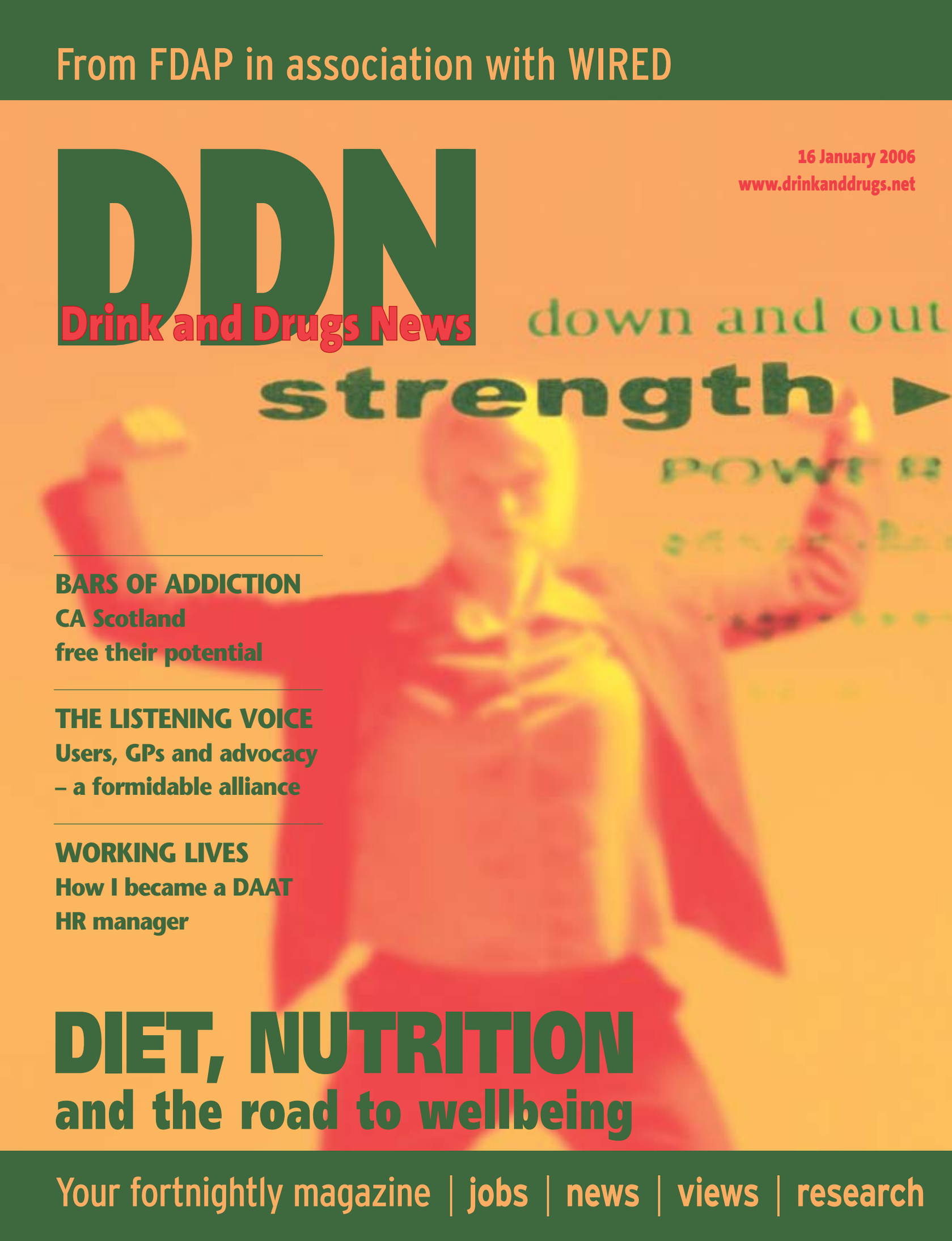
From FDAP in association with WIRED

DDN
Drink and Drugs News

16 January 2006
www.drinkanddrugs.net



BARS OF ADDICTION
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DIET, NUTRITION
and the road to wellbeing

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Modules
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- Substance Use and Misuse Treatment Intervention
- Enhancing Practice
- Enhancing Cultural Competence in Dealing with People with Drug and Alcohol problems
- Dual Diagnosis: exploring interventions for People with Mental Health and Substance Misuse Problems
- Substance Misuse Prevention Interventions for Young People
- The Criminal Justice System and Substance

Who can apply
The programme is suitable for a wide range of professionals working with alcohol and drug users including nurses, social workers, drug and alcohol treatment workers, those who work in homeless and youth services and in the criminal justice system, in both the statutory and voluntary sector.

Tel 020 8280 5705

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Drink and Drugs News

16 January 2006

Editor's letter

Welcome to our first issue of the year. I hope you've managed to get back into routine without too much of a struggle.

With every newspaper and TV programme telling us what we should and shouldn't eat at the moment, we decided to ask a nutritionist for sound advice for drug and alcohol clients. Helen Sandwell's approach makes very logical reading – but is frequently not considered as part of the treatment plan. We concentrate a lot on the best way to respond to a substance problem, but might find inspiration from considering Helen's straightforward ways to improve the body's entire machinery, helping it towards recovery and a renewed sense of wellbeing.

Advocacy has become a welcome buzzword throughout services, with many current and former service users filling an essential communicating role between clients and services. But there's still a long way to go in breaking down barriers between some GPs and their drug or alcohol dependent patients, to ensure adequate and appropriate treatment. Alan Joyce of the Alliance looks at the growth of user advocacy and why trained advocates are needed more than ever.

If the new year means a review of your job prospects, keep an eye out for our occasional 'working lives' features. Elizabeth Flegg tells us how she got into personnel and HR on page 14 and gives an insight to her role. And for a heartening snapshot of an energetic service user group determined to grow, visit The Roundabout Factfile on page 15. A very healthy new year to you.

If you or a colleague would like your own copy of DDN, just email your name and full postal address to subs@cjwellings.com and we will add you to our free circulation every fortnight.

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In this issue

New courts 'not a soft option for drug users'

Dedicated drug courts are being launched by government to get drug-using offenders out of the cycle of drugs and crime.

Leeds and West London magistrates' courts are piloting a new framework, which is 'not a soft option for drug users', according to Lord Falconer, Secretary of State for Constitutional Affairs and Lord Chancellor, who launched the pilot. The 18-month pilot will target offenders who carry out acquisitive crimes, such as shop lifting, to feed their drug habit.

Continuity in the sentencing process will motivate offenders and lead to higher rates of drug treatment order completion. When found guilty, the offender will be referred to the dedicated drug court (DDC) to be sentenced. The same magistrates and district judges will be involved in any future drug treatment order reviews, to provide continuity and decrease the probability of re-offending:

'Offenders will see the same faces every time they come for reviews of their treatment order, creating a more informal atmosphere where the goals set in the drug treatment order are reviewed,' said Lord Falconer.

The offender will also receive support and treatment through the Drugs Intervention Programme.

Lord Phillips, the Lord Chief Justice of England and Wales, added that the pilot could be the first step in helping offenders to turn their lives round, get off drugs and lead a productive life.

Services accessible to all – diversity forum to be set up in West Midlands

A new diversity forum is being set up in the West Midlands, to develop inclusive practice and inform local policy and service delivery.

Practitioners will be able to benefit from peer support while feeding into the development of national policy, through organisations such as The Federation and FDAP.

Organiser Cheri Gillings said the forum was being set up make services accessible to all. 'Some people are in drug treatment and find practitioners are not able to acknowledge or usefully work with issues of identity and sexuality, prejudice and discrimination,' she said.

Ms Gillings hoped the forum would be made up of people from diverse backgrounds: 'All are welcome, and I really do mean all. With benign curiosity, genuine interest and respect we can creatively work together towards solutions.'

The first bi-monthly meeting will be held on 31 January 2006 from 2pm-4pm at HIAH, 10 Pershore Street, Digbeth, Birmingham. For more information contact Cheri Gillings at The Cage, Dudley Drugs Project. Tel: 01384 457866.

Changing behaviour will bring about respect, says Alcohol Concern

Alcohol Concern has welcomed 'tough new measures' to tackle the root causes of anti-social behaviour, promised by the government's newly launched Respect Action Plan.

But Geethika Jayatilaka, Alcohol Concern's director of policy and public affairs, hoped measures would go further to address alcohol misuse – through the parenting support plan and in addressing the link between alcohol and crime.

Remedial action needed to go hand in hand with proactive efforts to help people change the way they drink, said Ms Jayatilaka. This in turn would reduce the likelihood of reoffending and complement tougher measures.

The charity would like to see a national programme of arrest referral schemes rolled out by government, ensuring that those passing through the criminal justice system for alcohol related offences are given access to the help they need.

More support needed for commissioners to be effective

Commissioning managers need more support to help them invest effectively in services, a survey in Commissioning News reveals.

With half of commissioners in post for more than a year, there was a need get to grips with ensuring that budgets averaging £5 million were controlled properly, according to the latest issue.

Help with coping with local problems was a priority. While there had been an increase in national and regional support from the NTA, support was needed with partnership disputes, workload, people and performance management, stifling bureaucracy and changing political demands.

'Effective commissioning is key to the drug strategy and there is a real need to support joint commissioners to enhance their skills and maximise their investments,' said the magazine's editor, Peter Mason.

The third issue of Commissioning News is published by the Centre for Public Innovation and Druglink and can be viewed at www.publicinnovation.org.uk/?page=pdf/CommissioningNewsThree.pdf

NTA amends targets on DANOS qualifications

The National Treatment Agency has amended its targets on DANOS-based qualifications to acknowledge that the NVQ in Health and Social Care is only one option under which practitioners can demonstrate their DANOS competence.

The amended target now reads that by 2008 '75 per cent of non professionally trained staff [should be] undertaking or have achieved NVQ level 3 or equivalent'. Full details of these and related targets can be found on the NTA site (www.nta.nhs.uk). For more information on the different ways in which someone might demonstrate their competence against the DANOS standards - including FDAP's Drug & Alcohol Professional Certification scheme - *see www.drinkanddrugs.net/training/danosquals.html*

Young people failed by lack of co-ordinated services

Lack of co-ordination between substance misuse and mainstream services is hampering young people's chances of getting help, according to Home Office commissioned research.

The report, researched by Turning Point and Addaction, points to failure to incorporate young people's needs into local service planning. There were particular gaps in provision for vulnerable groups, including those in care, ethnic communities and the homeless. Only 10 per cent of services were found to have dedicated provision for children of substance using parents.

Lord Victor Adebowale, chief executive of Turning Point, said the report gave an important starting point for government and other agencies to address deficiencies.

'I hope that policymakers, providers and commissioners will examine the research carefully and use it as a signpost towards future change,' he commented.

Addaction's young people policy and practice manager, Rebecca Cheshire, who co-wrote the report, said the research also revealed that the voluntary sector was only involved in service planning in 10 per cent of areas.

'We would like to see this expertise more frequently used in the planning and design of services in the future to more effectively support young people with substance misuse problems,' she said.

Interviews with 65 per cent of Drug Action Team areas (97 out of 147 DATs) revealed that only 10 per cent of young people's substance misuse services had been formally evaluated.

