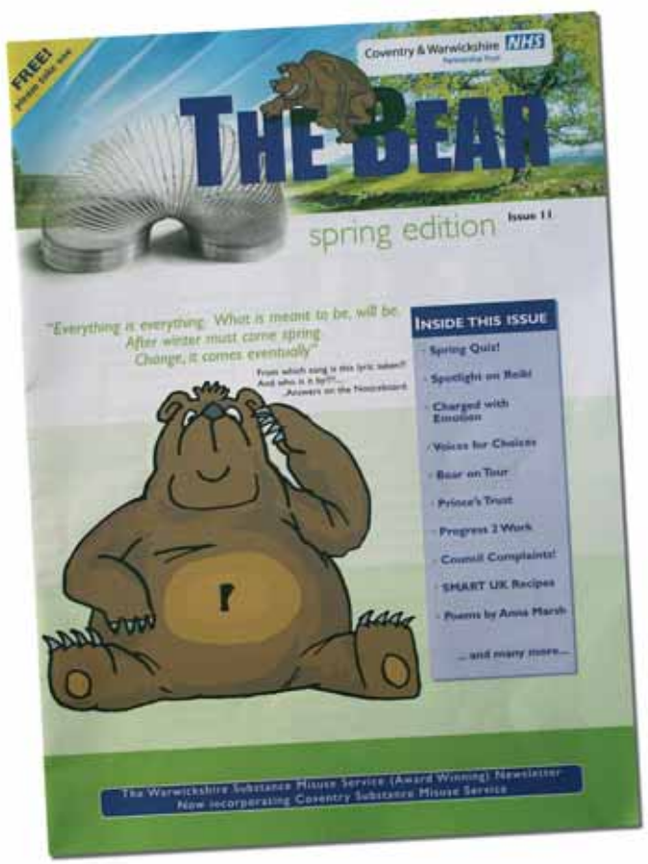
Traditionally this work is supposed to be carried out by CAMS and drug users under 18 years old are not supposed to be seen in general practice, but this seems outdated. The NTA Young Persons Team seem to agree and have recently been reviewing the treatment needs of the under-18s with substance misuse problems. They are also reviewing the need to develop training for primary care practitioners who work with this group. They now feel that the majority of the needs of this group could potentially be met by GPs with specialist training who would be able to address their wider general medical needs as well.

'The other four young people we have been sent are all 15 or 16 years old and come from one community. They got into heroin when there was no cannabis to be found, enjoyed it and became dependent. They come and see us once a week after school in their uniforms.'

This group of young people in our area has prompted all the teams who work with young people to come together for a meeting. All agreed that this joint working with general practice was the best approach and the idea now is to set up a special service level agreement to cover this.

We were presented with the 'Love Hearts' because Leo felt our court report had helped to get him a community sentence rather than a custodial one. Let's hope our early intervention and care in general practice with the other young people supports them to become drug free and helps keep them out of the criminal justice system.

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



Bear necessities

With drug services in Coventry and rural Warwickshire spread over a large area – and several teams – user involvement magazine *The Bear* has become an essential means for both service users and staff to exchange news and ideas. **DDN** reports

NOW IN ITS FOURTH YEAR, *The Bear* is a magazine that grew from the question of how best to communicate with service users and staff spread over a large area, much of it rural, with all the associated transport and connection issues. 'It's about people who live in a small village in rural Warwickshire – how do they get to know about what's happening in drug treatment locally and nationally?' says manager of the community integration team at Coventry and Warwickshire Partnership Trust, and one of *The Bear*'s two editors, John Walton.

The substance misuse service in Warwickshire has four community drug teams and covers Rugby, Nuneaton, Stratford, Leamington Spa and points in between while Coventry is a separate substance misuse service. *The Bear* includes all of them and has come to be seen as an integral part of the trust's strategy to meaningfully involve service users in decisions about their treatment, as well as making sure that staff know what's going on in other parts of the districts.

The Bear has grown substantially since the launch, and now prints around 325 copies of each issue as well being available on the internet and the trust's intranet. 'The first issue was black and white and not that thick,' says Emma Sansom, *The Bear*'s other editor and a drug worker at Rugby CDT. 'Then we started having more pages and looking into whether we could afford to have it in colour – now we have the front and back cover in colour and the rest is black and white. So it's getting a little more professional each time.'

The team publishes four issues a year – although this year the autumn issue is being dropped in favour of a bumper Christmas issue – and the aim is to move it as far towards self-sufficiency as possible in terms of funding. Pages are sold to local service user group Voices 4 Choices, Warwickshire Housing Drug Support Scheme and Cranstoun Drug Services, with the money then being put towards the next issue.

People were approached from each part of the service for their ideas and contributions, along with those not part of the partnership trust but who had an input into drug treatment – housing associations, voluntary organisations and, obviously, service user groups. A mix of personal stories, case studies, articles on alternative therapies, poems, jokes, quizzes and policy updates from the operations manager, the aim is to inform without turning the readers off.

'We try and keep it light hearted, which is why there are lots of terrible jokes in it!' says Emma Sansom. 'We want it to be something that people will pick up and read. There's an emphasis on harm reduction, but we don't want it to be boring and all about the service – we want it to be fun and informative and an opportunity for people to share. The idea is that anyone can pick it up and find out what's going on in the area.'

