DDN
Drink and Drugs News

12 February 2007
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Editor's letter

The most persistent strand running through our readers' survey responses was alcohol, alcohol services, lack of money for alcohol.

Putting all the pieces together, you get a very disjointed picture of treatment and funding. Detailed documents such as the NTA's 205-page long effectiveness review of alcohol treatment (see page 7) give interesting and valuable research – but are the key themes finding their way into better treatment?

At the very practical end of the scale, the user-led North East Regional Alcohol Forum (NERAF) is feeding into policy with the very real evidence from its members on what works. Their recent initiatives have included responding to the government's 'Know your limits' campaign on binge drinking, and launching a community detox and peer-led aftercare service for alcohol clients.

Somewhere in between, there are some tremendous initiatives going on regionally to involve clients with alcohol services before they come to the stage of desperate need. Our cover story writer, Alan Alker, explains how his area has introduced brief interventions – judged by several research studies to be the most effective action in tackling dangerous drinking – into primary care services. As with so many alcohol-related initiatives, it makes economic sense to incentivise GPs to take screening onboard. A statement in the NTA report leaps out: 'Commissioning brief interventions in primary care settings would have a major impact on public health'.

On that note, I am very pleased to welcome Alcohol Concern to our panel of DDN partners. I hope we can help to strengthen the ever-growing alcohol policy lobby, through publicising its successes and struggles, in return for the very welcome expertise they will offer our editorial.

Finally, a note of sincere thanks to all of you who returned such interesting and detailed readers' surveys.

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In this issue

Much more to do for children at risk, says review of Hidden Harm progress

An audit of progress on Hidden Harm has just been released, three years after the original report from the Advisory Council on the Misuse of Drugs.

A working group, convened by ACMD and chaired by Adfam chief executive Vivienne Evans, examined how services and local authorities have responded to the 48 recommendations made in *Hidden Harm – responding to the needs of children of problem drug users*.

The review highlights that areas that have achieved most progress have benefited from specific objects and targets, a clear strategic approach, and strong leadership to co-ordinate work across the different sectors involved.

But while there were areas of good progress, such as in working with pregnant drug users, there was still much to be tackled. Significant gaps included a lack of specific targets on child protection and welfare, which needed to be incorporated into new drug and alcohol strategies across England, Scotland and Wales from 2008.

There was a need for more dedicated services at local level, supported by ongoing funding and backed by widespread staff training and development throughout both children's and adults' services.

Vivienne Evans said the review had shown that there were still significant problems to tackle and that provision for children was by no means universal.

'Where commissioning has been strategic we have seen some real beacons of progress, but there is lack of consistency,' she told *DDN*. 'People need direct help and intervention. The issues are complex, but once they are grasped there can be real improvement.'

Addaction's chief executive, Deborah Cameron, commented that the review had highlighted lack of progress over the last three years.

'Far from becoming a main objective of the government's drug strategy as recommended three years ago, the ACMD are still calling for children of drug and alcohol using parents to be prioritised in all strategies,' she said. 'It is distressing that we still have no accurate picture of the actual numbers of children affected by parental drug and alcohol use – 350,000 is a conservative estimate.'

DrugScope voiced concern at the inconsistent way original Hidden Harm recommendations had been implemented across the UK, particularly in England.

'The original report was a wake-up call for the government [but] it seems that the Drug Strategy, with its focus on drug-related crime, has led to a failure to respond effectively to the needs of these children,' said chief executive Martin Barnes.

Hidden Harm – Three years on: realities, challenges and opportunities is available at www.drugs.gov.uk

Quality care 'should be the norm' for dual diagnosis

The complex issue of dual diagnosis has been tackled through new NHS guidance to help treat mental health patients with drug and alcohol problems.

Focusing on care provided in in-patient settings, the document recommends better integration between substance misuse and mental health services. It stresses that all clinical staff in mental health services should have the skills to assess and manage patients displaying symptoms related to substance misuse, and includes best practice examples for frontline managers.

Providing dual diagnosis patients with the treatment they need should be the norm, not the exception, according to mental health tsar Professor Louis Appleby, who launched the report.

'The evidence is clear,' he said. 'Misuse of substances, particularly cannabis, can worsen the symptoms of mental illness, interfere with people's recovery and medication, and increase the chance that someone could relapse.'

Dual diagnosis patients were more likely to harm themselves or others, were more frequently in contact with the criminal justice system, and were more likely to find themselves in hospital. They were also less able to comply with prescribed treatments and medication.

