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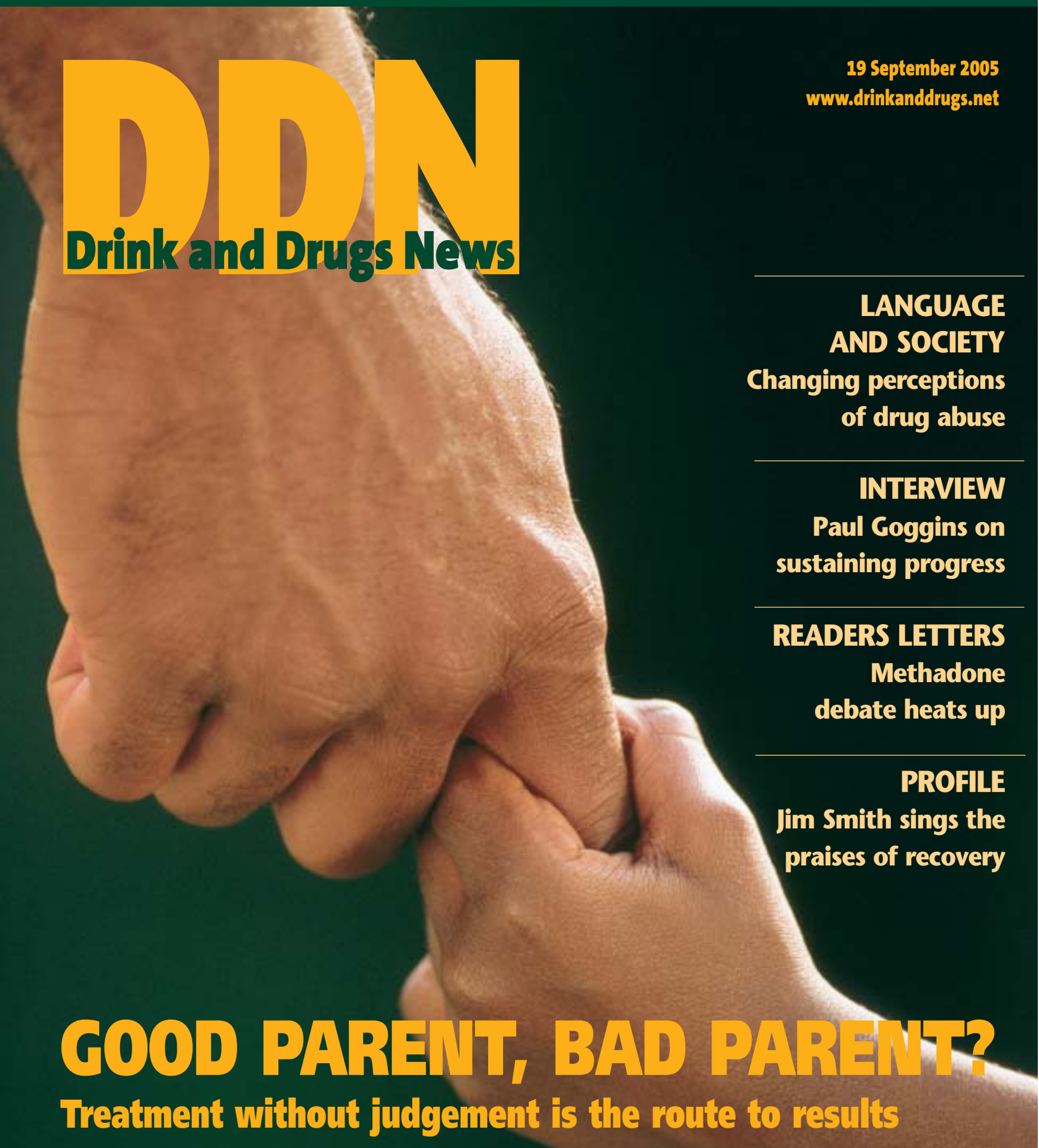

DDN
Drink and Drugs News

19 September 2005
www.drinkanddrugs.net

GOOD PARENT, BAD PARENT?

Treatment without judgement is the route to results

Vicky's Story is a frank and honest film which deals with many issues surrounding prison release, overdose and drug use amongst women.

An ideal training resource intended to stimulate discussion when used as part of a structured programme.

Commissioned by the Greater Manchester Drug Action Teams and launched at the National Conference on Reducing Drug Related Deaths in November 2004.

Copies of the video/DVD are now available, and priced at £20.00/£30.00 respectively (inc p&p).

For further information please contact
Lisa Linekar on 01204 492419 or
e-mail lisa.linekar@gmas.nhs.uk

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Drink and Drugs News

19 September 2005

Editor's letter

Stereotypes are rife where drink and drugs are concerned – and never more so than when parenting is involved. In untangling 'hidden harm', are we paying enough attention to parents who are scared to come forward for fear of what might happen to them? Rhian Cash has findings from a South Wales study that gives insight from service-using parents and examines some of the stumbling blocks to treatment from their perspective.

Information for service-planning of a different nature, on page 6, as LDAN's Roseanne Sweeney demonstrates the value of using data to plan investment. Once again alcohol services emerge as the poor relation to drug services. Will this always be the case, when results of the UK Alcohol Treatment Trial have revealed this week that for every £1 spent on treatment, £5 is saved on costs to society? Tighter data management will aid efficiency in the long-run – but it will take initial investment to set up, which may prove tricky for smaller agencies. LDAN offers help through its website.

When the drugs minister talked to DDN (page 7) he said he was impressed by the dedication of the drug and alcohol field. A look at this issue's letters page demonstrates once again that workers in this field not only have dedication to the job – they have passion about what they do and fervent beliefs borne of diverse (and often personal) experiences. There's certainly no sign of moving wordlessly in the same direction here, but the raw debate and deeply held views must surely make it one of the most interesting professions to work in.

Thank you for the excellent suggestions we've had so far through your responses to the DDN survey. We're scrutinising every one of them – so please fill one in at drinkanddrugs.net by 1 October if you haven't already.

Editor:
Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
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In this issue

Alcohol study shows treatment to justify its investment

Alcohol treatment programmes are a cost-effective intervention, according to new research involving 600 people with alcohol problems.

The UK Alcohol Treatment Trial (UKATT), published in the British Medical Journal, showed that for every £1 spent on treatment, £5 is saved on the costs of heavy drinking on society – which are estimated to be more than £18 billion a year, spent on the NHS and as a result of public disorder.

Researchers looked at two treatments geared to helping people carry on with their every-day lives, rather than residential rehab. Both treatments – social behaviour and network therapy, and motivational enhancement therapy – were found to achieve results in cutting alcohol consumption and dependency during three months of therapy. A follow-up study after 12 months showed participants were still drinking less and feeling better.

Alcohol Concern has been quick to welcome results of the research as strong evidence for both the effectiveness and cost-effectiveness of specialist alcohol treatment.

Director of policy and public affairs, Geethika Jayatilaka, said it backed up 'what we have known for years: treatment works'.

The charity is now calling for government to invest £100 million immediately in treatment services, to address the shortfall in alcohol spending. Alcohol services receive a fifth of the funding of drug services, despite three times more people dying as a direct result of alcohol than drugs, according to statistics from government and Alcohol Concern. AC has already highlighted a shortfall of up to 200,000 places in treatment each year in England alone.

'Alcohol treatment has been the Cinderella of healthcare for too long,' said Ms Jayatilaka. 'It is time to invest in reducing the damage that problem drinking inflicts right across our society.'

New inquiry report highlights failings of homicide teams

In May this year Mike Ward reported the findings of the homicide inquiry team investigating the treatment and care of Dale Pick (*DDN*, 16 May, page 9). The article highlighted the problem with so many of the inquiries into homicides by mentally ill people: that the client has significant problems with alcohol or drugs but the report fails to address how to deal with the substance misuse in its recommendations.

Another, more recent, report has highlighted the same theme in a very stark way, according to Mr Ward. In January 2005, Richard King was convicted of the manslaughter of his mother-in-law's partner. He had been in receipt of adult mental health care services since 1989 for a serious psychotic illness.

'However, the report also highlights a long pattern of excessive alcohol or cannabis use and the use of other illicit substances,' said Mr Ward. 'Indeed Richard King had used cannabis prior to the homicide. The report is unclear to what extent cannabis worsened his mental health.' However, it notes that 'those treating patients with schizophrenia should bear in mind the current thinking on the effect of cannabis on mental health when agreeing a care plan... Within care planning, proper regard was not taken of RK's regular use of cannabis and the impact of this on his health.' It recommends that 'the Trust should consider and develop policies... to address the problem which the use of illicit drugs carries to mental health care service users...'

The report goes on to say that: 'We do not have any obvious recommendations to make as to how such a problem can best be managed for a service user being located in the community, where such substances are all too readily available. However, it is the panel's expectation that those responsible for the Care Plan would take this into account' – another example, according to Mike Ward, of the inability of these inquiries to adequately address the issue of substance misuse.

'It is surely time that the Department of Health ensures that inquiry teams have the expertise to address substance misuse issues, and that they give this vital issue sufficient attention,' commented Mr Ward.

Panel report from the inquiry into the care and treatment of Richard King, June 2005, Norfolk. For details of how to access the report contact Michaeljohnward@btinternet.com.

Research and guidance

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

SACDM Working Group on Drug Related Deaths: Report and Recommendations
Report from Scottish Advisory Committee on Drug Misuse. Scottish Executive, August 2005.

National Investigation into Drug Related Deaths in Scotland, 2003
Report into background of drug related deaths. Scottish Executive, August 2005.

Peer education: from evidence to practice
Review of evidence and implications for practice on peer education of young people. NCETA (Australia), June 2003.

Out of sight? Not out of mind
Framework on children, young people and volatile substance abuse. DoH, July 2005.

Prevention and reduction of alcohol misuse – 2nd edition
Review of evidence base re the prevention and reduction of alcohol misuse.
NICE (England), July 2005.

Patients need more support in coming off prescription drugs

Patients' experiences in trying to come off psychiatric drugs show serious flaws in the doctor-patient relationship, according to mental health charity Mind.

Publishing its *Coping with coming off* report, Mind says 40 per cent of patients interviewed saw their GPs as 'not helpful' in helping them come off antidepressants such as Seroxat, which have been reported as having possible harmful side effects and harsh withdrawal symptoms.

Interviewees cited the internet and email groups as their favourite source of advice, with 94 per cent finding them helpful.

Alison Cobb, Mind policy officer and *Coping with coming off* project manager, commented that when the GP-patient relationship worked, it worked well, but that it was vital for doctors to listen to patients' perspectives.

'People who want to come off their drugs must have their decision respected, and be practically supported, even by professionals who may not agree with them', she said.