Unlike some similar magazines, however, *The Bear* not only features first person accounts of the experience of treatment but the views of service users on how that treatment could be improved. 'We wanted to make sure we had not just their personal experiences but what they thought about specific aspects of the services we provided, whether treatment, Progress 2 work or any other aspect' says John Walton. 'One example was clients with hepatitis C – how able were we to provide for them and was it any good?'

The trust helped set up a hepatitis C group in Warwickshire called Grapevine, publishing their views in *The Bear*. The group now provides a mentoring service to people with hepatitis C, letting them know what to expect from treatment, discussing issues and helping them support each other.

'They wrote that although they found the community drug team quite supportive in Warwickshire, when it came to hep C there appeared to be no real co-ordinated approach to it,' he says. 'The CDC would do their bit, the hospital consultant would do their bit but at 5 o'clock everybody would turn off the lights and go home – their views have now been fed into Warwickshire's substance misuse service delivery plan. I'm also very keen to ensure that all service development plans are communicated through *The Bear*.'

So what would his advice be to someone who was thinking of setting something up on similar lines? 'Get someone else to do it!' he laughs.

To get involved or to find out more about setting up a magazine, contact either john.walton@covwarkpt.nhs.uk or emma.sansom@covwarkpt.nhs.uk

Join hands

The merger of ARP and Rugby House early next year will create the largest alcohol service provider in the UK. **David Gilliver** spoke to the chief executives of both organisations to find out what the future holds

Next January's merger of two of the substance misuse field's heavy hitters, ARP and Rugby House, will create an organisation of 250 staff and a turnover of around £10.5m, providing services to more than 6,500 people. 'We'll be the largest alcohol service provider in the country – some say Europe, but I'm not sure about that,' says ARP chief executive Sally Scriminger. 'I don't know that's saying much, though, because there aren't a lot of alcohol services around.' It's this lack of focus on alcohol that both organisations hope the new strengthened body will be able to address.

Scriminger will be chief executive of the provisionally named Rugby House/ARP, while 22 years after founding his organisation, Rugby House, chief executive Andy Stonard is relocating to France, although he'll still be closely involved in the field through the Conference Consortium and other projects. 'I feel it's the right time to go,' he says. 'The organisation's grown up – we've got staff who've been with us for more than ten years, so there's a really good basis for the organisation to move forward. Ironically, when I first worked in London before setting up Rugby House it was at ARP, so it's been quite a circular journey.'

The impetus behind the merger was more than just 'bigger is better'. Both bodies want to use the added clout that merging will bring for a renewed emphasis on innovation and on the charitable ethos that some in the field feel is in danger of becoming a thing of the past. 'Both organisations are a similar size – around £5m turnover which sounds a lot but actually doesn't give you much cushion against changes in contracting, increasingly a big reality for alcohol,' says Sally Scriminger. 'We thought together we'd be a stronger, more robust organisation and able to develop in more innovative directions – we want to do something more with the organisations than we were able to with our current size.'

'Both organisations were coming to the same conclusions,' says Andy Stonard. 'That, given everything that's happening in our world, we would probably be strengthened by merging; that the two organisations were a good combination of drugs and alcohol; that there was very little overlap of services and, most importantly, that the ethos, visions and values of the organisations were similar.'

The two organisations are already working very closely together, with a joint directors' group already established and close collaboration on new business. Extensive staff, client and organisational consultations have been carried out and the due diligence completed, and the activities of the two organisations will now merge in January, with a big launch to follow in April.

Originally called the Alcoholics' Recovery Project, ARP was the first dedicated alcohol service in London and one of the very first in the country, launching in the late '60s. Ironically one of the things it was set up to address was widespread concern about the public disorder aspects of alcohol misuse. 'Things have come full circle,' says Scriminger.

ARP began as a residential project – the organisation is still classed as a housing association and had to get the approval of the Housing Corporation before the merger could go ahead – and one focus of the new body will be developing a range of accommodation-based care and support services, because of the number of transient clients who need permanent support. 'That's very exciting because accommodation-based treatment and care responses are lacking at the moment,' she says.

Given that she will be at the helm of the country's biggest alcohol service provider, what does she think about the direction the government is taking to try and tackle alcohol misuse in the UK? 'Obviously the initiatives around pricing and advertising have their place, but I think it's the wrong emphasis,' she says. 'There needs to be a much more comprehensive approach – prevention is important but much more needs to go into treatment. If you look at the numbers of people affected by alcohol misuse compared to drugs, the difference in money per head on treatment is shocking. There's a failure to grasp the enormity of the problem, I think – the long-term social costs and direct costs to the government and NHS are just so staggering. Something like price per unit is a waste of time – if they put all the money it would cost them to enforce that into treatment it would do much more good.'

The organisations are unified on the issue, with Andy Stonard recently writing an open letter to the PM and chancellor to ask why increases in alcohol tax were not being spent on treatment. 'Alcohol isn't properly addressed – it's a much bigger problem than drugs,' he says. 'Most alcohol-related harm is in the poorest ten per cent, so it's a real poverty issue, and then there are structural things like the way the regeneration of many town centres has concentrated on bars.'

