DDN
Drink and Drugs News
4 December 2006
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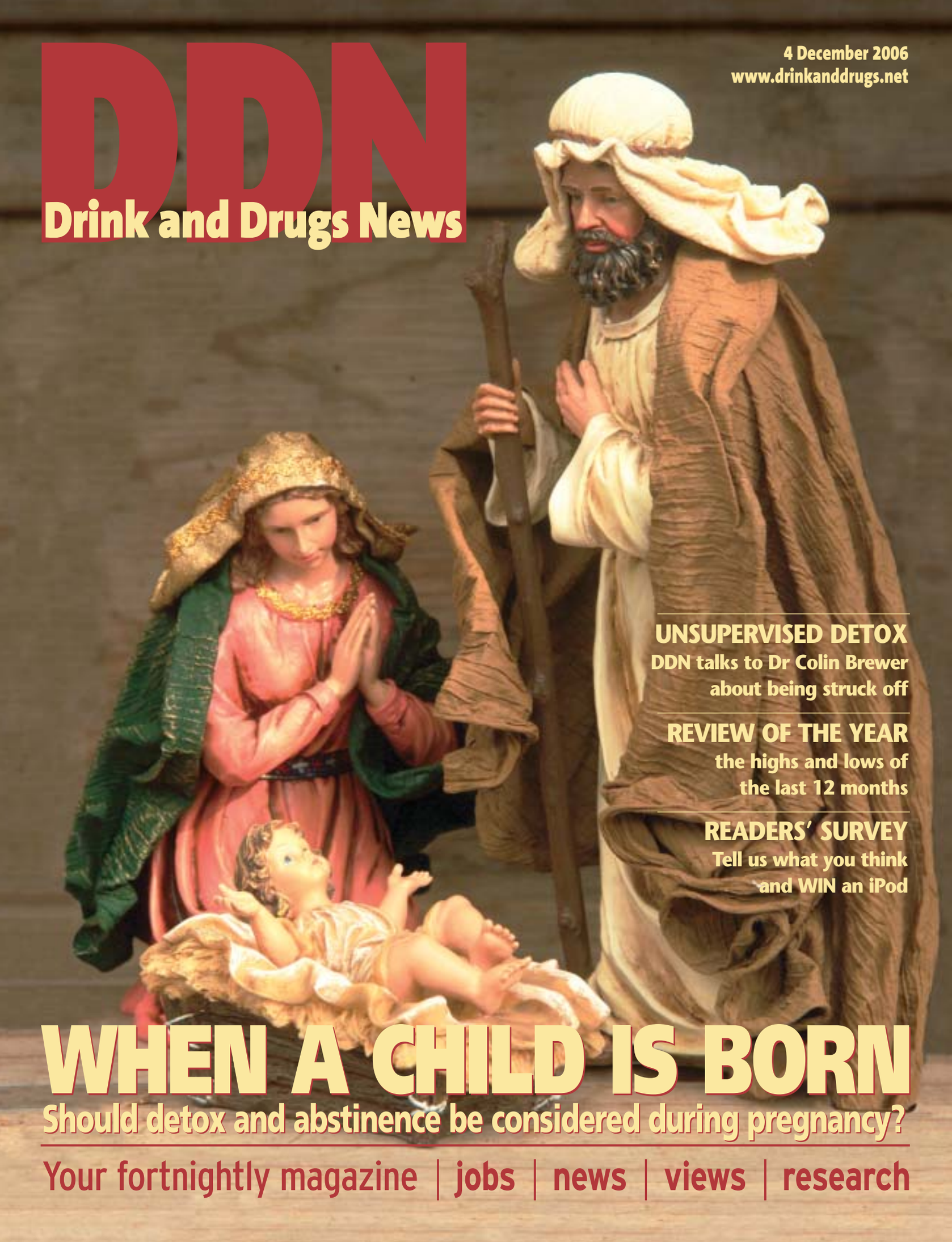

UNSUPERVISED DETOX
DDN talks to Dr Colin Brewer about being struck off

REVIEW OF THE YEAR
the highs and lows of the last 12 months

READERS' SURVEY
Tell us what you think and WIN an iPod

WHEN A CHILD IS BORN
Should detox and abstinence be considered during pregnancy?

Your fortnightly magazine | jobs | news | views | research

NDTC07

2007 National Drug Treatment Conference

Thursday 15th and Friday 16th March 2007
Novotel London West – Hotel and Convention Centre

Four major themes will be addressed by the conference:

- **Social exclusion, poverty and drugs**
- **Detox and aftercare**
- **Legal and political issues for drug treatment**
- **New treatments**

Key plenary and workshop presentation titles will include:

- Drug users and the prison system
- Treatment: evidence vs. popularity
- Detox: a high-risk treatment?
- Relapse prevention
- Effectiveness of rehab
- Non-medical prescribing
- Emerging treatments
- Employment and housing for drug users: is it realistic?
- Managing substitute prescribing and heavy drinking
- Access to HCV treatment
- Supervised consumption: therapy or punishment?
- Working with stimulant users
- The role of community pharmacists
- Good clinical governance
- Demystifying DIP
- User advocacy and involvement

For full details as they become available and online booking, see exchangesupplies.org

Call for papers
Papers and ideas for presentations are welcomed. We invite prospective delegates to submit short papers relevant to the conference themes. Submissions may be accepted for either oral paper presentations or poster displays. We are also very interested in receiving submissions of film or video work that can be shown. All abstracts/film submissions will be peer reviewed and judged on their relevance to the conference. The deadline for abstracts is 31st December 2006.

To discuss your ideas, please send an email to:
monique@exchangesupplies.org

exchangesupplies.org
See the website for updates and programme details.
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Drink and Drugs News

4 december 2006

Editor's letter

Have you voted in our website poll yet? Online voting has opened up a whole new world of instant feedback for us. Most voters decided that you should not need qualifications to work in this field – but there are some strong views on this debate in our readers' letters (page 8).

You may feel that this issue's poll (Should medically unsupervised detox be allowed?) is straightforward, until you read the feature on page 10. Dr Brewer did his utmost to make detox affordable for patients whom he felt would not be able to do it any other way, and his story will strike a chord with anyone who has put clients before perceived bureaucracy. But where does empowering the client turn into misguided risk? If you have strong views, please explain your vote.

A year on, Addaction's Next project is producing some life-changing results for students who are completing their training and moving on to work placements and full-time employment (page 14). Talking to participants at the charity's anniversary celebration, it was encouraging to hear that some there who were not yet students had heard about others' success and were registering to take their first step towards getting back into employment.

The fact that the scheme actively encourages people to join from their first day of leaving an institution demonstrates the effective role it can play in bridging the worlds before and after substance use. And if anyone needs reminding that the struggle is worth it, read John's story on page 13.

Please take a few moments to fill in our readers' survey on page 17, or return it online at our website. We read every response avidly, and your suggestions and feedback are proving thought-provoking and extremely useful.

We'll be back on 15 January. Until then, please stay in touch and have a wonderful Christmas.

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In this issue

Positive early signs for late licensing laws

One year on from the introduction of the Licensing Act 2003 there are encouraging signs that it is having a positive impact, says Licensing Minister, Shaun Woodward.

The Bill was introduced with an emphasis on prevention of crime, disorder and public nuisance, and evidence from the first year since the Bill's implementation indicates some limited success. Research carried out by Liverpool John Moores University, collating data from Arrow Park Hospital A&E department, shows a 15 per cent decrease in assault presentations since November 2005. This data has to be qualified however, as the period overlaps with a Home Office campaign on alcohol-related violence in the Wirral.

The main reason proposed for this decrease is the new staggering of closing times 'bringing to an end the old madness of everyone being thrown out on the streets at the same time contributing to crime and disorder', claims Mr Woodward.

A survey by the Department of Culture Media and Sport showed that less than 2 per cent of premises had applied for a 24 hour-licence and there was no evidence of a move towards a new standardised closing time. Commander Chris Allison from The Association of Chief Police Officers (ACPO) was optimistic, based on the evidence of the first year, but cautioned that data from a much longer period would be needed before the true effect could be gauged.

Home Office Minister Vincent Coaker meets Sam, a patient at Baytrees, Portsmouth PCT's refurbished detox unit. With a remodelled programme, the unit aims to 'launch a new era of residential drug provision and help patients to lead meaningful and creative lives'. Service users are given a choice of therapeutic intervention before entering the unit, such as anger management, loss and bereavement work, relapse and overdose prevention, complimentary therapies, drama dance workshops and IT tuition.

Last chance to contribute to young people consultation

Stakeholders' comments are invited on producing public health guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people.

The consultation is being carried out by the National Institute for Health and Clinical Excellence (NICE) on behalf of the Department of Health.

The draft guidance document is aimed at professionals with a direct or indirect role relating to substance misuse, and sets out preliminary recommendations developed by the Public Health Interventions Advisory Committee.

The closing date for comments is 8 December 2006. To participate visit www.nice.org.uk

Dual diagnosis patients stay under amended mental health legislation

The government's Mental Health Bill, introduced on 16 November to amend parts of the 1983 Mental Health Act, sets out the limited changes to mental health law that the government promised when its more radical changes to the Mental Health Act were abandoned earlier this year, *writes Mike Ward***.**

The Bill amends the wording of the definition of mental disorder in the 1983 Act, from 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind', to 'any disorder or disability of the mind'. It goes on to make limited changes to the conditions required for detention.

The Bill also changes the wording in the 1983 Act, which excludes those suffering from mental disorder 'by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs'. Instead, there is a single exclusion stating that dependence on alcohol and drugs is not considered to be a disorder or disability of the mind (ie a mental disorder) for the purposes of the 1983 Act.

This means that no action can be taken under the 1983 Act simply because people are dependent on alcohol or drugs. However, if a person who is dependent on alcohol or drugs also suffers from another mental disorder (including a disorder which arises out of their dependence or use of alcohol and drugs or which is related to it), they can be subject to the Act's powers.

This is a much smaller change than had been suggested at various points in the process of developing the original Bill, but does still emphasise that those with a dual diagnosis can, and should, be dealt with under mental health legislation.

Drugs more affordable than ever

Prices of illicit drugs are probably cheaper across Europe than ever before, according to the EU drugs agency's annual report on the state of the drugs problem.