Mental health professionals received positive comments through the study. Mind hoped to work with health professionals to make medication choices a reality for people taking psychiatric drugs.

Coping with coming off (£5.50 including p&p) is available from Mind Publications, www.mind.org.uk, tel: 0844 448 4448. A booklet, *Making sense of coming of psychiatric drugs* (£3.50 including p&p) will be available in October.

Diamorphine crisis: excuses 'unacceptable' says UKHRA

A call for a rational, swift response to the diamorphine shortage has been made by the UK Harm Reduction Alliance (UKHRA), which highlights a range of government excuses as unacceptable.

Shortage of the drug, triggered by problems at the Chiron supply factory in Merseyside, have escalated to a crisis for those whose treatment has been withdrawn since January. Despite repeated questions and campaigning, resolution is still not imminent.

The UKHRA, an alliance of drug workers and activists, users and ex-users, health professionals and academics, has investigated feasible options to resolve the crisis, and is fiercely critical of the highly profitable duopoly that governs the way the NHS procures its diamorphine.

In the short term, UKHRA wants swift repackaging and supply of imported diamorphine. The Dutch health service pays just £6.30 per gram for the drug, compared to the UK's £41.36. Production methods are cheaper – it is provided as powder, which can be dissolved for injection as required, instead of the expensive freeze-dried amps bought by the UK, leaving no excuse for extending the crisis, according to UKHRA.

A drop in price of 12 per cent over the past year for licit diamorphine, combined with the current world glut, makes the government's failure to resolve the crisis 'particularly worthy of condemnation', it says.

Greater use of opioids such as morphine sulphate are suggested as a second short-term option to resolving a crisis which the NTA currently predicts will continue until at least February 2006.

For more information on the diamorphine shortage, see *DDN*, 27 June (page 9) and *DDN*, 25 July (page 9).

Companies advised to look out for stress

Industry is not doing enough to address 'professional derailment' that can be triggered by addiction, according to a conference by Life Works and SHL.

Experts from mental health counselling and treatment, drug and alcohol policy, objective assessment and employment and disability law warned that companies needed to develop coping strategies for their employees to counter the £100 billion a year lost to the British economy through stress.

Less that 10 per cent of companies have a stress policy, yet 10 to 15 per cent of those in upper management are affected by alcohol and drug addiction, according to Steven Lanzet, Life Works' clinical director.

'Addictive disorders are among the most prevalent, costly and least intervened problems in the workplace today,' said Mr Lanzet. 'The good news is that burnt-out professionals respond well to intervention and treatment. The key is identifying an individual facing derailment early on.'

Eugene Burke, leading occupational psychologist at SHL, said the use of personality tests in industry usually focused on the 'bright side' aspects of an individual's personality. More attention should be given to 'derailment factors' that could prevent individuals from fulfilling their potential, he suggested.

Forty service uses from the Steps/Nacro project in Cheshire won a Royal Horticultural Society Award for their 'Choose Life' garden. The garden's theme is the experiences faced by recovering drug users and shows paths from chaos to order – a ladder representing the way forward and a 'snake' path showing ongoing temptation recovering addicts must overcome. The Steps/Nacro project works to break the cycle of crime from drug use and homelessness. Their garden was sponsored by drug testing company Altrix and was on show at the Tatton Park Flower Show.

Media watch

Grampian's drug action group has decided not to issue citric acid to drug users. The sterile single-use sachets had been widely available as a safer alternative to vinegar or lemon juice. The city's joint alcohol and drug action team, which includes NHS, city council and police, is waiting for a study into the benefits before reviewing the decision.
North Scotland Press, 6 September

Spain tops the table of cocaine use, according to a report for its state prosecutors, which declares 'Spain occupies the top place in the world'. With more than one in 40 using the drug, Spain has overtaken the US and left Britain and Ireland behind. The high rate is blamed on much of Europe's cocaine being unloaded onto Spanish beaches.
The Guardian, 7 September

Afghan opium is thriving despite the EU's 'difficult and complicated struggle' to contain it, according to home secretary Charles Clarke. European justice and home affairs ministers have agreed to step up their support for Kabul's counter-narcotics drive. Britain has promised to put a further £46m towards developing alternative livelihoods for Afghan opium farmers.
The Guardian, 10 September

Liverpool education officials want better warning labels on alcopops, and an alcohol education programme in schools. Education director Colin Hilton launched the campaign after statistics showed Liverpool teenagers have some of the worst alcohol problems in the country. 'The way forward is to illustrate to them the damage it can cause to their skin, figure and maybe even their desires to become successful in sport,' he said.
Liverpool Daily Post, 12 September

Drugs campaigners have welcomed a former High Court judge's controversial call for doctors to provide heroin for addicts. Edinburgh-based Lord McCluskey suggested that drug deaths and crime would be cut if substances such as heroin were offered to addicts 'in a medically controlled setting'. Graeme McArthur, of the Scottish Drugs Forum, described the view as 'quite sensible'.
Edinburgh Evening News, 13 September

More than one in seven drivers stopped during a police campaign tested positive for drugs – twice as many of those found to have been drinking. The government is being asked to look into setting a drug-driving limit by the RAC Foundation. Executive director Edmund King said: 'Setting legal limits on drugs and driving would clarify and simplify the process for police officers, as well as sending a message to drivers. That limit may of course be zero.'
What Car magazine, 15 September

Cosmetic giants and fashion retailers are considering the future of contracts with supermodel Kate Moss after newspapers made further allegations of drug abuse. The 31-year-old, who makes millions from lucrative deals with companies including Burberry, Dior and Chanel, has previously admitted taking drugs in the past. In a series of photographs in a London national newspaper, Moss is seen allegedly snorting cocaine in a west London recording studio.
The Daily Mail, 16 September

Time's up for the alcohol data drought

Lack of information on alcohol treatment makes it difficult to plan services based on demand. Roseanne Sweeney reveals LDAN's project to bring data based insight to alcohol service planning.

Last year the Alcohol Harm Reduction Strategy for England highlighted the lack of information available on alcohol treatment and difficulties this causes when trying to assess the demand for and effectiveness of treatment. There is currently no overall body monitoring alcohol treatment, like the National Treatment Agency does with drug treatment, and no system like the National Drug Treatment Monitoring System (NDTMS) for collecting alcohol statistics centrally.

It was against this background that the London Alcohol Statistics Project was set up. Initiated by the London Drug and Alcohol Network (LDAN) a membership network for frontline substance misuse services in London, it set out to collect NDTMS type data from a range of alcohol service providers. It was hoped that the information collected would provide some insight into alcohol treatment in London, facilitate comparison with drug treatment statistics and explore the capacity of agencies to collect statistics. The project was supported by the Association of London Government and funded by the Kings Fund.

Initially 13 agencies agreed to take part in the project. These were chosen on the basis that they represented a cross section of alcohol services in London – in other words there were both statutory and voluntary sector agencies, large and small, and were based in inner and outer London. They were asked to provide information on clients using their services in 2004. This was then input to a database and analysed. In the event, seven organisations provided usable data within the timeframe requested.

Overall, statistics on almost 7,000 clients across 27 London boroughs was collected. This provided some useful information on the demographics, referral routes and waiting times of people using alcohol services. After comparing the statistics with drug treatment data for a comparable period supplied by the NTA, it also allowed some comparisons to be made with drug treatment services and clients.

Some of the project's main findings are:

- The average waiting time for the 3,774 clients whose waiting time was recorded was 37 days or 5.3 weeks. This compares with average waiting times for drug users in London during the last quarter of 2004, of 1.4 weeks to be treated by a GP and 2.8 weeks for inpatient treatment. Only four providers were able to supply data on waiting times and unlike with drug treatment the data collected did not differentiate between types of alcohol intervention. But the statistics still clearly indicate that alcohol misusers are waiting significantly longer for treatment than drug users.
- Clients using alcohol services are most likely to be in the 36-50 age group, suggesting they are older than those in drug treatment. Men outnumber women by a ratio of 2 to 1 – much like in drug treatment, while of the over 5,000 clients whose ethnicity was recorded four fifths were white, a significantly higher figure than in drug treatment.
- The most common means of referral was by GP (23 per cent) and self-referral (21.5 per cent). Referral source varied according to ethnicity with for example, Asian and Asian/British clients least likely to be referred by a substance misuse service while black clients and those of mixed ethnicity were most likely to be referred by probation. Overall, the figures suggest that alcohol misusers are much less likely to self refer than drug users.
- Alcohol services struggle to keep on top of data collection. Most of the agencies that provided usable statistics struggled to do so in the format and timeframe required while participating agencies unable to provide statistics cited resource issues as the main reason. Despite the fact that information on alcohol treatment is not collected centrally, service providers still have to commit considerable resources to gathering information for both clinical purposes and to satisfy the requirements of commissioners of alcohol services. Most agencies have several funders and are required to provide different information to each of them adding to the workload.

As a result of the findings, the London Alcohol Statistics Project report made the following recommendations:

- More work needs to be done to explore why the wait for alcohol treatment appears significantly longer than for drug treatment, and to address resource issues arising. As report author Libby Ranzetta wrote, if fast access to treatment is a worthy goal then surely this should apply to people with alcohol problems as well as those with drug problems. The national audit of treatment services set in train by the Alcohol Harm Reduction Strategy is due to be published over the next month, and this should add substantially to our understanding of the extent to which the demand for services is being met.
- Commissioners and alcohol providers should agree and adopt a standardised minimum data set for alcohol treatment. With alcohol services stretched to cope with the volume of clients coming through their door, having to duplicate efforts by returning different statistical data to different commissioners appears a poor use of scarce staff time and resources.
- Data collection, although an onerous task particularly for smaller agencies, is important given the information it provides on problem drinkers and treatment. The London Drug and Alcohol Network will continue to make the case for data collection to its 200 plus members and work to ensure they have the tools, training and support to do this.

The report can be downloaded at www.ldan.org.uk

Roseanne Sweeney is Communications Manager at the London Drug and Alcohol Network.

Sustaining the **mission**

Take heart, we're making good progress, is the rallying cry from Drugs Minister Paul Goggins. DDN finds out more.

'We're getting about 2,000 a month into treatment – and that's ahead of where we thought we would be... If you can make it more immediate, the impact will be greater, and the better the chance of getting them off.'

While drugs are clearly still a huge menace, we need to have a debate that also reflects the progress that's being made, says drugs minister Paul Goggins.

Since switching roles from Prisons Minister after May's general election, Goggins has set about demonstrating that investment is producing results.

Use of Class A drugs is stable, he points out. Use of cannabis 'is actually falling'. And on the harm index that government uses to measure overall impact of drugs 'is showing a reduction – 9 per cent over the last two years. Government statistics also show a drop in drug related crime.

