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DDN
Drink and Drugs News

28 November 2005
www.drinkanddrugs.net

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Oxfordshire Service User Team

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A younger generation's perceptions of drug use

RELEASE

Release Drugs University V

CRIMINAL JUSTICE AND THE FUTURE OF DRUG TREATMENT IN THE UK

The Bill is now an Act

Friday 27 January

at the Royal Institute of British Architects, London

The year 2005 has seen some of the biggest changes in drug related legislation in modern history. The Drugs Act 2005 has introduced measures such as mandatory drug testing, and assessment for treatment without charge or conviction for any crime. The development of the Drug Interventions Programme increasingly situates the understanding of addiction within a criminal justice framework.

The conference offers a rare and exceptionally good value opportunity to see some of the most respected experts in the law, drug treatment and ethics. We have set the delegate fee at the very low price of £99 per person, including lunch, to make it a developmental opportunity for as many people as possible.

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- *Civil liberties – centuries to attain, only weeks to lose*
  Geoffrey Bindman, Founder and former Senior Partner, Bindmans
- *The Government's drug strategy - is it effective?* Followed by Q & As
  Vic Hogg, Head of Drug Strategy Directorate, Home Office
- *Prison and treatment rights*
  Dave Marteau, Prison Health, Department of Health
- *You had it so good until you tried to be like us*
  Ethan Nadelmann, Executive Director, Drugs Policy Alliance, USA
- *Hepatitis C – a sleeping giant with legal implications*
  Prof. Graham Foster, Consultant Hepatologist, The Royal London Hospital

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drugs and alcohol today

Pavilion

Date: Wednesday 5 April 2006 **Venue:** Business Design Centre, London

This one-day event, comprising a full and comprehensive conference programme and a large exhibition, will provide a valuable opportunity for everyone involved in the sector to come together to debate the big issues, share best practice and network.

Seminar topics to include:

- anti-social behaviour
- young people
- local alcohol strategies
- testing – how to use results and understanding results
- preserving relationships and protecting children
- social work – drugs and alcohol
- treatment effectiveness.

For further information call Pavilion's customer service team on 0870 890 1080
or visit www.drugsandalcoholtodayexhibition.com

"The exhibition was an extremely lively event and was a great chance to meet people from all areas of the field. It'll certainly be on our calendar for next year."

Claire Brown *Editor*, *Drink and Drugs News*

Tickets:

£20 inc VAT in advance
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M-1037-11-05

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RELEASE

SMMGP

Drink and Drugs News

28 November 2005

Editor's letter

Going up to Gloucestershire for the Substance Action Groups' county conference last week proved to be a value-packed experience.

London conferences are obviously easier for me to get to, but getting submerged in a local event has a different climate. Not only was the networking more immediate in an everyday-useful kind of way, but there was a logic to knitting together services and creating dialogue between service providers, co-ordinators and users in the area.

I was struck by the need to shout louder on issues raised at workshops. At London conferences backed by the Home Office or the NTA, there's likely to be a politician present, who might even stay for questions. But delegates in Cheltenham wanted to know why none of the local MPs had thought it important enough to be there.

Our workshops had raised issues relating to young people, alcohol and dual diagnosis that could make a difference to local planning and funding – issues that would now need to be consigned to a letter to the local constituency office, instead of delivered through the reasoned and impassioned arguments of people who worked with these issues each day and needed the acknowledgement that someone with political influence could take them forward.

For me, the conference was a snapshot of what's happening in the area and opened a new line of enquiry on young people's attitudes. Our cover story on page 8 looks at Michelle Duffin's study of young people's perceptions from a series of questionnaires and focus groups in three different areas of the country. The study highlighted the important role schools and colleges play in getting useful information through to young people, and we will be following up what seems to be effective in drugs and alcohol education in future issues.

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Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Printed on environmentally friendly paper by the Manson Group Ltd

Cover:
David Hoffman Photo Library

In this issue

Notes from the Alliance – Methadone and beyond

We have to be honest about open access to all, if we're ever going to make headway with user involvement, says the Alliance's Daren Garratt.

Why is it that whenever you talk to drug using peers about the noble art of user involvement, some of them will dismiss it as a false, tokenistic exercise that only throws up barriers to active participation? Why do they tell you tales of how their local worker has actively campaigned to exclude them from local or regional involvement, or of how they have found that they've been unable to work effectively with their local user group because their own user status or philosophy is at odds with its core members?

It's because we need to be honest and acknowledge that some local, regional and national mechanisms for involvement actually conspire to exclude users from getting involved.

We need to accept that the reason some users feel discriminated against is not because of a blanket policy that forces ALL users to jump through ever constricting hoops, but because they're the victim of a personalised campaign aimed squarely at them.

We need to be open about how the theory of 'open access to all' is never going to be as straightforward in practice, particularly when one considers the personality clashes, histories, conflicting agendas and threats to burgeoning career opportunities that influence and shape this arena.

How, for example, do we effectively challenge user and advocacy groups that exclude users who've never actually approached them to join?

How do we support or question a group's decision to exclude a user if they operate without terms of reference or a constitution and fail to keep minutes that document the process that enabled them to arrive at their course of action?

How do we work with 'open' meetings that suddenly talk of membership when an ex-member they've had run-ins with requests access to information?

How do we protect users and workers from the negative personal and professional impact that unsubstantiated and defaming accusations, smear campaigns and rumour can have on an individual's health, wellbeing and future career?

How do we even begin to address these issues if we suspect that it's actually a worker that is allowing this bad practice to continue because they've got an issue with someone they used to use with? Someone who knows aspects of their past that they don't want to be reminded of now that they've crossed the threshold of respectable, long-term employment?

It's bad enough when fellow users do it – and I'm sure we can all cite numerous instances of that – but when it's a professional it leaves a really bitter taste in the mouth.

This is certainly not a criticism of workers or a facile 'them and us' rant, because the Alliance is very aware of the many fantastic initiatives that are being rolled out nationally, and we will always be a champion of such inspiring practice.

This is an honest observation about the problems that can arise when you throw people into the theoretical mix, and it is important to acknowledge that this does happen.

Personalities, prejudices and pasts can and do influence our decisions and interactions.

It's true, however uncomfortable that may seem.

However, when our prejudices inform our practice, that becomes discrimination, and that is unacceptable.

The Alliance is in the process of developing a national model that will result in increasing numbers of local users acting as advocates in their own town, county, city, district and region, with people they will undoubtedly have had histories with. Personality issues are very real and pertinent fears for us and we need to establish mechanisms to ensure that everyone – whether user or worker – is protected.

Addiction charity takes aim on binge drinking

An alcohol campaign has been launched by Action on Addiction to get health professionals involved in tackling the 'national health crisis' of binge drinking.

The charity has put forward policy suggestions to government that it hopes could have a significant impact on drinking habits in the UK. It recommends providing funding for an alcohol nurse or workers in every hospital, as up to a third of admissions to Accident and Emergency are alcohol related, and brief interventions have been shown to be very effective for non-dependant drinkers.

In a different approach to taxing alcohol, the charity suggests that tax should be based on the alcohol content of the drink – a suggestion based on research in Australia, where introducing tax based on alcohol percentages, combined with introducing cheaper lower alcohol alternatives, was shown to be effective in switching drinking habits, even among heavier drinkers.

The third strand of the campaign is to test the effectiveness of warning labels on bottles and advertising, by using four key health warning messages – research that has not been done in the UK before.

Supporters of the campaign include experts and clinicians from universities, the National Addiction Centre, the Royal College of GPs and the Institute of Alcohol Studies.

Lesley King-Lewis, chief executive of Action on Addiction said the campaign was in response to nearly 100 medical conditions associated with drinking too much, which cost the NHS nearly £1.7 billion per year. Through directly targeting health services instead of just alcohol related disorder, the charity hopes to change Britain's reputation for having the worst teenage drink problem in Europe.

Campaign will sting underage alcohol sales

More than 5,000 sting operations will take place in the run up to Christmas, targeting sales of alcohol to children.

The crackdown, which involves £350,000 being awarded to trading standards officers by the Home Office, is part of the government's £2.5 million blitz on alcohol fuelled disorder, that accompanies last week's change in licensing laws.

From 24 November, convicted licensees will be liable for a £5,000 fine and licences could be suspended, altered or revoked.

Young people will themselves face sanctions of a £50 fixed penalty notice and a fine of up to £1,000 on conviction.

Home Office Minister Paul Goggins said 60 per cent of shops and supermarkets failed in a recent sting operation carried out by Nottingham police, and warned shopkeepers and licensees that they could expect an undercover visit from trading standards and police over the festive period.

Ron Gainsford, Trading Standards Institute chief executive, said that retailers who flouted the law could expect to be dealt with severely. He advised them to always ask to see a PASS approved proof of age card.

NTA launches first care planning toolkit

The first national care planning toolkit has been launched by the National Treatment Agency, to help drug workers improve clients' journeys through treatment.

Dr Emily Finch, NTA clinical lead and author of the toolkit, recognised that current practice was variable and said the toolkit offered a framework for developing and reviewing care plans in partnership with clients. It would also ensure that there was 'constant progress in terms of their drug and alcohol misuse, physical and psychological health, social functioning and criminal activity', she said.

Urging everyone in the sector – service users, carers, drug workers and commissioners to take part in the consultation, Dr Finch said this was 'a real opportunity to influence an essential part of drug treatment'.

The toolkit includes a set of proforma documents that can be adapted for use by drug treatment services, and is in line with the newly updated Models of Care framework. The NTA is asking for feedback on a range of issues, including accessibility, applicability, and service user and carer involvement in care planning.

The consultation version of the toolkit and consultation questionnaire are available on the NTA website at www.nta.nhs.uk. Responses should be sent to consultation@nta-nhs.org.uk by Friday 27 January 2006.

The Federation of Drug and Alcohol Professionals, Conference 2005

The bigger picture

We need to learn to live with drugs, because the one thing we know is that psychoactive substances are here to stay, Professor David Clark told FDAP conference's 'Future Vision' session.

Looking at the history of drugs was essential, 'because you see things cycle'. Griffith Edwards had written about drug ecology systems: 'if you tweak one part of a system nothing may happen. You tweak another and you get a ripple'. Prof Edwards had also considered how we build a climate of acceptance, which was 'very relevant to what's happening with alcohol in this country at the moment', according to Prof Clark.

With 1.8 million people drinking at harmful levels, the increase in chromic liver disease was just one reflection of alcohol-induced harm.

Prof Clark's team at the University of Wales had studied binge drinking in female students and found that 66 per cent of subjects drank above the government's weekly limit – many of them 'way above it'. Almost half of them got drunk more than once a week, and a quarter reported that their drunken behaviour concerned them many times. A third said drinking affected their work.