As far as the Treasury goes, he believes it has actually become a hindrance in

'We've got people who we know are going to take seven years to fully turn their lives around and we're being asked to do it in 13 weeks with a little bit of add-on care. It frightens me how many people we set up to fail in treatment now.'

tackling the problem. 'The field has traditionally been at loggerheads with the producers and pub chains but there's a real scope for linking up,' he says. 'I think some people in the industry would be much keener to invest money in treatment if it didn't all go straight to the government – who then don't spend it on treatment. In some ways the Treasury is a real stumbling block in terms of tackling alcohol misuse. It's a difficult issue.'

After 22 years in the field he believes the most significant change has been the obstacles faced by staff trying to develop a human relationship with their clients – with assessments now more about processing people than helping them decide whether services are appropriate to them, alongside a fundamental change in the commissioner/provider divide.

'While that's sharpened some practices and the delivery of contracts it's taken away the creativity of the field and led to, I think, a really burdensome design,' he says. 'You do have some brilliant commissioners out there but you also have some who don't understand – or have the experience or knowledge of – the field. It's become procurement, rather than development, of services and I think a lot of people feel quite disillusioned with what they're asked to deliver and report on, compared to what their clients need. We've got people who we know are going to take seven years to fully turn their lives around and we're being asked to do it in 13 weeks with a little bit of add-on care. It frightens me how many people we set up to fail in treatment now.'

Both organisations believe the strong robust organisation the merger will create will allow for a renewed focus on the human aspect of the work and the charitable ethos of the sector. 'We both looked at our charitable status in the light of our field becoming less charitable and more business-minded,' he says. 'Sometimes organisations don't reflect the needs of their clients as much as they say they do and that shift – certainly under the drugs strategy – means the field has become more a vehicle for social control than charity-based. Charities have a rich history of developing services and representing groups who weren't getting what they needed. I certainly think a bigger organisation gives us a better position to be more geared towards helping individuals.'

Enhancing the charitable income of the new organisation will be a central focus, not only to allow for innovation to improve services but to inform best practice in the wider field. ARP already does a lot of specialist work with women, BME groups and ex-service personnel, and it is these sort of projects Scriminger believes the organisation will be able to develop and expand – it has just secured charitable funding to set up a service for young people affected by domestic abuse and alcohol.

'That's the sort of thing we want to be doing,' she says. 'There's the bread and butter of the local authority contracts, but we see our role as a third sector organisation. The reason the government has increased the use of the third sector is its ability to be flexible, innovate and ask questions in new and different ways, which I think we're able to do more quickly and flexibly than the statutory sector. So the charitable fundraising and piloting new types of services is about keeping that voluntary sector ethos of experimentation and pushing the boundaries alive.'

The new organisation will also keep service users centre stage. 'Both Rugby House and ARP are strongly committed to service user involvement,' she says. 'At ARP we have a service user forum which is part of our governance structure, so at both the governance end and the front line informing service improvements end we're really keen to develop that.'

So what is the vision for the new organisation – how can the new power best be harnessed? 'Obviously we want to grow to a degree where we can achieve our objectives for the services,' she says. 'We'd like to be the provider of choice for commissioners, but also the employer of choice. Employee development is key – we see ourselves as a learning organisation, and organisational learning is central to service improvement. That goes through all levels of staff to service users because we want to help service users learn a different way to be.'

And a final central focus will be on employment and training. 'We're only as good as the staff working in our service,' she says. 'We recognise the positive impact that integrating employment and training activities as soon as possible in treatment plans can have. One of the exciting things for ARP is that Rugby House has got a really well-established workforce development team running apprenticeships for ex-service users as well as NVQ training for workers already in the field. For us it's about sustainable growth, quality of services and the right services, rather than just being the biggest in the car park.'

Events

DDN/FDAP Events

13 January 2009 – London
6th Annual Drug & Alcohol Professionals Conference
This year's annual conference, in association with DDN, will take place on 13 January at the Royal Institute of British Architects, Central London. Plenary topics include: the new drug strategy and evaluation of the first drug strategy; working with families; young drinkers and implications for policy; getting people into employment; the Independent Safeguarding Authority and implications for our field; and diversity and inequality at work. A series of workshops and seminars will cover a range of issues, including: khat, ketamine and cannabis; diversity and dual diagnosis; prescribing interventions; and staff training and development.
For full details or to book visit:
www.fdap.org.uk/fdapevents/conf2009.html

29 January 2009 – Birmingham
Voices For Choices – The second national service user involvement conference
Building on the success of last year's 'Nothing about us without us' DDN/Alliance national service user involvement conference, 'Voices for Choices' will bring together policymakers, DAAT coordinators, treatment providers and drug and alcohol service users from all over the country for essential dialogue. This vibrant and interactive one-day event will focus on positive initiatives, and look at ways of constructively and meaningfully improving service user involvement. For full details or to book visit www.drinkanddrugs.net/Events/vfc_booking/

All other events

6 November – Liverpool
Alcohol The Debate Conference. Organised by HIT.
This conference aims to debate on alcohol, its consequences for individual health and impact on local communities. For full details or to book visit: www.hit.org.uk/displaypage.asp?id=15

12 November – London
ECCA 2008 Conference: Mind the Gap! The future of care
Organised by ECCA. This conference aims to give delegates the opportunity to hear the views of those at the very top in government, regulation and commissioning and to challenge the mismatch between the rhetoric and the practice. More details – Tel: 08450 577 677, e: conference@ecca.org.uk.