The newly published report of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) explores a five-year analysis of street prices and concludes that in the case of some drugs – including ecstasy and brown heroin – prices had fallen by almost half.

No direct link was made between price and the level of drug seizures; neither did the data reveal any simple link between drug prices and overall levels of use.

The report also highlighted that drug treatment services for women did not meet the level of need. Specialised services were needed to cater for pregnant drug users, those with children, and women who had complex issues surrounding physical or sexual abuse.

Around a fifth of those entering drug services in Europe were women, with nearly one in four of these living with children. While nearly all EU Member States offered at least one unit exclusively for women, such services were thin on the ground and mainly limited to large urban centres.

The EMCDDA report is available at http://docs.emcdda.europa.eu

DDN/FDAP poll result and new chance to vote

This fortnight we asked: 'Should you need a qualification to work in the field?'

More than 200 readers to our website voted. Your verdict was 'no', by 60 per cent to 40. Some more detailed comments were submitted to this issue's readers' letters (page 8).

Our new poll question is: Should medically unsupervised detox be allowed? (See feature on page 10.)

Vote at www.drinkanddrugs.net

Joint-strategy offers Gloucestershire alcohol support for three years

A new alcohol strategy, set up by the County Alcohol Strategy Group, is set to tackle alcohol-related harm in Gloucestershire for the next three years.

Aimed at providing support on alcohol misuse for the local people and communities, the strategy was devised around the Local Area Agreement approach for Gloucestershire and the views of users and carers.

Speaking at Gloucester Substance Action Groups' county conference, chief executive for GDAS, Peter Steel, said: 'The world is changing and at long last we are starting to talk about alcohol.'

The strategy's framework is linked to health, social care, district and city councils, housing, criminal justice partners and local neighbourhood and voluntary sector bodies.

Gloucestershire had more than 69,000 adults drinking at hazardous levels and above, and a high rate of chronic liver disease among men. Nearly half of all local binge-drinkers confessed to committing a crime under the influence of alcohol, Mr Steel told delegates.

In 2003 to 2004 there were 65 deaths and Gloucestershire still had the highest mortality rates in the South West because of drinking.

He added: 'I believe this time it will make a difference as it has clear objectives and set timescales for each one. Everyone can sign up and agree to it.'

Reducing drug-related deaths conference, Manchester

Supported housing can save lives

There is an attitude within the housing sector that some people are too difficult to help, according to Steve McKeown of Shelter, which had researched extensively for its *Safe as Houses* report last February.

'Some housing providers think drug users should remain homeless until they are willing to address their drug use,' he said. But by adopting more flexible policy, many projects had 'given people the chance to work at their own pace' in addressing their drug use.

Structured environments also had the chance to address wound care and overdose management, Mr McKeown suggested. St Mungos was among homeless charities that went further, with a specialist team providing support to generic staff, as well as onsite needle exchange and prescribing facilities.

Round-the-clock cover from properly trained staff was proven to reduce drug-related deaths, he added.

Kevin Flemen from KFx emphasised that people stood a much better chance of avoiding health problems when they were housed – although he emphasised that 'housing' did not necessarily equate to 'good housing' that would improve safety for drug users.

Homeless people were used to preparing hits rapidly, with dirty paraphernalia and a lack of hot and cold running water. Tenants in accommodation where drug use was banned could find themselves injecting in equally unsafe conditions, he pointed out.

Suggesting that many housing providers were 'best placed to take consumption rooms forward', Mr Flemen said it was ironic that hostels that did not allow use on site caused more problems in the community and encouraged 'nimbyism' in neighbourhoods, through allowing discarded drug litter on the streets.

Safe as Houses can be ordered at Shelter's website, http://england.shelter.org.uk

Push prison service boundaries for better integration

Prison services must push the boundaries to improve, as 'more of the same won't work', said Stephen Heller-Murphy and Ruth Parker of the Scottish Prison Service Addiction Team.

'We have started to change focus and include drug-related death in the service contract,' said Mr Heller-Murphy. Scottish Training on Drugs and Alcohol (STRADA) was being used alongside critical incident training from the Scottish Drugs Forum, including resuscitation instruction. Feedback from staff had been very positive.

Mr Heller-Murphy said there had been a shift from detox to substitute prescribing, and from reducing to maintenance. A research project was taking place on naloxone.

Giving prisoners access to care plans had been an important priority for Phoenix Futures, who ran the contract for most Scottish prisons, said Ms Parker. Care after release included a contract with service providers that accounted for prisoners' reduced tolerance.

Information on harm reduction was being distributed, through a magazine for women, a comic for young offenders and a safe tattooing booklet for men.

Acknowledging that a holistic planning process was needed to keep newly released prisoners in contact with support services, the Scottish Prison Service was aiming to make sure each released prisoner left with a community integration plan.

See page 12 for the DRD conference debate.

Research and guidance

Documents below are the most recent additions to the research and guidance section of our website, www.drinkanddrugs.net. A full listing on all subject areas can be found on the website, with links to the documents.

Integrated care:

Care planning practice guide
Guidance on care planning for practitioners and managers.
NTA, July 2006.

Models of care for alcohol misusers
Guidance on range of services to meet needs for alcohol misusers.
DH, June 2006.

Models of care for treatment of adult drug misusers: Update 2006
Update to original Models of Care for drug misusers.
NTA, June 2006.

Psychosocial treatment and rehabilitation:

Models of residential rehab for drug and alcohol misusers
Review of approaches to rehabilitation and relevant research.
NTA, October 2006.

Throughcare and aftercare:

Evaluation of Scottish Prison Service Transitional Care Initiative
Research report on SPS transitional care initiative.
Scottish Executive, SMRT, February 2006.

Alcohol:

Review of the effectiveness of treatment for alcohol problems
Review of alcohol treatment.
NTA, November 2006.

Familial substance use:

Evaluation and description of drug projects working with young people and families
Evaluation and description of projects with young people and families.
Scottish Executive, July 2006.

Detox and prescribing:

Best practice guidance for commissioners and providers of pharmaceutical services for drug users
Guidance from NTA, Royal Pharmaceutical Society and others.
NTA, February 2006.

Substance specific publications:

Khat report 2005
Report in to khat from Advisory Council on Misuse of Drugs.
ACMD, January 2006.

When a child is born

While methadone has a good record of safety in pregnancy, many expectant mothers want to use their life-changing event as motivation for abstinence. Clouds' GP *Dr Gordon Morse* explains how detox can be approached safely for mother and baby.

Finding yourself pregnant as an opiate addict, whether on substitution treatment or not, frequently accelerates motivation toward abstinence. This motivation arises from obvious concerns: There is the worry about delivering an infant in opiate withdrawal and of seeing your child in distress in an incubator on a special care baby unit; there are also fears (heightened perhaps by recent outspoken comments in the press) of that child being taken into care. And there is also a symbolic milestone on the personal addiction journey; perhaps the advent of a new life would be a good time to make a new life for yourself – a fresh start, and perhaps the feeling, rightly or wrongly, that abstinence would offer the chance to become a better mother.

Many of these concerns may be more perceived than real. Methadone has a very good record of safety in pregnancy, and not all babies are born with opiate withdrawal syndrome. Those that are, can be managed quite easily and there is no convincing scientific evidence that any lasting harm results from being born opiate dependant. And it is the quality of parenting that is the determinant of whether a child is taken into care or not, not the addiction status of the mother.

But nonetheless, pregnancy is a time when many women press their services for access to an abstinence-based programme, and this presents a challenge. The bald scientific facts are simple: methadone is known to be safe, and stability on methadone has much better pregnancy outcomes than continued use of street drugs. Furthermore there is little if any published evidence that detox in pregnancy is either effective, or indeed safe to the baby or the mother. However, it would seem sensible that a gentle detox in the 'special care baby unit' of the mother's uterus would be preferable to a Perspex bubble, and also that such powerful motivation to change should be seen as an opportunity to be grasped, not avoided.

So if detox in pregnancy is to be attempted, what are the options? Clearly there is no reason in purely detox terms, why a gentle methadone weaning should not be carried out in the community. But some agencies take the view that these cases need to be offered as much support as possible, and prioritise pregnant opiate users for residential treatment. Certainly the patient may be motivated, but much of that motivation (at first) may be more around abstract notions about what is best for the baby, rather than what is best for the patient – so perhaps a strongly supportive environment where motivation can be enhanced would be desirable.

Lapse and relapse is also potentially more damaging to a pregnancy than to an individual, and relapse in the security of a residential programme is less likely than in the community. And finally many pregnant heroin users default from their antenatal care – in a residential treatment centre, antenatal care can be brought to the patient, and medical facilities are on hand at all times.

'It would seem sensible that a gentle detox in the "special care baby unit" of the mother's uterus would be preferable to a Perspex bubble, and also that such powerful motivation to change should be seen as an opportunity to be grasped, not avoided...'

We have had a number of pregnant opiate dependant women apply for treatment at Clouds over the past decade. We think carefully about the applications, and invariably discuss with the patient all other treatment options, before accepting them. It is essential they understand that detox in pregnancy has not been subjected to rigorous scientific scrutiny, and that methadone treatment is (and probably always will be) viewed as the conventional option. But if after this counselling they wish to go ahead, then we are happy to accept them in their mid trimester – intuitively it seems safer to detox after the time of greatest risk of miscarriage and before the time of most risk of premature labour.

With the pregnant patient we are aware that we are detoxing both mother and unborn infant. It seems sensible to take a gentle approach and use the simplest and safest medications. And so we undertake a simple slow methadone weaning over four weeks or so – much more slowly than our standard 'grasp the nettle' approach that uses a number of drugs that are untested in pregnancy.

Treatment completion rates in these patients is broadly similar to our non-pregnant patients, and notably we have never experienced any untoward pregnancy events. Good antenatal care is associated with better pregnancy outcomes, and all the women we have treated have benefited from visits to Clouds by the community midwife. Drug using patients are often poor attenders of antenatal care, but with the patient in our care for six weeks it has been possible to complete what has frequently been very incomplete antenatal screening supervision.

Looking back over the pregnant women that we have treated over the past ten years, it is perhaps unsurprising but still gratifying to note that none of these patients posed any special problems and fitted into our programme extremely well. At a time when the entire treatment 'industry' is exercised by the many uncertainties of case selection for Tier 4 treatment, I would argue that pregnancy is a valid reason to prioritise for Tier 4 services, those women looking for detox and abstinence – it is an opportunity to exploit a motivational window, and an opportunity to enhance pregnancy outcomes.