Stresses in society and the tendency to settle down and have a family later in life were contributing to trend of taking the university drinking culture to their working lives. The government was missing this transition to heavy drinking in middle age through the concentration on 'yob behaviour', said Prof Clark. The climate of acceptance, combined with marketing of new forms of alcohol and 'the complicity of government which some people think exists' was bringing us close to a 'tipping point' in terms of alcohol use in our society.

In looking at the future of drug use, Prof Clark contrasted the government's figures on reduced drug use among young people since 1998, with Prof Neil McKeganey's bigger picture: the recent 'small trend' compared to 'the massive increase that's been happening over a longer period of time'. This was influenced by the traditional gender gap narrowing, as more women started taking drugs; people using earlier and staying in the system longer; and a massive increase in use in rural areas, particularly in Scotland. Prof McKeganey predicted that in 20 years time we could be looking at 1 million problem drug users; 6,000 drug-related deaths a year and 400,000 people being diagnosed positive for Hepatitis C, said Prof Clark.

But looking at the future was not all negative. 'Society in this country has produced changes,' he said, drawing on the example of smoking. 'Government has worked in partnership with industry and there's been a massive change in culture.' The same now needed to happen with alcohol, he said.

NTA political champion

Attempting to predict the future is a difficult game, as there are so many factors beyond treatment, said Russ Hayton, clinical and service governance manager at Plymouth DAAT.

The pendulum had swung away from maintenance prescribing in the 1980s, then back again in the 1990s, with increased funding and high dose prescribing of methadone.

The NTA had arrived as political champion of the field, bringing better access, improved joint commissioning, more reliable standards and practice, and 'the crucial entry of service users into our professional arena'.

Legislation, on cannabis and mushrooms for instance, illustrated the 'rather mad world we work in'. The demand for drugs and alcohol would continue in the future, influenced by availability and technology. It may be possible to root out genes for addiction in future, or to be vaccinated 'to ensure no pleasure from drugs or alcohol at all', he suggested.

Drug testing was likely to increase in the future, with testing technology likely in many public buildings. But sensitive technology increased the likelihood of us all testing positive, he suggested, because we all had contact with the outside world.

The 'war on drug use', increasing since the 1950s, had become a continuing war on drug users, according to Mr Hayton, and was more about 'a delusory belief system which enables governments to feel good about what they're doing to fight the drug problem'.

The drugs profession stood in a difficult place, between a tolerant approach and the expectations of government and society.

'It's up to us to interpret that role sensitively and creatively and act with integrity,' he said.

One of his greatest hopes for the future was that the existing social exclusion and stigmatisation of users would be tackled effectively: 'treatment must develop better routes into mainstream society if we're going to succeed in coming years,' he told conference.

Commissioning is amateurish

The state of commissioning must change in future, Ian Robinson, chief executive of EATA told conference. 'At best it's under-developed and at worst it amateurish and damaging to services and clients.'

'Far too much money seems to have disappeared into layers of bureaucracy,' he said. While there had been massive investment in treatment services over the last five or six years, he was 'not sure whether all that money has been appropriately spent'.

Uncontrolled expansion of DATs was 'plainly ridiculous' when money should be going to frontline services, and we should be clear about what roles people were playing. 'Everyone has to show value for money, and I'm not sure that's always the case.'

With current levels of investment unlikely to continue, providers and commissioners had a responsibility to make better use of resources to deliver effective quality services.

Mr Robinson had heard too many examples of commissioners having little understanding of treatment types and costs. While there were good examples of commissioning, 'woeful examples' in many parts of the country were 'a damning indictment of the state of this element of the drug strategy, that should have been a major priority of the NTA and should have been improved by now'.

Lack of understanding about what it took to provide quality effective services did nothing for the NTA's treatment effectiveness strategy and showed equal disregard for the needs of clients, according to Mr Robinson.

The future for effective services lay in thoroughly trained staff and realistically costed contracts that were reviewed and revaluated regularly, without unnecessary re-tendering. Better commissioning was about partnerships and improving the purchaser-provider relationship, he said.

FDAP's annual Drug and Alcohol Professionals Conference was supported by Skills for Health and the Home Office Drug Strategy Directorate. Presentations can be found at www.fdap.org.uk

Media watch

Cocaine use in Europe has risen dramatically among young adults in Britain and Spain and is almost as widespread as in the USA, according to a new report. About 9 million people in the European Union – 3 per cent of all adults – have tried cocaine, while up to 3.5 million are likely to have to have used it in the last year and 1.5 million took the drug in the past month, the report found. 'Historically, cocaine was a fairly rare drug in Europe,' said Paul Griffiths, scientific co-ordinator for the European Monitoring Centre for Drugs and Drug Addiction, which published the survey. 'Now it is very visible in national statistics in these countries and our concern is there could be further diffusion in Europe.'
Reuters, 24 November

A man out walking his dog in a Dungannon park discovered cocaine with an estimated street value of more than £100,000. He took it to a local police station where it was examined and confirmed to be cocaine. Police Sector Commander Tom Sinclair praised the man's 'observance and prompt action' in taking a substantial quantity of a highly dangerous illegal drug out of circulation.
BBC, 17 November

Brighton and Hove has been named as one of 10 'scrutiny councils' which will be used to help government assess the impact of new alcohol licensing laws. One third of the city's 1,000 licensed premises have been granted extensions to their opening hours, but most pubs and bars say they will not use them all the time and many intend to stick to their existing times. Licensing Minister James Purnell said the feedback would help in looking at the effects on tourism, crime and health.
Brighton Argus, 24 November

A police operation to scan pub-goers for illegal substances has been hailed as a success by police in Wooton Bassett. A team of 18 uniformed and undercover police officers used a police drugs dog, as well as swab testing drinkers in a local pub. The operation led to several arrests, including a 15-year-old in possession of ecstasy. Inspector Mark Levitt said police would act quickly on the information they had gathered, to carry out raids in the next few days and weeks.
Wiltshire Gazette and Herald, 24 November

A teacher responsible for implementing her school's drugs policy has been banned from teaching for four years after police found heroin in her car. Portsmouth Police discovered 12 wraps of heroin in the woman's car, and a later search of her house revealed a further 12 wraps. The secondary school science teacher, who was responsible for the drug education programme, claimed she was delivering the drugs to her sister-in-law, a registered addict.
The Daily Telegraph, 19 November

Paul Goggins: The case for DIP

DIP has had some negative press for its dependence on criminal justice to get drug users into treatment – not least in our last issue, which reported a vote of no confidence in DIP at a recent FDAP conference debate. Drugs Minister Paul Goggins talked to DDN about the wider picture.

'There's a bit of a myth that you've got to be an offender to access drug treatment. In fact four out of five people who access drug treatment are not offenders. The vast majority are not going through the criminal justice route.

But of course, for those who are misusing drugs, and offending to feed their habit, there is an urgency, both for them and for the communities where they live – because they're burgling people's houses and they're thieving from them, and we want to stop that. We know that we can't stop that unless we can get them off the drugs.

So there's an obvious benefit to the individual drug misuser, but there is a wider benefit to society. It is a myth that you've got to offend to get the treatment, treatment waiting times have come down for everybody: four out of five people accessing treatment are not offenders.

It's absolutely vital that we achieve an integrated agenda. At every single conference I've been to and in every conversation I've had with people involving DIP and wider drug treatment, the issue of housing support is raised, and government is committed to providing more accommodation and appropriate support. But clearly there are still gaps there, and we've got to work hard to fill them. Unless we're supporting people with accommodation and with opportunities to train for work, they can't sustain the change that they're making in their lives – at least it's more difficult to sustain the changes.

Colleagues in the department of the Deputy Prime Minister are very aware of this, and they're working hard to deal with the issues of drug misusers. But in other groups too – ex-offenders, people with mental health problems, there is a range of need there and we're striving to meet it. It's complex and it's challenging, but we're determined to do it.

We're going to develop this still further with the introduction of testing on arrest. This is going to bring the opportunities for intervention at an even earlier stage.

It's always about making choices available to people: treatment if you want it – and come on, we'll help you. And well, if you don't, there'll be a consequence for you. But there's a real opportunity for you to change your life and your behaviour.'

'At every single conference I've been to and in every conversation I've had with people involving DIP and wider drug treatment, the issue of housing support is raised.'

Drug Interventions Programme First Race and Diversity Conference

DIP strategy 'more responsive'

The Drug Intervention Programme is well on the way to reducing crime, changing lives and giving confidence to local communities, said Drugs Minister Paul Goggins, whose portfolio includes policing, security and community safety.

Drug related crime was down and strategy was becoming more responsive and reflective, he told the Race and Diversity Conference. There were excellent examples of community engagement, both locally and nationally, which gave a very strong base to take the strategy forward.

DIP had rapidly become the main programme for working with problem drug users and it was vital that we were all closely involved in the development of DIP strategy. Many clients had not received treatment or support before they came into DIP, but there were still large numbers whom we were failing to reach, and who needed 'better understanding', said the Minister.

Treatments had a duty to understand issues of diversity, if DIP was to be responsive to needs. 'One size doesn't fit all,' said Mr Goggins, 'it means knowing and understanding communities... we are dealing with individuals with all their complexities.'

It was important to build diversity into commissioning, and recognise that we were not just dealing with young white male opiate users. Outreach was central to strategy, 'not waiting for people to come to you and talking in terms communities can understand'.

Proactively involving service users was equally important in developing services, said Mr Goggins, as 'user engagement has particular resonance from those who have been through the system'.

Local projects bring DIP strategies alive

Focusing on diversity would benefit all areas of the community, according to Kate Davies and Yaser Mir, of the University of Central Lancashire's DIP Community Engagement Programme.

'It can be wide and varied – and that's the joy of it,' said Ms Davies. Key areas included faith, khat use, sex workers, HIV and Aids, women's needs, mental health and dual diagnosis, prisoners' needs and domestic abuse.

Community engagement was not about endless research, but about changing national policy, creating regional partnerships and equipping volunteers with skills to work in the criminal justice field.

The university's progamme was getting 'fantastic support' from other organisations in helping ex-offenders to become community researchers, relating local targets to community needs.

Eleven pilot DIP projects were running throughout the country, such as work with Reading User Forum to look at the needs of Pakistani prisoners.

Working with ex users and offenders was a central part of the project, which was not just a research exercise, said Yaser Mir. Capacity building was more important than the glossy report at the end, and DIP and drug action teams were supporting initiatives around building the workforce.

Existing diversity strategies had been gathering dust on shelves instead of being implemented at local level. Local projects were making sure that the voice of communities was being heard by government.

Diversity must be central to DIP

Diversity is not just about Black and Minority Ethnic (BME) communities: 'It is not the domain of any particular group,' said Abd Al-Rahman of The Federation.