The report's recommendations include a call to the National Treatment Agency to review the evidence base for providing intensive support to identify young people with substance misuse problems, and to evaluate different models including residential placements and foster care.

Developing the evidence base: young people with substance misuse problems. Available to download in pdf format on www.addaction.org.uk, www.turning-point.co.uk and www.drugs.gov.uk

FRANK's latest update aimed at vulnerable

Vulnerable young people are the subject of FRANK's latest action update.

The pack, aimed at all non-drugs professional audiences, aims to encourage confident dialogue about drugs by those working with vulnerable young people – who might include children in care, young offenders, school truants, young homeless, children of drug users, refugees, or those exploited by prostitution.

The pack's resources and activities aim to give genuine insight into issues affecting young people in these situations and gives new ideas for action.

Register at www.drugs.gov.uk/frank to download a free pack, or call Prolog on 08701 555455.

Young people challenged to devise 'viral game'

The Home Office is teaming up with Channel 4 to launch a competition for the FRANK campaign. Young people are being invited to submit ideas for a 'viral game' that will communicate the risks associated with cannabis use. A viral is an online game that encourages people to pass messages on to others, giving it huge exposure. The prize being offered is an expenses paid trip to London to spend the day at Channel 4, and the possibility of having their game being produced.

For information on the competition visit www.ideasfactory.com/new_media/features/frank_viral.htm. The closing date is 30 January.

Mentor reviews drug use in young

Preventing the effects of drug use on vulnerable young people is the focus of three comprehensive reviews from the Mentor Foundation.

Published this week, the reports look at how drugs are affecting young asylum seekers and refugees; young people in isolated areas; and those in the care of their grandparents.

They examine problems particular to each situation – isolation through language barriers, lack of local and accessible provision, and social situation – and would highlight the situation of young people who are particularly vulnerable to, or damaged by, problematic drug use, according to Mentor UK chief executive, Eric Carlin.

'We want to establish a base of knowledge from which to continue our vital work in reaching parents, carers, teachers, young people and youth workers,' he said.

Drug Prevention for Young Asylum Seekers and Refugees; Coastal and Ex-Mining Areas Project and Grandparents in Custodial Care of their Grandchildren are available on Mentor UK's website, www.mentorfoundation.org/uk

Liberal Democrat leader Charles Kennedy's resignation signaled feeding time for the media…

It never ceases to amaze me when someone has had the courage to tell the truth about his personal life he gets slapped down… It takes a lot of courage to admit, even to oneself, that there is a problem, let alone the world.
Gary Jones, Colwyn Bay, The Times Online debate

Yes he needs to step down. Someone who doesn't have the maturity and strength of character to stop drinking is hardly the kind of person who should be in a position of influence and power.
Kim Righetti, Upland, California, The Times Online debate

We all know that Charles is a gregarious character. But are we sure that he is actually what some have described as an alcoholic? Could he not just be what indeed I am myself, a hard-drinking man?
Jack McLean in The Herald

Kennedy is far from the first party leader with a predilection for a drink. Asquith's nickname was 'squiffy' and he was the undisputed leader of the Liberal Party until Lloyd George and the Northcliffe press ousted him when illiberal policies were required to prosecute the First World War. Even in 1918, the party still doted on Asquith as its leader. For Kennedy, alcohol is only the easy means of frogmarching him towards the exit.
Former Liberal MP Michael Meadowcroft in The Yorkshire Post

Charles Kennedy is not the first politician to have a problem with alcohol, but he is the first to admit it and to get help while being leader of his party... Churchill used to drink heavily all the time, often taking wine with breakfast, but he had a formidable constitution and pursued an incredible workload – something most others would not be able to manage while teetotal.
Hamish MacDonell in The Scotsman

If you were looking for someone to play the part of Tarzan, you wouldn't employ a one-legged actor, and if we're looking for someone to lead our party we wouldn't deliberately go for an alcoholic.
Baroness Tonge, Liberal Democrat Peer, BBC News

Charles Kennedy has actually done an incredibly courageous thing, and anybody who's lived with alcohol dependency issues, directly or indirectly, should be impressed with the courage that took.
Lembit Opik, Liberal Democrat MP, BBC News

He deserved better. Not just as a successful leader of a political party, but as a human being. Instead they treated him like a pissed man walking. In the shoddy downfall of Champagne Charlie, the Lib Dems have blown their image as the 'nice' party for ever.
Tony Parsons in The Mirror

Plenty of people in politics – and let's face it in the media too – drink more than they should.
Nick Robinson's Newslog, BBC News

The alcoholism-is-a-disease camp is itself troubled by contradiction, at once promoting the condition as something that sufferers are helpless to do anything about, and exhorting them to do something about it.
Where do you draw the line? Is an alcoholic an innocent, born with a chemical, perhaps genetic achilles heel, but a man with a 'drink problem' guilty of indiscipline? We may not choose our weaknesses, but can we choose whether to indulge them?
Lionel Shriver in The Guardian

Fuel for recovery

Achieving physical wellbeing is about more than just dealing with the effects of drugs or alcohol on the body. Good nutrition is a neglected factor that can play an important part in regaining health, as nutritionist Helen Sandwell explains.

It is now widely appreciated that good nutrition is essential to maintain a healthy body. And this is particularly important for drug and alcohol users, as active drug users and heavy drinkers are often malnourished. Food of any type is often low on the priority list of drug and alcohol users, with little regard given to nutritional content. Up to 50 per cent of heavy drinkers, for example, are estimated to be significantly malnourished.

Many drug and alcohol users have diseases resulting directly or indirectly from their substance use (such as hepatitis, alcohol liver disease and HIV), which make the need for a good diet even more important. Lack of nutritious food or simply insufficient quantities of food, together with the effect of alcohol, drugs and chronic disease reducing the body's ability to absorb and utilise nutrients, can result in conditions such as Wernicke-Korsakoff syndrome, osteoporosis and muscle-wasting. So it is important for their physical wellbeing that service users get good advice about a healthy diet, and that those with particular physical conditions get specialist nutritional support and guidance.

This much we do know. Yet drug and alcohol users have received very little attention from nutrition professionals in the UK. For instance, the professional body for state registered dieticians, the British Dietetic Association, produces no guidelines for the treatment of drug and alcohol users. In general, very little research has been undertaken in this area. It is no wonder then that nutrition knowledge and application among drug and alcohol professionals is somewhat scant, and what knowledge does exist may well have been gleaned from unreliable sources and those set to make financial gains, such as supplements companies.

Much of the nutrition advice that is given within treatment settings appears to be largely concentrated on those clients perceived to have a concomitant eating disorder. However all clients could benefit from optimising their diets and learning new eating behaviour during the course of their treatment – not only because of the importance of good nutrition to the physical wellbeing of service users, but also because of its potential impact on substance use outcomes.

Good nutrition has been demonstrated to decrease mood and behavioural problems including anger, depression and anxiety, all of which are associated with an increased risk of relapse. It seems likely therefore that developing a healthy diet and eating patterns could help prevent a client from relapsing.

A recent piece of research, for instance, found that in cocaine users, rates of relapse were much lower among those that had higher levels of

omega-6 and omega-3 fatty acids in their bodies. In fact, levels of these fatty acids were better predictors of relapse than past levels of cocaine use. Such results suggest that there may be a causal link between levels of fatty acids in the body and vulnerability to relapse.

So what constitutes a healthy diet for recovery?

Omega-3 fatty acids, like those found in oily fish, have been demonstrated to be effective in the treatment of a number of mood and behaviour disorders including clinical depression, anxiety states, ADHD and aggressive behaviour – and as noted above, may be significant in determining a person's treatment outcomes. In terms of what to recommend and serve up to clients, the Food Standards Agency now recommends a maximum of four portions of oily fish a week for males and women beyond child-bearing age and a maximum of two portions a week for women of child-bearing age (because of the chance of pregnancy and the possible effects on a developing foetus of environmental toxins present in oily fish). Because some people find oily fish unpalatable, the daily use of fish oil capsules may be the preferable choice for them (although pollutants may still be a factor in some brands).

Other major players in the prevention of negative mood states include folic acid, vitamin B6 and vitamin B12. Folic acid is found in green leafy vegetables such as spinach, spring greens and broccoli, which are better steamed than boiled since folic acid is easily leached out by water. Vitamin B6 is found in fish, meat, milk, eggs, wholegrains, nuts and beans. Vitamin B12 is made by micro-organisms and is found only in animal products including meat and dairy, meaning it is important for vegans to take a supplement or eat fortified cereals containing B12.

Another important factor in controlling mood disorders is blood sugar. Poor blood sugar control and sugar cravings can be common among drug and alcohol users, so slow carbohydrate release diets are of particular importance to them. A diet high in refined carbohydrate, such as sugar, white bread, white rice, pastry, cakes and biscuits means that carbohydrate is rapidly broken down through digestion to the component simple sugar glucose and quickly absorbed into the bloodstream, where it stimulates the release of large amounts of insulin, whose job it is to remove the glucose from the blood for the production of energy or to be stored as glycogen or fat. So, with such a refined diet, levels of sugar in the blood peaks and dips, with accompanying peaks and dips of energy, mood and alertness. And when blood sugar dips, as it will do so quickly following a highly refined meal, the body produces adrenaline to kick start insulin into releasing the body's energy stores and restore blood sugar balance. Such unidentified adrenaline bursts could be anxiety provoking in the anxiety-prone, or may cause irritability in others.

Another important issue is caffeine. People in recovery often replace drink and drugs with large amounts of caffeine – whether in coffee, or drinks like Coke, Pepsi or Red Bull, which are also high in sugar. As well as interrupting sleep patterns – which itself has a negative impact on psychological health – caffeine can also increase feelings of anxiety and irritability.

Overall, clients should generally be encouraged to eat slow energy release foods such as wholegrain bread, pasta and cereals, brown rice, beans and pulses, to avoid the blood sugar highs and lows. Additionally they need the high concentrations of nutrients found in fruit and vegetables, good sources of protein such as fish, meat and eggs, while leaving out highly refined fatty sugary foods. And of course, they need to keep a lid on their caffeine intake.

Changing clients' eating habits is only possible if they can see why the changes are going to have a positive effect on their lives and they want to, and believe, they can make those changes. The nutrition field is now employing the motivational interviewing techniques first developed in the drug and alcohol field, to bring about eating behaviour change. Although nutrition advice can be given successfully both in a group or one-to-one setting, care must be taken to tailor advice to individuals' needs.

'A recent piece of research... found that in cocaine users, rates of relapse were much lower among those that had higher levels of omega-6 and omega-3 fatty acids in their bodies. In fact, levels of these fatty acids were better predictors of relapse than past levels of cocaine use.'

An 18-year-old, for instance, may never have learned any cooking skills and the most appropriate help might be in teaching shopping skills and making healthy food choices. Someone with HIV may especially need to learn about food hygiene and how to avoid food-borne infections, which could be particularly challenging if that individual lives in a bed-sit without access to a refrigerator. Hepatitis C is likely to have a higher than normal protein and energy requirement but may find eating three full meals a day difficult because of disease symptoms or side effects of medication. They may need specific guidance on gaining optimum nutrition through several small snacks during the day.