'So there's absolutely no complacency – but nor should we feel completely overwhelmed by a problem we're actually making some progress on,' he says.

The next stage, according to Goggins, is to 'sustain what we're doing'. This is where a large increase in investment comes in. Last year the drug treatment budget was £253m; Goggins promises that in 2008 it will be £478m, giving a local drug action team an increase in its budget of more than 50 per cent.

Huge investment, more people coming into treatment, more agencies working together – particularly for those coming into the criminal justice system – is all beginning to make a difference, he says.

Drug action teams will have a very big say in how money is used, Goggins insists. He says he will be looking for DATs to divide the appropriate treatment programmes on the ground, 'because clearly they will be the ones who understand the level of need in their area and the kind of problems that they have'. Such emphasis on participation is also about making sure others share responsibility for reaching targets – and for this purpose government is attempting to simplify systems and make them more flexible.

Introducing the Community Order in April was part of this process, he says. The range of different components within it, gives agencies flexibility in dealing with individuals – the Drug Rehabilitation Requirement (which replaced the 'rather inflexible' DTTO) is now just one of these options, and should help drug treatment agencies and the probation service to provide 'the absolute right package for a particular individual', says Goggins.

Life as Prisons Minister, before the election, gave Goggins a useful overview of people's journey through prison and the investment in their treatment – but made him realise that there wasn't much happening to support them once they were discharged. The Drug Intervention Programme (DIP – which replaced the Criminal Justice Programme a year ago) is helping to rectify this, he believes, giving a more coherent approach and helping agencies to work more closely together.

Channelling a stream of offenders into treatment is a heavily emphasised component of government targets. The government's drug strategy, *Tackling Drugs, Changing Lives* states that 1,000 offenders a week must be entering treatment by 2008. Again, there has been good progress so far, says Goggins:

'At the moment we're half way there, we're getting about 2,000 a month into treatment – and that's ahead of where we thought we would be'. Reducing waiting times is also linked to targets, but Goggins is keen to point out that progress to date – down to two and a half weeks, from nine weeks just a couple of years ago – is about motivating people to change, instead of consigning them to a two-month wait from their court order to entering treatment.

'If you can make it more immediate, the impact will be greater, and the better the chance of getting them off really,' he says.

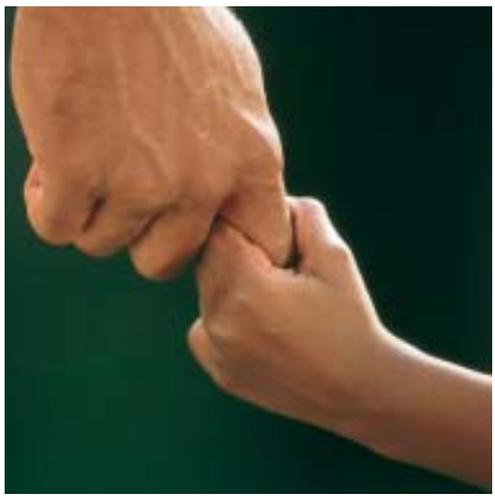
While conceding that it's the job of a minister to set the policy framework and make sure there are enough resources, Goggins is keen to emphasise that he's 'a great believer in acknowledging that it's the front line that makes the difference'.

His latest message in embarking on regional visits over the next few weeks, is 'well done to all those who are making a difference in this way... and don't be dispirited by some of the misleading headlines that sometimes indicate that the whole game is lost'.

Goggins wants workers in the drugs field to see 'that we're making progress' over 'very very tough work' and hopes that taking stock of the difference they are making to lives will renew enthusiasm and commitment.

He points to research on the results of DTTOs, involving 'some of the most chaotic drug users, some of the most difficult offenders in our community' and says that half of people who were able to get to the end of their treatment programme actually stopped offending – 'a fantastic achievement, that's changing people's lives dramatically'. The minister is convinced that the greater flexibility from recent changes to the system will help more people make it to the end of treatment.

For the moment, ahead of target and with the day of reckoning over two years away, he is focusing on positive achievements with the rallying cry for frontline workers: 'keep it up and do better – have the confidence in what you do'. **DDN**



Judgement day

Drug or alcohol use is not in itself an indication of bad parenting. Effective services will recognise this and work with the many complexities involved to help parents regain control, says Rhian Cash.

How can someone look after their child and take drugs at the same time? This was the question raised following the government's 2003 *Hidden Harm* report, which estimated that between 250,000 and 350,000 children were affected by problem drug users in the UK. Perhaps the most worrying factor is that the vast majority of parents who take drugs are 'hidden' in the sense that they are often too scared of what might happen if they ask for help. And unfortunately, while parents choose to hide their problems, their children's needs are also hidden.

A recent study in the South Wales Valleys aimed to tackle a number of these issues by asking parents who had been referred to the local drug and alcohol team what they felt was needed. Eight parents completed the in-depth interviews, about their experiences and how they had managed their drug and/or alcohol problems, and the effect that this had had on their children. Seven of the eight parents had problems relating to alcohol as opposed to other 'illegal drugs'. What came across from talking to parents was not only the fear and stigma attached to having a 'drug or alcohol problem', but the vulnerability of parents themselves. Parents described a range of different problems, such as mental health problems, domestic violence, financial concerns and housing difficulties, where their drug or alcohol use was often just a small part of the picture, or had developed as a way of coping with these difficulties. One father, Aaron, described how he started drinking following a bout of depression:

> *'You end up completely demoralised, you know things should be different but you don't know how to deal with anything, you loose a sense of judgement.'*

The sense of powerlessness and the gradual loss of control that Aaron describes was a common theme from the interviews. Parents often described a range of problems, which had reduced their ability to cope, and it was the combination of these factors that had impacted on their parenting. Another parent, Claire, described how she had started drinking following the death of her youngest child:

> *'I think that if I had had bereavement counselling when I lost her I wouldn't have been drinking or anything.'*

Claire felt that if she had received support that she needed at the right time then she wouldn't have turned to alcohol in reprieve from her grief.

During the interviews there was also a clear link with domestic violence, and several parents described how they had gone from one violent relationship to another:

> *'I've got to be honest, all the shit that I have gone through with social services and that, due to the fact that I have always gone with violent men.' (Millie)*

For Millie, taking drugs had actually felt like a positive thing that had helped her to cope with the violence of her relationship. Unfortunately, the fear and stigma that are attached to 'drug/ alcohol problems' had an isolating effect whereby parents were even less likely to ask for the help or support that they needed and, as far as possible, problems where kept 'within the family' to avoid the stigma of social services involvement.

As well as listening to parents' experiences and demonstrating the impact of drugs on parenting, the research provided an insight into how we can respond to these problems. It was clear that parents needed a range of services that would help them to make the long-term lifestyle changes that were needed, which ranged from practical housing/ financial support to specialist counselling and therapies. Asking parents what they need and offering a 'holistic approach' enables parents to develop more positive ways of coping with their problems, rather than seeking solace in a bottle of vodka. It makes sense that someone who started drinking to escape from a violent relationship, or losing their house, won't have the power or the ability to gain control of their drinking until they tackle these underlying worries. In response to this, the support that is offered to parents needs to be discrete and sensitive to individual needs, to encourage parents to come forward and talk about their problems.

'The vast majority of parents who take drugs are "hidden" in the sense that they are often too scared of what might happen if they ask for help. And unfortunately, while parents choose to hide their problems, their children's needs are also hidden.'

Another important point that emerged from the research, was that once parents had actually gained the courage to ask for help, they often encountered long waits for services. We have all experienced the frustration of waiting for something, and previous research has found that even significantly injured patients will give up and leave when forced to wait too long in a hospital waiting room. If we respond to parents when they first ask for help, then we have more chance of tackling these problems, and avoiding the inevitable crisis as things 'spiral out of control'. One child protection worker that was involved in the research expressed their frustrations:

> *'More workers are needed as it appears that parents are in crisis before action is taken.'*

The crisis intervention inherent in child protection work presents a danger that children will be used as 'agents of change', to give parents ultimatums to address their problems. Unfortunately, as we have seen, parents are often unable to sustain the targets that set for them. Even simple tasks, such

as attending regular appointments or going to parenting classes, can be unrealistic targets for those parents who have reached crisis point. In these circumstances we need to be as innovative and flexible as possible both in our response to parents, and in offering them help earlier.

Most importantly, by helping the parents to regain control over their lives, their children are also benefiting. The research showed how drugs impact on parenting, and unless we recognise parents' needs their children will also suffer. Hopefully, by encouraging joint working, and engaging with both children and parents simultaneously, the problem is tackled from both angles. In response to the original question, 'how can someone look after their child and take drugs at the same time?' asking parents how they felt offered an insight into the complex and dysfunctional lifestyle that can be attached to drugs and alcohol. It is this lifestyle and the inability to take control of their lives that affects parents' ability to look after their children.

Drug use by itself is by no means an indicator of 'bad parenting', and recognising these complexities offers the opportunity for a more effective and successful response.

Rhian Cash is a Substance Misuse Social Worker at Caerphilly County Borough Council.

References
Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the needs of children of problem drug users. London, Home Office.

Ashton, M. & Witton, J. (2004) The power of the welcoming reminder, Drug & Alcohol Findings 11, p 4-18.

'Family voices' competition

Do you know what it's like to live with someone else's drug or alcohol use (or work with families who do)? It can be a difficult subject to talk about and Adfam is looking for families' voices in a letter, composition, or poem (500 words or fewer) to show the reality of living with someone else's substance use. Adfam is a national organisation working with and for such families and our annual competition has proved an excellent way for families to share their thoughts, sadness, frustration and hopes. Entrants have always provided amazingly moving and compelling stories and we hope that this year will be no exception.

Closing date for entries is 7 November 2005 and the winning piece will receive £150. Two runners up will receive £100 each. Email for entries or more details is familyvoices@adfam.org.uk or call Adfam on 020 7928 8898.

Two of last year's winning entries are printed below.

Is this normal?

Lying awake in bed, I watch the clock. He isn't home yet. This is a good thing and a bad thing. It is already past midnight, he is bound to be drunk. Not being here is a good thing.

He will be back. The later the drunker. It can only get worse. This is the bad thing.

He will stumble in and lurch into bed, breathing beer into my face. His sleep will be so deep that he will snore and be unwakeable. After about an hour, he may leap to his feet, awakened by an instinct learned in infancy, and shuffle to the pile of ironing for a pee, sometimes it will be the bedside table. I will leap up too to limit the damage he may do. Mad and sad. My beautiful husband. The man I love, out of control and disgusting.

The next day he makes no mention. Shows no shame. I am sickened by the sight of him. He is amorous and acts as if nothing has happened, so convincing that I half believe him. That it was nothing. I don't want to fight anymore so I join in with the game. Let's pretend. I believe each time will be the last time. Feel shocked and stunned when, within a week it happens again.