'We have already done much to ensure that both services work more closely together, and this guidance builds on this,' added Prof Appleby.

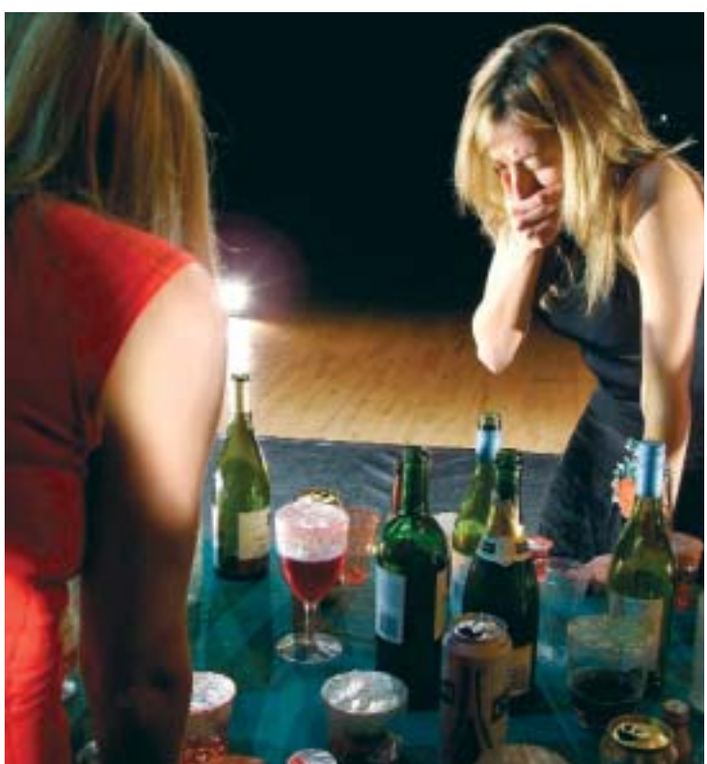
Dual diagnosis in mental health inpatient and day hospital settings is available at www.csip.org.uk/cannabisandmentalhealth

Contribute to latest drug guidance

Draft guidance on psychosocial interventions and detox, published by the National Institute for Clinical Excellence (NICE), is now out for consultation.

Also undergoing consultation is guidance on the use of naltrexone, buprenorphine and methadone in the treatment of drug dependence, published by NICE last November.

FDAP and DDN are collating responses from the field on the new draft guidance. This is your chance to contribute to the consultation process: please email us at office@fdap.org.uk.



Teenagers in Sefton are shown the dangers of too much alcohol through dance performances in youth centres and schools. The Arcane Dance Company performed 'Ten green bottles' after canvassing the views of 14-16 year olds in a series of debates. Following the performance the audience took part in workshop sessions to explore behaviours and attitudes relating to alcohol. Artistic director Jo Rhodes said most of the young people had been very receptive: 'Feedback suggested that it not only made them more aware but also made them think about their own aspirations.'

Drug problems push prisons further towards crisis point

Drug dependency is among a raft of deep-seated problems that are pushing the prison service towards crisis, according to the British Medical Association.

Speaking at a BMA conference on prison health, Dr Redmond Walsh, a London based prison doctor said both doctors and prisoners faced a 'constant battle' without adequate resources and suitable systems in place.

'It is ridiculous that offenders sometimes don't see a prison doctor immediately after conviction and irresponsible that they are not registered with a GP after release,' he said.

'The whole situation is chaotic and getting worse.'

Four out of ten prisoners used illegal drugs at least once during their time in prison, with a shortage of services to help them with dependency. The increasing prison population meant that many of those on drug treatment programmes were unlikely to be able to continue their programme when transferred to another prison.

Dr Clare Jenkins, chair of the BMA's civil and public services committee, called on government to commit to tackling problems in the prison system.

'Leaving the status quo intact, especially with the extra burden of a rising prison population, is not an option,' she said.

The committee referred to a recent report from BMA Wales, highlighting day-to-day problems faced by prison doctors, and called for its recommendations to be given serious consideration throughout the UK.

Young people's pilot shows no link between DIP and crime reduction

An evaluation of Drug Interventions Programme (DIP) pilots for children and young people, released as DDN goes to press, has found that arrest referral and drug testing has little effect on offenders' behaviour.