'It's about shared values,' he explained. This meant understanding what was similar and taking away paranoia, asking questions and learning from communities – a central aspect of any race and diversity strategy.

Equality and diversity were interdependent, and the race side of diversity was critical. Individuals from Black and Asian communities were more likely to be stopped and searched, more likely to be arrested, and represented a disproportionate part of the prison population. Home Office statistics showed a rise of 113 per cent in Black prisoners since 1994 and an increase of 75 per cent for Asian prisoners, compared to 34 per cent in White prisoners.

The success of DIP was to a large extent dependant on its workforce. 'There's still a lot of feeling around "what are you doing about it?" But it's about "what are we all doing?",' he said. DIP must be diverse enough to engage the clientele most likely to be represented.

Tackling diversity was more subtle than having a diverse workforce, 'though that's a good start', he explained. 'It's about more than race – it's about engaging with the service group.'

The area of diversity would not change overnight; it would take time, commitment and effort, and there was still a lot of fear about discussing race. It was a 'newish area' of a constantly evolving field but there were enough well-written guidance documents out there. 'What may be lacking is the drive and confidence to implement change,' he said.

DIP presented an excellent opportunity, according to Abd Al-Rahman. The Federation's role was to make sure that the programme took account of the needs of diverse individuals.

This house believes... A reply

I was dismayed to read the article in *DDN,* 14 November, in which after a debate held at the FDAP conference it was agreed that DIP has done more harm than good.

I hoped and believed that we had gone beyond such facile debates which do nothing to further the interests of clients. Yes of course we need a balance between public health and criminal justice type initiatives. But it is nonsense to suggest that the advent of DIP has tipped the balance too far towards criminal justice interventions.

Let us be clear that we as a sector have benefited greatly from the political and financial support provided through the drugs strategy. It is a myth that all of the new money has gone on DIP related programme activity, by far the majority of the funding has gone into the pooled treatment budget. Thankfully, we have moved away from the days where drug treatment was at the bottom of the pile in terms of funding priorities and where most services were reliant on HIV prevention monies in order to survive and provide vital services such as needle exchange.

Other areas of social care would welcome the level of financial and political support that the drugs sector receives. Just ask anyone working in the alcohol field who are regrettably fast becoming the drugs sector's poorer cousins.

It is clear that much of this support from the centre has been based on the arguments of reducing crime through treatment, an argument which the treatment sector itself was happy to perpetuate.

Politically some of us may be dismayed by some aspects of the government's agenda on crime, such as drug testing on arrest. But this should not prevent us from embracing the opportunities that have arisen in expanding the sector and working with an even greater number of clients who we have previously failed to engage with. Too many people in our sector act as apologists, happy to take the money but unwilling to accept where it came from and for what.

Treatment is treatment, and I believe it is a great insult to the many workers and services who work in difficult conditions, with often the most complex clients, to suggest that they are not delivering high quality and necessary services. Pressure should be placed on local drug action teams to ensure that services are readily available to all – regardless of their referral routes. All areas should have a full menu of services available for all clients in line with models of care. It isn't DIP which has created any perceived imbalance of service provision, but the poor management of available resources at a local level.

'I hoped and believed that we had gone beyond such facile debates which do nothing to further the interests of clients. Yes of course we need a balance between public health and criminal justice type initiatives. But it is nonsense to suggest that the advent of DIP has tipped the balance too far towards criminal justice interventions.'

Let us also look at what else DIP has given us. It has forced through the idea of care co-ordination, common assessment tools and most importantly aftercare – things which the NTA nationally, and DATs locally, had all talked about but failed to deliver on.

If DIP makes us wake up to the idea of client journeys through treatment, then it will have been all worthwhile. If we are able to access more clients and provide high quality end to end services to all who need them, then I for one will be happy.

Ian Robinson, chief executive – EATA

Talking dirty

I was upset to see your headline 'ex-prisoners need better support to stay clean' (*DDN*, 31 October). The opposite of clean is dirty and we do no-one any favours by degrading drug-users. Please, the proper description is drug free. Can we stop using clean as well as junkie – as professionals we should do better.

District Judge Justin Philips,
West London Magistrates Court.

The road to hell is paved...

Consumer rooms. Wet houses. Harm minimisation. Warm and welcoming environments, for drug users, funded with tax payers' money by local councils. So on and so forth.

Is it not a fact that such facilities enable the users who have become dependent, to continue to ravage their bodies, minds and souls, rather than empowering them to arrest the progress of the damage already done and subsequently, insofar as possible, recuperate? Of course the purveyors of such facilities argue that there is evidence supporting their claims of 'reduced crime'; 'safer streets', together with 'less damage to vulnerable users'.

Some readers may recall a documentary on a 'wet house', in South London, shown on Channel 4 some 12-18 months ago. Even allowing for dramatisation, anyone viewing it would be hard pressed to claim that the policies pursued by the founders, unless those policies included accelerating the deterioration of the residents, were in any way successful.

On the other hand 'programmes' such as that offered by Ron Hubbard, of whom I'm anything but a fan, seeking to wean the user away from the substances, which have the power to physically and/or mentally destroy the user, are dismissed for 'lack of scientific evidence'. The same could be said about AA. NA, and other self help groups, but we know they work. Those who query their effectiveness, may find enlightment in studying the long term and comprehensive research carried out by Harvard University.

Where, may I ask, can one find significant and independent, studies/research/evidence, to substantiate the claims for the success of consumer rooms etc – Claims made by those who enable users who have formed a dependency on their drug(s) of choice to continue to feed their addiction. It would be helpful if such evidence fulfilled the following criteria:

- Given that drug-related crime continues to increase, what objective and independent evidence of specific decreases in drug-related crime exists?
- What similar evidence is available to confirm usage reduction, thereby fulfilling the 'harm minimisation ' prophecy?
- The methodology of how such reductions were/are measured.
- The period of time over which it was measured.
- Subsequent follow-up procedures, that confirm or otherwise, whether the claimed reductions have been sustained.
- The number of areas where such research has been carried out, together with the number of areas, and numbers involved, where the facilities advocated already exist.
- The names of the independent bodies who monitored and audited the above.
- Where any such evidence is in the public domain.

The NTA emphasises the need for evidence based practice. I am of the opinion that practice based evidence, can be of equal, if not greater value in our particular industry. However for such evidence to be accorded respect, it should be independently verifiable.

It is my hope that the good intentions of those who clamour for public monies for ventures, such as that recently announced in a *Daily Dose* bulletin involving Barnet council, are willing and able to prove the efficacy of their claims. In the interim period, since the majority of clients in my private practice seem to stem from referrals and/or 'harm minimisation' programmes, I should be grateful for the efforts of those involved in the latter.

Peter O'Loughlin,
The Eden Lodge Practice

To the point

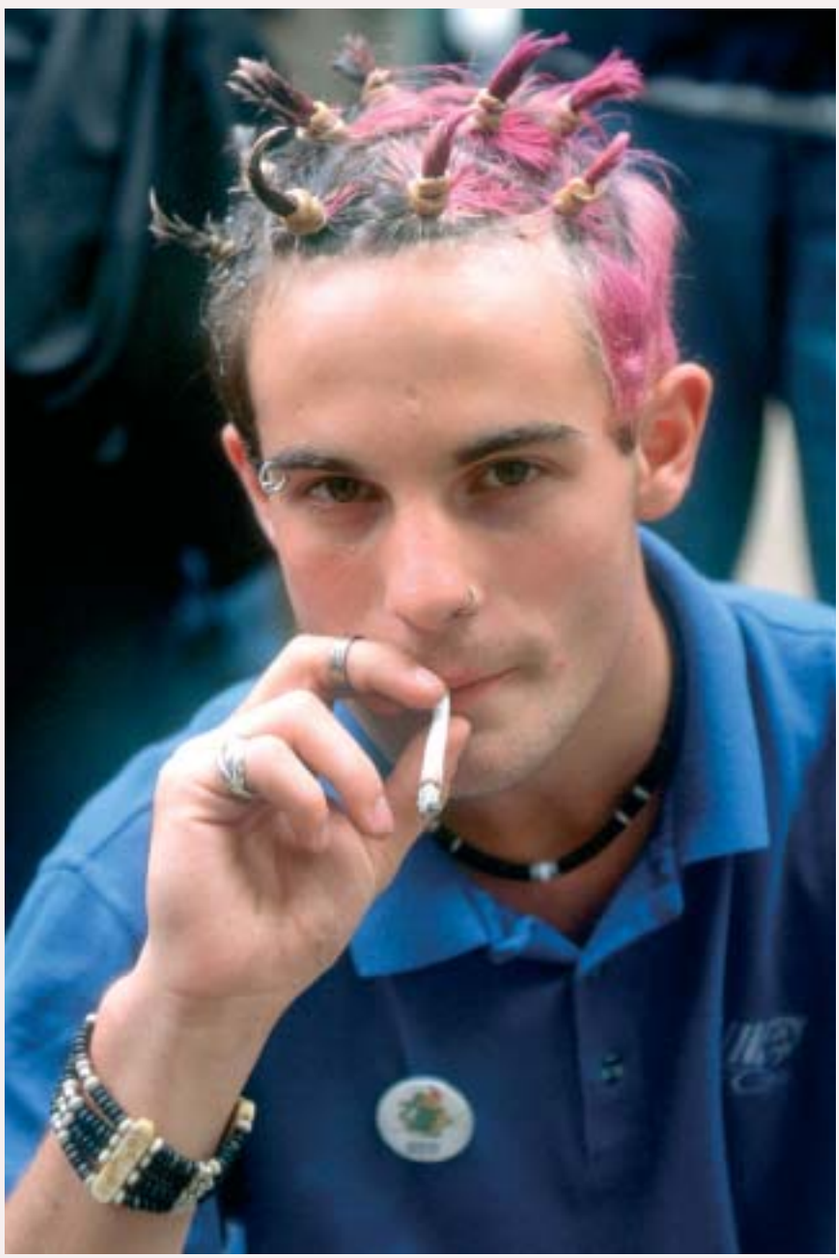
'Recovery nest'????? (Liz Cervio, Ad feature, *DDN* 14 November, in directory insert)

Pseuds' corner anyone?

Andy Maguire, by email

Editor responds: I should point out that, while we are very grateful for the support of our advertisers, we do not take responsibility for the content of articles marked 'advertising feature', which represent the advertiser's views and are not written by DDN.

Inside young minds



The most common reasons why young people first started using drugs and drinking alcohol, were out of curiosity to see what it was like, to be sociable or cool, to be like their friends, and on special occasions. Findings suggested that there is a positive drinking culture among young people.