What is it tonight? Someone joining the company? Or leaving? A 'babycham interview'? (Yeah right.) Perhaps a new contract has started? Or finished? Or a birthday? A new baby? A new house? Car? Pen? Whatever it is, he will patiently point out to me that, 'It is important to make people feel valued'.

When I protest that I never see him, that I too would like to feel valued, the sneer that curls his lip makes me want to stab him in the heart. When I remind him that I married him for love, that I am lonely without him, that I miss him, he usually sighs resignedly, shakes his head wearily and says, 'It's always about you isn't it?'

He is very angry that I do not understand how hard he has to work. Very angry to be met by this red-faced fury, with her stupid questions.

So I try to be better. Less of a nag, less weepy, less needy, less angry, less demanding, less disappointed. Less disappointing.

Just less.

Until one day he hits me.

And so does the truth.

This is taking up all my energy, taking over my life.

One of us is mad. It isn't me.

He stays out and drinks because he wants to. He needs to. It is not my fault.

It is not up to me to find the magic words that lift the scales from his eyes and allow him to see the pain he is causing, the damage that is being done.

There is nothing I can do to stop him drinking.

There is nothing I can do to stop him drinking.

There is nothing I can do to stop him drinking.

I can stop trying to save him.

I can save my children.

I can save myself.

One day at a time.

Desi

To whom it may concern

My son is broken beyond repair; to whom do I complain?
When I first got him, he was in perfect working order
But over the years he has taken himself to bits, bit by bit
And now there is very little left to recognise him by.
I don't want a replacement; I wanted a guarantee
But this child was so rare and unpredictable I wasn't offered one.
I once thought love was the ultimate guarantee; I was wrong.
Love just makes losing someone more sad.

Written on Mother's Day 2004
Coleen

The **magnificence** of ordinariness

Jim Smith struggled with his addictions for years before he rediscovered his creativity and enjoyment of life. Now he tours the country encouraging others to do the same.

'It's a powerful medium and can touch your heart where sometimes conventional therapy can't'. On another level, 'it also shows people that if they want to pick up some area of creativity in recovery, they can.'

By the age of 15, Jim Smith was well and truly entangled with alcohol and drugs. By the time he was 18, he was in trouble at home and with society and had been placed on probation.

'It was pretty disastrous really,' he says. But it didn't stop there. Aged 21 he was drinking surgical methylated spirits; a mixed up kid living with his parents on a caravan site in Sevenoaks. He tried to get help and was directed by a local doctor to a 12-step fellowship, but his needs were complicated. He went in and out of mental hospitals, overdosed, and was sectioned twice under the Mental Health Act.

On 27 October 1976, Jim lay in a hospital room having come out of intensive care. His father and mother had died a year and a half ago and he felt beaten and alone. But he was surprised to realise that he did want to get well. He went to Pinel House at Warlingham Park Hospital in Surrey, one of the only alcoholic units in the Europe at the time and that, in his own words, is where he started his recovery.

'I often say that the longest journey is from the head to the heart, and I'm still on that journey,' says Jim. Over the last 28 years he's done many of the things plenty of other people do – passed his driving test, got married (and later separated), had three daughters and two grandchildren, and qualified as a social worker.

But for Jim, his personal recovery is symbolised by regaining his creativity. A keen singer and guitarist, he auditioned for Cat Stevens when he was 16 – but let the chance slip away because 'when I got there I was a total mess'. Drink and drugs were destroying his music. More than 60 jobs followed, before he became 'unemployable at the age of 22'.

In recovery, he set about rediscovering his life. Then three years ago, a friend Brian, manager of The Coach House, a secondary care house run by The Priory, suggested he went over to play guitar for the residents.

'So I went over and played to the group, and I found I was linking up the songs with stories about my life in recovery,' says Jim. 'And I was kind of choosing songs that were relevant.'

That first, very personal, experience evolved into a two-hour presentation with music, songs, poetry and readings, that he now takes to different rehabs. He is frequently told he is 'inspirational', and puts this down to 'music reaching people on a lot of different levels… it's a powerful medium and can touch your heart where sometimes conventional therapy can't'. On another level, 'it also shows people that if they want to pick up some area of creativity in recovery, they can,' he says. He encourages members of the group to participate and share experiences back with him.

These days Jim radiates optimism, though he is the first to acknowledge that he has his bad days, like anyone else. He's learnt a lot about himself through rehab and is still 'peeling back layers of the onion', through his adoption as a child, bouts of pain and loss, life's ups and downs.

But a 28-year struggle has brought him round to being excited about life. Words like 'sober' and 'abstinent' terrified him at first, and he propped himself up with Valium for 15 years, which left him anxious for a long time.

Working with addictions as a care manager has made him realise 'it's a big world out there'. He has friends in recovery and others that have nothing to do with recovery, and realises that we're all human; we all have struggles with life.

Everyday struggles are the foundation of his work, according to Jim. From thinking that life was 'all about knowing famous people, travelling to places, excitement, power money, all that kind of materialistic stuff' he now takes enormous pleasure in 'the magnificence of ordinariness' – a phrase that his sponsor in 12-step fellowship used to say.

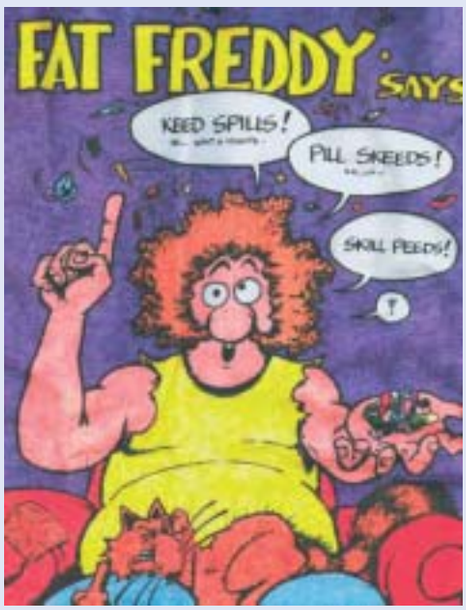
These days he revels in life's possibilities, and wants others to feel the same. Taking the sessions to rehabs all over the country is a struggle on a practical level, and he faces the usual all too familiar competition for funding, but he has found encouragement in being asked back to those he's visited.

Jim's particular satisfaction is when he is approached by people he's met in rehab, a couple of years down the line when they are clean and sober, to tell him they enjoyed his session. He is hopeful that his alternative therapy will catch on further: 'Many managers think this is the way ahead, the way to work. A lot of people find speaking in groups intimidating, so somebody up there with a guitar and music is an icebreaker. It's amazing, different songs mean so many different things to different people.' **DDN**

If you are interested in contacting Jim about his work, you can call him on 07957 185425

Old snow – **new avalanche**

Language and associations with different social settings can make a difference to how dangerous a drug is perceived to be, say Dr Michelle Cave and Christopher Hallam



'Meanwhile – especially those whose memory reaches back a couple of decades – powerful sensations of deja-vu may descend. Those of sufficient maturity in years may even dig out their old Speed Kills T-shirts.'

The recent appearance in the popular press of a deadly new drug – Methedrine – which threatens to spread like plague amongst the young and vulnerable, is liable to provoke a range of reactions. The 'average readers' of the tabloids, if they exist, may pray that their kids steer well clear; as for the politicians, they'll either work themselves up to some vigorous Drug War rhetoric, or sigh deeply and wonder when their party leaders might permit a reasoned set of alternative policy proposals. Into the jaded minds of front line drugs workers, meanwhile – especially those whose memory reaches back a couple of decades – powerful sensations of deja-vu may descend. Those of sufficient maturity in years may even dig out their old Speed Kills T-shirts.

This recycling of ancient terrors may also, however, give us pause for thought regarding some curious characteristics of drugs in general, which the everyday blur of events tends to obscure. What are 'drugs', after all? Of course, examine a dictionary and you'll be informed that drugs are chemicals which act on the central nervous system, changing mood or state of mind. Naturally no-one would wish to argue with such a proposition. But is this all they are?

Words and Things

The answer to that question is in the negative. Whatever a drug may be at the chemical level, it is also a word, a concept, and an entire set of associations connecting out indefinitely with all the other words and thoughts in our language. This language is, in its turn, embedded in social forms and institutions, where it circulates, and produces material changes and effects in our lives and experiences.

These elements of language, then, do not simply point to real objects, or reflect them in a mirror, pure and clear; rather, they play a role in shaping the realities they denote, a role which is no less important because it usually goes unnoticed. Let us take an example – one that has a resonance in the present.

My eyebrows are on fire

In the late 1970s, cocaine aficionados in the United States had adopted a new mode of administering their favourite drug – smoking it in glass pipes. The cocaine used was not the usual form of cocaine powder, cocaine hydrochloride, but a chemically altered form known as freebase. As the name implies, this involved the chemical release of the base form of cocaine from its associated hydrochloride molecule (by the use of ammonia). While some purists from this era insist that the base must be washed out with diethyl ether, in fact this process is not necessary. When the practice of smoking base migrated across the Atlantic, most English enthusiasts employed either ammonia or sodium bicarbonate. The advantage of avoiding the use of ether stems from its highly volatile properties, which can easily cause explosions if the user lacks the technical expertise of a trained chemist.

Freebase cocaine was smoked by rock stars, the friends and dealers of celebrities, the rebelliously rich and famous. In mid-1980s London many mid-level dealers took to smoking base on tin foil, often in combination with heroin. But the drug never acquired the highly charged notoriety of crack cocaine; indeed, in the UK it appeared to be little known to the media. Its US profile was somewhat higher, but remained associated with the experimental hedonism of wealthy bohemia; the most publicised dangers were those attendant upon using ether to make the drug. There were some prominent cases of explosive kitchen chemistry: the comic Richard Pryor succeeded in blowing himself up while freebasing in 1980, and thereafter incorporated the misadventure into his routine.

The Strange Case of Crack

An entirely different cultural reception greeted the advent of crack as its use swept 'like an epidemic' across American cities in the mid 1980s. Reports focused on its 'instantly addictive' qualities, the feelings of indestructibility it supposedly invoked (particularly in criminals), its links with a black urban milieu of guns 'n gangs. It was announced as a new and qualitatively different drug of unparalleled danger, progenitor of 'crack babies', the 'poor man's drug'.

And yet these two drugs are, chemically speaking, one: whether freebase or crack, what we are referring to is the base form of cocaine. What differs is the social and historical setting, the language and cultural construction in terms of which each is addressed. However, this is more than a question of 'mere words'; these words matter, colouring the ways in which a drug is perceived both by users and by the press and public, by law enforcement and medical authorities, scientists and academics.