When a group of individuals has such varied and complex nutritional requirements, nutrition professionals should ideally become involved. This is even more important where clients have severe chronic illness or if an eating disorder is identified, when medical, psychology and nutrition professionals should work in unison.

Particular care should be taken with nutrition supplements – which are widely offered in treatment settings, yet can do more harm than good. Iron supplements, for example, can further harm already damaged livers; likewise some herbal supplements.

And of course residential and structured day care services need to think not only about the advice they give their clients and any supplements they might offer, but also what they feed them. In often providing hearty comfort food which is frequently high in refined carbohydrates and fat but relatively low in nutrients, many services are not providing clients with diets for either a healthy body or a healthy mind.

Nutrition is only one of a number of lifestyle changes that can contribute to helping to improve clients' health and long-term treatment outcomes. For example, exercise is known to increase positive mood as well as being key to immunity, heart health and maintaining bone and muscle mass – all of major importance to people with a history of drug and alcohol misuse. Sunlight is another important factor for boosting vitamin D (involved in bone health) and serotonin levels (since serotonin helps improve mood).

Diet is a very important factor, which has been neglected for too long. Hopefully the time has come for treatment providers to consider enlisting the expertise of nutrition professionals to provide training to staff and clients and help influence positive outcomes in treatment programmes through dietary change.

Helen Sandwell MSc NutMed is a nutritionist. You can contact her by emailing helen@goodfoodandhealth.co.uk

Career resolution

Dear DDN
I've made a New Year's resolution to keep a professional portfolio this year, as I want to get organised about progressing to the next stage in my career. I can see the sense in continuing professional development, and I know it will give me a better chance of promotion or finding another job in the field.

My problem is, I don't know where to start. How do I begin collecting evidence, and how can I tell what's appropriate to include?
Yours, Frankie

Dear Frankie
We'll find out everything you need to know to get to grips with your portfolio, and report on it in the next issue – on one condition: that you keep a diary for us on how you get on compiling yours.
Yours, DDN editor

Find out how to compile a good portfolio in next DDN; follow Frankie's diary in future issues.

Complimentary conference

Dear Editor,
I have been asked by Andy Stonard in his capacity as Chair of Conference Consortium, to rectify a misunderstanding that has arisen in the publicity material for our forthcoming conference Prisons and Beyond (16-17 February 2006). I am happy to do so.

Prisons and Beyond is being organised by the National Offender Management Service and is not designed specifically as a replacement for the Prison Drug Workers Conference. The latter conference previously run by Cranstoun Drug Services is being continued by a consortium of Drug and Alcohol agencies (including Cranstoun Drug Services) entitled 'Addressing the Balance' (13-15 March 2006).

I see the two conferences as complimentary with Addressing the Balance targeted at the much wider criminal justice drug treatment community.
Yours faithfully,
Martin Lee
Head of Drug Strategy Unit

East-West endorsement

After reading an article in *DDN*, I thought perhaps you would like to include my letter in your magazine for the benefit of other readers. I am 49 yrs old have been using amphetamine (speed) since age 13. Also with the emergence of crack cocaine, I was using this also. I've been in prison a few times, and been to two rehabs, only to start using again within days.

That was until I came across East West Detox, which involves some initial counselling from Mike Sarson (East-West Detox co-ordinator) and then a trip to Thamkrabok, Thailand, which is a Buddhist monastery two hours drive north east of Bangkok. I underwent five days initial vomiting and herbal medicine throughout my stay there of seven weeks. (In all I vomited 25 times.)

Then there is the spiritual aspect of being there: a part of me that was lost, my spiritual self has now been found and I now feel whole again, found through meditation, and spiritual discipline. I would recommend to anyone who is wanting to rid themselves of their addiction be it drugs, alcohol, even smoking, that Thamkrabok is the place to go.
Steve West, Newbury

'Mike Sarson has all the right credentials, a social worker, addiction counsellor, and years of experience in the field, but above all he has an intuitive quality together with great compassion and total dedication to his vision. This in turn motivates all who support and are involved with the ongoing work of East-West Detox.'

An Alternative Way

Recently, I was fortunate to be present at the October East-West Detox road show and found the day both uplifting and informative.

A mixed group of professionals working in the field of addiction, together with recovering addicts and some family members, were gathered in the beautiful surroundings of Winford Manor Retreat Bristol, to share a truly stimulating day. Winford Manor has been my spiritual home for many years and regularly hosts such events offering space and quiet in its lovely chapel, house and extensive grounds. It was good to be back again.

Mike Sarson and his team have revolutionised the methods of detox and recovery by marrying East and West in a unique and positive way. People who are seeking recovery travel many miles to Thamkrabok, a Buddhist Monastery in the north of Thailand.

For most of them this is a journey through unchartered territory and requires of them total commitment to change and a sincere wish to 'let go' to the process, and move forward to a life clean of drugs or other substances, to freedom.

Everyone deserves a choice and this is exactly what is on offer.

We were at Winford Manor to hear how the programme works, from Simon and others who had already made the journey.

East-West Detox is a charity offering a unique, non medical treatment for individuals suffering with addiction. It allows westerners to experience the world renowned detox programme at the Thamkrabok monastery, where they have had a success rate of 70 per cent over the past 58 years. This speaks for itself and individual costs vastly undercut any in the West.

Some may have seen the BBC documentary 'kill or cure' – the story of Simon and Rebecca, two young people desperate for recovery and a drug free life. Mike and his team support them from the beginning in the UK to the final process at the monastery in Thailand, where they both go through a complete life change. I have watched the film many times, each with renewed enthusiasm.

Simon took us through his story of many years of addiction, to his final experience at Thamkrabok. He has no doubt that his chosen path is working for him. Dr Vanessa Crawford consultant psychiatrist and director of East London and City Specialist Drugs and Alcohol Addiction Services, spoke highly of the East-West Detox method of treatment. She has made the journey to the monastery in Thailand and taken the herbal medicine herself.

Mike and Vanessa held a comprehensive and informative question and answer session, and Vanessa fully endorsed the work:

'I have great respect for the treatment… calmness of the surroundings, the positive wisdom of Buddhism and the importance of being entrusted with a vow, all add to the success'.

I was interested to hear what she had to say, as I too felt that the initiation ceremony was what had first struck a chord for me, combined with the monks' chanting to the drumbeat whilst herbal medicine is being administered. All addicts taking part in the process are requested to wear robes and take a vow to abstain from drugs for the rest of their lives. This ritual I feel works on all levels as it takes place in a sacred space. Not only is the body purged of all substances and toxins, the spirit is also cleansed – by all accounts a gruelling experience, but nevertheless liberating. It is also worth mentioning that there is no requirement of any religious belief.

The five day detoxification period consists of taking herbal medicine and steam baths daily.

I personally feel all the symbolism and ceremony adds to the path of change and movement from the old life to a new one.

Louise, a good friend of mine gave a heart rending account of her son Charlie's journey to recovery and Simon's mother added her comments. This mixture of perceptions from all quarters helped those of us present to get a full picture.

Mike Sarson has all the right credentials, a social worker, addiction counsellor, and years of experience in the field, but above all he has an intuitive quality together with great compassion and total dedication to his vision. This in turn motivates all who support and are involved with the ongoing work of East-West Detox.

In conclusion I feel most disappointed for those who, in the light

of the present recommendation from the NTA are unable to make the choice, between an alternative path with East-West Detox, which already has a high success rate, and the conventional route, which intends to increase the existing dose of methadone and abandon any counselling support. Surely everyone seeking recovery is entitled to a choice.

I am so grateful to have experienced such a full and inspiring day.

Many thanks to Mike, Nick and the team, James, and all at Winford Manor Retreat.

Wendy Gregory, by email

For an article about treatment at Thamkrabok, see DDN, 24 January 2005. All our back issues can be viewed online at drinkanddrugs.net

Cycles of change

Home Office statistics disclose that 89 per cent of the offenders engaged in drug treatment reoffend. While that figure is highly disturbing, without being informed how it compares to the relevant target figures, we cannot know if it indicates a failure, or its extent.

If, as seems likely it is a failure, then because public money is involved, we are entitled to an explanation. Hopefully, this will prove to be substantially different than the kind one normally associates with instructions on the indoor growing of mushrooms. Forthright explanations do not need to be accompanied by the usual platitudes of 'internal inquiry', 'lessons learnt', 'more robust action', 'modified procedures', 'more studies' promises to do better *etc, etc*. Experience shows that banalities rarely, if ever, materialise.

Failure demands change; in this instance, we need to consider less hypothetical and more holistic solutions. The almost universally acclaimed 'gold standard', within the transtheoretical model of the 'Cycle of Change', gifted to us by Prochaska and DiClemente, has withstood the tests of time and considerable critical appraisal, and is a constructive framework to work within. In truth, given its antecedents, it would be less than professional not to use it extensively for endeavours that are intended to substantially reduce the number of those on DTTOs who reoffend.

There are compelling reasons for using this model – not least of which is the fact that it is based on extensive research. This provides reliable and addiction-related, numerical evidence, identifying the stages that people actually go through, consciously, or unconsciously, with or without outside assistance, to effect changes in behaviour and habits. That evidence alone places it in marked and vastly superior contrast to more hypothetical models.

An almost equally convincing reason for working within its framework is that the authors became aware that recovery from addiction follows an uneven, protracted and unpredictable path, prompting subsequent research that focused on the principle models of psychotherapy and self help groups, used to bring about change. This research revealed that while each 'has its own sphere of excellence', using different models at each stage of the cycle proved to be more effective than exclusively using any single model. It therefore recommended the use of five specific models which, together with self-help groups, accelerate client progress through the various stages. It is interesting to discover how the seven underlying principles of the '12 steps of recovery' can be elegantly fitted into each stage.

Prochaska and DiClemente's research also indicates that although using the framework as recommended hastens progress through each stage, because of the resistance that can and does occur at each stage it is unrealistic to expect clients to complete stages within a pre-determined period of time. As it is not uncommon for clients to 'cycle' back and forth through the stages, it may be the amount of time that we would need to spend with our clients, rather than the necessary skills and knowledge required, that is the reason why the model is not used more widely, or in the manner the authors recommend.

There is an abundance of the requisite skills and dedication to be found in our industry, especially among frontline workers in large organisations, to enable application of the Cycle of Change. Unfortunately, they may be denied opportunities to develop them, because their employers, presumably under pressure from their political paymasters, appear to be pre-occupied with increasing numbers in 'treatment'.

Assuming that we wish to assist our clients in a way that minimises the chances of relapsing, and consequently reoffending, we need, as the NTA urges, to focus on 'evidence based practice' – rather than attempting to 'reinvent the wheel', by the expenditure of money, time and other valuable resources on 'large studies' of 'what works', as well as largely hypothetical interventions and relatively unimportant politically correct issues. Would it not be more profitable to invoke the extensively researched, time tested, critically appraised, transtheoretical model?

Given the research and evidence of its unparalleled effectiveness, perhaps it's is not so much a question of if we should use it, but a question of how willing we are to use it more extensively.

Peter O'Loughlin,
The Eden Lodge Practice

Comment

More dealers are being arrested, therefore the drug strategy is working says the Home Office. Give us the full story, says Steve Rolles.