Heroin and crack cocaine were regarded negatively by vulnerable young people, particularly if drug users shared injecting equipment. Sharing needles was regarded as high-risk behaviour which often leads to blood borne diseases such as hepatitis and HIV/AIDS. Injecting drugs was also perceived negatively by some young people who associated needles with 'dirty' drug users and 'tramps'. Heroin and crack cocaine were regarded as expensive and were often associated with criminal activity.

Some young people labelled crack cocaine and heroin as 'dirty' drugs and associated their use with committing acquisitive crimes such as burglary and robbery to feed drug addictions. They also associated heroin and crack cocaine with life problems, because of the way they are classified by law.

Interestingly, young people perceived alcohol more negatively than cannabis, because of its association with violent offences, drink driving and health implications. More generally, the use of alcohol (with the exception of those who did not drink alcohol because of religious beliefs) and cannabis was considered to be socially acceptable, although some young people understood that cigarettes caused more deaths than heroin and ecstasy. Young people from black and minority ethnic communities thought that smoking tobacco was one of the worst drugs – firstly because of its addiction, and secondly, because of the number of people that smoke.

Some young people commented on the mixed messages sent out by the government regarding the use of cannabis, and thought this influenced decisions to use the drug. Service providers in one area suggested that young people thought that using small amounts of cannabis would not cause them any long-term harm. The declassification of cannabis was thought to contribute to young people's perception that cannabis is not a dangerous drug, with reports that some believe cannabis is legal, largely because there is not enough publicity telling them otherwise. Several young people had fairly strong opinions about the legalisation of cannabis and argued that it should be legalised for those aged 16 plus. The benefit of using cannabis for medicinal purposes was also recognised, including its strength as a pain reliever.

The majority of nine to 12 year olds thought that it was wrong to use any illegal drugs and had a good knowledge of the negative impacts of drug use. Although 13 to 18 year olds also had extensive knowledge of the negative impacts of using drugs, benefits of drug use were also widely recognised.

There was an element of uncertainty among some young people about the negative impacts of drugs. Findings suggested that they have more negative perceptions of drugs than alcohol, and hold the view that drugs can have a more damaging effect on various aspects of life. In one study, 16 to 18-year-olds had already developed fairly strong attitudes regarding the effects of drugs and alcohol, whereas under 16-year-olds still had an element of doubt and were undecided about the effects of drugs on certain aspects of life – for example whether drugs and alcohol had a good or bad effect on relationships with friends.

Most young people felt that if something bad happened to a friend or family member, that would stop them from drinking alcohol and using drugs. Other events that would stop young people from drinking alcohol and taking drugs included: being kicked out of home, getting a job, being sent to prison and becoming ill from taking drugs and alcohol. Nine to 12-year-olds were more likely than 13 to 18-year-olds to agree that nothing would stop them drinking, because they don't want to drink anyway; this compares to 16 to 18-year-olds where more young people agreed with the statement 'nothing, because I enjoy it'.

Generally the likelihood of using drugs in the future increased with age for most drugs. Nicotine and cannabis were

Knowing more about young people's perceptions of drugs and alcohol increases the chance of communicating with them effectively with safety messages, says Michelle Duffin. Here she shares results of a research project on attitudes.

reported as more likely to be tried or used again in the future. Excluding these two drugs, less than 10 per cent of respondents intended to use drugs in the future (although a small number did intend to use amphetamines, ecstasy and cocaine).

There were mixed opinions among one group of young offenders regarding future use of drugs. Some thought that using drugs was part of growing up and that they would stop when they got older; however, a number of young people remarked that they did not have any intention to stop using cannabis because they enjoyed it.

Young people were questioned about their awareness of services and preferred information sources. More than half of them had heard of FRANK, highlighting the effectiveness of the 'Talk to Frank' advertising campaign. Connexions was also well known among young people and awareness of services increased with age.

The main sources for accessing information about drugs and alcohol were school or college, friends (particularly for the older age groups), parents or guardians, and the media – television, radio, magazines or newspapers.

Following school or college, parents or guardians were considered the most useful source of information regarding drugs and alcohol, particularly among younger age groups. The usefulness of friends as a source of information increased with age.

Young people were asked how they prefer to find out about drugs and alcohol; the internet and face to face were cited as the preferred methods and teachers, and in some cases drug workers, were documented as the most popular person to approach. More of the younger age groups (nine to 12 year olds) stated that they would like to find out information from their teacher, suggesting that the teacher is a trusted source of information for younger children and highlighting the importance of teachers providing information to this age group in school.

There was some evidence from consultation with vulnerable young people that suggested that they have a general mistrust of methods of confidentiality. For example, some young people would not trust the telephone because of call monitoring and recording; others would not trust speaking to somebody face-to-face, even when reassured of confidentiality, because they did not feel that they could trust them. Similarly, young offenders in one area were adamant that young people should go to their friends for help and advice, rather than to an agency or organisation where they would see someone they did not know.

When asked to consider how the onset of drug use could be prevented among young people, 'more diversionary activities, choosing your peer group more carefully, more police on the streets and stopping production' were suggested. Young people had negative attitudes towards drug dealers and believed that they should be dealt with using punitive measures. More generally, young people had their own suggestions to improve service delivery including drug education in school presented in a context that young people can relate to; education for parents; drug awareness advertising; and increased and improved diversionary activities.

The research studies presented some evidence to prompt a number of recommendations. For those in the younger age groups who like to find out information from teachers, there is a need nationally to ensure that teachers have access to appropriate resources in schools to educate young people. Given that parents were also considered a useful source of information for drugs and alcohol, it is important that parents are trained so that they have the knowledge and awareness of drug and alcohol issues to correctly inform young people.

With age, young people tend to lean towards their peers for guidance and advice and there are no guarantees that the advice provided by peers is correct or accurate. Peer-led approaches aim to use the interaction between peers to promote heath-related behaviours and reduce drug use. Some young people were unclear about services available to them locally and nationally; this often has probable links to the location of services, which are mostly city based. There may be opportunities to include young people in the redesign and remarketing of services to ensure that they find them accessible.

Michelle Duffin is research consultant at Perpetuity Research and Consultancy International (PRCI). For more information on this research, contact her at m.duffin@perpetuitygroup.com.

The study

Perpetuity Research and Consultancy International (PRCI) undertook a series of studies regarding trends and patterns of drug and alcohol use among young people aged between nine and 18. They were carried out at a city neighbourhood level in the East Midlands, a citywide level in Yorkshire and a countywide level in the East of England. Two methods of consultation were used: the dissemination of 960 questionnaires to young people in schools, and consultation with young people (including those considered to be 'at risk' or perceived as vulnerable) through a series of focus groups.

All three studies had very similar objectives and examined young people's experiences of drugs and alcohol; their opinions about the effects of drugs and alcohol; where young people go for help if they need information; advice or treatment for drugs and alcohol; how they find out information; and how they usually prefer to obtain that information.

A local case study: research with Gloucestershire schoolchildren

Nikki Coupland and Holly Magson have been carrying out research into young people's relationship with alcohol.

From questionnaires distributed in Gloucestershire, they found that most of their study group drank at weekends, rather than on school nights.

They drank lager, beer, alcopops and wine, which they obtained most commonly through older members buying the alcohol and giving it to them. Some bought it from a shop that didn't check ID; some had bought alcohol themselves with a fake ID; and some had had it bought for them by a friend.

The reasons the young people gave for their underage drinking were because their friends did; boredom; because it improved their self-esteem; because they enjoyed the feeling of being drunk; and because the alcohol was easy to obtain.

At Gloucestershire DAAT's conference in Cheltenham last week, Coupland and Magson asked what else we need to know from young people. Workshop participants said they should ask about first experiences and what triggers drinking; about their family situation and parents' attitudes to drinking; and what motivates them – are there favourite local drinking hotspots? What are their drinking highs and lows? Is their drinking linked to underachievement at school – and is there a way that schools can communicate with them better, with more meaningful information?

Drinking in the home environment was an area of strong concern. Parents were seen to be ignoring, forgiving and condoning their children's drinking – so the need to constantly raise awareness, find messages young people could relate to, and reinforce those messages, had never been stronger.

Nikki Coupland is anti-social behaviour co-ordinator at Cotswold district council, and is carrying out research for her degree in community enterprise and development at Warwick University. Holly Magson works for the substance misuse service and youth offending service in Gloucestershire.

These comments were recorded at Gloucestershire Substance Action Groups County Conference, held in Cheltenham on 18 November.

Reaching them young

Are we making enough effort to intervene with young people early enough?, asks Addaction's acting chief executive William Butler

Shortly after the 2001 General Election, Addaction held a conference about children and drugs at which the Health Advisory Service launched its seminal review: The Substance of Young Needs. Its message was loud and clear – that early intervention was crucial for the health and wellbeing of children and young people.

Addaction's surveys of adult drug users at the time, indicated that many had begun their drug use as early as 13 and had gone through their teenage years without coming into contact with drug treatment services. Often it was only after dropping out of education, missing employment opportunities, impairing their health or getting into trouble with the law, that they accessed help. And at this stage the support they needed to change their lives was more intensive, and consequently harder and more costly to deliver.

Too often we track back on the lives of young people when things have gone very wrong and ask – why didn't anyone intervene earlier? For many young people, drugs and alcohol misuse are symptomatic of other underlying problems that, by the time they reach maturity, have become the main problem.

Now, almost five years after the 2001 conference, the landscape for children and young people's services has altered significantly. With its commitment to putting children at the centre of policy, *Every Child Matters* has become the kind of inspirational policy that has the potential to unite rather than divide a whole range of professionals seeking to make a difference. With the *Youth Matters* Green Paper, it seeks to improve the end-to-end support for children and young people in mainstream and universal services from early years onwards, examining the means of targeting support towards those who are most at risk from harms such as substance misuse.

For 1.2 million children in England and Wales, these risks centre on both the consequences of parental drug and alcohol misuse, and the increasing prevalence of binge drinking among young people. Indeed, estimates from the DfES on drug misuse suggest that 20,000 young people go on to become adult drug users each year, many of whom from our current knowledge, probably began experimenting with drugs, alcohol and tobacco by the time they were 13.

However, since trends in drug and alcohol use and misuse are embedded in culture and among young people, trying to identify and respond appropriately to need still means navigating uncharted waters. But it is clear that without appropriate and effective interventions, the prospects are that much greater for a large expansion in numbers of adult drug and alcohol misusers with entrenched problems in the future. Are all measures possible being taken now to intervene and respond earlier, and are we targeting support to those most at risk? We are still very much at the 'work in progress' phase and while many excellent efforts are being made, much more needs to be done.