Dr Gordon Morse is GP and medical consultant at Clouds House, Wiltshire

In experienced hands

DDN asked treatment centres about the options they offer pregnant women.

From street heroin to stablisation

'Andrea was injecting heroin when she came to us. We gave her slow reduction in rehab and she now has a healthy son.'

Andrea was admitted to The Huntercombe Centre in early March 2003. Our 34-bedded specialist detox and rehab service in Sunderland provides titration, stabilisation and full detox services, and we have worked with a number of pregnant drug users, and other clients with specialist needs.

At this stage Andrea was 23 years old, and had had three previous successful pregnancies, the children of which had all been adopted. Before she was admitted, we liaised with Andrea's PCT to identify a community midwife who would provide specialist support throughout her stay.

At the point of admission, Andrea was injecting two bags of street heroin each day, and was prescribed 30mg of Diazepam daily. Her local social services department had already instigated proceedings to protect the unborn child, and it was agreed by Andrea and her carers that the initial treatment goal should be titration onto methadone followed by a slow reduction at 5mls per week to a level that Andrea felt comfortable on.

After initial titration and stabilisation in detox, Andrea requested a placement in our rehab programme. Although this was a departure from the initial plan, it was felt by all that the extended support she would receive would be of significant additional benefit. While we normally stipulate that clients going into rehab need to be drug free, this requirement was waived in Andrea's case due to the complication of her pregnancy. It was agreed to continue a slow reduction of up to 5mls methadone per week up to the 30th week of pregnancy, and to maintain stable scripting from there on.

Andrea finally completed her rehab in mid June, and was discharged home with continuing support of her local community addictions team, midwifery service and social services. Happily, Andrea had a healthy son some three months later, and continues to care for him today.

Mick Davies, The Huntercombe Centre

Teenage choices

'A pregnant girl could detox here as long as the doctor confirmed it was safe. She would join in most of the same activities as our other clients.'

We haven't had many teenage pregnancies, but when we have they have been either two or three months pregnant. When they come to our rehab, they are dealt with in according to whether they are addicted to alcohol or drugs. Middlegate takes teenagers from 11 to 17 years old.

We try to treat everyone the same regardless, so if a pregnant girl came here she would get the same process of enrolling into this rehab and the same activities. However, if she was heavily pregnant we wouldn't expect her to join in any strenuous activity.

Whether she should detox or be maintained on methadone would really depend on the doctor or nurse's opinion, once they've carried out the health check. There wouldn't really be much point in anyone coming here if they weren't going through detox though.

Gordon Beattie, Middlegate

Joint working for a safe prescription

'We work with each mum-to-be to find the safest package of care.'

We have had a few pregnant mums come into the clinic and be stabilised on methadone. Detox or methadone maintenance depends on the stages of pregnancy. We have had some pregnant women complete a successful detox at around their sixth month. The final semester is when it becomes unsafe.

Here at Trevi House, we work with the pregnant user and refer her to a drug worker and the local hospital to work out the safest package to ease her off drugs. A lot of times it depends on the amount of street drugs she has taken, as this will have an effect on the baby once it is born. We look at every case individually, but the last thing a lot of mums want is a baby born on a script.

Angie Brooks, Trevi House

'Should you need qualifications to work in this field?' (DDN, 20 November, page 6) provoked a decisive reaction on our online poll. Sixty per cent of you voted 'no'.

Professional standards

I believe alcohol and drug workers should have a qualification and be accredited with a professional body. It is very desirable that counselling, advice workers and support staff maintain certain professional standards and subscribe to a code of ethics and standards.

We work with very vulnerable people – sometimes very vulnerable people indeed – and the first rule is 'do no harm'. While 'caring' staff may not realise, however, that too much sympathy can kill, there is also the danger of negative labelling, which may eliminate any hope that the client may have for themselves.

Not understanding abuse or addiction to chemicals may also contribute to a carer becoming irritable, stressed and impatient when working with clients who are having difficulty achieving or maintaining their goals. Jargon and negative labelling are at best meaningless, and at worst self-defeating and very destructive.

Training ensures that carers remain professional, and accreditation ensures that standards and ethics are maintained and carers do not become burnt out or stressed unnecessarily. They also need to have good support and supervision within a team.

Christine Wilson, by email

Proposer missed the point

I was dismayed to read the motion proposed by Kevin Flemen at the NTA/FDAP conference reported in the last issue (*DDN*, 20 November, page 6).

My dismay lies largely in the fact that a training professional of Kevin Flemen's experience and renown has so completely misunderstood the point. I can only hope that there is some devil's advocacy going on, but I fear not. It is enormously ironic that much of the argument laid out in support of the motion is precisely why the current line on qualifications has been taken, and if Kevin actually understood how these modern qualifications work he would realise that they are in fact the solution to most of the problems he outlines.

The motion 'being competent shouldn't be entangled with being qualified' should really be turned on its head: 'Being qualified should necessarily be based on being competent'.

The proposer goes on to say: 'Some qualifications don't qualify anyone for anything. They show someone's attended something for the day and managed to stay awake'. I absolutely couldn't agree more, such so-called qualifications are worthless – but these are not the type of qualifications people are being encouraged to obtain. In fact, the stipulation of competence assessment in the qualifications framework serves to actively discourage any reliance on such worthless tat.

For the last 20 years the whole of the UK and quite a bit of Europe has been moving away from vocational qualifications that are awarded simply on the basis of the take-up of learning, and towards those based on the demonstration of safe, effective, competent practice.

This is why large amounts of work and brain power (not to mention a few English, Welsh and Scottish pounds) have gone into bringing about a range of qualifications which can only be awarded on the basis that an individual can perform effectively – and it is these qualifications to which the NTA treatment planning guidance refers.

With qualifications which are based on a course of learning and assessed on the basis of absorption, regurgitation and re-presentation of knowledge many have become 'qualified' while lacking the basic competence to engage with a substance misuser, let alone assess their needs. With that type of qualification, the 'belief that by having a group of workers who are qualified, they are competent' is indeed misplaced.

Perhaps it's the term 'qualification' that causes the difficulty. But the type of qualification which the field has been exhorted to acquire is not that which Kevin describes: It is different in almost every respect. The substance misuse field has been asked to achieve competence assessed qualifications *ie* qualifications which are awarded without requiring any particular course of learning but depend entirely on the ability to consistently perform to the national standards that they (the field) agreed. In this case, one can be assured (as far as is possible) that the worker who is qualified is competent.

The inclusion of relevant units of these expert-devised competencies into the competence-assessed vocational qualifications for the hinterland of 'peer educators, youth workers, housing workers... *etc* 'will help to ensure that their interaction with substance misusers also is safe, competent and informed by consensus good practice. That's what the sector skills councils, arm's-length bodies, government departments, and large portions of the field have been striving to achieve.

This approach is the antithesis of restrictive and exclusive. On the contrary it is aimed at recognising the diversity of the 'substance misuse workforce', at breaking substance misuse out of its silo and helping that diverse workforce to recognise and identify its substance misuse role.

Every time I hear an objection such as this to the value of qualifications in improving services, that objection is based on misunderstanding and criticism of something entirely different from reality.

Another ill-thought-out criticism is that people don't only need competence, they also need learning – as if the fact that qualifications don't require a specific course of learning means that learning and theory are not required. Of course they are. If one needs theory in order to practise effectively and one doesn't have that theory, then one will not be able to perform competently and will not be able to become qualified.

There is simply a move from measuring the uptake of learning (which may or may not result in effective practice), to measuring the application of knowledge and skills (wherever they were acquired) at the business end. It's really not rocket science and those who understand this fairly simple premise tend to agree that measuring the proof of the pudding rather than examining the ingredients is a good idea.

Perhaps the secret is in throwing out our old concept of qualifications as being necessarily about recognising learning. The qualifications which have been developed for, and recommended to, this field by the NTA/Home Office are about quality assurance of day-to-day work and professional accountability and recognition.

Iain Armstrong,
alcohol and drugs advisor (workforce development), alcohol policy team, Department of Health

For the sake of balance

I voted 'no'. While I appreciate that there should be qualified workers within this field especially when it comes to recovery medication, I think there should be a balance.

I work as a project co-ordinator for an access service that provides help and support for people with drug and alcohol dependency problems.

I took on this role in February 2006

with no degree or qualifications in this field of work. (I have since done a motivational interview skills course and alternative therapy courses.) However, since I have worked with clients, I have found that compassion and empathy are among the most important parts of this job. Clients have confided their innermost thoughts and demons to me. If the clients want further help, I have been able refer them to the relevant local services.

At the access service, myself and a support worker colleague have set up an alcohol dependency self-help support group.

We run a seven-week programme on drink awareness, health effects, alternative recovery therapies and relapse prevention. Through our and the group's support, some of those members have cut down their drinking and some have had success in becoming abstinent.

When we started this I had very little knowledge in this field. But over time, through finding out information and the help of the members, I have learnt so much that I am able to give to future members.

Also, recovering addicts can be among the best support workers as they have been there and experienced the difficulties. They have knowledge of what can work and what does not, and can provide a lot of advice to other people that are struggling to recover.

While I said 'no' on the opinion poll, I think that a balance of qualified and non-qualified workers, with other life skills to offer, can bring a good balance to the service that we provide.

Lorraine Green, Project Co-ordinator, Woodgrange Access Service

Hands-on results

To be of value, any route to effective training in the rehabilitation field must contain at least two main components:

The system of rehabilitation being studied must be effective *ie* it must have a finite end result in the form of comfortable long-term abstinence, and, It must be 'hands on' so that the student can directly prove for him or herself the viability of the system, and thus know with certainty that it works.

Kenneth Eckersley, the Narconon Programme

More than just accreditation

I've worked in the addictions field for 16 years, I am accredited (NCAC) and I do possess qualifications – despite most of my significant influences being from 'unqualified' people, many who have inspired me through both their knowledge and experience. It would damage the creativity, openness, and acceptance of difference in this field to bar people without qualifications.

As a counsellor/supervisor I have actively campaigned against accreditation; it effectively bars many candidates, often because of cost issues. It is increasingly difficult to meet the costs of professional practice, and I know through experience that accredited and 'qualified' people don't always make the best practitioners. They meet the costs of training, accreditation etc and can put together a good portfolio – but some lack insight and empathy.