The pilots, conducted in five areas, indicated that arrest referral provided an intervention where other service input might be lacking for vulnerable young people. Few of the young people charged tested positive for Class A substances, and the evaluation concluded that testing only improved access to substance misuse services when combined with effective arrest referral.

The report can be viewed at www.homeoffice.gov.uk/rds/drugs1.html

Alcohol Concern joins DDN partnership

DDN is delighted to welcome Alcohol Concern as a new partner in the magazine. The partnership reflects our strong commitment to supporting the need for more and better alcohol treatment, in proportion to its impact on society.

Don Shenker, the charity's director of policy and services, commented: 'Alcohol Concern are proud to become partners with *DDN* and contribute to the work and ethos of the magazine. We are keen to ensure that professionals, service users and commissioners are able to express their hopes and frustrations in dealing with alcohol misuse at local, regional and national level and we see *DDN* as an excellent vehicle for such debates.

'The Alcohol Strategy is being reviewed, PCTs are being paid £15m to deal with alcohol misuse and regional offices are beginning to take on a much greater role in tackling alcohol harms, so continuing to pressurise local and national Government through the press and media is our number one priority.

'We hope that our partnership with DDN allows all of us to engage positively, share best practice and provide a voice for all those involved in tackling alcohol misuse and promoting sensible drinking'.

Open University and FDAP launch training for line managers

Building on their competence-assessed Professional Awards for drug and alcohol practitioners, FDAP and the Open University have joined forces to launch a new training package and Professional Award for line managers.

The new training programme for managers of drug and alcohol practitioners comprises: 'Understanding management', a distance learning course from the Open University (OU); 'Line management of drug and alcohol practitioners', a one-day workshop from FDAP focusing on the skills required to manage and develop front line staff; and 'Developing and demonstrating competence', an online e-learning course on DANOS and developing and demonstrating staff competence.

FDAP and the OU have also launched a Professional Award for Managers of Drug and Alcohol Practitioners, based on an assessment of competence against four National Occupational Standards units – drawn from DANOS, and the 'management and leadership' and 'learning and development' suites of standards.

For more details visit the FDAP website – www.fdap.org.uk

Media Watch

Doctors have warned of a rise in alcohol-related brain damage in young people, as Scotland braces itself for consequences of an explosion in teenage binge drinking. Clinics across the country are dealing with drinkers in their twenties and thirties who are suffering from brain damage, including those with Korsakoff's syndrome – an irreversible form of dementia caused by excessive drinking. Tom Wood, chairman of the Scottish Association of Alcohol and Drug Action Teams, said: 'Twenty years ago the classic Korsakoff's case was in his fifties or sixties, but with people starting to drink heavily in their teens in Scotland that is already dropping into the thirty-something zone.'

The Scotsman, 8 February

A specialist alcohol counselling service in Milton Keynes is facing closure because of lack of funding. The Drug and Alcohol Counselling Service (DACS) was started seven years ago and offers a one-to-one service as well as out of hours sessions for those in full time employment. The service stopped receiving DAT funding in March 2006 and has survived through private donations and limited help from Milton Keynes Council. 'If no cash is forthcoming the service could close this spring,' said DACS spokesperson Diana Savage. 'The money is simply not there from the Government – alcohol misuse is the neglected issue at the moment.'

Milton Keynes Today, 8 February

Pictorial health messages on cigarettes act as a greater deterrent than plain text warnings, according to a Canadian study. Sixty per cent of Canadians took notice of the pictorial warnings carried on their cigarettes compared to 52 per cent of smokers in Australia where large text warnings cover nearly 30 per cent of the packet, and only 30 per cent of Americans where cigarettes only carry small text health warnings. Deborah Arnott, of anti-smoking charity Ash, said: 'This study provides evidence to support the UK government's proposal to add picture warnings on tobacco products.' Simon Clark, director of the smokers' lobby group Forest, countered that the warnings were disproportionate: 'It is all about stigmatising smokers. Why don't we put warnings on cars about the risk of crashing?'

BBC News, 6 February

Lambeth Council has proposed launching a website to 'name and shame' people convicted of drugs offences within the borough. The move is an attempt to crack down on perceived 'drugs tourists' who come to Lambeth to buy drugs. No date has yet been announced for the website's launch.

South London Press, 2 February

One in five young people admitted to driving under the influence of drugs, in a survey carried out by Hertfordshire County Council's road safety unit. Results revealed that many young people considered cannabis to be the safest drug to take while driving, and thought it was safer to drive after consuming illegal drugs than drinking alcohol. Road policing officer PC Andy Chittenden said there needed to be more education on the issue. He added: 'We have now all been trained to test drivers for driving that has been impaired because of the use of drugs.'