13-14 November – York
The Society for the Study of Addiction's 2008 Symposium
Organised by SSA. This year event focuses on 'Addiction Across the Life Span, Tracking Processes of Recovery'. More details – e: graham.hunt@leedspft.nhs.uk, Tel: 0113 295 2787.

17-19 November – Belfast
ACPO Drugs Conference. Organised by ACPO. This conference aims to examine how the rule of society combined with legislation can be used to assist law enforcement. More details – Tel: 0845 052 9602, w: www.acpodrugsconference.co.uk.

2 December – London
Making Every Adult Matter. Organised by Homeless Link. This conference aims to mark the beginning of an important new coalition that will work to achieve positive change by influencing policy making and public debate. More details – Tel: 0207 960 3032, w: www.homeless.org.uk/events.

3 December – London
2nd National Day Programme Conference: Lessons from home and abroad. Organised by KCA.
The conference aims to compare experiences of delivering day programmes to meet the diverse needs of substance users in different European countries. More details – Tel: 01474 326168, e: tcw@kca.org.uk.

Time to be FRANK

FRANK will be celebrating the very best of local innovation and good practice in its 2009 stakeholder awards. So get nominating….

'BEING PART OF THE AWARDS WAS SUCH A POSITIVE, GOOD NEWS STORY FOR THE DAT AND ITS PARTNERS,' says Jacqueline Cave. 'The awards really got us thinking about the work that we do and how we could create more imaginative and innovative campaigns.'

Cave, a young people's co-ordinator at Croydon Drug and Alcohol Team, was a regional winner in the last FRANK stakeholder awards back in 2004 for her drugs leaflet aimed at parents and carers. The awards aim to recognise and reward those organisations or individuals who have used the FRANK campaign to successfully deliver local substance misuse messages, and FRANK is now calling for entries for the 2009 stakeholder awards.

Invitations are open to anyone who thinks their project or campaign would make a deserving winner, and the recognition that comes with it can also help provide positive feedback at a local level. James Morley, previously carers commissioning manager at Bedfordshire County Council Drugs and Alcohol Team won the national FRANK award in 2004 for developing innovative 'Top Trump' style cards about drugs which was recognised for its originality, consultative approach and wide distribution.

'Winning the FRANK award allowed us to say thank you to all the young people and partners involved who helped us create this idea and celebrate its success,' he said. 'The process we went through to develop the cards really showed the importance partnership working to ensure you have the right product and the right distribution process.'

Nominations are invited for the 'FRANK communications aimed at young people' category as well as 'FRANK communications aimed at the wider community.' There will be two awards in each of the nine government regions, after which an overall winner for each category will be selected. There will also be a special judges' award for the overall best use of FRANK.

This year the judging panel includes representatives from the Department of Health, Home Office, Department for Children, Schools and Families, Mentor UK and *DDN*. The panel will be chaired by the Home Office.

'We want to reward people working in communities who are at the heart of the effort to educate and support young people with drug issues,' said Home Office Minister Alan Campbell. 'It is the commitment and effort of stakeholders and organisations across the regions that really makes a difference.'

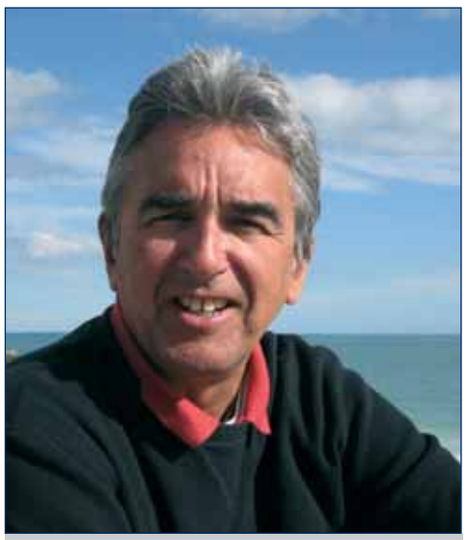
Anyone can nominate a colleague, team, organisation or individual – including themselves – and can also send supporting material such as images or video footage. The deadline for entries is 19 December – successful nominations will be available to be viewed online from January, after which people will be able to vote for their favourites. Winners will be announced in March and invited to a reception at the Home Office.

FRANK was launched in 2003 following a rebranding of the National Drugs Helpline by the Home Office (*DDN*, 22 September, page 11). The FRANK helpline recently received its two millionth phone call.

Nomination forms are available at http://drugs.homeoffice.gov.uk/communications-and-campaigns/frank-campaign/awards Supporting materials should be sent to FRANK awards, Crime and Drug Safety Directorate, Home Office, fourth floor, Peel Building, London SW1 9AT.

Untangling treatment (Part 2)

Professor David Clark continues to discuss what treatment involves (or should involve) and how it helps people along their journey to recovery.



'Let's begin with one of the most simple and important facts. Recovery comes from within the person.'

IN MY LAST BRIEFING, I described the findings of a large-scale qualitative research project conducted by Lucie James and myself. This research involved interviews with inmates of one male and one female prison who were participating on a RAPT treatment programme.

This successful and highly regarded programme has a 12-Step approach at its core, complemented by various other elements from different treatment types.

Our study participants believed that this treatment programme was life-changing. They had decided to stop using drugs and try to ensure that this decision was maintained once they left prison.

The participants found that a wide variety of elements operating within the treatment programme were critical in helping bring about the cognitive, emotional and behavioural changes occurring in themselves. They emphasised the importance of the programme focusing on all aspects of their lives, not just their problematic substance use.