Mike Robinson, by email

Tier 4 – Where is the law?

I have been following the debate in *DDN* about Tier 4 services with some consternation.

For ten years I was a commissioning manager in social services and was involved in the development of community care in the substance misuse field from the outset in the early 1990s. So I am constantly surprised about the framework for the debate about the development of residential care. Where is the reference to the law?

Little mention is being made of the legal framework of the NHS and Community Care Act. The Act and subsequent legal rulings gives a very powerful framework for improving the provision of residential care and in a way would reduce the costs to the NTA.

It is almost as if the drug and alcohol field is so used to working in a world where progress is made through negotiation and cajoling of reluctant partners, such as primary care or mental health, that we are unused to having the law on our side.

However, the law is on our side. Every local authority must offer an assessment to any drug or alcohol misuser who requests it. If this person meets the nationally established eligibility criteria then there is a duty to fund. This has been clarified by legal judgements over the years.

The reason there is a problem in the provision of residential rehab is that local authorities are skirting round these legal duties. In my current role as a consultant, I have visited area after area where access to community care funds has become so obscure that no-one bothers to ask anymore.

A more effective and cost-effective way of developing the field is to:

a) Enforce the requirement that local authorities advertise their assessment procedures and eligibility criteria.

b) Require local authorities to publish figures on assessments and placements for drug and alcohol users.

If service users are not getting access to community care funds, then there should be encouragement for a legal challenge. If drug and alcohol agencies fail to appeal against decisions that are unfair or challenge processes that make access to community care funds difficult, then we are colluding with the local authorities' poor practice. By not subjecting community care to the legal challenges that have been relatively common in other care groups, the substance misuse field is failing to clarify and define service users' rights.

Mike Ward, by email

Does anyone care?

'National and international evidence consistently shows that good-quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing-drug related offending.'

The above is stated on page 7 para 2.1 of *Models of care for treatment of adult drug misusers: Update July 2006*, published by the NTA. If that statement is true, then with re-offending now at 92 per cent of those on DTTOs, an increase of 3 per cent on last year, it would seem reasonable to ask what's going wrong.

Is it the models of treatment being used? The time that is devoted to individual cases? A failure to engage service users in the models being used? Worse still, given that in the latest NDTMS report, the contents of which were hailed as a success by both Caroline Flint and Paul Hayes, there is no reference to this deplorable state of affairs, does anyone care?

It may be that the models of treatment being used are effective for those who simply misuse drugs, and for such people it may well be possible to find methods of persuading them to reduce their consumption. But there is scant evidence that what might work in such cases can ever be effective with those who are unfortunate enough to have become addicted.

There is no reliable evidence that those who are addicted can be 'educated' to use illicit drugs in a manner that could be described as safe. Attempts to cut down, no matter how sincere, simply do not work for any meaningful period of time; therefore, so called 'harm minimisation' in such cases, is as effective as a candle in a force 10 storm. With that in mind, perhaps the NTA would care to answer the following:

Does present assessment of those on DTTOs allow for screening of 'Drug Dependency Syndrome' as described in ICD-10, and/or DSM-1V?

How many of those currently in treatment have been screened for 'Drug Dependency Syndrome' within the specified criteria?

Given that both standards urge abstinence in such cases, what abstinent-based methods are being used in current treatment strategies?

What percentage of those who have been diagnosed as 'dependent' are being treated with abstinence based interventions?

If abstinence based treatment does exist, how many of the above have been continuously abstinent for a minimum of 12 months?

If, as it appears, attempting to get those who are 'dependent' off of drugs has been abandoned as a primary objective in favour of 'more realistic targets', is the escalation in re-offending included in such targets? If not, is there a target figure for re-offending – and if so, what is it? If not, why has such an important target not been included?

I do hope that the amount of taxpayers' money that has been spent on current treatment strategies is sufficient justification for expecting jargon and rhetoric free answers to the above, thus avoiding the necessity of seeking the answers via the Freedom of Information Act.

Peter O'Loughlin, The Eden Lodge Practice

Home detox: a step too far?

Dr Colin Brewer has just been struck off the medical register for 'irresponsible' practice. He was trying to bring affordable detox and maintenance to his patients, and has been punished unfairly, he tells DDN.

Last month Dr Colin Brewer, founder of a pioneering drug addiction centre, was struck off the medical register for 'irresponsible' practice. Central to the case was the death of a 29-year-old man who had died during the course of a home detox, prescribed by Brewer, that would have been continued with a naltrexone implant at the clinic. The patient's parents had misunderstood that they were meant to watch him for 24 hours around the clock, even during his sleep; the GMC ruled that the drugs were prescribed too freely and said Brewer had become 'over-confident' in his treatment.

A case had been building up around Brewer's addiction clinic, the Stapleford Centre, over the past eight years. Accusations had been directed not only at Brewer, but at six other doctors who worked at the practice, for their liberal prescribing policy. By the time the GMC delivered its verdict, the case had not only become the longest in the council's 145-year history; it had divided experts on the way drug-dependent clients should be treated.

For Brewer, his story contradicts any intention of over-zealous prescribing. Qualifying in the 1960s as a psychiatrist, he was drawn into becoming an alcohol specialist, 'maybe because everyone else didn't like alcoholics, and I didn't mind them'. He was impressed with the useful effects of using antibuse with his patients for detox and relapse prevention – which led him onto extensive trials of naltrexone, at a time when the drug was unknown in the UK. Using naltrexone for detox gave impressive results, says Brewer. He was surprised then when the NHS 'weren't interested in it… in fact they were actively uninterested'. Having 'more or less left the NHS' at that stage, he continued using it and believes the results justify his enthusiasm for it to this day.

Back in the 1970s, attitudes to addiction were at a crossroads. From the 'quite good prescribing programmes available in the 1960s, when it was easy to get methadone', the climate changed and abstinence became the keynote of drugs policy.

From his already busy practice, Brewer was not looking to become involved with heroin addiction. 'But when the NHS stopped providing methadone maintenance in the 1970s, patients were desperately looking for someone to continue their prescription. A doctor I knew called Dr Ann Dalley had gradually acquired a fair collection of patients on methadone maintenance and did very well by them,' he explains.

When Dalley was prevented from prescribing controlled drugs – the result of suspicion by a GMC 'rabidly against maintenance' that medication was being diverted – Brewer came back from holiday to find a queue of patients in his waiting room saying 'we've been told by the Home Office that you treat addicts and thought maybe you'd continue our methadone'.

At first he was horrified. 'I'd never supplied methadone apart from to one or two patients, a week or so before detox.' But a phone conversation with the Home Office persuaded him to take the patients on.

The decision wasn't taken lightly, and Brewer adopted a meticulous approach to understanding methadone maintenance. His first few patients took him on a steep learning curve.

'The first thing I wanted to do was see whether patients actually took the amount of methadone they said they were taking,' he explains. 'The first guy I saw said he injected 70mg of methadone. I said "that seems an awful lot" – you can see how little I knew at the time! I told him I wanted to see him do this, as I'd never prescribed injectable methadone. He looked at me as if I was an idiot, rode off on his motorbike to a pharmacy and got some injectable methadone, rolled his jeans down and whacked 70mg into his femoral vein, and said "there you are doctor, there's nothing to it is there". It was just as if he'd smoked a cigarette for all the effect it had on him.'

From then on Brewer would make a point of getting everyone to demonstrate their claimed tolerance, either injecting or swallowing. He learned that most patients were 'pretty sophisticated' and knew roughly what their need was, so he carefully calculated the equivalent amount of methadone – a routine that continued 'for years and years without serious trouble' and 'certainly no deaths, because we'd have jolly soon heard about them if we had'.

What seemed a logical way forward to Brewer was taking him down a different path to that laid by the establishment. Practices which the GMC recently termed 'irresponsible', Brewer prefers to call 'a bit unorthodox', but he still believes strongly that that they did much more good than harm. The case has been a bitter blow to a man who believed so strongly in the value of individually tailored treatment that he set up the Stapleford Centre as the only way to provide it.

His motives related to filling a treatment void, he explains. By and large he was not dealing with middle-class patients with a reasonable income, who were covered by insurance and wanted a more deluxe service than the NHS. Rather, patients came to him because they had no other choice.

'At that stage there was very little maintenance, lousy detox facilities, and in many areas of the country nothing at all,' he says. 'There were waiting lists of months or even years to go into detox, with a high risk of failure.'

Brewer was also coming into contact with families who had spent all their money on a spell in rehab for their son or daughter – only to realise they may need several more attempts to detox. He tried concertinaing the content of a two-week stay into a detox lasting two or three days, which 'made it cheaper, even though the nursing was more intensive'. But some still couldn't afford that, he says, so he resorted to offering the alternative of a home detox, with 24-hour phone contact and advice. At around £250, the home detox was still a large amount for some families, but for many it offered the difference between treatment and resorting to a life of illicit drugs.

For patients wanting maintenance – and he is a strong believer that stabilisation can often be the best route to getting an out-of-control life back on track – his mission was to provide accessibility and choice. He would involve the family wherever possible, which as a psychiatrist he had been used to doing anyway, but his trusting prescribing practice pushed his methods towards further scrutiny.

'If someone trustworthy came with the patient, I would say "you look after the medication, so there's no need for them to go to the pharmacy every day, or to come back and see me every day".' It made perfect sense to Brewer as his patients came from all over the South East of England: 'It was not like we were running a neighbourhood service where we could say "come back and see me tomorrow". Quite a few patients were desperately trying to keep a job and didn't want to take more time off work. Flexibility was combined with choice: some patients worked best with morphine, some preferred buprenorphine, others would be happy on a methadone programme.'

For 15 years Brewer offered his services 'without any serious problems'. The death of his patient was not only an isolated incident that left him so devastated he seriously contemplated suicide; he also feels that it gave critics who had been circling him for years the chance to pounce.

Whatever the personal toll on him, not least the blight to his distinguished career, Brewer has emerged still as passionate about certain underused forms of treatment. Naltrexone is still the great enabler, as far as he is concerned – the drug that 'does what it says on the tin'. His belief holds firm that the drug should be used within the criminal justice service, to give offenders chance to calm down and be receptive to the support they need.