While £23 million has been invested in young people's substance misuse services following the updated drug strategy of 2002, we know from national research that there are too few intensive tier 4 services, including a dearth of residential services. We also know that while all children's and young people's substance misuse services are largely dependent for referrals from external agencies, many who could benefit are not being identified and referred when they should be. Despite such obstacles, there has never been a greater opportunity to maximise progress and remove the barriers that have hindered delivery.

Screening for substance misuse problems requires specialist skills, and while in some areas they are being applied appropriately, there are too many systemic failures in identification and referral. However, we should not underestimate the difficulties of substance misuse being hidden from view by young people themselves and their reluctance to engage with relevant services voluntarily. And while engaging with young people through arrest referral services works well for identification, it also presents a challenge for continued engagement – particularly when young people are presenting with multiple problems, many of which preceded their drug related criminal behaviours.

If wraparound services are not available or delivered in a timely way, if the young person is faced with negotiating complicated routes for help, or with numerous different key workers located in different places and is expected to repeat their story half a dozen times, it is not surprising that many will not show up.

There is nothing more important for us than to close the gaps in support for young people, which is why we believe voluntary sector agencies such as ours must become embedded as real partners with children's trusts in every locality as new arrangements come into force and the agenda is rolled out. Wherever young people are, on the streets, at school, within a youth service, in custody, in care, in mental health services, or in the local GP surgery, there is immense potential for cross-sector working and training, to close gaps. Putting children and young people at the centre of substance misuse policy and practice means being prepared to deal with the inter-related challenges of addressing disadvantage, making inter-agency partnerships equal, changing processes and culture, being accountable and exposing failure.

So, although Addaction and other specialist voluntary agencies offer fine services and want to run more of them, we also want to see more generic youth workers trained to deliver substance misuse services to high standards in appropriate environments for young people. We also know that schools are crying out for expert help to deliver policies that work for substance misuse, and that the field is already offering much training expertise across different statutory sector services.

But whether we are providing specialist substance misuse treatment services or acting as key partners in training and education to generic statutory providers, the contribution of a vibrant voluntary sector is critical to building the capacity of all interested agencies to make the kind of early interventions that can make a real difference to the lives of children, young people and families.

This article is based on contributions made by Addaction on the Youth Matters Green Paper and at the Young People Now national conference on youth policy held in Birmingham on 24 November.

As a small alcohol agency with a good reputation (we're always in the local press) we find it quite easy to attract inexperienced staff for interview. Our huge problem is holding onto them once they have some training under their belt. We're in a constant state of turmoil, because as soon as we've trained someone up to a decent level, they're off looking for a job with a bigger agency with more benefits – good pension, flexi-time and twice the salary. A very demanding question – but has anyone hit on ways to inspire loyalty?
Jenny, Sheffield

Cash talks

Dear Jenny
In answer to *'a very demanding question'*, although it may not be possible to buy loyalty, it is possible, if as indicated, you are operating successfully, to pay a competetive salary. One alternative you may want to consider is that instead of employing trainees at a low salary, you seek to appoint professionals at a rate worthy of their experience and qualifications.
Peter O'Loughlin,
The Eden Lodge Practice.

Structural adjustment

Jenny,
Firstly I must congratulate you for providing an employment entry point into the sector that is paid and provides a training programme that clearly makes new workers extremely employable. This type of initiative is something that is not often on offer in the sector.

Secondly, do you carry out exit interviews and therefore have evidence to support that they leave the organisation for better pay, pension scheme, flexible working, *etc*: the latter of which all agencies are required by law to provide? Things aren't always what they seem and you may find there are other reasons for them leaving or their reasons for leaving are mainly about just one of the areas, reducing what you need to do to address the situation.

I have worked with organisations in the past who have come across similar situations. My first suggestion is: you have no problem recruiting staff to the 'trainee' roles and therefore salary would appear to be perfectly attractive at this level. Would it be possible to decrease starting salary and increase the salary upon completion of the training as a means of anchoring your developed workers? Connexions have a good career pathway and pay system to reward experience and qualification attainment, usually explained in adverts. My second suggestion would be to implement a training retainer clause *eg* 'if you leave our employment within one year of receiving your training you will be expected to reimburse the organisation by 50 per cent of the course costs' or similar. I know of quite a few organisations who use this anchor, you may find some will not work for the organisation but this usually points out those whose commitment stems purely around receiving training before moving onto something 'better'.

I wish you luck in finding the happy solution.
Elizabeth, Sussex DAATs

Older workers

Dear Jenny
Be more fussy on who you employ. People who are older and who do not require material things in life. People who are conscientious and have worked in other jobs for a long time.
Chris Hannaby, Vale House

Reader's question

I have a client who's now doing really well in treatment. He's reached the stage when he really needs to reconnect with and have support from his family. The problem is, his family are less than keen to come in, saying they have 'heard it all before'. Has anyone got ideas on how I can persuade them to give him another chance?
Colin, Manchester

Email your suggested answers to the editor by Tuesday 6 December for inclusion in the 12 December issue of DDN. New questions are welcome from readers.

Fact file

Service User Groups

This issue: Glenda Daniels from
OUT – Oxfordshire User Team

When and why did you start your group?
The group was started off by me and Rowan Williams, the Oxfordshire DAAT User Involvement worker. I met Rowan while living in a local hostel and began working with her full time as part of a placement I was doing at college. I met her just after I stopped using, which was perfect timing as I was too chaotic while still using to have had any input.

The group started gaining momentum from an Overdose Prevention project that Rowan started while still working for the Arrest Referral service in Oxford, SMART. Once I joined the project, she began teaching me about U/I and all that surrounded it. The first meeting I attended was the first South East User Group Forum in 2002.

I then set up the OUTLive Hepatitis C workshops as my main project for my college course, and it all went from there.

How many members do you have?
We started off by asking users who accessed our Peer Education workshops if they wanted to become members of OUT. This meant if they wanted to become as involved as Rowan and I were, they could. If not, they would receive invitations to education workshops, be called upon to consult on services in Oxfordshire to aid the DAAT in the development, planning and delivery of local services. At one point we had over 150 members. This has now changed into core group members, who are volunteers, and a staff team of three, plus our advisor, Rowan, who is sadly leaving us in December to continue other work with Oxfordshire DAAT. She has been my biggest inspiration throughout my user involvement career.

How did you obtain funding?
When we first started, we received funding from Oxon DAAT for the OD prevention project and training. We then put in a bid to the Millennium fund and used that money to rent, equip, and run an office.

We received some cash from Roche Pharmaceutical company for our Hepatitis C project for the first year. Since then it has been funded by the DoH and Oxon DAAT.

My post is part-funded by the NTA, and part by Oxon DAAT, as I work for the NTA for 2.5 days per week setting up U.I. in the SE DAAT regions.

Our other two staff are our harm reduction worker, Gavin Rogers, who is funded by the DAAT, and a volunteer coordinator who is funded by a charitable trust.

Our core running costs are generated by short term projects we take on: consultation, booklet producing, training and other small projects that our volunteers work on to gain experience to take on paid work in the field.

We became a registered charity in 2003-4 so can now approach funding bodies. It opens so many more doors for your group. We have just finished helping Reading User Forum to gain their charitable status and continued funding; it can be done, even by those of us who have no experience whatsoever.

Where, and how regularly, do you hold meetings?
When we first started we held a meeting once a week at a local church hall. Now we meet with our volunteers once a week to give out activities and petty cash for the week and anyone can access the office when they wish, provided there is someone there to open up!

We usually grab users off the street or advertise in local drug services, asking them to come along to our workshops or consultation meetings, and pay for their attendance.

How do you keep it going?
When I first started, we kept it going by energy and enthusiasm alone really, plus a driving ambition to ensure that services in our area improved to help those trying to access treatment to get it quicker and better than we did!

What have been your highlights so far?
Having the chance to speak at conferences to tell others how user involvement in Oxfordshire has helped to improve services and waiting times and how they can do the same in their areas. Having the chance to build a life for myself and my family so soon after becoming clean from street drugs. The people I have met along the way and the things I have learned about the drug treatment system that I never knew before. Helping users to get better, quicker and more humane forms of treatment and educating them on their rights while they are in treatment, and what they should expect as aftercare.

How do you communicate with your members?
We consider all drug users in Oxfordshire to be our members and we are representing them and consulting with them on a weekly, if not daily, basis. We have a newsletter, we put up posters, we go and talk to users we know on the street, in hostels, services – everywhere. We talk to them, ask them their concerns and try to address them if we can.

Have you any tips for others starting a service user group?
Yes, work with your DAAT and the NTA, not against them. Most of them do want you involved, they just don't know how to go about it. Some have never had any experiences with users, and the ones they have had sometimes are not good. Get yourself some training – we can provide it if you wish – and start to link up with other groups who can give you advice. Visit other groups – most user groups are different from the next one, so all have something in the way of help and advice they can give you to help you on your way to becoming an integral part of the treatment system in your area and making positive changes.

Getting into shape through

FDAP's Drug and Alcohol Professional Certification provides workers with a professional certification against the DANOS national occupational standards. Registered status under the scheme is a first step to demonstrating DANOS competence. Accredited status provides externally validated evidence of competence – it complements the NVQ in Health and Social Care in this regard, and is aimed in particular at those practitioners (project workers, counsellors etc, as well as health and social care professionals) with existing qualifications in the substance misuse field.

Simon Shepherd, Chief Executive of FDAP, tells DDN about a series of recent initiatives to make getting certified more straightforward.

FDAP certification made simpler!

Wider recognition of existing qualifications

To be accredited under our Drug and Alcohol Professional Certification scheme, practitioners need to have qualifications which provide complementary evidence of competence in a total of 10 DANOS units. Our Professional Certification Advisory Panel (PCAP) is responsible for determining which qualifications are 'recognised' as providing complementary evidence and against which DANOS units. When we initially launched our accreditation scheme, the panel erred on the side of caution in this. Following a review of the list, the panel have now recognised a number of other qualifications. They have also widened that range of units which some qualifications are recognised against. This will make it easier for many workers to get accredited. For instance, health care professionals (nurses, doctors, social workers etc) who have a qualification (at level 3 or above) relevant to working with substance users, will now automatically be eligible for accreditation, provided their competence is confirmed by a workplace assessment.

(Note – The list of recognised qualifications is under constant review, and it is likely that further qualifications will be recognised in due course. The PCAP will review any qualification brought referred to them by members who have already achieved registered status under the scheme.)

DANOS-based competence awards

Another common complaint of practitioners wishing to get accredited as a Drug and Alcohol Professional, is that they have the required complementary evidence in a number of DANOS units, but need to 'top up' their evidence in a small number of additional units. To help with this, FDAP has teamed up with the Open University to develop DANOS-based competence awards.