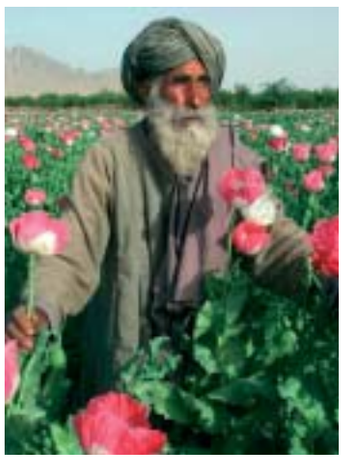
The Home Office love to loudly proclaim drug seizures and arrests of drug dealers. In the latest blizzard of expensively produced Home Office literature to persuade us that the drug strategy is working, under the title of 'delivering the difference' we are told that 'FACT: the total number of class A drug dealers brought before the courts has been rising since 2001'.

Elsewhere among the piles of snazzy 'tackling drugs – changing lives' niknaks, beneath the mouse mats, beakers and key rings, I find a fancy looking cd-rom pack – featuring on the cover, in bold brightly coloured capitals: 'There have been record seizures of class A drugs, recovery of drug related assets and disruption of organised criminal groups.' Impressive.

But the problem with all this is that there is another set of facts that the Home Office don't want you to know about. These are that class A drugs are cheaper and more available than they ever have been. Now, given that a central aim of the drug strategy is to reduce drug availability, it is only fair for us to ask why the Home Office is proclaiming seizures, arrests and so on – which give the impression that the situation is improving – when measures that actually provide an indication of availability (*ie* price and purity of street drugs) show the exact opposite.

The answer is obvious. They know full well that supply side controls aren't effective (and never have been – anywhere); that for every kilo seized, 10 make it through; and for every dealer arrested there is a queue of willing replacements – and you are being willfully misled.

Even the Number 10 strategy unit acknowledged the futility of supply side controls in the recently leaked report (commissioned by and presented to the Prime Minister himself) which noted that: 'Government interventions against the drug business are a cost of business, rather than a substantive threat to the industry's viability.' The report goes further, noting that even if these efforts were effective at increasing drug prices overall harm would actually rise as addicts would just commit more crime to pay the inflated costs. Perhaps this was why the report was suppressed.



'Supply side controls aren't effective (and never have been – anywhere)... you are being willfully misled.'

So next time you are at a Home Office event and they start talking about seizures 'preventing (insert large number) kilos of (insert drug) from reaching the street' – ask whether this has any effect on street availability, why availability targets have been dropped from the national drug strategy, why availability is measured in drug and asset seizures and dealer arrests – (which don't reflect availability in any way) or whether by 'delivering the difference' they are referring to the fact, noted in the Prime Minister's report, that 'Despite seizures, real prices for heroin and cocaine in the UK have halved over the last 10 years'.

Until we can get past this nonsense and propaganda, what hope is there of a rational evidence based debate on policies that might actually decrease harms instead of increasing them?

Steve Rolles, Transform Drug Policy Foundation www.tdpf.org.uk

The Unhooked Outsider

A perspective by William Pryor

Most addicts are outsiders, in that they don't fit in, they disdain how insiders deal with pain and pleasure, life and work, purpose and ambition, private and public. An outsider is alienated, as both Albert Camus and Colin Wilson made clear, not part of the social glue that sticks 'ordinary' people together, someone whose worldview is at odds with any consensus. The outsider finds the social community of the world around him uncomfortable and threatening, and, in his addiction, creates his own, safer, more knowable and predictable reality.

The medical, addiction treatment and criminal justice establishments seek to annex these realities, to bring addicts in from their outsider status by fitting them into their illness story, locking them up when their behaviour is unacceptable and prohibiting their sacramental substances. We have to have standards, the mythologies of addiction tell us, and addicts are either sick or crooks or both; definitely a danger to society. We must cast out their devilish practices.

Confronted by the obvious suffering, chaos and criminality that imbues and surrounds addicts, the various establishments are compassionately and politically driven to react, to wring their hands, to do something, anything. Anything but understand that addiction is, in part, an expression of the dysfunctions of families, communities and whole societies. Indeed addiction is a dramatic way of saying you don't fit in, and is fast becoming the route of choice to becoming an outsider. Societies and families will accommodate your needs – they will despise, misunderstand, patronise, criminalise and medicalise you to your hearts content – all you have to do is adopt the addict position. The big problem is that the micro-climate the addict creates for himself is even less sustainable than is the world humans have, more generally, built for themselves; they both contain the seeds of their own destruction.

The big question is why would anyone want to adopt such an uncomfortable outsider status; why would they want to be criminalised, patronised and medicalised? It doesn't make sense – they must be ill, poor things; can't know what they're doing. But it is a symbiotic relationship: to maintain a coherent idea that it works, that its goals are worthwhile, its morals worth fighting for, society has to have a clear example of what it is not. So the mass of insiders need the odd outsider to confirm it is a good thing being on the inside, that it is worth overlooking the moral ambiguities and contradictions of society. Anyway it's not a question of the outsider wanting to cast himself out, but that he feels himself to have no choice: he condemns society around him for its shortcomings.

Most addicts are outsiders, in that they don't fit in, they disdain how insiders deal with pain and pleasure, life and work, purpose and ambition, private and public. An outsider is alienated... not part of the social glue that sticks 'ordinary' people together, someone whose worldview is at odds with any consensus.

Take the psychiatric, medical and addiction treatment professions: they find it useful to describe addiction as an illness. They also find it useful to 'discover' 57 different varieties of depression, all of which require medication. To remain insiders they must overlook the fact that this medication is what they would otherwise call addictive, in fact more devastatingly so than many banned substances. It's enough to drive one to become an outsider!

www.unhookedthinking.com

Q&A

I work in a rural area and am trying to think of ways of interesting local youth in drug safety messages. Many of the young people in our county are spread out without easy access to a youth centre. Can anyone suggest how to get drug and alcohol messages across to young people in rural areas?
Hugh, Cumbria

Those in the know

Hi Hugh

Ask your local schools for advice. That's the one place that (most) kids will turn up to regularly. Schools I have approached have usually been only too pleased to share thoughts on how to make drugs education more meaningful – particularly of there's anything you can contribute.

In my last job I often visited local schools to take part in lessons with Key Stage 3 (11 to 14-year-old) children. It can be quite rewarding to be directly involved in changing misconceptions.

Tim, Warwickshire

We're all individuals

Dear Hugh

Find ways to get information to local young people without having to round them up to meet. It's notoriously difficult to get them to meet regularly outside their chosen peer groups, unless you're offering some flash (and usually expensive) activity.

Distribute messages where they will see them – cards with website addresses on, where they can explore drug safety messages for themselves. As well as the more obvious ones such as the government's www.talktofrank.com, you may find there are sites for local organisations that can lead young people (or their parents) to get in touch with local services if they need more help with a particular issue.

If you search on the web you will find all sorts of excellent websites that offer advice and the chance to ask confidential questions. Barnet DAAT's www.wotzdafactz.co.uk is a good example of a comprehensive local initiative. See if there's anything that would be relevant to your area.

Good luck!

Cheryl, London

Hanging around

Dear Hugh

You could ask local doctors and dentists if they'd be happy to put some leaflets in their waiting rooms. You could also approach schools, although that would have to be done with some sensitivity. Why not try and place posters in any places where young people are likely to go – try asking bus companies and the owners of internet cafes. Finally, what about suggesting to topical local radio programmes and local newspapers that they do a feature on drugs?

Ian Wheeler, patient services manager, Harrogate Clinic.

Useful connections

Dear Hugh

One way to get the drug and alcohol message to young people would be to liaise with your local Connexions Office and ask if there is any education work they can deliver in schools across the area. You could also consider setting up community sessions. Where I work in Fareham, Hampshire, we use community sessions to work with young people and their parents, and this has been positively received by the local school, community and community Police.

I am also aware of a project that took place in the Yeovil area whereby a mobile unit was sent out in the evenings to outlying areas to deliver interactive drug and alcohol sessions. This had a positive impact on substance usage in rural areas.

Simon Defty
Connexions personal adviser
South Central Connexions

Reader's question

Tobacco smoking is one of the deadliest addictions, yet seems to be largely ignored by the substance misuse field. Do any treatment providers give advice on stopping smoking while treating other addictions?
Jodie, smoking cessation co-ordinator

Email your suggested answers to the editor by Tuesday 24 January for inclusion in the 30 January issue of DDN.

New questions are welcome from readers.

Reaching through the bars of addiction

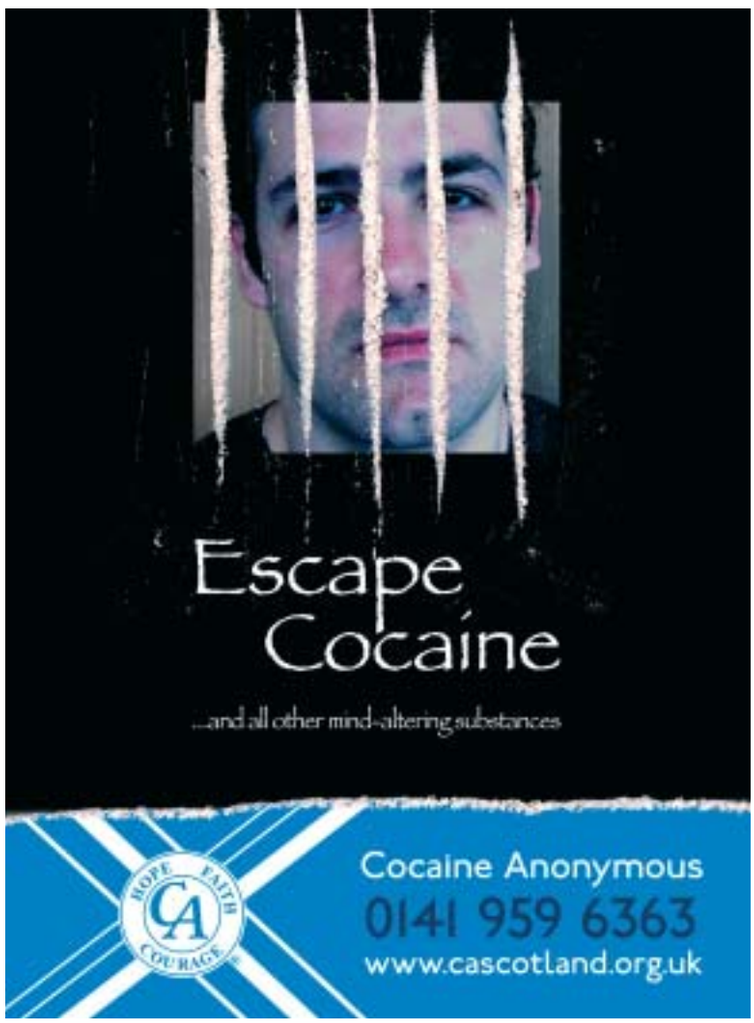
Cocaine Anonymous Scotland had plenty of help to give, but was struggling to reach those who needed it. David M explains how their new website has freed the organisation from the boundaries of anonymity to reach an exciting stage in development.