'The lost opportunities with naltrexone make me weep,' he says. 'When I think of the number of people who could have been kept out of prison for useful periods and who are never even offered it…' He reflects on how things have changed since, not so long ago, the Home Office approached him about setting up a model treatment system for prison medical care.

His recent experiences have made him feel so far outside the system that he is convinced that government, the NHS and rehabs are going out of their way to put obstacles in the way of fair treatment.

'They're deliberately making it difficult for addicts, saying "we only want the ones who are really keen on treatment, so we'll give them lots of hoops to jump through",' he says. 'But you wouldn't do the same with psychiatric patients, would you? You wouldn't say to a schizophrenic patient, "we'll take you into hospital, but if you have one more hallucination we'll throw you out".'

'It's the same with rehab,' he adds. 'When addicts' urge for drugs doesn't disappear, they kick them out. It'd be laughable if it wasn't so serious.' It's clear that his experiences have left Brewer seriously disillusioned with the system. **DDN**

Should medically unsupervised detox be allowed? Vote at the DDN online poll, www.drinkanddrugs.net

I am a recovering addict of nearly five years and I am interested in becoming a substance misuse counsellor once I have completed the final year of my BSc in Psychology. Would anybody be kind enough to recommend pathways into this area as there are so many courses available it is hard to know which ones are effective, accredited by the relevant governing bodies, at the level needed in this field and so forth. Any help would be most appreciated.
Scott, by email

Common ground

Dear Scott
As you say there are many paths, but there are some commonalities:

It is generally agreed that to practise as a counsellor you need to have a minimum qualification of a Diploma in Counselling.

A degree is psychology is great but it's not a counselling qualification.

Some specialist knowledge or training is essential if you want to work with substance misuse or dependency.

You can approach the qualification framework by first getting a Diploma in Counselling and then specialising in addictions, or you can set out to qualify as an addictions counsellor from the start.

If you take the general counselling route, then you need to decide which 'model' of counselling you wish to study and take it from there. There are a myriad of possibilities and most colleges and universities offer counselling courses in a variety of packages.

If you decide to go direct to training as a substance misuse counsellor, there are relatively few options. There is still a bit of a divide between the harm minimisation school and the abstinence-based approach, which you might want to investigate. Below are a few suggestions:

Dedicated treatment centres which also offer 'in-house' counsellor training – eg Castle Craig.

The Hazelden Foundation – a well-established American-based training unit.

Clouds House – offers a Foundation Degree, either full or part-time.

Leeds Addiction Unit – provides some distance learning courses which include addiction issues.

RAPt – one-year full-time Addiction Counsellor Training Course, RAPt Diploma plus CPCAB Accredited Certificates at levels 2 & 3.

Good luck with your route.

Jane Norton, Training Manager at RAPt

Many routes

Dear Scott,
There are as many pathways into this field as there are interfaces to work at. If you have the opportunity, choose where you'd like to be (setting) and then figure out what it takes to get there. A way to do this might be to consider the setting where you'd like to counsel substance misusers.

If you are unsure, visit as many agencies as you can, in as many settings… and talk to the clients. Ask yourself, are you interested in meeting them where they're at? Can you hear what they are saying to you? Could you make a difference? The agency will tell you what it requires with regard to competencies.

Try not to be influenced by the rubbish about counselling models you might hear in the counselling bazaar. There are hundreds of them, with new ones being invented every year. Why anyone would want to spend another shilling or write another word comparing one against the other is beyond me when all they ever discover is the same thing: none is more effective than any comparable other. There is significant research which demonstrates that the most important factor in eliciting change is the resources the clients themselves take. The next most important factor is the therapeutic alliance.

So, models are crucial… to the practitioner. Among other things, they offer a lens through which to focus and make sense of the client's presentation. In my experience, if we can't see the client properly, it's because there's something wrong with the camera, not the client. We know they have the strengths and resources and choices that will make a difference. Find a camera you're comfortable with.

The organisation I work with has placements in training from the Clouds foundation degree. We also have placements on a local integrative diploma and a local CBT diploma. All are excellent courses, but it is the individual qualities the placements demonstrate that make a difference.

Agencies have different employment polices. In a counselling position, we won't employ anyone with less than a recognised, accredited diploma. However we do employ a range of practitioners, addiction counsellors, Rogerian counsellors, CAT practitioners, psychodrama practitioners, systemic family therapists, CBT counsellors, and eating disorder specialists. Many cameras! And I'm bound to have offended someone by forgetting one.

You're welcome to visit here and meet with the clients and the staff, if you find it useful and practical.

Kind regards and bon voyage.

John Trolan, programme director, The Nelson Trust

Reader's question

I am nearing the end of a mandatory life sentence, having spent the best part of 18 years in and out of detention centres, borstals, prisons and institutions. During my time in prison I have learned to read and write and educated myself to GCSE level. I completed every course the education department had to offer and have over 50 certificates. I am about to do a diploma course on counselling children and adolescents, after which I would like to do some voluntary work. I really want to put something back into the community: please can anyone point me in the direction of any contacts, a company or organisation that might be willing to give me some voluntary work?
Terry, Parkhurst Prison

Email your suggested answers to the editor by Tuesday 9 January 2007 for inclusion in the 15 January issue of DDN. New questions are welcome from readers.

Reducing drug-related deaths conference: **Debate**

'This house believes that increase in abstinence services will result in more drug-related deaths.'

Proposing the motion:
Dr Chris Ford, GP in London

This is a very important debate. We know that many if not most drug-related deaths are preventable, and this includes overdose and deaths from bloodborne viruses. Both types are preventable with treatment.

Overdose is most common in opiate users after they've left prison, or left treatment prematurely, and often they're in a situation where they don't have clean equipment.

Since 1991 deaths have been going down. Why? Has there been an increase in drug treatment? Is it related to meth and buprenorphine being prescribed? The reality is that the quantity and quality of treatment has improved, and we know that well-managed methadone treatment can improve prospects.

Detox can be dangerous and is not very often successful. Death rates are higher in recently detoxed patients. Even the wonderful NTA, who I sometimes disagree with, says the realities of detox must be discussed, based on research by John Strang and the Home Office.

Many people request detox but we need to recognise that maintenance is a very worthwhile option. Maintenance patients need our support – including psychological support – and harm reduction has to be our goal.

The NTA says rehab providers have to provide mechanisms for rapid referral into maintenance programmes. Getting people off drugs is dangerous.

Bill Nelles, founder of The Alliance, said: 'Let's take the morality out of drug treatment and put the humanity back in'. Judy Bury [GP] said it is our job as GPs to keep people alive until they are ready to change.

There's not much evidence for long-term effectiveness of detox, but it can reduce tolerance. People

Working lives:

John Fox, young people's service worker, Kirklees

John Fox's dream job at Lifeline Kirklees gives him the chance to give young people the help he couldn't find in his own teenage years.

When I took my role within Kirklees User Forum (KUF) in September 2004. I had been accessing treatment through Lifeline Kirklees' structured day care service Outlook, which offers educational and structured activities for people wanting to return to mainstream society. I became involved with the KUF because of the problems I had in the past with my years of substance misuse and the hardships I experienced while trying to access a service for my heroin addiction, when I was 21.

The service I had contacted had such a huge waiting list I could not wait; and so I did my cold turkey, which was a nightmare. But it helped me to turn my back on smack and I have been clean for nearly ten years. I then developed a problem with cocaine, which ripped through my life and left me with nothing – not even any self-respect. This was not crack addiction, but a drug every one thinks is fun and manageable. It's seen as even more socially acceptable now, rather than a life-destroying experience. KUF gave me a passion, a role, and a movement that could make a change. It could give the user a voice and, also help the services to become more user-friendly and more accommodating to their needs.

Lifeline and our local DAT invited us to meetings, which helped us all to improve services. We attended national and local meetings to shape policies and procedures in our local services. We also took part in producing two pieces of research, one for adults and one for young people, around services and substance misuse issues. I started to volunteer for Lifeline's young person service, Drug Sense in Kirklees. It involved doing outreach around the Huddersfield area, engaging with groups of young people, delivering advice around substance misuse, and taking part in and organising diversionary activities. I kept my role within KUF and attended my treatment programme, keeping myself totally motivated and on the road to recovery.

I continued with all my ongoing responsibilities and a post came up as a trainee support worker for Drug Sense – a job I had always wanted to do. Although I thought I had no chance of getting it, I sailed through the interview and got the post. I then stood down from KUF, as I could not manage a full-time job as well as my responsibilities there. My time with KUF ended a year to the day I joined – and what a fantastic year it had been for me all round, personally and professionally.

When I started my new post, I had a structured training program which involved working with a fantastic team of individuals with different qualities and working styles. I worked within multi-disciplinary agencies and held a small caseload. I had training around clinical interventions and prescribing for young people and was able to cover the young person's clinic.

My contract ran out and a Tier 3 generic worker post came up, which I applied for successfully. Working with young people has made me so positive about being able to deliver the help that I found so hard to find in my teenage years. So being promoted and winning another year contract has been amazing.

Working in the field has brought out something in me that I thought I had lost years ago, and it's installed in me a pride and passion for the job I do. Not many people can say they like a Monday morning.

I hope that other ex or current users can find some hope in this story and also know that our field need hands-on experience. I want to thank Lifeline for giving me the chance to express my dedication and passion for the job, and also for helping me out of my nightmare of addiction to live a clean and passionate life.

John would like to thank Kirklees User Forum and Kirklees Drug Action Team for all their much-appreciated support over the past two years.

cannot do abstinence when they walk in the service. The move toward abstinence-based treatment is dangerous and will increase drug-related deaths.

Opposing the motion:
Dr Gordon Morse, GP in Wiltshire

Healthy drug treatment should be about choice. There's an enormous – and justified – enthusiasm for harm reduction. But I hear of many services that begin and end with a script, and that is wrong. There are two sides of the coin. People have to have both; a choice.

The debate's wording is not proposing that we disinvest in harm reduction services. We desperately need more services for alcohol and crack cocaine.

But disinvesting in abstinence services and shoving all our money into harm reduction would be a terrible derogation. Would we tell people in this room who have achieved abstinence that they've taken an unnecessary risk? It's preposterous!

Where does personal responsibility come into the equation? Drug-taking is risky, but we should have both options. Our patients want abstinence. Sixty per cent arriving at services ask for abstinence, but 95 per cent get harm reduction. We owe it to our patients: It's about offering them choice.