Our qualitative analysis revealed four inter-related themes that we labelled 'belonging', 'socialisation', 'learning', and 'support'. Each of these themes impacted on a fifth theme, 'personal change', which comprised the participants' self-esteem and confidence, and their motivation to change. These are known to be critical elements influencing a person's ability to overcome their substance use problems and find their path to recovery.

I'd now like to switch attention over from this piece of research, to look at the wider issues of what helps people find their path to recovery from serious substance use problems and what role treatment plays. My reflections in this and forthcoming Briefings also involve my opinions of what we need to do to improve our treatment system, so we can help more people overcome problems caused by substance use.

Let's begin with one of the most simple and important facts. Recovery comes from within the person.

Addiction is not fixed like a broken leg and, therefore, the classical medical model – with doctor diagnosing and treating a passive patient – is not applicable, as I discussed in my Background Briefing of 6 October 2008.

'Other people, however skilled they may be, never make a drinker or drug user better. It is always the client who does the work. Helping professionals can make assessments, point the way, offer suggestions, provide interventions tailored to meet a client's needs, give appropriate counselling, and do what they can to improve the client's environment, but success, when it comes, always belongs to the client, never to the professional worker.' (Tom Waller and Daphne Rumball, *Treating Drinkers and Drug Users in the Community,* 2004.)

In this earlier Briefing, I described the views of Arthur Bohart and Karen Tallman (*How Clients Make Therapy Work: The Process of Active Self-Healing*) that clients possess self-healing capacities and resources that are responsible for the resolution of problems and for changes in their everyday lives.

Clients, like all people, have a built-in capacity for learning and creative problem-solving, which can help them overcome problems in their lives. Their capacity for creative problem-solving can be enhanced or supported – or limited or distorted – by their internal resources, and interpersonal and physical environments.

Their capacity for creative problem-solving can also be limited by low self-esteem, feelings of discouragement, and a lack of hope.

Clients come for help with their 'problems' when their self-healing capacities or resources cannot be accessed or are blocked. Of course, they may come to a treatment agency for one of a number of reasons. Some people want help in dealing with the pain and anguish occurring as a result of their substance use and associated lifestyle, but may have no intention of giving up using. Others may experience strong ambivalence, oscillating between wanting to use and wanting to give up.

Others will want to stop using and find a path to recovery. These people may possess various degrees of commitment, and various degrees of knowledge and understanding of addiction and how it can be overcome. They will come with varying degrees of resources, both internal (*eg* self-esteem, mental and physical health) and external (*eg* living circumstances, social support).

Some of this group will have poor life-skills, be lacking in the ability to communicate and mix with others, and feel emotions in a way that helps them deal with what life has to throw at them. They may not trust other people.

They will likely bring along to treatment a great deal of baggage, some of their problems originating long before their problematic substance use – and may be a major precipitating factor. And they may have been to treatment agencies before and felt that they had little to offer.

In general, when a person who wants to overcome a serious substance use problem enters the door of a treatment agency, they come for much more than 'just help in stopping using drugs'.

And if they are going to find recovery, they are going to need help on a variety of levels.

They are likely going to need to feel they belong, learn or relearn some basic life-skills, understand what addiction is and how it can be overcome, understand themselves much better, and receive a wide variety of support. Their self-esteem and motivation to change must increase to help them on the way to recovery.

For all this, the client is going to need the right environment.

[to be continued]

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We have a vacancy offering the opportunity to join a progressive organisation committed to providing quality healthcare to our community.

Specialist Primary Care Nurse - Substance Misuse

Ref: 535-BA-808NL

Band 6 £24,103 - £32,653 per annum **Full Time**

An exciting new position has been created for an experienced RMN or RGN with at least two years post qualification practice and experience in Addictive Behaviour, harm reduction and Counselling, to work jointly for the Primary Health Care Team and the Bradford and Airedale Drugs Services. Handling your own caseload and providing input on others, you will provide the holistic management of patients and clients suffering from drug and alcohol dependency.

Reporting to the Service Manager - Substance Misuse you will advise clients at the clinic, providing an effective service of the highest professional standard. You will put into place systems to measure outcomes and healthy gain and train fellow professionals with your specialist knowledge. In addition you will be required to monitor and titrate medication in accordance to the tPCT/General Practice guidelines and in accordance with any statutory training and professional competence, and support the General Practice in its prescribing practices using the principles of safe prescribing and drug efficacy.

You therefore should have a proven track record in the care of those displaying addictive behaviour and an insight into the mental, physical and emotional needs of service users. Evidence of case management, of leading and motivating others and being committed to team working are vital.

For further information please contact Anthony White on 07967 443906.

To apply please visit www.jobs.nhs.uk quoting the above reference number.

Closing date: 17th November 2008

This post is exempt from the provisions of section 4(2) of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. Applicants are not entitled to withhold details of spent convictions.

Bradford & Airedale Teaching Primary Care Trust is an Equal Opportunities employer and welcomes applications from all sections of society regardless of disability, age, gender, ethnicity, sexual orientation, race, religion or belief. The tPCT has a no smoking policy in operation.

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Substance Misuse – Development Officer

Salary: Sc 31 – 33. £25,320 – £26,835 pa, plus 5% towards stakeholders pension
Hours: 40hrs per week, based in Cardiff

The post holder will be responsible for development, implementation and management of Huggard substance misuse services.