CA Scotland had a problem. We knew we had an effective programme to help those trapped in addiction, but few people knew we had a presence in Scotland. True, we were young among 12-step groups, having only been around for four years, but we were growing, our meetings were full and people were getting and staying clean. We wanted to show that our programme works, but how were we to do it?

'We knew we had something exciting to pass on,' remembers Nicholas, the secretary of the Public Information Committee. 'Our meetings were full of clean, recovering addicts, something drug agencies needed to know about. Yet all we got were blank stares when we talked about CA Scotland'.

There were posters, and word of mouth had already proved very effective – but there was a feeling in the fellowship that we could be doing better. Graeme, who is now responsible for keeping the meetings list up to date, points out that 'carrying the message is the fundamental purpose of our 12-Step programme'. It's a valid point: communication is foremost.

So what is the message? One of the first members of CA Scotland explains: 'Carrying the message – the 12 steps – helps us stay clean and sober and helps others to achieve the same freedom'. CA is concerned with helping individuals who think they have a problem with cocaine, crack or any other mind-altering drug to find abstinence.



'We took the Scottish flag as our theme. We wanted the site to show that when you are trapped in addiction, here in Scotland, there is hope and that we have found a way out.'

The public information committee was formed at the beginning of 2005 to communicate our message to the public (particularly drug treatment professionals), to let them know they could refer clients to us. Says Nicholas, 'We wanted to look at ways of letting others know that there are alternatives to the revolving door of getting clean for a few days and relapsing. We decided on developing a website, a helpline with a rota of volunteers to operate it and a poster campaign as well as writing a press release to let local press know we were here'.

The people in Cocaine Anonymous are diverse in terms of age, sex, social background and training and education. 'Talent and enthusiasm are things we are not short of', Nicholas points out. It was simple to draw on this pool of expertise to help us communicate.

Ian, whose partner is in recovery from drug addiction and who is a member of 12-step fellowships himself, used his professional background to design the website. What concepts did he bring to the table?

'The philosophy of 12-step recovery is to "keep it simple", and that became our overriding aim. We weren't going to repeat information that was available elsewhere', he explains. 'This was a local message for a local population, the net was the ideal medium'.

'CA is a world-wide organisation; there are already World and UK websites. What we wanted to emphasise was that this message was for those with a drug problem in Scotland'.

Ian explains how the site became reality. 'We took the Scottish flag as our theme. We wanted the site to show that when you are trapped in addiction, here in Scotland, there is hope and that we have found a way out.'

Though the theme of the site is simple, the pages on it are practical and helpful. The meetings list tells people where to find us. There is a link to a self-test for cocaine addiction, a downloadable Scottish CA poster and links to the UK and World sites.

The site gets about 500 hits a month, mostly from the UK, but also from the USA, Australasia and Europe. Several national agencies have added links to us from their own sites and the site has attracted coverage in newspapers and magazines.

The most popular pages on the site are the stories from members' own experiences. Those logging on can identify immediately with how low addiction can take you and yet how hope and recovery can blossom through involvement with CA. As one recovering addict says on the site 'I lost everything that was important to me… but thanks to the people in the rooms of CA who loved me until I could love myself, I am now 18 months away from my last drink or drug and that is a miracle!'

Our convention at the beginning of November was featured on the site and ended up attracting over 400 people to the Hilton Glasgow Grosvenor Hotel for a spectacular weekend, showing to the world that CA really does work. Come and have a look for yourself on www.cascotland.org.uk.

Why do we need **user advocates?**

User advocates are essential to making sure drug users have an effective relationship with their GP – while avoiding the mistakes of the past. The Alliance's senior advocate, Alan Joyce, explains.

The problems associated with drug use, from dependence to HIV, from Hepatitis C to psychosis, from cirrhosis to heart conditions, present complex challenges to general practitioners. Health consequences of problematic drug use go beyond the individual patient to impact on the family, other users, community, and society.

When treating problem drug use, GPs find themselves at what one could term a 'nodal point' where a number of different discourses, power struggles, and judicial, ethical, social, criminal, personal and political influences converge – both in the body of the user seeking treatment, and in the practice of the GP who is asked to treat them.

Historical precedents for this undoubtedly complex situation involving the GP and drug user, can help to demonstrate why user advocacy is of such importance. Consider the history of the medical treatment, diagnosis and care of women. We live within recall of a time when an unmarried woman with a child could find herself consigned to an institution for life. Predecessors of today's medical practitioners played an active role in diagnosing and treating women for 'aberrant sexuality', promiscuity, and 'hysteria'. Sadly some eminent members of the medical profession supported and thereby legitimised practices that would now be regarded as unethical, to put it mildly.

Likewise, consider the medical view of gay and lesbian sexuality before the gay rights movement of the late 1960s. Many eminent medical practitioners 'treated' homosexuality as an aberration, as a form of mental illness or obsessive dysfunctional behaviour that could not only be treated but 'cured', consigning 'sufferers' of this 'affliction' to all manner of cures and treatments – electro-shock therapy, psychoanalysis, institutionalisation in the asylums, barbiturates, sedatives, bromine – often with tragic consequences.

The drug user's condition is the focus of considerable social, political, cultural, religious and moral forces. Berridge and Edwards' *Opium and the People: Opiate use in 19th century England* along with Marek Kohn's *Dope Girls* and *Narcomania* show how these forces gave rise to the medical model of the opiate 'addict'. It is also evident that this medical model was itself the subject of considerable debate – not just in society, but also within medical science and practice.

It is no wonder then that the current treatment of the drug user in general practice is contingent not upon 'pure' medical science and a confirmed evidence base, but is dependent on the personal belief systems of the GP (and for that matter the specialist consultant) and upon the social, cultural and political forces that impinge on them as a human being and member of society.

The problems that this would suggest are further compounded by the training that the aspiring medical practitioner will receive before they are qualified and beginning to practise. The figure given varies between training institutions, but it would appear that a total of somewhere between four and seven hours is spent on training doctors to treat problematic drug use and its consequent health and social problems.

In the absence of thorough and consistent training, it is inevitable that treatment of drug users will be a postcode lottery. Beacons of informed and enlightened best practice can be surrounded by areas where punishment and treatment, medical ethics and 'personal morality' have become interbred. In the absence of knowledge, it is likely to be a mixture of received wisdom, personal belief systems, moral judgement, overly restrictive and punitive 'practice' – as well as confusion – that will determine what treatment is given and what is refused.

These inconsistencies thrive against a backdrop of growing political and medical recognition that much of the treatment given to the drug user has been of negligible value or help to them and also to the communities in which they live. Put bluntly, much of the treatment has simply been poor or failed. This has led to a political demand in the UK that those funded to provide treatment are also held professionally, fiscally, and socially accountable for its delivery and results and has led to the creation of the National Treatment Agency.

Alongside this 'top down' initiative, a 'bottom up' argument has grown louder, about what constitutes treatment and about the diagnosis and constitution of the user. In other areas of health – such as relating to HIV and mental health – change wasn't just 'top led'. It came through patients' advocacy movements, in response to pressure from people and communities who found themselves at the receiving end of contested diagnostic procedures and medical practice. In a similar way, it must be becoming increasingly evident to GPs that the diagnosis and treatment of drug users is increasingly subject to question and direct challenge from the patients, their families and carers. This is partly in response to changes in the NHS that speak about patients' rights, patients' charters, the 'expert patient', and a growing inclusion of patients in the decision-making processes that inform 'treatment practice'.

The emerging 'user consciousness' was also informed by the experiences and struggles of drug users in other countries. In the USA in the 1970s, the 'Group of 11' emerged in New York. Members of this group in turn founded and developed the first model of drug user advocacy, NAMA (National Alliance of Methadone Advocates). In Europe, partly as a legacy of the politicisation of many drug users and students during 1968, we saw the emergence of the JunkiesBond, the first drug users' union. Both NAMA and the JunkiesBond are vibrant, active user led organisations to this day.

In the UK, informed user activists emerged to be directly involved in the foundation of the harm reduction movement during the 1980s, in Liverpool, London and Manchester. Today this is reflected in the UK Harm Reduction Alliance and user groups' and advocates' open espousal of a 'harm reduction' led health and treatment agenda in the UK in the mid 1980s. We also witnessed the first UK example of 'direct' user activism – an organised protest in response to

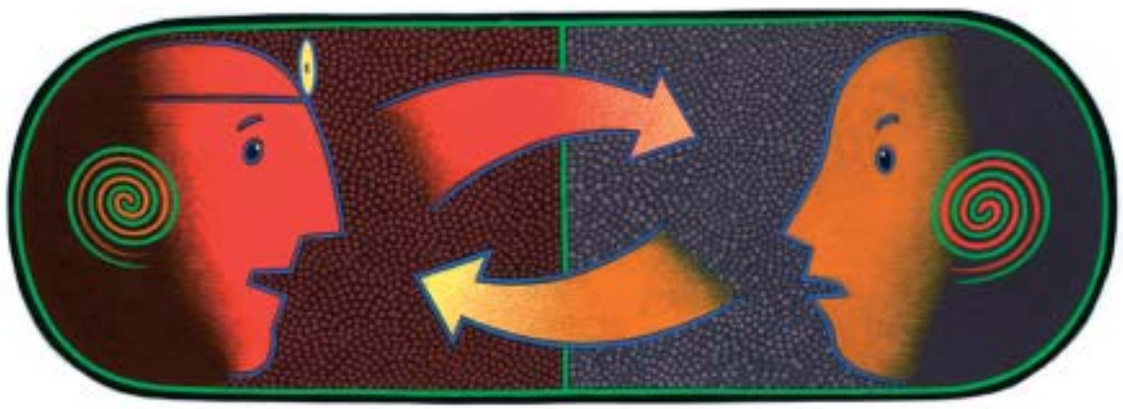
the punitive 'treatment' of Dr Ann Dally, a well-respected private doctor and specialist in the treatment of drug users, by the General Medical Council.

In 1998 a group of committed current and ex-service users joined with some supportive and sympathetic professionals to found a user led organisation and alliance in the UK, that would embrace the advocacy model as a way of articulating users' needs, defending their rights and promoting good treatment and practice. The Methadone Alliance, founded by Bill Nelles, was formed to ensure that drug users became actively involved in the debate about their treatment and care at every level. Through this team – now known as just 'The Alliance' – the idea of user advocacy was developed and put into practice.

Eight years later, there is still much to do. There is overt hostility on the part of some practitioners to the very idea of 'treating' drug users, exemplified in the words of one GP to a patient for whom I advocated: 'I am not here to provide you with free drugs. Come back when you are clean.' In other surgery windows, signs have proclaimed 'drug users are not welcome here' or 'drug users and their families will not be treated in this practice'. Less overt, but still common, is the intimidating surgery receptionist who discusses the patient's medical history or drug problem in front of other patients in the waiting room. The user feels so unwelcome at the practice that they leave and take their problem elsewhere.

If the user makes it beyond the surgery door to find a doctor who will treat them, they will still face continuing problems. One chronic problem is under prescribing – or more correctly, sub therapeutic dosing. Many GPs prescribe methadone at levels way below government guidelines, refusing to consider a realistic dose. Understandably patients continue using on top, or relapse, and treatment is routinely associated with poor outcomes.