Borehamwood & Elstree Times, 8 February

Screening and brief interventions are being recognised as effective ways of helping hazardous drinkers. Alan Alker describes how setting up a National Enhanced Service in primary care is making the process easier for both GPs and patients.

Brief intervention

The district of Tameside and Glossop has areas of both economic deprivation and affluence. It consists of several small to medium-sized towns in the Eastern part of the Greater Manchester conurbation, and a relatively rural area in North Derbyshire close to the Peak District National Park. The area has been identified as having an above average rate of alcohol-related mortality.

At the end of 2005, Tameside and Glossop Primary Care Trust established a National Enhanced Service (NES) for Alcohol Misusers on the back of introducing new contracts for GPs. The contracts allowed GPs to provide more specialised or enhanced services than would normally be offered in a primary care setting, such as anti-coagulant monitoring, intra partum care, treatment for minor injuries and IUCD fitting.

Many PCTs have established enhanced services to treat drug problems, but very few have initiated similar provision for problem drinkers. Tameside and Glossop PCT was among the first to offer a National Enhanced Service for the treatment of alcohol dependency.

The service was developed by looking at guidance in several recent documents, including the Alcohol Needs Assessment Research Project (ANARP), Standards for Better Health, the Alcohol Harm Reduction Strategy for England and the SIGN report, The management of harmful drinking and alcohol dependence in primary care. Models of care for alcohol misusers (MOCAM) was also consulted. although this does not specifically mention NES provision.

The service is offered to anyone resident in the district, regardless of whether or not their GP is part of the NES scheme. If the patient's GP is not part of the scheme there is an obvious need to ensure effective communication between the two GPs, especially about prescribing and medical issues.

The NES is provided by around 25 local GPs working in ten different practices throughout the district. Each GP in the scheme was offered a one-day training programme with a small team of experienced and skilled clinicians, followed by regular additional training and updates on clinical issues through a bi-monthly forum facilitated by the PCT.

The service is supported by a full-time primary care alcohol worker – a qualified psychiatric nurse, managed by the local NHS Trust's substance misuse service – and two alcohol counsellors, one full-time, one half-time, who are managed by a voluntary organisation, Alcohol and Drug Services.

While two of the NES clinics cater for relatively rural populations, most are within densely populated urban areas. The service is designed to meet the needs of those problem drinkers who can be effectively treated in primary practice. Others with particularly complex problems, including mental health issues, child care concerns and severe physical health problems such as alcoholic hepatitis, are referred to the statutory treatment services for more intensive input.

It is anticipated that each clinic will offer brief intervention programmes to around 50 patients a year. At present the service as a whole receives around 50 referrals every month, with an attendance rate of around 60 per cent. Self-referrals are accepted, though most are initiated by primary care teams. The service aims to offer an initial assessment appointment within two weeks of receiving each referral.

The GP practices involved in the NES are provided with a three-year contract and receive a fixed yearly payment from the PCT.

In the two years that the service has been running, initial findings suggest that the NES model can offer distinct advantages that begin with allowing patients to be treated within their own communities, and in many cases by their own primary care teams. For many patients, the service

offers a more acceptable way of entering treatment, compared to attending large specialist substance misuse services.

The common problem of 'postcode lottery' is avoided, as if a patient's GP cannot treat them for any reason the clinic provides an alternative option nearby. There is further encouragement for the patient to stay in treatment through the service's provision of a 'one-stop shop': they are offered a continuous journey from screening and assessment, through community detoxification, to relapse prevention.

The service has also been a positive experience for the GPs involved. Their role in alcohol dependency is formally recognised; they are acknowledged financially and are given training and support from substance misuse services.

However, there have been some teething troubles to tackle. Referrals from GPs outside the scheme have been much lower than expected, suggesting a reservoir of need that remains undetected and unmet. The NES team is tackling this through carrying out promotional visits to all district GP practices. It has been found that some GPs are refusing to provide treatment for alcohol dependency (such as home detox prescribing) on the grounds that this is not their 'core work', or work for which they receive any reimbursement.

Attendance rates for initial appointments have been disappointingly low, although they are much higher for follow-up appointments. Practices are now sending their patients 'reminder' text messages.

Few referrals have been received from BME communities, despite two of the clinics being based in areas with large ethnic minority communities. While this may be a reflection of religious beliefs, more effective promotions of services to BME groups is being planned.