It's not schizophrenic to entertain both. There are far too few abstinence-based services available because of the predilection for harm reduction services.

We're seeing the answer in a prescription pad; it's easier than the alternative when you won't go down a more difficult route. But we'll get more and more methadone patients in their sixties.

If that's the only act in town, it sucks!

Seconding the motion: Dr Tom Carnwath

Abstinence isn't an appropriate goal for therapy. You get premature abstinence which leads to relapse. Be pragmatic. Go for harm reduction.

Seconding the opposition: David Marteau

Lots of young people drink methadone without any idea of how much is enough to kill you. It's not particularly safe stuff. It seems safe – but it depends on how you read the figures from studies on safety.

Result: Motion defeated.

Addaction's *Next* project is proving a successful route to professional training and employment. **DDN** reports from the first anniversary celebration.

After addiction… What's Next?

When Linda Bush started managing the Next project, she noticed that progress into work by service users was really uneven: 'Some were confident, but others were unsupported. They lacked confidence and were not necessarily being given what they needed. They were full of skills, but didn't know how to use them.' The project, funded by the European Social Fund and the Association of Local Government offered a way of opening doors.

In May last year Bush took on her first group of trainees, with a mission of taking them forward to work in the field. Bringing them into the project, she asked them, 'you've been a client; what does it take to be a worker?'

The next three months were dedicated to finding out, by piecing together knowledge on all areas of the field through two days' training a week. Modules addressed personal development as well as professional training in drugs work. Half way through the training, students were offered an administrative work placement in a substance misuse service for one day a week.

Eighteen months on, ten people from this and subsequent groups are in full-time employment at organisations including Westminster Drugs Project, Thames Ridge Bondway and Addaction.

More than 100 people have completed the course over the past year, 61 per cent of them ex-offenders and 3 per cent who have been homeless. Seventy per cent of participants now have jobs or have entered further education. Another 18 have started the Smart Scheme – professional training leading to a level 3 NVQ in social care – and 32 are in voluntary work or further training. Equally important, the students have a chance to gain work references and referral on to other services, to embed them in future employment.

At last week's celebration of the project's first anniversary, where many of the participants were presented with certificates from the Open College Network by Addaction's chief executive, Deborah Cameron, Bush's pride was discernable alongside that of successful students'.

'Some projects require a period of clean time; we don't,' she emphasised. 'They can start on their first day out of rehab. Their achievements are down to commitment, talent, dedication, and a fantastic staff team [of Frankie Sikes, Laura Ponti and Rebecca Lundberg].'

'It's a disgrace that more skilled people don't get back into employment,' commented chief executive Deborah Cameron.

'The Next project gives us a pool of able and skilled people from different backgrounds. We now need to think about all kinds of employment opportunities.'

The Next project is open to ex-substance misusers living in London boroughs who have completed a course of treatment or a 12-step programme and are no longer using. To arrange an assessment interview, call 020 7017 2868.

Chula joined the course after completing rehab and has used it as a springboard to teaching others.

I'm now a structured treatment practitioner for Westminster Drugs Project, where I've been for about a year. I'd been drinking and smoking from the age of nine; then onto marijuana at 12. I was smoking dope all through school and throughout my teens. I experimented on everything I could get my hands on.

It went from bad to worse over the next few years. I lost my family and friends. My life was falling to bits. I didn't have a lot of hope.

A counsellor kept saying I should go into treatment, but I kept thinking if I tried a bit harder I'd be able to stop. In February 2003 I woke up and realised I couldn't stop by myself.

I came out of treatment drug free. Having used drugs for 17 years, to be drug free was amazing. I was inspired by counsellors, and wanted to give something back. I realised I had only just started to work on myself.

I found Progress 2 Work and got to know about the Next project. I learned about all kinds of things, including models of addiction and harm reduction. I facilitate groups of ten to 15 people now.

There's not a bit of wasted information from that course; I keep a file on my desk. The information now reaches other people who need it.

Michelle was in the first group to start the Next project, having 'kind of got there by mistake'.

I'd phoned Addaction to ask about voluntary work and they suggested I came down to do an assessment. I felt like a square peg in a round hole. Amazingly they phoned me back and said I'd got on the course.

I thought 'you lot can't tell me anything about drugs'. But I was so wrong. I struggled, but I learnt so much. The course was about personal development for me. I thought I'd have the ex-junkie label for the rest of my life.

The staff were so supportive. But what I learnt was that I really love to give something to others. I didn't believe I wanted to give anything back to society at first.

I don't have the junkie label anymore. I'm a mum of three. I had learnt to commit to recovery – now I've learnt to commit to a career. I got my first month's wages this morning. I can pay my rent for the first time!

I would say to others: 'Put one foot in front of the other. Keep turning up.' Now I've got a job. **DDN**

Social Learning and Coping Models: Part 2

Professor David Clark continues his look at the social learning model of substance use and misuse.

In my last Briefing, I introduced Social Learning Theory (SLT), which describes the effect of cognitive processes on goal-directed behaviour. SLT considers the human capacity for learning within a social environment through observation and communication.

I described the role of reinforcement, cognitive expectancies and modelling in influencing substance use and misuse, and pointed out that SLT forms the basis for therapeutic interventions such as coping skills training and cue exposure treatment. I also briefly looked at the role of stress, and a coping model of substance use and misuse.

In this Briefing, I will look at self-efficacy, another key element of SLT. Self-efficacy is the level of an individual's confidence in their ability to organise and complete actions that lead to particular goals.

Robert West (2006) points out that self-efficacy affects the goals that people pursue, the level of effort used to achieve those goals, as well as how long people will persevere in pursuit of their goals when encountering barriers. Self-efficacy affects the likelihood of the goal being achieved.

Self-efficacy can be influenced by the success or failure that an individual has previously experienced on the particular task, although there a variety of other influences (*eg* views of other people) that can play a role.

It can be related to a specific task (giving up drinking alcohol) or be more general in nature. Self-efficacy is not just related to behaviour, but also to an individual's 'level of perceived control with regard to his or her thoughts, feelings and environment'.

A person's self-efficacy for alternative behaviours can play an important role in influencing whether they drink in a specific situation. Their confidence that they can cope in a specific situation, and their estimation of the chances of succeeding, will determine the selection and implementation of coping behaviours. One of these coping strategies in stressful situations can be the consumption of alcohol.

The self-efficacy of a person who has developed problematic drinking following long-term use of alcohol to cope with life's stressors is likely to have been badly affected by the excessive drinking, so they are even less likely to feel confident of using alternative coping strategies when faced with stressful situations.

Let us consider the various principles of SLT in a hypothetical situation, taken in part from the excellent book by Peter Monti and colleagues (see below).

Paul is in a high state of distress because of a recent marriage break-up and work pressure. He attends a party, where he expects to relax and have fun. His friends are already drinking and having a good time (modelling influences). His coping will be determined by his general and alcohol-specific coping skills, cue reactivity (reactivity to cues previously associated with drinking), and self-efficacy.

'The self-efficacy of a person who has developed problematic drinking is likely to have been badly affected by the excessive drinking, so they are even less likely to feel confident about using alternative coping strategies when faced with stressful situations.'

Paul's self-efficacy percepts will be influenced by his current stress level and history of coping in similar situations.

His expectations about the short and long-term effects of drinking on behaviour will also be important. He focuses on the immediate positive reinforcing effects of alcohol (*eg* relaxation, euphoria), while ignoring the longer-term negative consequences (*eg* hangover, heightened anxiety, car accident).

Paul has low self-efficacy about relaxing and socialising without a drink. When drinking is initiated, various reinforcing effects of alcohol come into play. His expectations of alcohol reducing his stress and allowing him to enjoy the evening more, will likely be confirmed.

Mary is abstaining from alcohol because of previous problematic drinking. She has discussed with her counsellor the factors that they believe have contributed to her problematic drinking.

Mary has talked through and then rehearsed various coping strategies and alternative behaviours that could be used in difficult situations. The role of conditioned cues and their ability to produce cognitive and physiological reactions that can interfere with her ability to use alternative coping strategies have been discussed.

Her counsellor has gradually exposed Mary to more and more difficult situations, and as she has coped and avoided drinking in these situations, her self-efficacy has increased.

Mary attends the party with the belief that she will not drink alcohol. She is armed with information and techniques that will help her achieve her aim. She will want to relax and have fun at the party, but she will have learnt to do this without the aid of alcohol.

I will look at these therapeutic strategies in more detail in later Briefings.

Peter M. Monti, Ronald M. Kadden, Damaris J. Rosenhow, Ned L. Cooney and David B. Abrams (2002) Treating Alcohol Dependence: A Coping Skills Training Guide. The Guilford Press.
Robert West (2006) Theory of Addiction. Blackwell Publishing. (Available at discounted rate from the DDN bookshop at www.drinkanddrugs.net*)*

David Clark has recently taken early retirement from the Department of Psychology, University of Wales Swansea, to concentrate on running WIRED on a full-time basis. He is now an Emeritus Professor at the same University. David wishes all his readers a Merry Christmas and Happy New Year. He is very grateful for the kind comments he has received about the Background Briefings over the past year.

You can find out more about WIRED and the Daily Dose news portal it operates at *www.wiredinitiative.com* and *www.dailydose.net*.

Who would a manager be?

You've got the manager's job… now what? Tim Morrison gives a guide to bringing out the best in your team.

You have just got the manager's post – at last, finally, you have the recognition and the power to make a difference to the service users and the working conditions of staff. All your predecessors had similar aspirations but how can you learn from their experiences and avoid their mistakes... Quickly?

Expectations on you from all sides are high, the clock is ticking and there is a lot of paperwork that must be got through. The situation can be made even worse where there is a requirement to combine staff management with a client case load – something has to give and when it does, it tends to be the supervision and staff guidance bits of the job that can always be put off until next week.

Becoming a manager

Routes into management jobs in the sector are diverse. It appears, at least anecdotally, that many get appointed into management roles for some or many of the following reasons:

- their clinical skills are excellent;
- they are the last person left surviving in the team;
- they have been acting up into the role and feel pressurised into applying;
- they are scared of who else might get the job;
- it seemed like a good idea at the time;
- and lastly (but importantly) it's simply the only way of getting more money.