Another common problem is punitive response to a user exhibiting symptoms of their condition. Opiate use is described as a chronic medical condition characterised by relapse. In no other branch of medical treatment would a patient exhibiting a classic symptom of their condition find their treatment withdrawn on 'punitive' grounds. Yet this is all too often the reality faced by the dependent opiate user experiencing problems with their condition – and quite often as a consequence of poor treatment and practice.



'By listening to the patient's voice, both drug user and treatment provider will cease to find themselves in an enforced embrace characterised by mutual misunderstanding, incomprehension, distrust and antagonism'

Overly rigid prescribing and dispensing practice can cause further problems. While it is understandable that supervised consumption may often be a necessary and appropriate measure to be taken when initiating, prescribing and stabilising the patient, it can all too often be applied in a dogmatic and inflexible manner that makes it very difficult for certain patients to remain in treatment – parents for example, or those users who are in work or full time education; those for whom the nearest chemist may be 10 miles away; or those who live in rural areas, where their identity as a user can become known due to the pharmacy's role in the local community.

Another common problem is a refusal by some GPs providing treatment to follow the science or evidence base – or even current guidelines. The right to exercise 'independent clinical judgement' is deployed as a fig leaf to cover what is, at best, down to poor training and ignorance – or at worst the doctor's imposition of their own personal morality and belief system on the patient.

In some medical practitioners, this can give rise to a fixation on abstinence-based recovery. While for some users cessation of drug use is a laudable and achievable goal, for many others it is not. Other treatment options that focus on harm reduction and maintenance are denied to such patients. Sometimes this can have a drastic impact on treatment provision in a whole region, and we can identify such 'problem' areas by the number and type of cases we receive. Sadly, one can also identify such areas by high overdose and drug related mortality rates.

As the Alliance has grown and evolved, the need for user led advocacy has become increasingly apparent beyond the needs of just opiate users. Stimulant users for example find treatment difficult to obtain, a problem compounded by the lack of substitute medications. Even where a substitute medication, such as Dexedrine, could help, there is often a reluctance to undertake prescribing.

Another area where we are encountering growing problems is in relation to dependence on benzodiazepines. Where in the past they have been over prescribed, the benzo-dependent user can now find themselves subjected to poorly planned, and in some cases dangerous, cessation of prescribing and 'detox' plans.

We also find the Alliance increasingly called upon to provide advocacy and support to polydrug users, who may be concurrently dependent on opiates, benzos, alcohol or stimulants. Understandably this presents doctors engaging in treatment with a complex set of presentations and needs – which often results in poor treatment for one or all of the problems they face.

It is important to recognise that user led advocacy does not necessarily imply a confrontational and adversarial approach to the resolution of problems facing our clients. User led advocacy is about educating and empowering the user and the practitioner, about redressing the historical imbalance of power in the relationship between treatment provider and the drug user, and about encouraging the best practice possible, as widely as possible, in the hope that previous and present wrongs will be righted.

By listening to the patient's voice, both drug user and treatment provider will cease to find themselves in an enforced embrace characterised by mutual misunderstanding, incomprehension, distrust and antagonism, and become equals in a therapeutic alliance.

For more information on user advocacy, visit the Alliance's website, www.m-alliance.org.uk

Working lives

Elizabeth Flegg, Human Resources manager at Sussex DAAT

How did you become an HR manager?

I had worked in retail, engineering and social care when I decided my future ambitions lay in human resources. So I bit the bullet and returned to full time education. I took a Post Graduate Diploma in Personnel and Development in July 1996, followed by an MSc in Human Resources Management in 2001. The courses widened my knowledge and understanding of strategic HR.

I gained work experience in personnel in both the public and private sectors, but the main part of my HR employment was with West Sussex County Council advising managers in their Social and Caring Services Department.

It was during this job that I first came into contact with West Sussex DAAT (at that time a DAT), which is hosted by the local authority. A new DAT Co-ordinator had been appointed and was keen to recruit a small team to assist with young people and adult joint commissioning and the far-reaching communities agenda.

We found ourselves ploughing through endless bureaucracy and paperwork during our meetings and realised the need for a more proactive approach to workforce planning and development. Everything to do with job evaluation and recruitment took too long.

The following year funding was sought and the DAAT HR Manager role was born; I applied and was appointed. This was initially a part time post (2.5 days per week), but Brighton and Hove and then East Sussex DAATs quickly got on board extending funding to make the role full time.

What does your job involve?

My job was busy from day one. The Sussex DAATs had been proactive leading up to my appointment, and had set up our 'Workforce Planning Task and Reference Group', which was keenly awaiting my arrival. The group involves key people and agencies from across the sector within Sussex and provides a good example of partnership working. We hold quarterly meetings, including our annual Workforce Planning Stakeholder event. Around 70 people attend this free event to receive updates and news on developments.

I often receive phone calls or letters from people wishing to work in the sector seeking information about how to 'get in'. When I started in my role in 2003, I was unsure what to advise, and after some investigation found it incredible that there was actually little guidance to give these people, beyond 'you could become a volunteer and grow from there'.

There was no career pathway, information on working in the sector was thin and often out of date, and there were few educational routes to follow. My background in social care had demonstrated how difficult it was to recruit and retain good workers even with good information and campaigns in place. It was concerning that the sector lacked such strategies and had few plans to take this challenging agenda forward.

'My background in social care had demonstrated how difficult it was to recruit and retain good workers even with good information and campaigns in place. It was concerning that the sector lacked such strategies and had few plans to take this challenging agenda forward.'

But there was an 'up' side: having little in place in Sussex provided me with a blank canvas to develop and build workforce planning and development requirements for the local sector.

What have been your biggest challenges?

DANOS was born in 2003 so there was an immediate challenge in bringing this to fruition and making implementation easier for our local organisations. We held workshops to help our local sector to understand and implement DANOS and quickly signed up to the Home Office Workforce Planning project along with Bradford and Middlesbrough DAATs. This study was undertaken by Cranfield School of Management and provided us with extremely helpful information regarding the size and image of our sector and its recruitment and development requirements. This then started to inform a Workforce Planning and Development Strategy which was born in April this year complementing the individual Sussex DAAT strategies.

The Workforce Planning and Development Group is responsible for overseeing the implementation of the strategy, so my personal challenge is to make sure systems are put in place and co-ordinate activity to help our sector to recruit, train and retain the workforce more successfully.

One large project I am currently overseeing is the implementation of the City and Guilds Progression Award in Community Justice – Drug and Alcohol Services, at two of our local colleges. This course forms part of the training completed by NTA apprentices and has been successfully running as a standalone course in the West Midlands, and they have helped me to make it a success in Sussex. At last we have a part LSC funded educational programme for people looking to work and volunteer in the sector and information to provide to those wishing to work in the field.

Another major demand of my job is to take part in service contract reviews and contract tenders to assess whether their HR and training systems are in line with our expectations. I am responsible for collecting the quarterly workforce data required by the NTA, much to the relief of our commissioning managers. I analyse and compare this data across Sussex, which provides the DAATs with interesting and useful feedback on how our services are managed.

The Workforce Strategy can be viewed at www.eastsussexdaat.org.uk and www.westsussexdaat.co.uk

Fact file

Service User Groups

This issue: Clair McDaid from

The Roundabout User Group

When and why did you start your group?
We all met while on a structured day programme, which closed due to loss of funding. We wanted to continue supporting each other and others suffering with alcohol and substance problems. The DAAT funded a church hall and tea and coffee. We began meeting once a week, but after three months we had lost 11 of our 14 members so Jason Smith and Andy Hall and myself began meeting at each other's houses to keep the group going. We heard one of our members had died of an overdose, which made us even more determined to keep the group running. In November 2004 the local DAAT contacted us to help us re-establish the Roundabout User Group. We moved into our office February 2005 and have been going from strength to strength ever since.

How many members do you have?
We currently have a team of two part-time paid staff and three volunteers, with around 20 members who regularly use The Roundabout.

How did you obtain funding?
We were approached by the DAAT, which with initial support from DIP offered to fund an office, equipment and later, two paid part-time 'user co-ordinator' posts. They are also funding training for all staff and volunteers, as well as support.

Where and how regularly do you hold meetings?
We have offices in St James House, 1st Floor, St James Square, Grimsby. We're open Mondays, Wednesdays and Thursdays, 10.30am to 3.30pm with drop-ins running between 11.00am and 1.00pm. We have a mobile number, which is available 24 hours a day, and we will always phone clients back, so they are not out of pocket. We also provide email support.

What do you hope members get from attending?
Our members get comfort and support and feel valued and part of something. They enjoy speaking to people who have had and have addictions and have been through the services, as they feel they understand better. They feel it's a non-judgemental environment where they can be themselves without repercussions and prejudice. It also improves their confidence and provides a new network of friends, as well as advice and information on triggers, safer injecting, treatment, budgeting, health, training and housing.

How do you keep it going?
We have designed our own leaflets, posters and business cards, which we have circulated to all local service providers, shared care, pharmacies, D.I.P, Addaction, Salvation Army and Harbour Place Homeless Day Centre, housing associations, community centres, job centres, hospitals and C.A.B. We also have regular drop-ins and do outreach work to attract new and hard to reach members, and are currently expanding outreach to rural areas. We are also in the process of designing our own website and newsletters.

What have been your highlights so far?
We've had many highlights, including being part of the treatment planning process, regularly attending meetings such as Models of Care, Drug Task Group, Regional Users Network Forum, D.I.P., Addaction's PAC meetings as well as reviewing The Junction's (local service provider) service agreement and the specification for the new Structured Day Programme. We've also been able to, with the combined help of Addaction, Probation, and DAAT, provide gym passes to our clients and, thanks to D.I.P., an allotment where clients have their own plot of land and can cultivate crops. Both of these are great for our members, as it gives them other hobbies and activities to fill their time. We've also linked in with Addaction's women's and men's groups, which have such activities as a beautician, trips to the hairdresser's, confidence and triggers groups and trips out like bowling. Other highlights are being able to help clients into treatment and help them when they're experiencing problems with treatment, housing *etc,* which is the most rewarding. We also arranged a Christmas buffet for all our members.

How do you communicate with your members?
We communicate face-to-face in drop-in sessions and outreach work, and stay in contact via phone, text and email. We also meet clients who are wary about coming into the office in town, for coffee. We also go out and speak to users on the street and at other centres.

Have you any tips for others starting a user group?
I'd suggest to anyone interested in starting a user group to approach their local DAAT for help with funding a venue, equipment, expenses and support, and also contact your local NTA representative for help and advice. I'd also say recognise the fact that members will come and go, due to a number of problems faced by using. However, stick with the group as you will get new members. Starting a user group is not about statistics and the number of people attending, but about supporting and helping the members you do have and making services better. I'd also say listen to users and ask them what they want out of a user group – and don't be afraid to speak up on their behalf when something is wrong or isn't working. I'd also say take time to visit other user groups; this will give you ideas and help in setting up your group and different ways of funding, as well as showing you different structures and activities, groups and ways of working with agencies.

East Kent NHS
NHS and Social Care Partnership Trust

Careers in healthcare across East Kent.