The PCT is now evaluating the service through an anonymous service user satisfaction survey. All service users seen during a three-month period will be canvassed for their views on waiting times, staff attitudes, involvement in treatment decisions and contact with medical staff. The findings, along with an ongoing analysis of treatment outcome, will be used by the PCT to determine the future development of the service.

Having used the Christos tool to assess service outcomes, the service found that this method was not capturing positive change as well as they had expected, so are now planning to use the Alcohol Outcomes Spider. This outcomes tool (explained on the Alcohol Concern website, www.alcoholconcern.org.uk) uses an easy-to-score chart to make observations on a client's overall wellbeing, including emotional and physical health, relationship with their family and friends, contact with the criminal justice system, and their working life, as well as their drinking levels.

The Primary Health European Project on Alcohol (PHEPA, 2006) has recommended the implementation of screening and brief interventions for hazardous and harmful drinkers. The NES model may provide the ideal vehicle to meet these aims.

Alan Alker is team manager at Tameside and Glossop Substance Misuse Service.

NES interventions

- Screening for problem drinking, using validated tools such as the 'FAST'.
- Specialist assessment, including testing with biological markers for problem drinking.
- Advice and information on sensible drinking and alcohol reduction.
- Brief intervention programmes (six to eight therapy sessions).
- Community alcohol detoxification programmes.
- Adjunctive prescribing including disulfiram and acamprosate.
- Support and guidance to carers.
- Referral on to other agencies, including services for housing, employment, in-patient detoxification.

Brief but effective...

DDN looks at recommendations of the NTA's alcohol treatment effectiveness review, published last November.

- Brief interventions have been ranked as the most effective action that can be delivered in a range of settings.
- The NTA's 'Review of the effectiveness of treatment for alcohol problems', written by respected researchers Duncan Raistrick, Nick Heather and Christine Godfrey, ranks brief interventions as the best chance of changing the behaviour of 7.1 million hazardous or harmful drinkers.
- At least 56 controlled trials give evidence of their effectiveness in reducing drinking to low-risk levels. Furthermore, the effects of brief interventions have been shown to last for periods of up to two years – and in some studies, up to four years.
- While hospitals and A&E are likely to see many patients with drink-related ailments or injuries, and so have an obvious opening to ask questions about regular alcohol intake, GPs have an opportunity that tends to be vastly underused.
- Studies have shown that brief interventions by GPs could reduce the hazardous drinking of 250,000 men and 67,500 women to safer levels every year.
- Why don't they take this opportunity at the moment? Many GPs cited lack of time, support and suitable screening methods. It was also found that many were not adequately trained in asking the right questions and were worried about raising alcohol issues with their patients, believing that they would not listen to their advice. Some GPs felt they would not be reimbursed for the extra time this work would take.
- The report points out the essential intervention of commissioners in changing a situation where most healthcare professionals do not use brief interventions and most GPs miss hazardous drinkers who present to their practice. 'Commissioning brief interventions in primary care settings would have a major impact on public health', it says, among its conclusions.
- The report adds that more research is needed on ways of including brief interventions in routine practice, to overcome the barriers that currently exist.

This report can be ordered (free of charge) from the NTA. A pdf summary is also available at the website, www.nta.nhs.uk

The pooled treatment budget for 2007/8 has just been announced, alongside a new system of allocation. **DDN** examines the detail and asks head of the National Treatment Agency, Paul Hayes, to explain the arithmetic.

Summing up

The pooled treatment budget (PTB) allocated for this year is £398m, an increase of nearly 3.5 per cent on last year. While significantly less than last year's 28 per cent increase, there will be relief that the figures are continuing an overall upward trend after a year of 'belt tightening' warnings for the drugs field, against the backdrop of constant crises in NHS funding.

Of the £373.3m allocated for community based treatment, £361 will be made available to primary care trusts – either directly or via their strategic health authority – for adult treatment. An extra £10m has been earmarked for capital spend, and £2.3m is being held back to cover any discrepancies between the projected year end and actual year end figures. This will be distributed to PCTs in the summer.

The remaining £24.7m of the budget is for young people's services, which will come from the Department of Health, via the Home Office, to be distributed through the Young People's Substance Misuse Partnership Grant.

This year the NTA has shaken up the system for allocating each area's budget. Through analysing each regional partnership's annual return of data about their treatment activity, collected through their National Drug Treatment Monitoring System (NDTMS), money has been allocated according to the demand for treatment in each area.