It can appear that management activities are a diversion from the more glamorous elements of working with people in trouble, but this attitude is simply wrong: the manager's task could not be more fundamental – its primary role is to ensure that a consistent service is provided in a safe, efficient and effective way to people who need it.

Unless decent management practice is in place, all sorts of abuse can, and does, take place. Where staff are not supervised and their practice monitored, then there is a risk of danger to the client, the organisation and to themselves. Put directly, decent and consistent client care cannot take place without proactive and coherent management practice.

Many will have had the ability to learn how to manage by their own experience of being handled well themselves but, in a sector where practice has historically sometimes been haphazard, it is not uncommon for workers to have had little or no experience of supportive and effective supervision, appraisal or performance management at all.

The NTA recognises a problem exists; hence, in its guidance notes to the adult drug treatment plans 2006/07 issued on 3 October 2005, it stated the expectation that by 2008 '90 per cent of managers are undertaking or have achieved an appropriate management training programme, as defined by their employers'.

Planning any type of learning must begin with some kind of needs analysis to identify the gap between current skills and the demands of the new role. This necessitates some level of self-analysis and reflective practice, and this is an obligation on all workers and not just those in a management role.

DANOS and the job description (JD) provide a good starting point. All JDs in the sector should by now have been mapped against the standards – hence there should be a list of appropriate units easily available. The actual units can be downloaded from the Skills for Health microsite http://www.skillsforhealth.org.uk/danos/.

There are two criteria for suggesting which ones to prioritise:

- How essential is it for my role?
- How competent am I in carrying it out?

I determine my competence by reading through the performance criteria in an element (see BC3.2: 'Evaluate proposed changes for benefits and disadvantages') and asking myself how I could demonstrate to a neutral assessor my ability to meet them in a range of circumstances. This process will result in my being able to make a structured list of my training needs that I can take to my own manager in the appraisal process and to start identifying ways in which needs can be met.

Using available resources

Not much sector-specific management training is available at the moment – however, this should not be a problem as the kinds of issues that managers will face are the same across health and social care. A number of FE colleges and universities offer generic appropriate courses.

Some sector specific resources:

- Some D(A)ATs and a few of the larger services have started developing their own management development programmes.
- LDAN's Developing First Line Managers course gives those new to management the opportunity to explore their development needs and their skills to improve their day to day practice. It is particularly relevant to those who have recently moved from a practitioner or clinical role and taken on staff supervision. The course runs over four days and has now trained more than 180 staff from across London.
- NTA Human resources toolkits that describe the stages in performance management and supervision are available on its publications/ workforce development page.
- Also from the NTA, and on its publications/ drug services policies pages, are a series of guidance reports on issues like joint working, data protection, appraisal and so on that managers must be clear about.
- DrugScope will shortly be publishing *The Essential Service Manager* by Ian Robinson.

Tim Morrison is a university lecturer and freelance trainer. His website is www.alcohol-drugs.co.uk

Readers' Survey

We are very keen to hear what you think about the magazine, so please take a few minutes to fill in the DDN readers' survey. The easiest way to do this is to fill in our online survey at **www.drinkanddrugs.net** or if you would prefer, please photocopy or cut out this form and return it to us at: **Readers' Survey, Drink and Drugs News, CJ Wellings Ltd, Southbank House, Black Prince Road, London, SE1 7SJ**

All completed forms received by **22 December 2006** will be entered into a draw to win an ipod shuffle.

Personal details

Title _____

First name _____

Second name _____

Address _____

_____

Town/City _____

Postcode _____

Country _____

Telephone _____

E-mail address _____

Job details

Do you work in a drugs or alcohol service?

❑ Yes
❑ No

If yes, in what capacity?

❑ Front line worker
❑ Line manager / supervisor
❑ Senior manager / director

If no, which of the following best describes you?

❑ Commissioner / funder / referrer
❑ Policymaker
❑ Service user
❑ Worker in related area outside specialist drugs / alcohol field

Do you read the job vacancies section of DDN?

❑ Regularly
❑ Occasionally
❑ Never

Are you responsible for placing advertising?

❑ Yes
❑ No

The magazine

How useful / interesting do you find the following sections of Drink & Drugs News: From 1 (not at all) to 5 (very much)

News & media watch

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Letters & comment

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Q&A

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Background briefings

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

(More overleaf)

DDN reader's Survey

How useful would you find the following: From 1 (not at all) to 5 (very much)

Book reviews
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Research & guidance reviews
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

How many people on average share your copy of Drink & Drugs News?

_____

How often each month do you visit the drinkanddrugs.net website?

_____

The website

How useful / interesting do you find the following sections of the website: From 1 (not at all) to 5 (very much)

Events
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Training & development
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Guidance & research
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Standards
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Management resources
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Getting help
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

In your opinion

What are the three most significant challenges facing drug and alcohol services?

What three changes do you believe would have the greatest positive impact on services/service users?

What three issues would you most like to see covered in Drink & Drugs News over the next 12 months?

Which figure would you most like to see interviewed in Drink & Drugs News?

What question would you most like to see them being asked?

Any other comment(s) you may wish to add

2006 and all that

As we prepare to leave this year and look towards the future, DDN glances back at the issues that have made an impact, whether for good or bad.

January

The beginning of the year brings the UK Drugs Act into effect. The launch of a pilot scheme of dedicated drug courts encourages offenders out of the downward spiral of drugs and crime. The hospitality industry demonstrates co-operation with the BMA against smoking in all public places by recommending a total ban. Charles Kennedy confesses his alcohol addiction: 'I've come to learn that a drink problem is a serious problem indeed.'

February

A leaked report from Downing Street's strategy unit revealed a call from the PM's former strategy adviser, John Birt, for free prescribed heroin to undercut the illegal drug market. The European Commission presents an EU Drugs Action Plan 2005-08 with the aims of halting the increased drug use within the European population and tackling the drugs trade. In the same month, the government reveals up to 35,000 UK children under 16 are using heroin.

March

London is the world's 'cocaine capital' with clubbers replacing ecstasy with the 'white gold'. The UN calls on rich nations to help drug-producing countries combat farmers' dependence on illicit crops such as opium and coca. Alcohol Concern warns that problem drinkers face homelessness because of lack of funds for residential services, and by the end of the month police have the right to drug test on arrest.

April

Home Secretary, Charles Clarke, warns the organised criminal underworld to 'be afraid' as intelligence is used to tackle drugs with the launch of new law enforcement agency, SOCA (Serious Organised Crime Agency). Controversy rises among the Scottish police force with requests, from the Strathclyde Police Federation (SPF), to legalise all drugs. 'We should legalise everything from class A-C, including heroin, cocaine and speed,' said Inspector Jim Duffy, chairman of the SPF.

May

Alcohol and drug users with mental health disorders are included in the revised Mental Health Act 1983. A group of experts from the Independent Working Group suggested drug consumption rooms should be piloted in the UK: 'They are a unique and promising way to help lessen fatal overdoses as well as take drugs off the streets and would have an impact on some of the serious drug-related problems in the UK,' said Dame Ruth Runciman, chair of IWG.

June

Furious rows were ignited as Scotland's drug tsar admits defeat in the drug war: 'We can never as a nation be drug-free. No nation can, so we must accept that,' said Tom Wood, a former deputy chief constable. Crystal Meth was upgraded to Class A. At the end of the month, after weeks of worried speculation, the Pooled Treatment Budget was announced to DATS: 28 per cent more than last year, but still much less than the 40 per cent originally promised. Tier 4 was finally allocated £56m by the Department of Health for capital development.

July

MSP Duncan McNeil faced media hostility by suggesting drug users sign a 'social contract' to prevent them starting families until they had ended their habit: 'What's proposed dehumanises people who are in need of help and support,' said a spokeswoman for the Scottish Drug Forum. Consultation on smoke-free premises in England was launched through draft regulations for introduction the following summer.

August

A letter from 11 leading charities and academics was sent to Children's Minister, Beverly Hughes, calling for government to address the plight of 1.3m children in the UK affected by parental alcohol misuse. Turning Point's chief executive, Lord Victor Adebowale, said: 'The government cannot ignore the children and families affected by alcohol misuse any longer.'

September

Young People's binge drinking was targeted by Thames Valley Police and the Borough of Kensington and Chelsea, with a 'four strikes and you're out' scheme. Proposals for an automated needle and syringe exchange machine in North Wales were met with mixed feelings. One project director, Danie Strydom, said: 'Police should take a zero tolerance approach to drugs rather than advocating the use of a machine to administer them.'

October

Neil McKeganey of Glasgow University's Centre for Drug Misuse Research blamed Scottish policy for failing Scottish heroin addicts as it 'aims to stabilise users rather than getting them permanently off drugs' with 97 per cent still being stabilised after three years. The Home Office calls off a proposed drug class review: 'Those involved in the criminal justice system have not raised the classification system as a concern that affects them with me,' said Home Office Minister, Vernon Coaker.

November

Health Secretary, Patricia Hewitt, calls for higher taxes on booze following figures, from the Institute of Alcohol Studies, that 55 per cent of teenagers were binge drinkers. UN Drugs chief, Antonio Maria Costa, warns Europe on its upward trend in cocaine abuse: 'Europe is contributing to the environment's destruction, bankrolling drug traffickers, insurgents and terrorists,' he said.

December

The start of England's smoking ban is announced as 1 July 2007. Heath Secretary, Patricia Hewitt, said: 'This is a triumph for public health and a huge step forward for health protection. Thousands of people's lives will be saved and the health of thousands more protected.' **DDN**

DDN / FDAP One-day workshops

Healthy eating for a better life

14 February – Central London

Helen Sandwell – Nutritionist MSc NutMed

This workshop is aimed at all those who work with substance misusers. It will explore why diet is so important to their physical and mental health, as well as their long term drug / alcohol outcomes. The workshop will focus on healthy eating related to the particular problems experienced by the individuals who come into contact with drug and alcohol workers.

Re-run due to popular demand
£110 + Vat per delegate (includes a light lunch)

Qualifications, competence and government targets – making it work

26 February - Central London

Presented by Carole Sharma – Former NTA work force development lead.

This one-day workshop will assist those responsible for workforce development in creating local systems for the development of the substance misuse workforce. Using experience from her time at the NTA, Carole will demonstrate how to work towards a competent workforce and achieve government targets. This workshop provides essential information for anyone responsible for managing staff.