CANTERBURY

Highly Specialist Cognitive - Behavioural Alcohol Therapist (*)(🚗) - Ref: R419

• Band 7: £24,198 - £35,527 p.a.

We are looking for an experienced and enthusiastic individual to plan, implement and deliver Cognitive-Behavioural Interventions within our multi-disciplinary and multi-theoretical team.

Joining a team, which delivers alcohol services across East Kent, you will need experience in the addictions field, a core professional qualification and able to show evidence of a commitment to working with this client group. You will need to have Diploma level qualification in Cognitive Behavioural approaches, or be working towards such a qualification. You will manage your own caseload of clients.

This requires the ability to conduct treatment in individual, group and family settings coupled with the ability to work collaboratively with partners in other agencies. You will be based at the Headquarters of Mount Zeehan in Canterbury, but will be required to travel to our satellite clinics across East Kent. You will need to demonstrate an ability to balance autonomous working with effective teamwork.

For an informal chat call Bill Reading on 01227 761310.

Completed applications by: 30th January 2006.

TO APPLY:
We encourage applicants to apply on-line - go to www.jobs.nhs.uk and click on employer list. Alternatively contact our 24-hour recruitment line on 01227 812244 quoting the above reference number, or write to the Recruitment Team, Personnel Consortium, EKPT Headquarters, Littlebourne Road, Canterbury, CT1 1AZ.

The Trust positively welcomes applications from people who have experienced mental health problems.

We are in the process of implementing Agenda for Change

(*) Employment in this post is subject to a satisfactory Enhanced Disclosure from the Criminal Records Bureau. (🚗) Car owner/driver essential, subject to the provisions of the Disability Discrimination Act (1995).

For other job opportunities visit our website
www.ekpt.nhs.uk

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Substance Abuse Subtle Screening Inventory

The psychometric test which identifies substance misuse problems even in clients who are unable or unwilling to acknowledge the existence or symptoms of a problem

adult and adolescent versions

identifies – analyses – engages – motivates

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This course has been mapped to the DANOS standards and can be found on the DANOS Learning Resources Database. It helps people develop their knowledge, skills and competence in the following DANOS units: AA2, AC1, AF, AG, AI1, AI2, AJ, BA, BB1, BC, BE, BG1, BG3. BG4, BI2, BI4, CA, CB,

RAPt

REHABILITATION for ADDICTED PRISONERS TRUST
'STOPPING ADDICTION, STOPPING CRIME'

RAPt, one of the country's foremost providers of drug treatment services in prisons are currently looking for staff in the positions and locations listed below. At RAPt we offer a generous employment benefits package including work-related clinical supervision allowance, competitive annual leave entitlements, a contributory pension scheme and comprehensive training opportunities.

Treatment Manager: The Island Day Programme, Tower Hamlets

Starting Salary £29,500 (plus £1,000 London Weighting)

We are looking for a Treatment Manager for our primary rehabilitation programme at The Island Day Programme. You will need experience of working in a primary addiction programme and have a thorough knowledge of, and commitment to 12-step drug treatment and knowledge of other addiction approaches. A recognised counselling qualification and experience of clinical supervision of others is essential as is previous experience of working within the drugs and/or criminal justice field. You will need to be highly motivated, efficient and determined, with the ability to work in a challenging environment. If you would like an informal discussion regarding this post, please contact Dave Mulvaney on 0207 587 3033.

Counsellor: HMP Littlehey, Cambridgeshire
HMP The Mount, Hertfordshire

Starting Salary £21,000 (plus £1,000 London weighting for HMP The Mount)

We are looking for counsellors to join our teams at the above establishments. To be successful, you would need to have a thorough knowledge of, and commitment to 12-Step. Counselling qualifications and experience are essential, with experience of working with addicts desirable. Some level of training will be provided for staff with limited experience of working with this client group. You will also need to be efficient and determined, with the ability to work in a challenging environment.

Community Drug Worker: RAPt Criminal Justice Services Southwark

Starting Salary £21,000 (plus £1,000 London Weighting)

An exciting opportunity has arisen to work with our Drug Intervention Programme team in Southwark, South London for someone with experience working in the criminal justice and/or substance misuse field. The post holder will provide continuity of care services including assessment, care planning and engaging service users successfully into treatment. For this position, the successful candidate will be asked to apply for a CRB Enhanced Disclosure. Further information about the disclosure service can be found at www.disclosure.gov.uk

CARAT Worker: HMP Bullingdon, Oxon (1x full time, 1x part time)
HMP Winchester, Hants

Starting Salary £21,000

We are looking for CARAT workers to join our teams at the above establishments. For these positions, a good understanding of the drugs field and experience of working with this client group is essential. Previous experience and a clear understanding of the CARAT system are also desirable. You will need to be enthusiastic and very determined to be able to work within the challenging environment of a prison.

If you are interested in any of the advertised positions and would like to receive an application pack, please send an SAE for 45p to Mandy Coburn, RAPt, Riverside House, 27-29 Vauxhall Grove, London, SW8 1SY, clearly stating which position you are interested in.

Closing date for completed applications: Monday 30 January 2006

RAPt strongly encourages applications from Black and Minority Ethnic individuals and from those in recovery from addiction.
NO AGENCIES PLEASE www.rapt.org.uk Registered Charity no. 1001701

.focus futures

Focus Futures is part of the UK's leading social investment agency, Prime Focus and contributes real help daily to improve the lives of those experiencing disadvantage. It also provides affordable housing and practical support to people experiencing difficulties relating to unemployment and poverty.

Senior Worker

Older Homeless Tenancy & Alcohol Support Team Birmingham

Circa £19,000 depending on experience • 39 hours

An opportunity has arisen in an interesting and varied role supporting people who are experiencing tenancy difficulties relating to alcohol use or those aged over 45 who have a history of unsettled living and require support to maintain independent living.

Working well with a wide range of people, you will lead and manage a team supporting up to 80 clients in both supported accommodation and independent tenancies. Your goals will be to concentrate on the individuals and the skills required in sustaining accommodation and building community networks.

Experience in housing management and working in a relevant support setting along with the ability to work on your own initiative while supporting and motivating others is essential.

If you can make a real difference please contact Marie Boardman for an application pack on 0121 233 6370, email marie.boardman@focus.co.uk or download an application form from www.focus.co.uk.
Closing date for applications: 27th January 2006.

We strongly encourage applications from all sections of the community and require all our employees to be committed to equal opportunities

NEED A FIX?

How do you keep your workforce up to date with the latest requirements of:

- National Occupational Standards
- Every Child Matters
- Diversity legislation?

How do you ensure that they learn the latest on group work interventions using CBT, Child Protection, and emerging best practice in relation to addressing sexual offences with young people?

FIX - the Factual Information X-change is the new name for In-volve's training service. In-volve has over 15 years experience of providing accredited training for professionals on drugs and alcohol issues.

FIX trainers deliver high quality, up-to-date training for those working in the drug and alcohol field to support professional development and enhance service provision. **All courses are mapped to DANOS.**

To find out more, see the insert in this issue, check out www.needafix.org or email: Training@in-volve.org.uk

Challenging Addiction

At Phoenix House we're in the business of helping substance misusers rebuild their lives. Our innovative range of services includes prison projects, community based initiatives and holistic rehabilitation programmes across the country – and we are continually developing and extending our expertise to meet the changing needs of our clients.

In a recent procurement exercise with Her Majesty's Prison Service, Phoenix House won a number of contracts to deliver drug treatment services. In partnership with the London Area Office we are looking for a number of Drug Workers for our rehabilitation units at HMP Pentonville, a category B Prison that houses around 1,200 men, and HMP Brixton, also a category B Prison housing around 750 men. Have you got what it takes to join us at these key projects?

PRISON DRUG WORKERS – REHAB

£22,427 – £25,370 • HMP Pentonville and HMP Brixton

Working as part of the drug rehabilitation Prisons Addressing Substance Related Offending (PASRO) team, you will carry a challenging personal caseload working directly with offenders, both individually and in groups. You will deliver the programme in accordance with HMPS directives whilst drawing on your own skills, knowledge and experience to get the best out of the client group. Previous experience of working within rehabilitation, treatment and re-offending prevention services would be beneficial. PASRO training will be given. The starting salary for this post is £22,427 or £23,015 depending on experience. The higher salary in the range can be achieved through annual performance appraisal.

Along with an attractive salary, you will receive a first class range of benefits including a final salary pension scheme, generous holidays and ongoing training designed to support your personal and professional development.

For further information or to download an application pack and job description for this role please visit www.phoenixhouse.org.uk or email Hasna.begum@hmps.gsi.gov.uk Alternatively telephone Hasna on 020 7023 7045 please quote Ref: PBHB1. Closing date: Monday 30th January.

phoenixhouse
www.phoenixhouse.org.uk Rebuilding Lives

Committed to a policy that promotes equality and diversity
Charity registration number: **284880**

Addiction Counselling Trust

A Company Limited by Guarantee No. 3164431 & a Registered Charity No. 1054524

Counselling Supervisor (Ref: 5275)

£28,630 to £30,993 per annum pro-rata 28 hours per month

This is an opportunity to provide clinical supervision to ACT's salaried Tier 2 and Tier 3 Substance Misuse Workers. The successful candidate will have experience in integrative supervision and a good knowledge of substance misuse issues.

Closing date for the above post will be 10th February 2006
For an application pack please contact Nicola on 01296 425329.
For further details on this post contact James Sainsbury.

Substance Misuse Worker

High Wycombe, Buckinghamshire £19,922 to £22,076 per annum

ACT is the principal provider of non-statutory substance misuse services in Buckinghamshire. This post will provide substance misuse counselling/support, as well as advice and information, group work and assessments within a multi disciplinary team.

Application closing date is Monday 30th January 2006
For an application pack please contact Nicola on 01296 425329
or email Nicola@addictioncounsellingtrust.com

PROVIDENCE PROJECTS
Helping you find the way

Full Time Therapist/Drug and Alcohol Worker

The Providence Projects were established in 1996 and are leaders in the field delivering quality detoxification and full 7 day week treatment services via a Quasi-Residential setting. Our seven 'Sober Living Houses' have 24 hour cover and are overseen by our accreditated PSP (Providence Supporting People) team.

Due to on-going expansion, **The Providence Projects** *- Pioneers of Quasi Residential Treatment Services - are looking to recruit a fully qualified and accreditated drug and alcohol therapist. An exciting opportunity exists to join our new state of the art centre in Bournemouth. The successful applicant will need to be experienced in the delivery of 12 Step abstinence based treatment and be proficient in case management, one-one counselling interventions, group work and the delivery of workshops. Literary skills are important as all interventions must be evidenced.The successful applicant needs to enjoy working as part of a multidisciplinary team and be flexible to the needs of our diverse client group and programme.*

Salary open to negotiation and dependent upon experience and qualifications.

The Providence Projects are an equal opportunities employer.

Please send you C.V. or ask for an information pack:
Steve Spiegel,
The Providence Projects,
Henley Court,
32 Christchurch Road,
Bournemouth,
BH1 3PD

T: 01202 555000 *F: 01202 555100*
E: info@providenceproject.org *W: www.providenceproject.org*

Award winning tv production company **betty** is making a documentary for Channel 4 focusing on Intervention therapy. The aim is to help families and addicts turn their lives around through Intervention and subsequently, treatment. We will tackle this film in a sensitive way as we try to shed light on the subject of addiction and the options for the families and friends who suffer.