The point is not that we should use one term over another: all terms are laden with meaning and value, and none is neutral. Rather, we should be aware of the 'tight embrace' that exists between words and things, their imprinting by history and culture, and the effects that this may have on our cognitive and emotional responses to the drugs we use, study or treat, and by which each of us reading here is, in one way or another, intoxicated.

Dr Michelle Cave is an analytical chemist; Christopher Hallam is a writer and researcher on the history and culture of drugs

Methadone opinion dangerously blinkered

I struggled long and hard to resist my attempts to respond to your anonymous correspondant, 'John' (*DDN*, 5 September, page 8), because everybody is entitled to an opinion.

But John's piece falls foul of two particular ideological engines: the cyclical fashion trends that the drug treatment field succumbs to, and the tendency of both service users and practitioners alike, to try and extrapolate from their own experience to the needs of the general population.

Unlike John, I started using opioids in the early seventies, but I was fortunate enough to live in an area that had a sensible doctor who, though he may not have had a mountain of randomised controlled trials, could see from his own clinical experience that methadone was having a positive impact on some of his patients.

But the drugs field has always been driven by fashion, not evidence. So in the sixties and seventies, methadone was in; then in the eighties, methadone was out again.

Over the last few years, the NTA has insisted on practice being grounded in evidence based research, and so naturally, as there is an overwhelming preponderance of evidence in support of methadone maintenance, it's hardly surprising that attempts to improve both the size and the quality of the treatment field in the UK will initially focus upon methadone treatment as one aspect of their work.

I'm glad that John was able to successfully complete his residential rehab, and that he was able to sustain his sobriety afterwards. However, I'm sure that he's only too well aware that not everybody wants or is suitable either, for abstinence based treatment – and even of that proportion who do opt for it, a very small proportion actually complete the programme, let alone manage to sustain their sobriety afterwards.

And do some people stay in methadone treatment for a long time? Why yes, they do. That's rather the point of the whole thing. Dependence on opioids is a chronic and relapsing condition. Research shows that the average drug-using career is around 13 years. Now, many people will quit after the first year or two. Others though, will be using for 30 years or more. The question then is, do we abandon these people to a life of street use, crime, poor health and disease, or do we offer them a treatment that is proven to reduce the prevalence of all of these issues? I think we already know the answer to that.

But the thing that angers me most about John's comment is the implication that methadone isn't a legitimate form of treatment and one form of recovery, but is simply another type of drug misuse. As somebody who has been in methadone treatment for the last 30 years, I've managed more than a couple of accomplishments during that period. Accomplishments like a first class degree and a masters. Careers in the drugs field, journalism, and IT. Like successfully raising three wonderful children, one of whom works in a bank; the middle one is just about to leave home for her university course in journalism.

Could I have achieved more if I'd been abstinent? Well, perhaps. The fly in the ointment though, is that I'm just not convinced that I ever would have been able to achieve abstinence. It isn't as though I never tried. In fact, in my experience, most long-term users make numerous attempts to quit – and some proportion of them do inevitably fail. For people like that, and I include myself in that number, methadone has saved our lives – indeed, given us a life where before we just led a depraved existence.

Which is not to say that there shouldn't be decent abstinence treatment available to all who need it. I regularly speak to service users who tell me that they are desperate to get into a residential or in-patient detox facility because some arrogant worker (or even, in some areas, a commissioner) has judged that they 'aren't ready for it yet'. Of course, if they'd bothered to read the research, they'd know that there is no way whatsoever to reliably predict who will or will not achieve and sustain abstinence after a period of structured care away from their usual environment. Prior motivation certainly isn't a predictor, and so in light of that, surely we have to let everybody who wants to try this sort of treatment take a shot at it.

Surely this field is mature enough now to be able to take that message on board, without denigrating a form of treatment that works very well for a great many people. And where it isn't working that well, rather than denigrating the patient, one has to ask oneself exactly what it is that the paid professionals do in these circumstances? If a cancer patient isn't responding to chemotherapy, the oncologist tries something different. Many people working in drug treatment though, seem only to happy to let their patients stumble along with one particular treatment regardless of whether there are any improvements in their personal circumstances.

Hopefully, these are some of the issues that the NTA's effectiveness strategy will begin to address over the next three years. And as an NTA board member with three children between the ages of 17 and 25, I'd be happy to respond to John's question about what sort of treatment I'd want for them if they came to me, telling me that they had a problem and needed treatment. Personally, I'd want them to be able to access treatment that was both effective and suited to their individual needs. If that meant residential rehab, then fine. However, if it meant methadone maintenance, then that would be fine as well. The reality is that most people will generally try a range of different treatments before finally hitting on the one that works for them. The sooner they reach that point, the better.

Peter McDermott

'Dependence on opioids is a chronic and relapsing condition. Research shows that the average drug-using career is around 13 years. Now, many people will quit after the first year or two. Others though, will be using for 30 years or more. The question then is, do we abandon these people to a life of street use, crime, poor health and disease, or do we offer them a treatment that is proven to reduce the prevalence of all of these issues?'

A suggestion on public liability insurance

I read with interest your article on the discriminatory effect of the Rehabilitation of Offenders Act and the resultant difficulty in setting up community projects (Alliance column, *DDN,* 5 September, page 5).

Back in the nineties, I worked for a large housing association and, together with a group of like-minded individuals, decided to do something to offset what we thought to be the 'draconian anti-asylum regulations'. We met with the usual difficulties of getting insurance, but found that medium to large institutions, (housing associations, charities, *etc)* tend to be a little over-insured and can extend their insurance cover to develop new projects and pilot schemes at zero cost. This was certainly the case with my employer and we were able to resolve that difficulty.

It might be a good idea to talk to some of the larger players. They can get all sorts of good PR and goodwill from potential funders to give you a hand, without it costing them anything. It also looks good to agencies you might be approaching for support, particularly in the current climate where partnerships are very much flavour of the month.

Kevin Patton, Mainliners

Sweeping statements are cause for concern

I found the letter from Roy Fisher, 'Let's challenge addiction, not collude with it' (*DDN*, 5 September, page 8) very concerning. Never have I read such arrogant and misinformed twaddle. The fact that this comes from someone who works in the field is even more alarming!

I guess I must be one of those 'people' like Mike Linnell. I fully hold my hands up to thinking about addiction in practical terms. To say that addiction has no rhyme or reason to it is down right stupid. There are many reasons why people become locked in a world of addiction – and many more reasons that keep them there. To make statements like this shows a total lack of understanding of problematic drug use – worrying to say the least.

Making sweeping statements saying that 'educating' drug users is a waste of time and effort, is offensive to both drug users and workers alike. My experience of working in the field for 18 years, and having been around drug users for over 30 years, I know drugs users can and will make positive changes – given the right support and treated with respect and dignity. Of course there are going to be some who will continue to engage in high-risk activity. Yes, people will continue sharing syringes for all the reasons Roy Fisher states. But surely this only confirms the arguments that services should be meeting the needs of those clients who are at most risk, by making their services more accessible, less punitive and operate in hours more conducive to a drug users lifestyle.

'The best form of harm minimisation is not to use drugs'? How patronisingly insightful! The fact is that many people do choose to use drugs and therefore they have a right to truthful and factual information if we are to reduce harm. And whilst there may well be no 'safe' way to take drugs, you can certainly make it 'safer' – just as you can sex. The best way to not catch sexually transmitted infections is to not have sex, but we know that is unrealistic. So why should drug use be viewed any differently or less pragmatically than sexual health education?

Certainly, quoting theoretical models

does not make anyone an 'expert' – but then again neither does being an ex-user either. The fact is that the majority of people who use drugs do not have problems with them. Just because Roy Fisher had a problem with his drug use does not give him exclusive insight or expertise into the world of addiction – not everyone's experiences are the same. I know many current and ex users who would totally disagree with his sentiments and would find them extremely offensive and patronising to say the least.

Roy Fisher fails to fully grasp the true spirit of the harm reduction philosophy. Harm reduction has many aspects and if someone wants to become drug free that is also part of the continuum of the model. Those who believe in harm reduction don't preach to their clients, they help facilitate positive changes. Methadone is only one component of harm reduction – but it certainly has made an enormous difference to many people's lives.

Lyn Matthews

Giving choice is the only decent model

Whilst not wishing to carry on a personal literary spat with Roy Fisher (*DDN*, 5 September, 11 July, 27 June) – I don't think you're a weak-minded moron Roy, I just think your argument was shit – I do think the issue raised by his reply to my 'vitriolic' response to his original letter and the letter from 'John' on the same page is worth arguing about.

I agree with some of the things Roy now says in his reply, but there are just one or two points I'd like to pick up on. Whether I think methadone is 'helpful ' or not is not the issue, as there is clinical evidence for its effectiveness. Is methadone helpful for everyone? Of course not. Is methadone 'useful in the short term under medical supervision when detoxing'? No: it's rarely used for that anymore as the evidence says it has a dire success rate – that's why we go to the trouble of getting evidence. Do I think its right to breach a client on a DTTO who refuses methadone? No, of course not. But that is a failure of a system and whoever's job it was to work out your clients care plan – not of methadone.

Is the best form of harm reduction not to use drugs? Of course it is, but so what – I also think an end to poverty, starvation and war would be a good thing, but I don't know how to achieve that either. Do I 'support a model that helps virtually no-one'? What model? I support giving people choices – nothing works for everybody. A hundred yards from where I'm sitting we run a needle exchange and in the same building we have the base for a 'home detox' service. The needle exchange has 3,000 users at any one time – the home detox service is lucky to have a dozen – does that tell you something about people's choices? Do I think people who want detox and rehab should get it? Absolutely, rehab works for some people, but for many more they don't and never did – even in the days when that was the predominant philosophy. Which brings me on to John's letter.

Dear John, I'm glad you have a good life now, thanks to the kindness of your parents paying for you to go into rehab, but I'm sure you are aware that the vast majority of clients of drug services aren't so lucky. I presume you, like me, don't think it is a coincidence that drug services' clients tend to come form the poorest most marginalised sections of our society and that not many on benefits can afford to maintain a habit.

I'm sure you must have noticed that people are currently being drug tested when they are arrested and can be given the option of compulsory treatment rather than prison. Conservative Party policy going into the last election was to (somehow) create 20,000 rehab places and like you and Roy, they presumably believe (without any evidence) that this will be more effective than the current treatments on offer. Now let's see, a client is on a DTTO but wants state funded rehab rather than methadone, so the courts send them to rehab rather than jail. Do you think they will have the option of going home if they can't stand it? What happens to those who 'split', will they go on the run? What about those who get caught using in rehab, will they be sent to prison or given 'extra days' on their treatment? If rehab is compulsory, why not just call them prisons in the first place; if rehab is voluntary, do you think any government would spend billions setting up and running them?