Like an NVQ, these awards will be based on an assessment of workplace competence. Practitioners will be able to gain awards based around individual units, or around a number of 'clusters' of units. The cluster-based awards will include: Working with and on behalf of clients (based around AA2, AA4, AA6 and BI5); Personal professional development (based around AC1 and AC2); Assessment of substance users (based around AB5, AF2/AF3); Assessment and care planning for substance users (based around AB5, AF2/AF3 & AG1); and Core competences for drug & alcohol professionals (based around the nine core units in our Professional Certification scheme - AA2, AA4, AA6, AC1, AC2, BI5, BD4, AB5, AF2/AF3). These awards will be available from April 2006. For more information on these awards contact FDAP.

DANOS-based training

FDAP and HIT are about to launch a series of DANOS based training modules specifically designed to help address any shortfalls in practitioners' competence against the DANOS standards – focusing in particular on the units included in our

There are various ways in which drug and alcohol practitioners can demonstrate their competence, to comply with the NTA's Treatment Effectiveness Strategy. Iain Armstrong explores the options.

Demonstrating competence

As part of the Treatment Effectiveness Strategy the NTA want practitioners to be able to demonstrate, through externally validated qualifications, that they are competent in four generic units in the DANOS standards seen as core for working effectively in any health and social care setting (relating to effective communications, health and safety, ongoing professional development, and promoting choice, wellbeing and protection) – as well as at least four other units of relevance to their particular roles in the drugs and alcohol field.

There are various ways in which workers will be able to demonstrate their competence and this variety can be both a blessing and a curse. Deciding on the right way will make for effective, marketable services with competent, quality assured staff. Choosing an inappropriate route could prove expensive, frustrating and demotivating.

One route, of particular relevance to workers who are not health or social care professionals (nurses, doctors, social workers *etc*) is through a Level 3 NVQ in Health and Social Care.

To be awarded the Health and Social Care NVQ at Level 3 practitioners will have to demonstrate, to a qualified assessor, that they can apply in practice the skills and knowledge contained in the four core generic units listed above, as well as four others from a basket of more than 100 optional units, including the substance misuse units from DANOS.

While many colleges offer NVQ 'courses' – NVQs are not essentially training-based qualifications and many colleagues who have been working in the field for years are already competent and only need assessment to achieve the awards. The Open University Assessment Service, among others, will assess people against any of the units in the health and social care suite, without requiring them to attend a training course first.

NTA accept that workers who are already qualified as health and social professionals – for instance, doctors, nurses, social workers and probation officers – would have had to demonstrate competence in the four generic health and social care units in order to become professionally qualified in the first place, so they are not required to demonstrate this again. An alternative to the NVQ for them is the planned Continuing Development Awards (CDAs) in Substance Use. These will be NVQ-type awards, based around the DANOS standards, and will typically contain four units.

A major strength of NVQs and related awards is that they do not require people to have any existing qualifications. On the other hand, they can not take account of existing qualifications either. Another route to demonstrating competence, which has been designed to address this particular issue, is FDAP's Drug and Alcohol Professional Certification scheme.

To be accredited under their scheme practitioners need to provide independent evidence of competence in nine core units (the four core units of the Level 3 NVQ in Health and Social Care, plus five others) and one additional 'specialist' option.

Unlike the NVQ, FDAP's scheme is designed to take in to account existing qualifications, where they provide what FDAP term 'complementary evidence of competence' in a given unit. These can be health and social care professional qualifications, or college / university awards. FDAP Accreditation can be a more straightforward way for some practitioners with existing qualifications to demonstrate their DANOS competence.

The Open University and FDAP are also working on a set of DANOS-based

training

Professional Certification scheme. There will be five separate modules in the new training programme: Working with substance users (covering AA2, AA4, AA6 and BI5); Assessment of substance users (covering AF2/AF3 and AB5); Professional development (covering AC1 and AC2) and Ensuring effective health and safety (covering BD4). As with the OU competence awards, these courses will be available from April 2006. For more information / to book a place on one of these courses, contact HIT - t: 0870 990 9702, or visit w: www.hit.org.uk.

Evidence checker

Many practitioners who wish to become certified as a Drug and Alcohol Professional tell us that they find it difficult to work out from the documentation what evidence they need to have.

To make it easier for people to check out about their eligibility for certification, and to find out what further evidence, if any, they require, FDAP is about to launch an on-line 'evidence checker' (at www.fdap.org.uk). Practitioners will be able to enter details of their qualifications and the 'evidence checker' will give them a read out, indicating their current eligibility and identifying what further evidence they require to become either registered or accredited under the scheme. Final testing is taking place, and the service will be launched shortly.

For more information see www.fdap.org.uk, or contact FDAP at Unit 84, 95 Wilton Road, London SW1V 1BZ, t: 0870 763 6139, e: office@fdap.org.uk.

competence awards designed to help practitioners gain any additional evidence of competence required to become accredited as a Drug and Alcohol Professional. Practitioners will be able to apply for OU/FDAP awards based around individual DANOS units, or around particular clusters of units, such as 'assessing substance users' (based around three units on assessment) and 'core competences for drug and alcohol professionals' (based around the nine core units in the FDAP scheme).

Having been closely involved with the development of the DANOS standards and the NVQs, as well as the FDAP Certification scheme, I am pleased that the stage finally seems to be set for the implementation of quality assured competence on the ground, and that there is a range of options available to demonstrating DANOS competence to suit the needs and circumstances of individual workers and employers. I do have some concerns too however.

With the patent nonsense I hear all too frequently from some of the less well run NVQ centres and with funding streams that are allocated more around the funders' needs than the employers', I have visions of the field as one of those herds of wildebeest crossing the Serengeti, leaping into rivers and providing a feast for the waiting crocodiles.

I am also concerned that many employers and individual workers are confused about what they need to do when it comes to demonstrating DANOS competence, and what option is most appropriate for them.

I hope that the relevant stakeholders in the field will help to address these issues, so that after so many years of hard work the role out of DANOS will be as smooth, and pain free, as possible.

Iain Armstrong is a consultant, and can be contacted at iain@iarmstring.co.uk or through the website www.iarmstrong.co.uk

Opportunity knocks

Three deserving candidates have just been told that they have won Euromed's training and accreditation bursary, which will give them financial support for a place on an accredited training programme. Here the winners, Tammy Owers, Sue Davies and Stephen Fatuga, explain what the training opportunity means for them and their careers.

Tammy Owers

Winner of Euromed's bursary for The Drug and Alcohol Workers Core Competencies Certificate (Addaction)

I am a residential drugs worker at Tyneside Cyrenians. We provide direct access homeless accommodation. I work with clients wherever they are in their lives, however chaotic. Sometimes a client will be out of prison with nothing – no benefit, only the clothes they are wearing. We take a holistic approach to client care. It incorporates anything the client needs.

When a client comes in we don't always do a full assessment of needs straightaway. They may not admit to having a drug problem at first, so we concentrate on more pressing issues like wound care and harm minimisation. Later we refer to PCT teams to help get clients into treatment. When they move, for example to an external housing provider, I will do outreach work with their new key worker to see if there are any problems and this helps to provide consistency.

I have always had an interest in the drug and alcohol field and have been working in it now for 18 months. I completed a Level Three social work course at college and instead of going to university I thought I would get experience working with homeless people. That's when I started as a floating support worker at Tyneside Cyrenians. Later I received formal training from them.

I want to become more effective at my job – there is still so much to learn. The DANOS standards made me realise I needed more specific drug training and I became a FDAP member. I knew from my work about Addaction's Core Competencies Framework but never dreamt I'd win the Euromed bursary that's enabled me to do it. I have now been to Addaction's course induction and have received the course units. There's a lot of work to do, but I'm looking forward to it.

I think everyone agrees more professionalism is needed in the drugs and alcohol field to increase the quality of service provision. Tyneside Cyrenians employ over 90 staff and to train all of us would be hugely expensive. I think the government should provide more grants for training programmes based on the DANOS standards. At least through winning the bursary I shall be able to pass on what I learn from the course to my colleagues at work.

Stephen Fatuga

WInner of Euromed's bursary for the Foundation Degree in Addictions Counselling (Clouds)

I started to train as a 'generic' counsellor on a diploma course, but I've always wanted to work in the addictions field. Human behaviour has been a life-long interest, but I am particularly fascinated by addiction and my own personal history was tied up with it at one time. I had read about Clouds in *DDN* and had heard very good feedback from friends about the foundation degree, and I realised that general counselling would not equip me with the skills to become an effective addictions therapist. I don't mean that's true for everyone, but it's true for me. Counselling gave me a good grounding but I think there are very specific tools needed for addictions therapy to help broaden one's understanding of how a drug dependent person is thinking and behaving.

I came from a background of being a client and I want to be able to provide the best service I can for my clients. I'm fortunate to have won the bursary – it would have been very hard to do this course without it. I've been studying at Clouds now for a month and already the course has switched round my own understanding of my past situation.

A good education gives you an insight and a means to interpret experience. I feel that with the Clouds course I will be able to meet the DANOS standards in my work.

The vast majority of treatment workers are doing a valuable job, but the issue of treatment effectiveness has a strong link with quality of training. The NTA wants higher standards – we all do – but it's very hard for those at the sharp end to support themselves and train at the same time. Really there needs to be more investment in training and education. It's up to the government to put more resources into this.

DDN will be launching Euromed's 2006 Bursary in January. This will be opened to include more course providers. If would like to register your interest either as a student or a course provider, visit www.euromed.ltd.uk and click on the 'Bursary' link.

Sue Davies

Winner of Euromed's bursary for The Professional Diploma in the Management of Addiction (Stoke-on-Trent College)

I have worked in the behavioural field for 20 years in a variety of settings, and specifically with addictions for the past 10 years.

I was born and brought up in an impoverished community in Wales in the Rhymney Valleys, but it was none the less a 'community' where people supported each other. People used drugs socially; in fact drug taking was considered a 'social activity'. But I saw a number of people who become dependant and some who suffered long-term adverse effects. The impact this had on me was a realisation that we all need to 'escape' and that we do so in different ways, and led to my interest in working in the field.

'I specifically chose Stoke on Trent College as the tutors come from an addictions background, which for me is fundamental to good training as the practical skills development is as important as the theoretical background.'

With the help of the bursary, my long-term goal is to finally specialise in a subject that I have worked in for many years. This qualification will amplify the specific skills that are needed to work in the field of addictions, and help to ensure that service users are receiving appropriate treatment. Once I have qualified I would like to see myself in a position of influencing treatment at government level. I specifically chose Stoke on Trent College as the tutors come from an addictions background, which for me is fundamental to good training as the practical skills development is as important as the theoretical background. This bursary will certainly make the learning process much easier.