We would like to speak to you in confidence about anyone you feel might benefit from taking part in this process. The behaviour could involve alcohol, drugs, gambling, compulsive spending or sexual addiction.

If you know anyone in this situation or wish to find out more about the project email rebecca@bettytv.co.uk or call Rebecca at 0207 290 0660.

Please mention
Drink and Drugs News
when responding to advertisments

Lighthouse project

"Reducing harm caused by substance misuse"

Lighthouse Project is one of the leading providers of services to substance misusers, and those affected by substance misuse, in the UK. Established for over 35 years, we are one of the largest independent drugs agencies in the North West.

HOPE STREET

SUBSTANCE MISUSE WORKER

£20,295 – £22,512 per annum (Sp Pt 26-29) – Ref: SMW001

To act as duty officer, being the first point of contact for individuals presenting to the Project. You will undertake initial assessments and formulate effective care plans. With responsibility for a caseload of clients you will deliver a range of Tier 2 interventions, working closely with colleagues in ensuring the provision of effective and holistic services.

SYRINGE EXCHANGE/DUTY OFFICER

£20,295 – £22,512 per annum (Sp Pt 26-29) – Ref: SED002

To take overall responsibility for the operation of the syringe exchange, providing clean injecting equipment and advice in respect of harm reduction and a range of health and social issues. You will also be included on the duty rota, acting as first point of contact for drop-ins, undertaking initial assessments and offering appropriate advice and support.

LIVERPOOL & SOUTH SEFTON

SHARED CARE WORKER X 2

£20,295 – £22,512 per annum (Sp Pt 26-29)
Liverpool – Ref: SCL003, South Sefton – Ref: SCSS004

To carry a caseload of opiate using clients, offering a range of interventions to support them in addressing their substance misuse. Working in partnership with GPs, you will plan and manage effective packages of care, undertaking assessments, formulating care plans and referring to other, appropriate services to support and facilitate clients in making positive progress towards achieving stable lifestyles.

SOUTH KNOWSLEY

INTERMEDIATE SHARED CARE WORKER

£20,295 – £22,512 per annum (Sp Pt 26-29) – Ref: ISC005

You will manage a caseload of opiate using clients, offering a range of appropriate interventions. Responsibilities include planning, organising and managing packages of care for service users, in partnership with local Primary Care nurses and GP's. You will also manage and be responsible for the care and support of a caseload of clients, the majority of whom will be working towards transfer to Primary Care Service.

For the above posts a formal qualification in the substance misuse field would be useful, although it is more important that applicants have experience of working with a drug service. Knowledge of the range of services and interventions is essential, as well as the ability to motivate and encourage clients.

CROXTETH

ADULT COUNSELLOR

£20,295 – £22,512 per annum (Sp Pt 26-29) – Ref: ACC006

To provide structured counselling in one-to-one and group work settings. You will also contribute to the overall work of the team by undertaking assessments, formulating effective care plans and working closely with colleagues to offer holistic packages of care to service users.

A Diploma in Counselling is essential for this post, as is experience of working in this or in a related field.

Lighthouse Project is an Equal Opportunities employer and welcomes applications from all sections of the community. We are committed to staff training and development in line with national occupation standards – DANOS.

To receive an application form and further details, please send a large s.a.e. quoting reference no. to: Lighthouse Project, 46-48 Mount Pleasant, Liverpool L3 5SD.

CV's will not be accepted.

www.lighthouseproject.co.uk

Lighthouse Project Registered Charity No. 519859

Applications must be submitted before midday on Friday, 3rd February 2006.

Adfam exists to raise awareness about, and take action to alleviate, the problems faced by families dealing with drugs and alcohol. Adfam is looking to recruit a:

FEMALE PART TIME SUPPORT WORKER

(Initially 6 months with possibility of extension)

Adfam - Holloway
£12,600 per annum (incl. LW) + 6.5% contributory pension scheme for a 21 hour week (Monday/Tuesday/Wednesday)

Adfam's Holloway Project is a dedicated criminal justice project working with families of women currently, or recently, held in custody who have concerns around drug and/or alcohol use. It aims to improve family resettlement prospects and reduce re-offending by offering family focused services that inform, educate and support – not only in terms of drugs and alcohol but also relationship/communication skills. The post holder will be required to provide a range of advice, information and support services as part of Adfam's Holloway project.

We are looking for someone who can demonstrate knowledge and awareness within the drugs/alcohol and criminal justice fields. This is a challenging yet rewarding post requiring a candidate with good listening skills and empathy to help and empower individuals. The position is subject to prison security clearance.

Closing Date: Thursday 26 January at 1pm
(NO Late Applications will be considered).
Interviews will be held on Tuesday 31 January 2006.

For informal discussion please contact Cristina Osorio on Tel: 07910 255542.

Application packs can be downloaded from our website at www.adfam.org.uk.

Alternatively, please phone: 020 7202 9443 or email: prisons@adfam.org.uk.

Charity Number 1067428

This post is advertised under Section 7 of the Sex Discrimination Act 1975.
No Agencies please.

Adfam
Families, drugs and alcohol

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Are You Looking For Staff?

We have a comprehensive database of specialist substance misuse personnel to meet your needs

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"The staff Solutions Action Management Ltd supplied to us in the form of a team of DiP consultants and Joint Commissioning manager, have proved invaluable in the preparation of the project plans to carry out needs assessments and development budgets and treatment plans/ documents for the NTA and Government Offices in consultation with the Swindon staff team. I would have no hesitation in recommending you and contacting you again in the future should we require staff to support our plans"

Drug and Alcohol Team Manager
Swindon Community Safety Partnership

Contact us today to discuss your recruitment needs:
020 8987 6061 or register online at: www.samrecruitment.org.uk

CRI

Crime Reduction Initiatives contributes to public safety by preventing crime and alleviating its worst effects. Specialising in services for substance misusers, women, young people at risk and ex-offenders, our dedicated team delivers high quality interventions, support and residential services.

Equinox

TACKLING DRUGS CHANGING LIVES

CRI and our partners Equinox have been commissioned to deliver an exciting new drug and alcohol service in Brighton and Hove. The service opens on 1st April 2006 and will deliver comprehensive Tier 2 and Tier 3 services across the City. We work in close partnership with the Substance Misuse Service who will be sharing our premises and ensuring that care and treatment is fully integrated. The services provided will include; Open Access Advice and Information, Needle Exchange, Drug Intervention Programme, Structured Day Care including DRR, Care Planned Counselling and an Ambulatory Detox for alcohol users.

We are passionate about delivering effective services that improve the quality of lives for those affected by substance misuse but are equally committed to protecting the community from the harm caused through drug misuse and offending.

This is a unique opportunity to transform substance misuse services in Brighton and Hove and to provide high quality and innovative care and support to our service users and the community.

Service Manager *(Ref MP176)*

Salary scale 43 – 47 (£33,808 – £37,100)

37.5 hours

We require a talented, enthusiastic and experienced manager to lead this service. Suitable candidates will have an excellent understanding of substance misuse and related offending, sound knowledge of the treatment and criminal justice systems and demonstrable experience of developing and managing a team effectively within a performance management framework. If you have a relevant professional qualification, this will greatly support your application.

Closing date: 6 February 2006

Interview date: Week commencing 13 February 2006

For an application pack and further information visit: www.cri.org.uk or call our recruitment line on 01273 523611 (24 hour answer phone) quoting the relevant reference number.

The successful candidates will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

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Safer communities through purposeful lives

Registered Charity No: 1079327

SAFER WOLVERHAMPTON PARTNERSHIP

SUBSTANCE MISUSE CO-ORDINATOR

Salary: £30,000 - £35,000 pa 37 hours per week

Safer Wolverhampton Partnership has responsibility for translating the National Drug objectives into effective local strategic plans, including the Crime and Disorder, Drugs Strategy and the Local Area Agreement. Safer Wolverhampton Partnership requires an enthusiastic highly skilled individual to build on existing good practice and partnership working arrangements.

Applicants should be a Senior Manager with a broad range of experience within substance misuse or a related field, with a thorough knowledge of the National Drugs Policy, and a proven track record of co-ordinating multi agency strategic partnerships. You should possess excellent communication and negotiation skills.

The post holder will require drive and vision to facilitate the further development and delivery of effective drug action in Wolverhampton.

This post is subject to an Enhanced CRB Check
Closing Date for Applications: Friday 27th January 2006
Interview Date: Tuesday 21st February 2006

For further information and an application pack please telephone 01902 371553 or 01902 371559 or write to Safer Wolverhampton Partnership c/o Wolverhampton YMCA, 29-31 Temple Street, Wolverhampton WV2 4AN
E-mail: hr-ymca@btconnect.com

EXTRAORDINARY JOBS
EXTRAORDINARY WORKPLACE

HM PRISON BEDFORD

Drug Facilitator – Full Time (37hrs per week)

Salary: £17,029 – £20,892 plus a Local Pay Allowance of £2,600 pa

A vacancy has arisen for a Drug Facilitator worker in HM Prison Bedford. Applicants should preferably have experience of group working within the criminal justice setting. Successful applicants will need to demonstrate a positive approach to rehabilitation orientation, have high levels of motivation and commitment, excellent problem-solving and communication skills, and be able to adopt a systematic approach. Full job description available on request.

Annual leave entitlement commences at 25 days per annum plus 10.5 days for bank holidays/privilege days.

Please download an application form from our website www.hmprisonservice.gov.uk under the current recruitment section or contact Bedford Jobcentre Plus, Wyvern House, 53-55 Bromham Rd, Bedford MK40 2EH or tel. Anna on 01234 361545.
Closing date: 20th January 2006.

Please note that all Prison Service posts are open to part-time and job-share applicants. Applicants are required to declare whether they are a member of a group or organisation which the Prison Service considers racist. The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age, sexual orientation, disability or any other irrelevant factor.

INVESTOR IN PEOPLE!

POSITIVE ABOUT DISABLED PEOPLE

HM PRISON SERVICE

Head of DAAT, West Sussex

Office Base Chichester

£46,755 to £49,779

WEST SUSSEX DRUG & ALCOHOL Action Team

We are looking for a proven leader to drive local implementation of the national drug strategy on behalf of the West Sussex DAAT Partnership Board.

West Sussex is a well established and leading DAAT with many good initiatives and systems in place. The new financial year brings additional funding to DAATs and it will be one of the most important and challenging times so far. The DAAT agenda overlaps with the work and plans of many organisations in West Sussex; therefore continuation of effective partnership work will be a prime function. You will lead an innovative and diverse team who commission and provide a range of well-respected services locally.

A professional qualification in a relevant subject area is essential; a management qualification is preferable. Proven effective management and leadership experience are essential to this role, as are people and financial management skills.

For informal discussion please contact John Leaver (DAAT Chair) on 01243 777661. For further information please visit www.westsussexdaat.co.uk

For an application pack go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 777503 (24 hour hotline). Please quote the advert reference number 5337.

Closing Date: 27th January 2006.
Assessment Centre: 24th February 2006.