John asks emotively at the end of his comment, 'if your son or daughter came to you and admitted they had a heroin addiction, would you be satisfied if they went to a drug service and ended up on methadone maintenance, or would you want them to go away to a first rate rehab, get the help, motivation and encouragement to come off drugs and stay that way?' Let me ask you this John, would your parents have preferred you to have been maintained on methadone rather than put them through the 'madness' you describe between '81 and '87? Would rehab have worked for you in 1981?

Would you support methadone for people waiting to go into 'first rate rehab'; would you support it for those who couldn't stick with the programme or had tried rehab before and failed? Would you support methadone for people who don't want to go to rehab or have been successfully maintained on methadone for many years and don't want to stop it? Would you take it away from them?

Comment

Coercing people into treatment – Does it work?

In every industry there are phrases that have become tantamount to cliché, phrases that every worker takes for granted and follows unquestioningly.

In IT it is 'it's not the computer it's the operator', which we all know is up for debate. Every drug and alcohol worker will, almost to a man, say that drug and alcohol work at tier 2 level is voluntary. It has to be they will say, otherwise it will not work; a person has to have accepted that they are concerned about their use before they can then work on it. In motivational interviewing it is called being in contemplation stage. The benefits of a client already prepared to work on their concerns are apparent – however in today's system, is it really the case that every client attends their sessions with a drug and alcohol worker voluntarily?

Working within the criminal justice system it becomes immediately apparent that very rarely are things said categorically and set in stone. In this era of appeals, and more importantly the financial penalty lavished on an organisation that gets caught up on the wrong side of an appeal, outright protestation is fast becoming a thing of the past. As a result work is undertaken on a double layer – what is being said and what is being meant – and the clients too have noticed and accepted this style of working. Which means misinterpretation is rife.

So when a probation or a youth offending team worker suggests a session with the drug and alcohol worker, what the client often hears is 'if you don't go, I am going to breach you' and responding in the same double layered style, the response is 'of course I'll go, I'd like to work on this'. Through no-one's fault, a non-responsive client ends up sat in front of a worker, both of them mildly bemused at the situation.

The criminal justice system isn't the only place where the boundaries can get blurred. Incentives to engage with substance misuse work can often be misconstrued by the client as leverage. When a social worker, who is involved with the family in child protection procedures, suggests involvement with a drug and alcohol charity or organisation, the client is naturally going to feel obligated.

The biggest issue with coercion into treatment is that it is not overt and indeed, workers usually don't realise it is happening. It is a product of a change in culture towards softened words and double meanings, which service users have recognised and adopted accordingly.

So the big question is: can treatment at a tier 2 level be of any benefit to the client at all? Well first of all, it depends on the type of work being delivered. If it is counselling, it is unlikely that the work will achieve its potential. It is in this situation that the coercion factor can be detrimental. It can increase feelings in the client of being talked at; it also undermines anything discovered by the client in the counselling process, because it will be attached to feelings of defensiveness and lack of control. To the client it can appear that indeed those feelings are induced by the systems that forced them to be somewhere, totally devaluing them in the client's mind.

In simple one-to-one intervention and support, like that provided by probation officers and youth offending team officers, it will of course never be as effective as it would be in an entirely voluntary situation. However it does provide a platform for awareness-raising and possibly minor harm reduction work. It may create a situation that will lead the client into the contemplation stage or be a catalyst that brings the issue to the forefront of the client's mind.

It also provides the opportunity to at least try to ensure that the client is safer, opening discussion over the specific dangers – issues such as clean needles, using around trusted friends and discussion over date rape with alcohol use. Although it would not be able to move past the information stage, it means that the information is being given to those in more need and who may not look at the material sent to youth clubs, libraries *etc* – so those who would not seek safety information by choice are at least being told the realities. It will not stop the use, but may reduce the number of deaths associated with substance misuse.

The old adage is true: a captive audience will listen. They may not change their behaviour, but at least they may do it more safely. Most workers will agree that anything rather than nothing in some situations is better – provided workers realise that counselling or high-end work on behaviour change is detrimental in a situation in which a client is feeling coerced, but awareness raising and safety information is still a step in the right direction.

So although the foundational belief of substance misuse workers is true, that change has to be on a voluntary basis, awareness and support can still be of benefit even when coercion has either directly or indirectly been applied, intimated or interpreted.

Caroline Spillane, drug and alcohol worker, Torfaen and Monmouthshire

My client has made great progress in fighting his alcoholism, but recently his father died from liver disease and it has set him back significantly. Alcoholism runs in his family and he has become convinced that it's in his blood to follow the same fate. How can I convince him that he can take his future into his own hands?

Graham, drug and alcohol worker, Glasgow

Unconscious desire

Dear Graham
I have worked in the addiction field since 1991, and during my training as a psychotherapist came across the remarkable Family Systems work practised by Bert Hellinger of Germany. Hellinger trained extensively as a psychoanalyst and psychotherapist, and has much experience working with families from all cultures all over the world.

It is a common phenomenon that when a parent, partner or close relative or friend dies the one surviving, consciously or unconsciously, wishes to follow that person, and share the same fate. It may be prompted by loving that person so much and in identifying with them it does not feel possible to survive living without them, or feeling guilty or suffering survivor guilt.

Hellinger works with this problem by setting up the 'Family Constellation' in a workshop, where the dead father would be represented by one of the men in the workshop, and either putting in a representative, to begin with, for the son (your client), or putting your client into the constellation straight away to face his father. The workshop members (usually up to 20 people) provide the 'holding circle' for this work, which is experiential – 'to see what is there'. The dynamics are very powerful and authentic. Some grief and many other different emotions rise to the surface, and the facilitator (who has been trained in this work) may suggest sentences to be spoken between the two, or words that need to be spoken may arise spontaneously.

The facilitator may possibly add further members of the family or other loved ones to this constellation to support the grieving person. Eventually, if it feels right, it will be suggested that the survivor (the son in this case) can say something along the lines of 'I love you Father (Dad, Daddy), you gave me life, I honour you, and in honour of your memory I will stay and make the very most of this life you have given me'.

This usually leaves the survivor feeling more settled and calm, and more with the feeling that this is his own life and in honour of his father he will make good life choices. There is now much literature supporting Bert Hellinger's work and his books can be obtained from Amazon.

I am now leading family workshops in London, Hertfordshire, Bristol and Chester, and would be happy to talk to you more about this work. The work is comparatively new in the UK but is carried out extensively in Europe and many other countries. It is my belief that it is particularly relevant to families who are suffering, or who have suffered from, addiction and alcoholism and it is my desire to further the work within the treatment field.

Yours sincerely
Christine Wilson,Hertfordshire.
Tel: 01442 391737,
email: christinewilson3@ntlworld.com

'It is a common phenomenon that when a parent, partner or close relative or friend dies the one surviving, consciously or unconsciously, wishes to follow that person, and share the same fate. It may be prompted by loving that person so much and in identifying with them it does not feel possible to survive living without them, or feeling guilty or suffering survivor guilt.'

Relapse excuses

Dear Graham
Your client currently has two major things going on in his life; his ongoing battle with alcoholism, and grief over his father's death, but he appears to be trying to link the two together.

He is convinced that alcoholism is 'in his blood' because of his family history, but the real danger is (even although he may not realise it) that he is using this as an excuse for a potential relapse.

I imagine he is very frightened at the reality of death being a consequence of alcoholism, but he should be aware that medical opinion is divided on whether genetics truly have an impact on substance misuse, and it is not necessarily preordained that he will go down the same road as his father. It invariably comes down to choices, and he has the option to choose not to drink, even though his father chose the other option.

Tell him that he has already made great steps towards reshaping his future, and that whilst he can do nothing about the past, he can almost always choose the road he wishes to travel henceforth. He must remain very aware that his psyche will always look for excuses to return to drink, but perhaps this awareness will strengthen his resolve to make the best choice.

I wish him well.

Irene MacDonald
Cheltenham Parent Support Group

Power to choose

Dear Graham
I would suggest that you explain to your client that his fear based on self-fulfilling prophecy has no power if he understands that he has the power of choice. He can choose to change.

Andrew, Lancashire

Reader's question

My brother has completely lost it. I first did magic mushrooms with him a few years ago and, whereas my use of mushrooms is just a couple of times a year his usage has ballooned and now includes a lot of LSD. He also smokes a lot of skunk. He has become paranoid, reclusive, secretive, won't talk to me, it's like he's turning into another person. I suspect he's on the edge of some kind of psychosis but I seem powerless to do anything about it. I am so scared of getting any doctors or medical advice as I do not want him sectioned or given any of the chemical coshes I read so much about. Our mother seems to be in denial and is convinced there's nothing wrong and, as we're both in our early twenties, she would have no legal power over him anyway. What should I do?
Danny, Gloucestershire

Email your suggested answers to the editor by Tuesday 27 September for inclusion in the 3 October issue of DDN.

New questions are welcome from readers.

The drug experience and beyond: Amphetamine

Professor David Clark looks at the experience of taking amphetamine, including the subjective pleasurable experiences of initial use, amphetamine-induced anxiety and psychosis, and withdrawal symptoms following long-term use. He briefly considers various factors that can influence the amphetamine experience.

The 'drug experience' produced by a particular psychoactive substance depends on both drug and non-drug factors.

Drug factors are the chemical properties or type of drug used, the dose, route of administration, and presence or absence of another drug. Non-drug factors include personal characteristics of the user (*eg* biological make-up, personality, previous experience), and the context or setting in which the drug is taken.

A person will first try a drug because of social or intrapersonal factors, such as curiosity about the effects of a drug, or the fact that their friends are taking it. They will probably have certain expectancies about the effects of the drug from conversations with experienced users and/or because of media exposure.

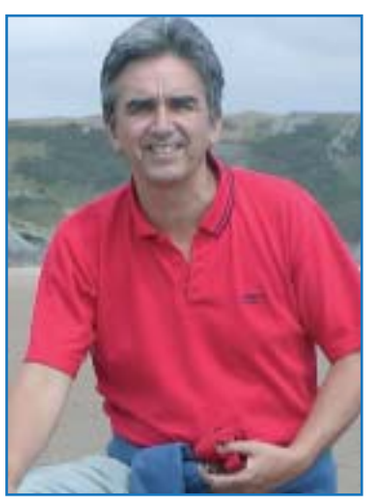
Once a person has taken a drug, the drug experience creates cognitive expectancies which become another factor that influences subsequent drug-taking. A person may continue to take the drug to increase his psychological comfort or change his level of consciousness.