This exiting and innovative new post will develop and implement accessible services to a wide range of substance misusers, initially helping them to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process. This should be achieved through both in-house service development and also through maximising opportunities to work in partnership with external agencies and treatment providers.

For an application pack please send an A4 stamped (54p) address envelope to: Mr Layton Jones, Operations Manager, The Huggard Centre, Tresillian Terrace, Cardiff CF10 5JZ

Or you can download an application pack from www.huggard.org.uk If you want an informal discussion about the post please contact
Tim Paddock on 029 20349980 or
timpaddock@huggard.org.uk

Interviews will be held on 17th December.

COMPLETED APPLICATION FORMS SHOULD BE RETURNED BY 5th DECEMBER 2008

Looking Inward - Moving Forward
DRUG AND ALCOHOL SERVICES
INWARD HOUSE PROJECTS

Inward House Projects is a registered charity providing residential and community-based rehabilitation for substance mis-users throughout Lancashire for over 30 years. Due to expansion of our T4 Residential Services we currently have the following vacancies:

Tier 4 Residential Programme Manager

Withnell House (near Chorley)

Salary range £26,321.06 – £30,801.24 (Band 6/7 equivalent)

As the leader of this exciting new programme, you will focus on further enhancing the quality of Tier 4 Residential Rehabilitation Services and developing best practice. You will be responsible for the maximisation of admissions, retention, occupancy, and successful outcomes for clients.

You will have a key role in managing the provision of residential rehabilitation services. The programme offers recovery focused opportunities to individuals with substance misuse issues and support in returning to live in their chosen communities.

The successful candidate will have demonstrable knowledge and understanding of service provision for complex clients and multi-agency working. You will have previous experience of meeting targets, performance management, team development and human resource management.

For further details and an application pack contact Sarah Barcas on 01524 37519 or sarah.barcas@inwardhouse.co.uk

The closing date for this position is 24th November 2008. Interviews will be held on December 3rd 2008.

The successful applicants will be subject to enhanced CRB checks.

Inward House Projects is an equal opportunities employer currently working towards Investors in Diversity

the nia project

the nia project provides a wide range of services for women and children who have experienced gender violence.

The organisation is seeking to recruit to the following roles as part of an exciting new project to provide safe accommodation and support to women with substance misuse issues who have experienced, or are experiencing, gender violence (including domestic and sexual violence and women involved in prostitution). All these posts will be based in London Borough of Haringey.

FAMILY SUPPORT SERVICES WORKER (SUBSTANCE MISUSE)

P/T 21hrs/wk
(NJC scale 27-30 (pro rata) incl ILW): £25,301 – £ 27,724)

The Family Support Worker (Substance Misuse) will work as part of a team to support children and young people (0-18yrs) by working directly with them, as well as with mothers/carers. The Family Support Worker will work to meet the children's practical needs through advocacy and support work, as well as working creatively with children individually and in groups.

Experience and knowledge of delivering Family Support Services to vulnerable families, providing childcare as well as a sound knowledge of gender violence and an ability to provide advice on issues including parenting and child development are sought. Strong communication skills and knowledge of child protection are essential.

GROUP AND OUTREACH WORKER (SUBSTANCE MISUSE)

F/T 35 hrs /wk
(NJC scale 27-30 (incl ILW): £25,301 – £27,724)

the nia project is seeking to recruit a committed and dynamic person to work as an Group and Outreach Worker (Substance Misuse). You will be responsible to coordinate and deliver group work services to women with substance misuse issues who have experienced gender violence. You will work closely with other nia project teams and external partners to raise awareness and develop specialist services.

Knowledge and experience of group work and training is essential as is an awareness of issues faced by women with substance misuse and the impact of gender violence on their day to day living. Strong communication skills and previous outreach experience are an advantage.

Previous applicants need not re-apply

These posts are funded by Supporting People Haringey and London Councils

These posts are open to women only under S7 (2) (e) of the Sex Discrimination Act 1975. Successful candidates will be required to undertake an Enhanced Criminal Records Bureau Disclosure.

To apply for any of the above posts you can download an application pack from our website: www.niaproject.info, or send a large A4 sae(98p) to: Administrator, the nia project, PO Box 58203, London N1 3XP

Closing date for both posts: 5.00pm Friday 14 November 2008

CV's will not be accepted.

Gloucestershire COUNTY COUNCIL

Invitation to Tender

Tier 2 Young People's Substance Misuse Service in Gloucestershire

Tenders are invited from organisations wishing to provide a Tier 2 Service on behalf of Gloucestershire County Council Children and Young People's Directorate.

Tenders are invited from suitably qualified organisations, able to demonstrate significant experience and a proven track record in delivering high quality services in the above service area.

The contract will be awarded for 2 years with a commencement date of 1st April 2009. The value of the contract will be up to £65,000 per year (£130,000 total)

The closing date for receipt of tenders is:
12.00 noon on Tuesday 28th January 2009

Tender documentation can be downloaded from:
www.gloucestershire.gov.uk/tier2substancemisusetender

Any queries please contact
Hilary Davis, Commissioning Manager
Tel. 01452 426957 or
e-mail: hilary.a.davis@gloucestershire.gov.uk

RMB Chair

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

RhYC CYMRU DIP WALES

The Drug Interventions Programme (DIP), a Home Office initiative, helps people in a wide range of circumstances to overcome the negative effects of substance misuse. DIP has been active in Gwent since 2006, significantly reducing both the personal and social costs associated with illicit drug use.