£145 + Vat per delegate (includes a light lunch)

Supervision, appraisal and DANOS

28 February – Central London

Presented by Tim Morrison – Former head of training and quality at DrugScope.

Performance management and supervision can sometimes be highly subjective and difficult experiences that appear like an additional burden to the normal workload. This one-day event will support managers to use DANOS as a tool to develop the skills of their staff and improve the experience of service users.

£110 + Vat per delegate (includes a light lunch)

All workshops are located between London Waterloo and Vauxhall and run between 10.00am and 4pm. They include morning coffee and a light lunch. A 15% discount is available to FDAP members.

Place numbers are limited on all of the workshops, so early booking is recommended.

For more information or to book your space please contact Ruth Raymond – e: ruth@cjwellings.com t: 020 7463 2085

NHS
Cumbria Drug & Alcohol Action Team

TACKLING DRUGS CHANGING LIVES
Cumbria Drug and Alcohol Action

INVITATION TO TENDER

Adult Drug Treatment Services

Cumbria Primary Care Trust, on behalf of Cumbria DAAT is seeking expressions of interest from suitably qualified organisations for the provision of the following contracts, either individually or collectively, across the whole of the county:

- Substance Misuse Training
- Structured Day Programmes and Care-Planned Day Care
- Harm Reduction and Health Promotion Service
- Drug Intervention Programme

In addition to evidencing the ability to deliver the required services, potential service providers must demonstrate innovation, creativity and commitment, together with evidence of integrated working with other partners and provision of professional advice on all aspects of drug misuse.

All interested parties are required to complete a Pre-Qualification Questionnaire the responses to which will be assessed to compile a short list of parties.

Additional information on each service is available, on request, from Janice Ruddie, Office Manager, Cumbria Drug & Alcohol Action Team, Tel: 01768 861270; Email: janice.ruddie@cumbriapct.nhs.uk

Each contract is for a 3 year period, subject to annual review and future funding allocations. These contracts vary in their commencement dates from 1 April 2007 to 1 April 2008.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to some of these services.

The deadline for receipt of PQQs is 12.00 noon on Friday, 26 January 2007. Under no circumstances will late applications be considered.

EXPRESSIONS OF INTEREST TO PARTICIPATE IN THE TENDERING PROCESS TO SECURE THE PROVISION OF YOUNG PEOPLES SERVICES (TIER TWO, TIER THREE & PRESCRIBING) IN ADDITION TO THE PROVISION OF FAMILY AND CARER SUPPORT SERVICES.

The Staffordshire County Drug and Alcohol Action Team are seeking expressions of interest from suitably qualified organisations wishing to participate in the tendering process for the provision of all or any individual element(s) of the following services:

- Young persons tier two drug and alcohol service
- Young persons tier three drug and alcohol service (including prescribing element)
- Family and carer support service

It is anticipated that the tender process will be undertaken in three stages. Firstly the submission of a pre-qualification questionnaire, secondly, suitably qualified organisations will be invited to participate in a scoping exercise and finally the submission of tenders.

The date for return of the pre-qualification questionnaire will be the week commencing **15th January 2007.**

It is envisaged that the scoping exercise, which will consist of a detailed confidential discussion between each prospective provider and the commissioner(s), will take place during the week commencing **19th February 2007.**

The total yearly value of contract(s) to be awarded is expected to be in the region of **£510,000 (approx).**

Expressions of interest should be submitted in writing to Young Persons Commissioning Officer, Staffordshire Drug and Alcohol Action Team, 24, Gaol Road, Stafford, Staffordshire, ST16 3AN and must be received by no later than **14th December 2006.**

Staffordshire County
Drug and Alcohol Action Team

ACT
Together, Tackling Addiction

Counselling Supervisor, Buckinghamshire
12 hours per week – salary negotiable

Person with experience of providing individual and group casework supervision for approximately 12 drug and alcohol volunteers at a rate of 1½ hrs each per month individually. Must be flexible about appointment times some evening/weekend work necessary. Suitable applicants will have counselling and supervision qualifications and experience of working with drug/alcohol issues.

Criminal Justice Alcohol Worker, Apex House, High Wycombe, Bucks
37 hours per week - £20,421 to £22,628 per annum

An opportunity to provide fast track interventions for alcohol misusers coming from the criminal justice system. Providing counselling groupwork and onward referral to other interventions. Some evening work necessary.

To apply for any of the above positions please telephone Justine on 01296 425329 or email justine@addictioncounsellingtrust.com
Closing date for above posts: 14th December.
Interview date: 20th December.

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Programme Assistants for adult residential treatment centre in Surrey. Shift work with flexible hours, well suited for students and others who have interest in the treatment field of addiction and dual disorders. Please contact Christine Summerfield on 01483 757 572 or Email CV to: csummerfield@lifeworkscommunity.com

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Go public with your ambition

Adult Services

User and Carer Empowerment Officer

■ Winchester ■ £20,895 - £24,708 ■ Ref: 11156

The Hampshire Drug and Alcohol Action Team (DAAT) is committed to ensuring that drug users and their carers are meaningfully involved in the development of substance misuse services in Hampshire.

You'll develop and implement strategies for user and for carer empowerment, in line with national and local priorities, to ensure that users and carers participate in the planning and development of the Hampshire drug treatment system and are represented in DAAT decision making processes. This will include providing support to users and carers, developing and supporting independent peer led groups across the County and working with other agencies and organisations to develop their user and carer participation.

You'll have a clear understanding of the needs and motivations of drug users and carers, with a knowledge of drug treatment issues and treatment services, particularly in Hampshire. You'll need to be organised with excellent communication and interpersonal skills to influence a wide variety of people from a range of backgrounds and professions within a multi agency environment.

A basic level of IT knowledge will be an advantage although training can be provided. The ability to travel across Hampshire is essential.

Applications are encouraged from former drug users or carers. For an informal discussion please contact Martin Parker, Joint Commissioning Manager on 01962 826025.

Closing date: 22 December 2006. Interview date: w/c 22 January 2007.

To apply online please visit www.jobs.hants.gov.uk Alternatively you can contact the Resourcing Centre on 0845 850 0184, or e-mail us at resourcing@hants.gov.uk for further information. Textphone users only can call free on 0808 100 2484.

IN PROMOTING EQUAL OPPORTUNITIES, WE WELCOME APPLICATIONS FROM ALL SECTIONS OF THE COMMUNITY.

Hampshire County Council

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addaction

leaders in our field... and still growing.

For almost 40 years, Addaction has been at the forefront of helping people overcome their substance misuse problems. our continued success means continued growth.

Service User Co-ordinator

37.5 hpw working across two sites:
Worthing • 18.75 hpw • Crawley • 18.75 hpw
£18,936 - £20,020 pa (pro rata)
Job Share applicants welcome.

Are you passionate about recognising that those in treatment and those who have identified a need for further treatment have the right to become involved in activities that affect their health and well-being? If you are, and are experienced in the substance misuse field, then you could be the person we are looking for to work with West Sussex DAAT, treatment providers, and service users to co-ordinate service user involvement in the planning, delivery, monitoring and review of services in West Sussex.

Addaction offers 28 days' annual leave, 6% contributory pension, plus excellent opportunities for personal development. Please visit our website to download an application pack. Alternatively, contact Ellie Coyle at e.coyle@addaction.org.uk or on 01903 217097 quoting reference SE124.

Closing date: 8 December 2006.

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www.addaction.org.uk

Derby Community Safety Partnership

Derby City NHS
Primary Care Trust

DERBY COMMUNITY SAFETY PARTNERSHIP

INVITATION TO TENDER – Adult Drug Treatment Services

Derby Community Safety Partnership, working with local agencies, has a reputation for the delivery of first class drug misuse services for adults and young people across the city of Derby. In order to maintain the highest standards and continue to meet drug treatment need, the decision has been made to reconfigure these services. As part of this plan, the Partnership invites expressions of interest from suitably experienced organisations to provide three adult services, either individually or collectively:

- **Tier 2 – Harm Reduction, Open Access, Information and Advice**
- **Tier 3 – Single Point of Entry, Key Working, Care Planning & Psychosocial Interventions**
- **Tier 3 – Specialist Mental Health Substance Misuse**

The services are commissioned through the Derby City Primary Care Trust. In addition to evidencing the ability to deliver the required services, potential service providers must demonstrate innovation, creativity and commitment, together with evidence of integrated working with other partners and provision of professional advice on all aspects of drug misuse.

All interested parties are required to complete a Pre-Qualification Questionnaire the responses to which will be assessed to compile a short list of parties to whom the final tender documentation will be issued.

An information pack and PQQ is available from:-

Karen Jones, Deputy Supplies Manager, Derby Hospitals NHS Foundation Trust, 4th Floor Education Centre, Derby City General Hospital, Uttoxeter Road, Derby DE22 3NE or email karen.jones@derbyhospitals.nhs.uk

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to these services. The aim is for the new services to be operational by 1st June 2007. The duration of the contract will be a minimum of one year and no longer than three years and subject to future funding allocations. The tender process will be running in parallel with public consultation.

The deadline for receipt of PQQs is 5.00pm on Friday 29th December 2006. Under no circumstances will late applications be considered. The formal tendering process will then follow within approx. 1 month.

Please quote reference : DH/470/T

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NHS Trust

WEST WALES SUBSTANCE MISUSE SERVICE, CARMARTHENSHIRE

CRIMINAL JUSTICE DEVELOPMENT WORKER - BAND 6

Fixed-term contract until 31 March 2008

We are looking for an experienced and enthusiastic worker in the substance misuse field, to take a lead in developing integrated ways of working between DIP, specialist treatment services and criminal justice agencies. The post will also manage a caseload with a restricted number of clients with complex needs, have a key role in signposting clients into services, and supporting the development of aftercare plans and services. This is an exciting and challenging post, which will work with a range of services and commissioners to enhance current ways of working and to inform future service development needs.

3 years' experience of working in the substance misuse field and of working alongside criminal justice agencies and mental health services, is essential. Experience in developing and improving services on a multi-agency basis is also a key requirement.

For an informal discussion, please contact Sue McRitchie, Locality Manager on 01267 244442.

Application forms and job descriptions are available by contacting the 24hr answerphone facility on 01267 239871 leaving your name, address and vacancy reference 8223 or email jobs@pdl-tr.wales.nhs.uk

Closing date: 22 December 2006