Low doses of amphetamine produce a number of subjective effects: feelings of euphoria; heightened alertness; increased energy and excitement; increased feelings of well-being, confidence and power; increased ability to concentrate and stay awake; increased sociability and friendliness; a feeling of being less bored or tired; hyperactivity, talkativeness, and a rapid flow of ideas; a suppression of sexual inhibitions.

With higher drug doses, there are other effects. These are much more likely to occur when the drug has been taken repeatedly rather than on a single occasion. The user may experience repetitive (stereotyped) thought patterns and show repetitive behaviours, *eg* continually take apart and re-assemble some object, or pick continually at their skin. They may show restlessness, irritability, and various types of anxiety condition, including panic states.

The person may develop suspiciousness, paranoia (delusions of persecution), and experience visual and auditory hallucinations. This is known as amphetamine psychosis, which resembles paranoid schizophrenia.

Amphetamine psychosis is usually seen with chronic use of drug, but can be seen after an acute administration. The incidence of amphetamine psychosis increases greatly when the user switches to intravenous drug administration.



The psychosis is transitory and usually terminates after drug use is terminated. Long-term amphetamine use can also lead to sudden and intense acts of aggression and violence.

The subjective effects of amphetamine and similar-acting substances are not fixed. The stimulant methylphenidate (Ritalin) is, paradoxically, used to treat hyperactivity in children. Some adults report the drug exerting a calming effect, allowing them to cope better.

In well-controlled laboratory conditions, under conditions where neither subject nor experimenter knew whether drug or placebo was administered, a fixed dose of amphetamine produced either euphoria or anxiety in different subjects.

Once a person has tried amphetamine, they may use the drug on a recreational basis, even over an extended period of time. They may keep a strict adherence to a particular pattern of drug use so that the drug is only used on certain occasions (*eg* weekends).

The user retains control over drug use and there may be no medical or social complications – however there is the possibility of legal sanction. Of course, a person may try amphetamine once and never do so again.

'The person... may experience periods of paranoia and anxiety when taking the drug, and periods of deep depression when not taking the drug. The impact of this on psychological wellbeing can be considerable.'

However, the pattern of drug-taking may intensify and a number of changes may occur. For example, a person may switch from oral or intranasal use to intravenous use. Drug effects will intensify when such a change occurs.

In another pattern of use, the person initiates repeated 'runs', taking amphetamine for hours and sometimes days. They may snort new lines of drug whenever they feel the drug effects wearing off. This pattern of drug-taking is more evident with cocaine, which is a much shorter-acting drug.

In yet another pattern of use, they may chronically abuse amphetamine in combination with depressant drugs. They may drink large amounts of alcohol whilst under the influence of amphetamine.

Users may use depressant drugs (benzodiazepines, alcohol, opiates) to take 'the edge off' the stimulant, and help them feel less anxious. Research suggests that users who abuse stimulants and depressants experience more psychological and physical problems than those who only abuse stimulants.

Tolerance develops to many of the psychological and physical effects of amphetamine, *eg* euphoria, anorexia, hyperthermia and hypertension. This tolerance may develop within hours to days.

However, there appears to be little tolerance to the anxiogenic effects of the drug. In fact, amphetamine psychosis may actually sensitise.

The effects of a single dose of amphetamine lasts two to four hours and generally leave the user feeling tired. It may take as long as a couple of days to feel normal again. With chronic drug use, feelings of tiredness, lethargy and irritability become stronger and may have a more dramatic onset following the wearing off of drug effects.

The user may want to keep taking the drug to avoid these feelings. Tolerance develops with regular use and higher doses will be required. Eventually, 'what goes up must come down'. The 'withdrawal' effects are even stronger when a user has completed repeated 'runs' over a period of days.

Amphetamine produces a withdrawal syndrome, which not only includes tiredness, but also anhedonia (an inability to feel pleasure), depression, anxiety, dysphoria, sleep disturbances, and a strong craving for drugs.

The person may experience terrible mood swings as he oscillates between periods of drug-taking and withdrawal. He may experience periods of paranoia and anxiety when taking the drug, and periods of deep depression when not taking the drug. The impact of this on psychological wellbeing can be considerable.

The Training Exchange

The Training Exchange
Drug & Alcohol Training Programme
Autumn/Winter 2005/6

One day courses (£95 + VAT)

Introduction to Drugs Work	13th October
Alcohol & Poly Drug Use	3rd November
Difficult & Aggressive Behaviour	21st November
Working with Diversity	30th November
Drugs & Housing	1st December
Personality Disorders	13th December
Crack Awareness & Users' Needs	14th December
Service User Involvement	17th January 2006
Women & Drugs	25th January 2006
Steroids & Steroid Users	31st January 2006

Two day courses (£180 + VAT)

Motivational Interviewing	19th & 20th October
Brief Solution Focussed Therapy	10th & 11th November
Relapse Prevention	6th & 7th December
Dual Diagnosis	19th & 20th January 2006
Young People - Mental Health& Emotional Support Needs	1 & 2 February 2006

the TRAINING exchange

All courses take place in Bristol.

All the courses in this programme are mapped to DANOS.

For further details and full course outlines contact
The Training Exchange,
Easton Business Centre,
Bristol BS5 0HE
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
www. trainingexchange.org.uk

The Training Exchange is an independent training and consultancy service. We focus on issues that affect health, young people and communities.

MAINLINERS

Working to Improve Quality of Life and prevent HIV, Hepatitis and drug related harm

SEPTEMBER

27-28	Advanced Drugs Awareness
29	Assessment Skills

OCTOBER

3	Working with Women in the Sex Industry
6	Overdose Awareness
7	Drugs, Women and Pregnancy
11-12	'A Nudge from the Judge' Drug Treatment Within the Criminal Justice System
13	Tackling Crack Use
14	Cultural Competence in Dealing with People with Drug & Alcohol Problems
18-19	Dual Diagnosis
20-21	Safer Injecting
25	Hepatitis C & Drug Use
26-27	Counselling Drug Users
28	Volatile Substance Abuse

NOVEMBER

2-4	Training For Would-Be Trainers
8-9	Basic Drugs Awareness
10-11	Performance Enhancing Drugs
14-16	Motivational Interviewing Phase 2
17-18	Facilitating Groupwork
22-23	Advanced Drugs Awareness
24	User Involvement
25	Drugs & Young People
29	Assessment Skills

DECEMBER

1	Tackling Crack Use
2	Drugs, Women & Pregnancy
5	Crack Use on the 'Beat'
6-7	Dual Diagnosis
8	Hepatitis C & Drug Use
9	Cultural Competence in Dealing with People with Drug & Alcohol Problems
12	Overdose Awareness
13-15	Motivational Interviewing Phase 1

For info on all courses call MAINLINERS on 020 7378 5480
Email: dmclarens@mainliners.org.uk 195 New Kent Road, London SE1 4AG

UNIVERSITY OF BIRMINGHAM

Social Behaviour & Network Therapy for Substance Misuse

Thursday 20th & Friday 21st October 2005

Uffculme Centre, Queensbridge Road, Moseley, Birmingham, B13 8QY

Social Behaviour and Network Therapy (SBNT) is an intervention package developed by integrating strategies found to be effective in other substance misuse treatment approaches and built upon the premise that social network support for change is central to the resolution of addictive behaviour. SBNT has been tested as part of the United Kingdom Alcohol Treatment Trial and also in drug use services in Birmingham. The core principle of SBNT is that positive change is promoted by support from a close network of family members and/or friends (referred to as 'network members') who provide a person who wishes to abstain from or reduce substance use with positive social support for change. The workshop will introduce trainees to the key principles and skills of SBNT. The workshop format will include presentations and skill practice exercises.

Trainers:
Dr Alex Copello, Clinical Director, Birmingham & Solihull Mental Health Trust and Senior Lecturer, School of Psychology;
Dr Ed Day, Senior Clinical Lecturer in Addiction Psychiatry & Consultant Addiction Psychiatrist.
The teaching comprises a series of short lectures, small group teaching and case-based learning.

Cost: The cost of this course is £220.

If you wish to attend, please contact Rachel West, Department of Psychiatry, University of Birmingham, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Birmingham, B15 2QZ. Tel: 0121 678 2356 Email: r.l.west@bham.ac.uk

THE 1st ANNUAL ADDICTION PSYCHOLOGY CONFERENCE

On the occasion of the inauguration of
The MSc in Addiction Psychology & Counselling

'PERSPECTIVES ON SELF-CHANGE FROM ADDICTIVE BEHAVIOURS'

FRIDAY 28th OCTOBER 2005

Venue: The Keyworth Centre, London South Bank University

Seven leading researchers will present and discuss relevant evidence from contrasting psychological perspectives - biological, cognitive, self, social-community & spiritual.

Professor Ian Albery: Professor of Psychology at London South Bank University, a cognitive psychologist specialising in unconscious cognition and addiction.

Professor Christopher Cook: University of Durham, a psychiatrist with major research interests in spirituality and addiction.

Professor Robin Davidson: A clinical psychologist at the Gerard Lynch Centre, Belvoir Park Hospital in Belfast, specialising in the psychology of recovery from addiction.

Professor Michael Gossop: From the National Addiction Centre, Kings College, London, who is the Principal Investigator on the National Treatment Outcome Research Study (NTORS).

Dr Marcus Munafo: A biological psychologist in the University of Bristol and specialising in the genetics of addiction.

Professor Geoffrey Stephenson: Emeritus Professor of Social Psychology at the University of Kent with interests in self-reflection and response to treatment in recovery.

Alma Thomas: A sports and counselling psychologist who has specialised in processes of self management in the performing arts, athletics, and more recently in addiction counselling specifically.

Registration Fee: £25 - Includes Lunch & Refreshments
Please send a cheque made payable to PROMS along with your registration form to:
PROMS, The Old Court House, Pinners Hill, Nonington, Kent CT15 4LL
Registration closes on 14th October 2005

For all enquiries contact 01304 841700 or e-mail m.williscroft@proms.co.uk

Appointment of contractors for the North Wales Drug Intervention Programme / Criminal Justice Integration Team

The North Wales Police Authority on behalf of the **North Wales Drug Intervention Programme Shadow Management Board** seek to appoint contracts with criminal justice substance misuse services to providing ongoing support and accessing/brokering treatment services to clients under the Drugs Intervention Programme. The main aim of the scheme is to reduce drug related offending in the counties of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham.

Services will be procured in one main lot. However a flexible approach will be taken where contracts may be awarded on a Divisional basis.