We are now seeking to appoint an independent Chair for the Regional Management Board (RMB). The RMB oversees the implementation and performance of DIP in Gwent and the Chair is crucial to the effective performance of the Board.

Chairing a board made up of representatives from the Police, Probation Service, Local Health Boards and County Borough Councils, you will need strong leadership and motivational skills. The work programme for the RMB is both challenging and diverse, and so your ability to influence and negotiate will be outstanding.

Full administrative support will be provided by a small, highly motivated Regional Management Team. The RMB Chair will also be expected to provide a degree of operational management support to the Regional Management Team.

This rewarding role calls for dynamism and enthusiasm and offers genuine satisfaction and opportunities for personal development in return, as well as the opportunity to steer and lead a key strand of the Government's response to substance misuse.

The role does not attract a salary nor will you be employed by the Regional Management Board. However, a small retainer plus expenses will be paid.

For an informal discussion about the role, please contact Mike Hardy, the current RMB Chair on 01685 729 080 or 07968475848.

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www.drinkanddrugs.net

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e: charlotte@cjwellings.com t: 020 7463 2085

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We're putting £250 million and your skills behind world class commissioning.

A strategic partnership established in 2002 between Hertfordshire County Council and the NHS has seen the development of a dynamic Joint Commissioning team with a budget of £250 million. Bringing together the commissioning of Mental Health, Learning Disabilities and Substance Misuse services for Health and Social Care across Hertfordshire, this exciting venture aims to transform delivery and realise fresh and original ideas every day - and you will operate at its heart.

Planning & Commissioning Manager - Drug & Alcohol

From £43,734 pa incl
Job share (two year fixed term contract/secondment)
Stevenage

Drug and alcohol misuse affects all sectors of the community, so it's vital we provide well managed treatment, from a best value perspective. Working in partnership with the current manager, you will help us make it happen, ensuring that all services are commissioned in line with the National Strategy set out by the NTA, as you develop visionary service strategies and plans, maintain expert knowledge on evolving drug and substance misuse legislation and conduct far-reaching negotiations with providers.

Whilst we will provide training in the technical aspects of commissioning, you must bring considerable initiative and ambition, and strong project management skills, coupled with experience of the drug and alcohol treatment agenda. Responsive to a fast changing environment, you will need good communication skills, enabling you to deliver positive change within a complex political environment. Enhanced CRB check and the ability to travel are essential.

For an informal discussion, please contact Tom Brennan on 01438 843511.

To apply, please email your CV to ricky.pateman@manpower.co.uk or call 01992 531951 for further information, quoting reference A0220102.

Closing date: 17 November 2008.

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Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,000 individuals a year.

HARM REDUCTION WORKER

Full-time, 35 hours. Ref DD01

This is an exciting opportunity to be part of a 6 day harm reduction service for drug users where reducing risk is the goal. Why do injectors share? If you understand why and can work imaginatively to do something about it, we are keen to hear from you. Some out of hours work will be involved. A full UK driving licence is essential.

For an informal discussion contact John Maliphant, Harm Reduction Services Coordinator on (0117) 987 6003

YOUTH WORKER

Full-time, 35 hours. Ref: DD02
(Maternity locum 7 months from January 2009.)

As part of the **Bristol Early Intervention Service** you will deliver effective, evidence-based services to young people within Bristol's Secondary Schools and to young people not currently in school. You will need experience of working with young people and of working with people with drug or alcohol problems.

For an informal discussion contact Jenny Cove, Mentoring Coordinator and Family Support Worker on (0117) 987 6009

Funded by Bristol Primary Care Trust

DETACHED WORKER

Part-time, 21 hours. Ref: DD03

To deliver our 'inreach service' within homeless hostels and support our work with women sex workers you will need the ability to make effective working relationships quickly and be committed to making every contact count. Regular evening/weekend work is involved.

For an informal discussion contact Ella Wheatcroft, Detached Senior Practitioner on (0117) 987 6003

Salary scale for all posts: £16,617 – £24,980 (pro rata based on 35 hours a week), starting salary for suitably qualified candidates: £22,156. A pay award is pending.

For all jobs you will need experience of working with drug users & we welcome past personal experience of problematic drug use.

Funded by Safer Bristol – Bristol Community Safety & Drugs Partnership

Closing date: Monday 24th November at noon

Please fax, e-mail or write to Angelo Curtis, quoting the job reference, for an application pack:
BDP, 11 Brunswick Square, Bristol BS2 8PE
Fax: (0117) 987 1900, E-mail: recruitment@bdp.org.uk

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation. No CV's agencies or publications.

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Derby City NHS
Primary Care Trust

Harm Reduction (Prescribing) Nurse

(Ref: 602-DB-CIT1121-08)
Agenda for Change Band 6 - £24,103 - £32,653 per annum
37.5 hours per week
Substantive
Based at Bradshaw Clinic, Derby

We are looking to appoint a highly motivated enthusiastic practitioner with excellent interpersonal and communication skills to work within the Harm Reduction and Needle Exchange service in a highly successful and developing service.

The successful applicant will need to have specialist working knowledge of substance misuse issues, treatment options and harm reduction initiatives.