The drug experience: Cocaine, part 2

Professor David Clark continues his examination of the seminal study by Dan Waldorf and colleagues on heavy cocaine use. He looks at controlled cocaine users in this study, and describes factors that might contribute to this form of drug consumption, and mitigate against the descent into cocaine addiction.

Cocaine is often portrayed as having a very high addiction potential and that most people who use it are risking serious physiological and psychological harm. While some cocaine users do develop difficulties, the majority do not.

The most comprehensive ethnographic study of heavy cocaine users was conducted by Dan Waldorf and colleagues in Northern California. They interviewed 267 current and former heavy users of cocaine, a sample that did not include people in treatment programmes or in prison. Most of the respondents were 'solidly working- or middle-class, fairly well educated, and steadily employed'.

These researchers showed that about a half of interviewees maintained a controlled pattern of cocaine use, some of them for even up to a decade. According to Waldorf, controlled use can be defined as either, 'regular ingestion without escalation to abuse or addiction, and without disruption of daily social functioning', or 'a pattern in which users do not ingest more than they want to and which does not result in any dysfunction in the roles and responsibilities of daily life'.

Based on their observations, Waldorf and colleagues described the ideal type of controlled users:

- Controlled users tended to be people who did not use cocaine to help them manage pre-existing psychological problems, and did not also abuse other drugs, especially alcohol.
- Controlled users generally had a multiplicity of meaningful roles, which gave them a positive identity and a stake in conventional life (*eg* secure employment, homes, families). Both of these anchored them against drifting toward a drug-centred life.
- Controlled users, perhaps because they are more anchored in meaningful lives and identities, were more often able to develop, and stick to, rules, routines, and rituals that helped them limit their cocaine use to specific times, places, occasions, amounts, or spheres of activity.

This research suggests that a stake in conventional life and identity are central for understanding continued controlled use. Such stakes seem to keep a person's drug use from overtaking their life and identity. They also facilitate an individual reasserting control after a period of problematic use (we will discuss this issue in a later article).

The fact that these social and social psychological factors mitigate against cocaine misuse and related problems suggests that not everyone need develop a problem with cocaine, even when using heavily as this population was.

'If the only frameworks in society for interpreting one's drug-using behaviour are addiction and abstinence, then the idea that one can and should exercise control can atrophy.'

At the same time, it follows that those people with the least stake in conventional life may be at the highest risk for problematic cocaine use. Cocaine, and in particular crack, have had a marked impact in poor neighbourhoods, causing problems to many individuals and communities.

Obviously, these forms of social control are not foolproof for maintaining controlled use. Some people with a large investment in conventional life did lose control of their cocaine use and develop serious problems. Waldorf and colleagues report that, 'after scouring our other interview transcripts, we could not put our fingers on any one magical "factor X" that explained why some people get into trouble and others did not'.

Other researchers in the US and other countries have reported controlled use of cocaine by a significant proportion of users (see Decorte, 2000 for review).

Waldorf and colleagues recognise that some well-intentioned parents and policy-makers might not want to broadcast findings about controlled use, for fear of facilitating the denial of some misusers or increasing the risks for some new users.

However, they contend that the 'considerable possibilities for exercising control over cocaine use can be seen as cultural resources that can facilitate personal capacities for control and social capabilities for harm reduction'.

The researchers made the very good point that if the only frameworks in society for interpreting one's drug-using behaviour are addiction and abstinence, then the idea that one can and should exercise control can atrophy. The interviews revealed that one important reason that control was possible for so many of the participants was that they believed that it was possible. They believed that cocaine was 'not necessarily addicting, that it could and should be used in a controlled fashion'.

While cocaine is often portrayed as a powerful reinforcing psychoactive drug, we sadly do not often hear that its powers are also mediated by users' norms, values, practices, and circumstances. We underestimate the powers of social, social psychological and cultural aspects, while overestimating the pharmacological power of the drug.

Waldorf and colleagues point out that heavy cocaine users have taught us, 'that beyond the drug itself, how users think about and behave towards drugs matters a great deal. Cultural norms matter. Subcultural practices matter. How closely we look out for each other matters. The uses to which we put consciousness-altering substances matters. The personal and social resources of users matter. The values placed on productive daily lives matters. And, of course, the social distribution of opportunities for productive lives matters...'

References:

'Cocaine changes: the experience of using and quitting' *by Dan Waldorf, Craig Reinarman and Sheigla Murphy. Temple University Press, USA.*

'The taming of cocaine: Cocaine use in European and American cities' *by Tom Decorte. VUB University Press, Belgium.*

Effective management, smart solutions

The Methasoft™ Treatment Management System is a fully integrated software package allowing the medical, physical and psychosocial assessment of a service user, development of structured SMART care plans and the generation of maintenance or detoxification schedules.

In the draft National Treatment Agency (NTA) Care planning toolkit released in November 2005, the NTA gives detailed requirements for the care journey experience. Methasoft™ will help organisations develop procedures to fully meet these requirements.

Key workers need to be identified and work with service users to develop a therapeutic relationship with the client. Methasoft™ allows service users to be allocated to a key worker. Whenever a key worker logs in to the system they can view their workload, including full details of service users expected at the start of each working day. The detailed information provided by Methasoft™ will allow the key worker to be fully prepared for the expected service user ahead of their arrival. Security controls within the program allow for access to all aspects of the records to be restricted to those individuals previously agreed with the individual service user.

The use of Methasoft™ on a local area network (LAN) allows the use of standardised medical, physical and psychosocial assessments throughout an organisation. In the current version of the program these assessments can be customised by Methasoft UK Limited to an individual organisation's requirements. On release of the new version of the program (early 2006), which will be distributable over a wide area network (WAN) or organisational Intranet, the assessments will easily be fully customisable by the organisation.

Methasoft™ also allows for standard care plan templates and risk assessments to be developed and stored on the system for ease of use. These templates allow for individual client centered customisation with the input of issues in the clients own words at all stages of the care planning process.

'In the draft National Treatment Agency (NTA) Care planning toolkit released in November 2005, the NTA gives detailed requirements for the care journey experience. Methasoft™ will help organisations develop procedures to fully meet these requirements.'

The care plan used within Methasoft™ allows the recording of multiple issues or problems, each with a series of goals supported by SMART objectives to aid the client in achieving those goals. Detailed interventions can be planned between the counselors and their clients to help them achieve those objectives.

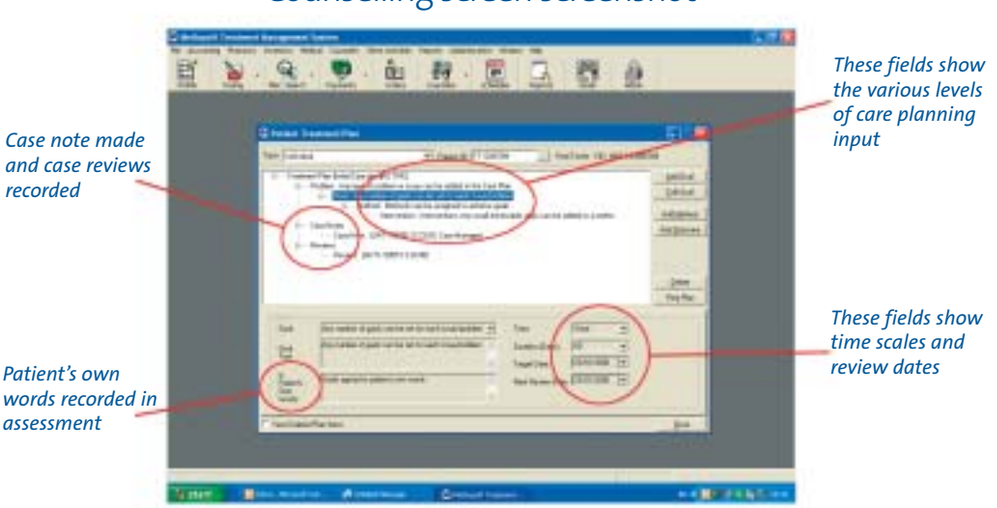
Once agreed between the counselor and service user, care plans may be printed so that relevant individuals have a copy for their own use. At all points the system allows for the identification and recording of individuals responsible for all aspects of the care plan. Review dates may be set and the system will automatically notify responsible individuals of the need to prepare for the specific reviews by email.

Methasoft™ is a flexible customisable system that will allow for the use of rating scales for use in outcome monitoring. These rating scales can be added as a standard reporting tool within the system, and easily completed with or by the client.

Once the new version of the software is available early in 2006, data collection tools such as the National Drug Treatment Monitoring Service reports can be built into the system, easily compiled and exported each month at the touch of a button.

For further information visit our website at www.methasoft.co.uk, or contact Robert Goff on 01642 715350 or by email on robert@methasoft.co.uk.

Counselling screen screenshot



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We turn lives around every day, by putting the individual at the heart of what we do. Inspired by those we work with, together we help people build a better life. Turning Point is the UK's leading social care organisation. We provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

HARTLEY HOUSE & MILLIKEN HOUSE, EALING Hartley House and Milliken House are committed to providing high-quality residential rehabilitation for alcohol dependant clients following their detoxification. Our aim is to support their journey from dependency to abstinence.

SERVICE MANAGER • £24,708 – £27,411 (plus £3,288 London Weighting)
You will be responsible for the management and implementation of effective models of care for two residential services. Maintaining partnerships and overseeing the development of the service to meet its clients' needs, you will also ensure both local and national requirements, such as DANOS and CSCI, are met. Working within agreed budgets, you will coordinate a range of initiatives. For example quality assurance schemes, ensuring accessibility and responding to residents' complex needs. With your three years' experience working in a social care environment, you must also have two years' experience managing staff in a residential setting. An understanding of current alcohol misuse issues is essential, as is a commitment to managing the service with integrity and humour.

OUR BENEFITS In return you can look forward to a final salary pension scheme, generous annual leave allowance, a season ticket loan and employee assistance programme – and some flexibility in working hours including the opportunity to jobshare if appropriate.

HOW TO APPLY For more information about this position and to apply online or download an application pack, please visit www.jobs-at-turning-point.co.uk/ddn You can also call 0845 055 0262 or email turning-point@peoplemedia.co.uk quoting the reference number L2643/2 and stating where you saw this advertisement. Closing date: 23 December 2005. Interview date: 20 January 2006.

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DDN
Drink and Drugs News

Readers' Survey

Congratulations to Robert Geldart of Lancaster, winner of our readers' survey prize draw and now the proud owner of an iPod shuffle.

dasl
drug and alcohol service for london

Drug and Alcohol Service for London is an innovative agency working across London to provide a range of services to people experiencing problems with alcohol or drugs. We are currently seeking to employ:

ALCOHOL DAY PROGRAMME WORKER

£23,316 for 35 hours p.w. – (Ref: 05/15)

Our Structured Day Programme for people with alcohol problems, based at our services on 108 Bellegrove Road, Welling, Kent, incorporates skills and therapy groups, alongside complementary therapies. You will construct, review and monitor care plans; plan, facilitate and document groups; develop and promote services to the wider community and assist in the day to day running of a Structured Day Programme, as well as covering evening groups on a rota basis. You will have an understanding of drug and alcohol use issues, along with experience of working within an Alcohol/Drug Day Programme, group work skills, assessment and key working skills.