Brief description of services

Providers of services will deliver a proactive Tier 2 type service to criminal justice substance misuse offenders which will include proactively accessing, contacting and providing on going support at all stages of the criminal justice system whilst co-ordinating/brokering access to the necessary treatment interventions. Services will include the following features:

Family Support – providing help to criminal justice clients in co-ordinating access to wraparound services such as housing, financial management skills and employment, developing social networks and support within families;

Specialist Prescribing Treatment Support – providing on going support to criminal justice clients accessing such treatment and help prevent disengagement;

Supporting the North Wales Enhanced Arrest Referral Scheme – linking with and supporting the above service which is normally delivered in police custody suites and courts;

Prison Link Development Work – assisting prisoner resettlement linking with prison based drug services and the local Transitional Support Scheme and

Volunteer schemes – developing the involvement of ex-users, volunteers and mentoring schemes.

It is anticipated that the initial period of the contract will be February 2006 to completing by March 2007. There may be an option to extend the contract on an annual basis up to March 2009 subject to continuation of funding through Central Government and the Drugs Intervention Programme.

The Contract shall be awarded on the basis of the Tender which is the most economically advantageous to the Authority using a price/quality of service/ flexibility/Service Delivery ratio of 40/20/20/20.

The Closing Date for expressions of interest will be 18th October 2005 and the return date for completed documents will be 2pm Monday 14th November 2005

A tenderer briefing meeting will be held at St. Asaph, DHQ, 10am on Tuesday the 11th October 2005, to answer any questions that tenderers may have and to ensure that tenderers understand fully the requirement.

Applicants should apply in writing (preferably via e-mail) to:
Procurement Department, North Wales Police Headquarters
Glan-y-Don, Colwyn Bay , CONWY LL29 8AW

Fax: 01492 511949
Email: Procurement@nthwales.pnn.police.uk

Haringey DAAT
Drug and Alcohol Action Team

London Borough of Haringey

Expressions of interest for the provision of Haringey Drug Interventions Programme

Haringey Drug Interventions Programme works to reduce drug-related offending by referring drug using offenders out of crime and into treatment.

Expressions of interest are invited from suitably experienced organisations for selection to tender to deliver Haringey DIP. The contract, to be managed by Haringey Council's Drug and Alcohol Action Team, will include accommodating and running the programme. The value of the contract will be approximately £1m. Ongoing evaluation criteria will be the Key Performance Indicators in force at the time, as laid down by the Home Office, National Treatment Agency as well as meeting the financial, managerial and other requirements outlined in the agreed service contract.
The expected term of the contract will be until 31 March 2009 and the contract should commence on or around 1 July 2006.

Expressions of interest are invited for all or for specific lots, from individual organisations or from agencies acting in partnership.

Lot 1	Provision of a beginning-to-end support programme that follows and manages offenders as they pass through the criminal justice system, covering the following areas: Police custody The courts Prison Treatment
Lot 2	Provision of Low Threshold Prescribing, 'Rapid Prescribing',
Lot 3	Provision of a Day Programme for people on a Drug Rehabilitation Requirement Order
Lot 4	Drug Rehabilitation Requirement Treatment Workers (supporting the Probation Team in treatment and rapid prescribing of statutory clients)
Lot 5	Provision of an 'Out-of-hours'/ 24/7 telephone Helpline for substance misusers
Lot 6	Provision of a comprehensive Throughcare and Aftercare Service Team for substance misusers, including the following elements:
Lot 6.i	Provision of an Employment Placement Worker as part of the Throughcare and Aftercare Service
Lot 6.ii	Provision of a CAB Advice worker as part of the Throughcare and Aftercare Service.

Written expressions of interest and requests for the tender documentation should be made to:
Paulette Haughton - DIP Project Manager, Civic Centre, High Road, London, N22 8LE

Fax: 020 8489 2992
E-mail: paulette.haughton@haringey.gov.uk

The closing date for Expressions of Interest is 13.00 on 17 October 2005 and packs will be sent out on 20 October.

LONDON BOROUGH OF NEWHAM

EXPRESSIONS OF INTEREST FOR PROVIDERS OF SUBSTANCE MISUSE SERVICES TO BE INCLUDED ON A LONDON BOROUGH OF NEWHAM PREFERRED PROVIDER LIST

The Newham Substance Misuse Partnership Board is seeking to establish a preferred provider list using framework agreements. Framework agreements are arrangements under which organisations from a preferred provider list, which has been drawn up through a short-listing exercise, are called upon to deliver services when required in accordance with agreed criteria. Therefore, The London Borough of Newham is seeking expressions of interest from organisations with relevant experience and expertise to provide Substance Misuse Services who wish to be included on the Preferred Provider List.

The range of services envisaged may include the following:

- Young People's Substance Misuse Services
- Young People's Arrest Referral
- Adults Arrest Referral
- 24/7 Phone Line
- Women's Substance Misuse Services
- Outreach & Community Services etc.
- Working With Homeless Drug & Alcohol Service Users.

Services will be provided across all age groups, client groups and cultures. Providers with experience in the delivery of substance misuse services should express an interest even if you do not provide any of the services listed above as funding may become available for the provision of other related services or interventions during the life of the Preferred Provider List.

Once the short listing has been completed the successful bidders can expect to be placed on the Preferred Provider list for a period of up to five (5) years. A contract for a specific service is not entered into until the services are identified and requested to be supplied. These contracts could be for any length of time e.g. six months to five years or one off pieces of work.

All providers will be expected to deliver the services in partnership with other agencies working with Substance Misuse Service Users and their Families/Carers in Newham, and with specialist substance misuse services.

Organisations wishing to submit expressions of interest should do so in writing by 14th October 2005: Vittorio Graziani, Contracts Officer, Projects & Partnerships, Contracts Team, London Borough of Newham Social Services, Broadway House, 322 High Street, London E15 1AJ, e-mail: vittorio.graziani@newham.gov.uk or fax: 020 8430 5026.

NB The closing date for the return of COMPLETED documentation is 5pm, 25th November 2005. Submissions after this date and time WILL NOT be considered.

Newham

FOUR SEASONS HEALTH CARE

TUNSTALL UNIT DRUG AND ALCOHOL DETOX/REHABILITATION

As part of the development of our residential rehab programme, we are seeking to recruit:

PROGRAMME CO-ORDINATOR
(DipSW/CQSW)
£27,411 PA

An exciting opportunity for an experienced addictions professional wishing to play a lead role in an important regional service. Minimum 2 years addictions experience necessary. Additional relevant qualification desirable.

For further information and an application form please contact: Mick Davies on 0191 5235516
Closing date: 14.10.05

www.drinkanddrugs.net

Specialist Addiction Counsellor Required

Salary Scale c £17,500 – £19,500

BROADREACH HOUSE

Broadreach House, 465 Tavistock Road, Plymouth, Devon

Broadreach House is nationally known for offering evidence-based interventions for those affected by drug and alcohol dependence. We currently have a vacancy in our first stage residential unit, a dynamic and challenging environment staffed by a multi-disciplinary team. We welcome applicants with qualifications and experience in the drug and alcohol sector.

For application pack contact Judith Wallace/Daphne White 01752 790000.
Closing Date 23 September 2005.

brighton housing trust

BHT Addiction Services

BHT's Addiction Services provide a comprehensive programme of support to men and women, many of whom are former rough sleepers in the City, who are committed to abstinence and recovery from their addiction to drugs and alcohol.

Deputy Manager (The Recovery Project)

Salary £22,512 – £24,708 per annum
35 hours per week
NJC Scale Point 29, rising by annual increments to scale point 32

We are seeking to appoint a Deputy Manager to assist in both the service delivery to clients within the Recovery Project and in the day to day management of the service. The job will require the post holder to undertake a range of management, housing management, support, and therapeutic interventions both on an individual and group basis. They will also be required to take specific responsibility for projects in agreement with the project manager and to deputise for the Manager in his/her absence.

The successful applicant will have a relevant professional qualification or be actively working towards this, experience in counselling and group work and experience of working with people recovering from addiction. They will also possess excellent interpersonal skills and be keen to join a committed and talented team. At least three years experience of working in a therapeutic or related field of work is essential, as is an ability to work within the 12 step model of recovery.

Closing Date: 12 noon, Monday 3rd October 2005
Interview Date: Monday 10th October 2005

This post is exempt from the Rehabilitation of Offenders Act of 1974

For further details and an application form, please write to the HR Administrator, Brighton Housing Trust, 144 London Road, Brighton BN1 4PH, specifying the post you are interested in and enclosing an A4 self-addressed stamped envelope (.46p). Alternatively, if you would like these documents emailed to you, please email jobs@bht.org.uk

Please note CV's will not be accepted.

BHT operates an Equal Opportunities Policy.

INVESTOR IN PEOPLE

CLOUDS

ADDICTIONS COUNSELLOR

Salary range £19,510 to £21,215 plus benefits

Since 1983, the charity Clouds has directly and indirectly helped thousands of people from all walks of life to recover from the effects of alcohol and drug addiction. Clouds has always worked tightly to the vision of offering help, hope and freedom from alcohol and drug dependency by providing interrelated services of the highest quality and effectiveness, all of which have a clear and ethical basis and which meet the REAL needs of our clients.

To continue the good work, we are seeking to recruit a qualified Addictions Counsellor who will be able to provide a full range of Counselling Services to our beneficiaries.

Clouds House is situated within beautiful countryside providing you with a setting to complement your skills and experience. Our benefits include a non-contributory personal pension scheme, minimum of 25 days holiday and Death-in-Service benefit.

For more information and to receive the application pack, please contact Mardeen Willows, Human Resources Assistant, on 01747 830733. Alternatively, please email your interest (providing a postal address) to mardeen.willows@clouds.org.uk

Closing date: 28 September 2005

Clouds, Clouds House, East Knoyle, Salisbury, Wiltshire SP3 6BE

www.clouds.org.uk

Deputy Chief Executive

Lifeline Project Ltd.

Manchester

c £65,000

The Lifeline Project, established in 1971, is a leading UK registered charity providing a range of drug and alcohol services for adults and young people. The organisation prides itself on taking a holistic view towards drug problems and is well known for providing meaningful and sustainable interventions that are innovative, distinctive or unique. Lifeline has experienced rapid growth over the last few years and now has a turnover approaching £12 million with a geographical presence across the north of England and more recently in London. With plans for further expansion the above new post has been created.

- You will work closely with the Chief Executive on strategic and business planning matters, providing advice and support on wide range of issues.
- Lead, motivate and inspire the current team ensuring successful attainment of organisational goals.
- Take an innovative approach to future service delivery supporting revenue maximisation through planned growth and development.
- You will be a strong leader with proven track record in winning business through competitive tendering and creating revenue growth.
- A strategic thinker and innovator with strong business planning and decision making skills.
- Have a passion and a commitment to work in a radical and innovative organisation working with a marginal population.

odgers selection search interim

To apply, please send for an application pack via our Leeds Response Centre, quoting reference AMM/8524DDN or download it from our website at www.odgers.com/8524 Closing date Monday 3rd October 2005.

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