In addition you must be able to demonstrate good self management skills and have experience of working closely with a network of multi - professional agencies.

If you would like any further information and to visit then please contact Yvonne Bell, Harm Reduction Manager or James Sutherland, Bradshaw Clinic Manager on 01332 221700 Ext 206.

FOR AN APPLICATION PACK SEE BELOW.

Find out more about this post and apply online at www.jobs.nhs.uk

For further information on this and other NHS Trusts please visit our website at www.southernderbyshire.nhs.uk

If you encounter difficulty in applying online, please contact Derwent Shared Services: Recruitment Services Team on 01332 868757 (quoting the job reference) who will provide the further support you require.

Closing Date: 17 November 2008

Derby City PCT is committed to providing comprehensive training and development opportunities; and is an equal opportunities employer.

POSITIVE ABOUT DISABLED PEOPLE

Cranstoun Drug Services -
tackling the harm caused by drugs to individuals & communities

Business Development Manager

£35,832 - £44,379 pa inc.
Surbiton, Surrey **Ref: 488**

High quality business and service development is one of the keys to the success of our organisation, and your role will take a lead in pushing this forward with effective results. We are looking for a proactive self-starter to review and enhance our business development strategy, whilst working closely with the senior management team and area managers.

Leading designated development teams, your role will ensure that growth is effectively implemented through the enhancement of existing service contracts and securing of new business for service delivery. You will also be involved in raising the organisation's profile alongside the Fundraising/External Affairs Manager and overseeing effective systems for forecasting income and expenditure with regard to business development.

It is important that you have already established yourself in a service delivery or management role, either from a third sector or commercial background, and, preferably, have a track record of business development. A graduate, or equivalent, you should have a high level of financial acumen and an ability to establish successful working relationships with a wide range of stakeholders.

If you would like an informal chat or more information, then please contact Peter Glass, Director of Services, on 020 8335 1830.

For an application pack please apply online at www.cranstoun.org or call our 24 hour recruitment line on 020 8335 1831.

Closing date: 21 November 2008. Interview date: 2 December 2008.

Cranstoun Drug Services, Central Office, 1st Floor, St Andrews House, 26-27 Victoria Road, Surbiton, Surrey KT6 4JZ.

We welcome applications from all sections of the community.

Cranstoun drug services

Registered Charity No. 1061582 Working towards Equality

CRI

Pathways To Recovery Service

CRI works to create safer and healthier communities.
We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

Recovery Day Programme Worker *(Ref NM106)*

Salary: £22,648 – £24,315 per annum pro rata (pay award pending)
30 hours per week

CRi are seeking to appoint a Recovery Day Programme Worker to lead on the development and delivery of an exciting and innovative recovery day programme that is being piloted at our P2R integrated drug treatment service in Warrington. The post holder will have specific responsibility for the delivery of 1:1 and group work sessions and setting up a peer support group. You will work closely alongside independent tutors and other relevant agencies and partners including Service User Groups.

You will have excellent communication and developmental skills, and substantial knowledge and experience of working with substance misusers so that you may deliver high quality services in accordance with NTA and NICE guidelines. Ideally you will also have knowledge of a range of interventions including CBT, NLP, BSFT and MI and also an understanding of abstinence based interventions. You will be committed to service user involvement.

You will be responsible for contributing to the overall performance of the service to ensure that contractual output targets are achieved.

You will be required to record and input client data and information in order that the service operates within contractual, administrative and financial requirements. There is an expectation that the post-holder will provide a degree of flexibility and contribute to the wider strategic aims and on-going development of the Service.

You will be required to work flexibly across operational sites as required and work flexibly within an agreed number of hours to maintain the most appropriate level of service provision. This will include evening and weekend work.

You will be expected to take responsibility for personal development, identifying personal training needs and participate in regular supervision and appraisal.

Closing date: 17th November 2008
For further information please contact: Carl Roberts or Peter Sheath on: 01925 415176.
To apply please go to http://www.cri.org.uk and send all application forms to james.davies@cri.org.uk
The successful candidate will be subject to a Criminal Records Bureau check at enhanced level.
In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.

INVESTOR IN PEOPLE

safer communities, healthier lives Registered Charity No: 1079327

St.Helens Council

Drug Intervention Programme Officer (DIP)

SCP29-34, £24,331 - £28,270 • Ref: CHS60
37 hours per week

As an experienced substance misuse worker, you will join an established team delivering treatment and care services to problematic drug users who are referred through the Tough Choices programme. Your role will involve working within a successful DIP case management team with a focus on an accurate assessment of client need, motivational work and the creation of meaningful care plans.

You will have excellent engagement, assessment and care planning skills and a flexible approach to working with this challenging client group. Some out-of-hours working will be required on a rota basis.

This post is subject to a pay and grading review, therefore the salary may change.

For an application pack, visit www.sthelens.gov.uk
Alternatively, email: CX@sthelens.gov.uk or call 01744 456778.
Closing date: 14 November 2008.

St.Helens Council is committed to equal opportunities.
The Council is committed to providing a smoke free environment.
Flexible working practices are in operation.

INVESTOR IN PEOPLE · POSITIVE ABOUT DISABLED PEOPLE · Beacon Council 2003 - 2004 Rethinking Construction · RATED A COUNCIL

For further information on the above job or to view a full list of current vacancies, visit our website at:

www.sthelens.gov.uk