ALCOHOL SESSIONAL COUNSELLOR

£17.50 per hour for 3 hrs/wk, may include evening or Saturday hours. Clinical Supervision will be provided (2 hours per fortnight, paid). – (Ref: 05/16)

To provide one-to-one counselling at various satellite venues in Greenwich and Bexley. You will hold a BACP recognised qualification in counselling, (or have evidence of working toward this) with experience of assessments, care planning and key working and some experience of working with substance use clients. You will be required to attend fortnightly group supervision on Monday afternoons (either 1:45 to 3:45 pm or 4-6 pm at BAGRA Offices in Welling).

Closing date: 9am, 30.11.05 Interviews: week commencing 5.12.05

DASL has an active Equal Opportunities Policy and we particularly welcome applications from members of Black and minority ethnic communities, as they are currently under-represented in our Greenwich and Bexley team. All applications will be treated on merit. (Race Relations Act 1976, S.38(3),(4)).

PUNJABI SPEAKING SUBSTANCE MISUSE SESSIONAL COUNSELLOR *(Ref: 05/17)*

6 hrs/wk, Tower Hamlets & Newham – will involve daytime, evening and/or Saturday hours.

TAMIL SPEAKING SUBSTANCE MISUSE SESSIONAL COUNSELLOR *(Ref: 05/18)*

3 hrs/wk, Newham - will involve daytime hours.

£17.50 per hour, Clinical Supervision will be provided (2 hours per fortnight, paid).

Post holders will work as part of the Community Alcohol Team, providing one-to-one counselling. A BACP recognised qualification in counselling, with some experience of assessments, care planning and working with substance users is required.

Race Relations Act 1976 S 5(2)(D) applies
Closing date: 9am, 12.12.05 Interviews: 16.12.05

All posts are eligible for Enhanced Disclosure by the Criminal Records Bureau.

For an application pack (paper/electronic packs available) contact DASL, Capital House, 134-138 Romford Road, Stratford, London E15 4LD. Tel: 020 8257 3068, email: jobvacancies@dasl.org.uk quoting job title and reference number.

DASL is committed to the principles of equality of opportunity for all. Registered charity 299535

TRIAGE AND EXTERNAL CARE CO-ORDINATOR

c£26,000

Worthing, Fixed Term Appointment to 31st March 2007
Chichester, Temporary Appointment for 6 months

The West Sussex Drug & Alcohol Action Team is looking for someone with proven assessment skills and experience in the substance misuse field to join their team of triage co-ordinators. You would be expected to offer and conduct triage interviews and organise onward referrals according to individual need. In addition you would case manage clients and co-ordinate services to them under the Drug Interventions Programme. Involvement with the Prolific and Priority Offenders scheme and provision of support and training to partner organisations are also part of the role.

This post is subject to a Criminal Records Bureau check.
Informal contact: Jonathan Richards on 01243 382932

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 5189.

Closing date: 16th December 2005 **Interview date: 3rd January 2005**

addaction

Helping individuals and communities to manage the effects of drug and alcohol misuse.

So. Why do you want to work for Addaction?

Area Manager - London **Up to £42k plus benefits**

It's the classic interview question, isn't it? And when we ask you, you'll tell us you want to work with a leading national drug and alcohol charity with a £24 million turnover and over 650 staff. You'll tell us you're excited by the challenge of strengthening our existing services in London and building on our success to deliver further growth.

But what will you ask us?

If you're the person we're looking for, the answer is 'plenty'. You'll want to know how diverse the challenges are going to be, how much responsibility you'll take on, and how big an impact you can make.

Charismatic, with proven leadership ability, you will have extensive management experience within the substance misuse or related field, and will be confident in your ability to tender for and win new business. Above all, you will have the vision and credibility to build relationships with our commissioners, and make the London area a model of success.

For further information and application details, please visit our website or email p.mcardle@addaction.org.uk

Closing date: 9 December 2005.

www.addaction.org.uk

DDN residential treatment directory
fully updated, downloadable pdf available at
www.drinkanddrugs.net

Birmingham and Solihull NHS
Mental Health NHS Trust

DETOX & STABILISATION SERVICES (DASS)

BAND 6 NURSE OR EQUIVALENT

• 2 POSTS • £19,523 - £30,247 PA • REF: 00522

These posts are open to allied health care professionals as experience gained within a non SMS setting will be recognised.

The Addictive Behaviour Centre provides detoxification, stabilisation treatment interventions for drug and alcohol users within a tier four Unit and is part of the wider community Drugs and Alcohol Treatment Service fitting the Models of Care guidance.

The Centre offers inpatient treatment to service users from the diverse community of Birmingham and Solihull. This post will require an enthusiastic approach in the delivery and supervision of skilled nursing care to meet the physical and psychological needs of our service users. Being able to identify and implement good nursing practice is essential and in return we offer regular supervision and access to training and development in a service striving for excellence.

This is an opportunity to develop your understanding of substance misuse and where your professional approach to treatment and contribution to the team will be valued.

A minimum of twelve months' experience at E Grade/Band 5 is required, together with a demonstrable interest in working with our service users. A rotational shift pattern is in place.

Relocation can be negotiated.

For further information please contact Magdalena Roskell on 0121 685 6258.

Closing Date: 14 December 2005.

You can apply on line at www.bsmht.nhs.uk, click on 'working for us' and follow the link to e-recruitment or alternatively call the vacancy line on 0121 678 3210 for a manual application quoting the appropriate reference.

Successful applicants are subject to a criminal records bureau disclosure.

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DIP Workers Counsellors ● Commissioning Managers
PPO workers ● TCAC workers ● Case Managers

Consultancy, Permanent, Temporary

"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 the Director to discuss your recruitment needs: Samantha Morris Tel/Fax 020 8995 0919

www.SamRecruitment.org.uk

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'STOPPING ADDICTION, STOPPING CRIME'

Following the recent Prison Service re-tendering exercise, RAPt has been awarded 14 new drug service units to provide CARAT Services and accredited 12-step based Substance Abuse Treatment Programme in HM Prisons across England. We are therefore undergoing a major expansion, offering many exciting opportunities to become part of one of the country's foremost providers of drug treatment services in prisons. We are currently looking for staff in the following positions and locations:

Treatment Manager: **The Island Day Programme, Tower Hamlets**
Starting Salary £27,000 (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.

Senior Counsellor: **HMP Coldingley, Surrey** **Starting Salary £24,000**

We are looking for a Senior Counsellor to join our treatment team at HMP Coldingley. To be successful, you would need to have a thorough knowledge and commitment to 12-step. Counselling qualifications and experience are essential, as is experience of providing line management. Experience of working with addicts is 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, enthusiastic and determined, with the ability to work in a challenging, sometimes pressurized environment.

Counsellor: **HMP Swaleside, Sheppey, Kent** (gym & steam room facilities)
HMP Everthorpe, East Yorkshire,
HMP The Mount, Hertfordshire, **Starting Salary £21,000**

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.

CARAT Worker: **HMP High Down, Surrey** **Starting Salary £21,000**

We are looking for CARAT workers to join our High Down team. 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.

CARAT Administrator: **HMP Pentonville, London**
Starting Salary £15,000 (plus £1,000 London Weighting)

We are looking for an administrator to provide administrative support to our CARAT team at HMP Pentonville. You will have previous administration experience, good word processing ability and knowledge of Microsoft Office, particularly databases. You will also have an organised and efficient approach to work. You will need to be enthusiastic and very determined to be able to work in 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.

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. 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**

South Downs Health NHS
NHS Trust

Hidden Harm Worker

Band 6 Ref: NAM612

Brighton

Salary: £22,328 - £30,247 pa

This post is fixed term for one year

You will have a qualification in social work, general or mental health nursing and/or health visiting with relevant experience in the management of people who misuse substances.

You will promote the well being and safety of children whose parents misuse substances. This will involve ensuring there is provision within existing services to support parents in bringing up their children and by ensuring that children do not take on excessive or inappropriate caring roles in their family.

You will be responsible for providing training and development initiatives for a range of multi-disciplinary and multi-agency staff; these initiatives will require the development of clear and competent practice within each service that is consistent with the core principles of the Joint Working Protocol ratified by Brighton and Hove Area Child Protection Committee.

You will be a source of specialist advice and support to workers assessing and/or working with familial substance misuse ensuring quality of assessment and intervention.

For informal discussions, please contact Andrew Kilkerr on 01273 242172 or Pauline Lambert on 01273 295993.

When applying for this post it is essential that you read the Job Description and Person Specification and use the "supporting information" space to demonstrate how your skills, knowledge and experience meet the requirements of the person specification, as your application will be judged against this.

Closing date: 7th December 2005

For a job description, person specification and application form please contact Personnel Department, Glynde Building, Brighton General Hospital, Elm Grove, Brighton BN2 3EW.

To apply online visit www.southdowns.nhs.uk
Telephone: 01273 242211 (24 hour answerphone)
Text Telephone: 01273 601518

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Umbrella
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You will provide a high standard of mental health support and emotional care to clients who either have a history of offending or are participating in a programme of rehabilitation, within four 4-bedded units throughout the Barnet area.

You will have at least two years' experience of supporting adults, whose primary needs are dual diagnosis, and/or ex-offenders. You will have proven experience of dealing with challenging behaviour and have an excellent understanding of issues relating to substance abuse and ex-offenders.

You must have NVQ Level 3 in Promoting Independence or a commitment to achieve this, and hold a full UK driving licence with use of a car.

For an application pack, please phone 020 7226 5074 (24 hours) or email jobs@umbrellacare.org.uk

Closing date: Monday, 12 December 2005.

www.umbrella.org.uk

2 Addiction Therapist's required

Salary £22,000 – £25,000

Lynwode Manor is a retreat in Lincolnshire for those suffering from alcohol and stress problems. We require 2 therapist's to complete our team who can deliver a variety of therapy approaches. You would need a minimum of 2yrs experience in the addiction field with some knowledge of 12 step philosophy. Our approach to recovery is varied and flexible resulting in a balance between structured groups and time for relaxation. The hours can be flexible and there is staff accommodation if required.

If this interests you please contact us asking for either Sue Allchurch or Julie Crosby.

e: sue@mimosarecovery.co.uk
t: 01673 849444

Closing date: 6 January 2006