In previous years, each area's budget has been based on their population. The new system is intended to even out the amount of money spent per head on treatment throughout the country, which means that there are winners and losers in this year's budget.

For example, the ten areas that have had an average of £882 to spend per head in the past year will have their allocation increased to £1,134; ten areas that have had their allocation reduced from an average £3,526 per head will now receive £3,370 per person.

So there will still be significant discrepancies in availability of treatment throughout the country, but the foundations of a fairer system are in place, according to the NTA, which plans to further close the gap in subsequent years.

Tier 4 funding allocations – dealt with separately through the Department of Health – are to be announced on 19 February, following a bidding process for funding for 2007/8 and 2008/9 that began in July last year.

On the spot: Paul Hayes answers DDN's questions about the new budget

Will the new system come as a shock?

No – at least it shouldn't. We trailed it last June, when we announced last year's pooled treatment budget. We also mentioned that this was the direction of travel at the treatment effectiveness conferences we had last year. We obviously haven't been able to go into detail, because we didn't know exactly how it would play out.

We said we would be looking to narrow the gap between the areas that are getting £4,000 a head and the areas that are getting £1,000 a head. I don't think that it's a surprise to anybody.

Are you confident information from the NDTMS is accurate?

Well it's certainly important that the information we get from the NDTMS returns is right. One of the reasons the numbers are so complicated is because we held some money back in case either the projections are wrong, or we find out that some of the money we're getting back from NDTMS isn't as accurate as it should be.

Inevitably, with 149 different partnerships reporting back on a monthly basis, reporting from thousands of providers, discrepancies will creep in. We're always very keen to follow up any intelligence we get that suggests the numbers might be wrong.

Of course as soon as people get wind of the fact that allocations might be dependent on NDTMS returns, there's going to be a tendency for some people to guild the lily, shall we say. We need to be very aware of that.

When it becomes problematic, is when somebody starts fiddling the books by inventing people, but I think it would be quite obvious if someone's numbers start to rocket. We'd send the boys round to have a look.

So the budget figures are non negotiable then, if they're based on this data?

Absolutely. We've used this data to work out things like star ratings in the past. It's the data that the Department of Health uses in deciding how much to allocate globally. So it would be perverse if it was deemed to be appropriate for those purposes, but not for this.

Do you think everyone understands the new budget?

I would doubt it! Although the direction of travel has been well signposted, the detail of how it's been worked out will be new to people, and it will take some time for them to adjust.

The easiest thing would have been to say everyone will get £2,000 per head, which is what it works out to roughly. But of course that would have meant that the over-funded treatment services – by which I mean the people who get a disproportionate amount of the resource at the moment – would have been expected to make adjustments that just aren't feasible. You can't all of a sudden halve your income and expect your system not to collapse. So we have to do this slowly.

Similarly, there isn't a lot of point in doubling someone's income, because they'll be unlikely to spend it well. So we made adjustments that, at most, mean that the areas that have the greatest impact from this will lose about 6 per cent of funding.

No-one loses more than 6 per cent, and the area that loses 6 per cent still winds up getting £4,000 per head to deliver, when the people who are gaining the most (30-odd per cent) are still only getting just over £1,000.

'When it becomes problematic, is when somebody starts fiddling the books by inventing people, but I think it would be quite obvious if someone's numbers start to rocket. We'd send the boys round to have a look.'

So there's still a lot of catching-up to be done?

Yes there is. For the next two or three years, this process will continue. Whether we'll use exactly the same mechanism or not, I don't know. But the direction of travel will remain the same.

Do you expect areas to adjust easily to how much they should be spending per head?

Well in a lot of instances it isn't that places are getting too much money; it's that they're underperforming. We'd be very happy to give some of the areas that are losing out more money next year, because we believe the clients are there. But often they haven't been very good at getting clients in.

In some cases it will be that they're actually getting too much money. In others it's dysfunctional partnerships that haven't got their act together, or certain providers that aren't very good.

Unfortunately for one or two of them, they will have actually recognised that their service providers aren't very good, and they'll have recommissioned the service; but now of course they've found they're not getting as much money as they thought they would.

We would expect that if they perform better next year, with the new provider, then the amount of money they get the year after will go up with the increase in activity.

What's the best way to tick boxes then, to make sure they get their services recognised as quality services?

It isn't really about ticking boxes – we haven't been able to build a quality dimension into this. We would like to do that ideally, and the treatment outcomes project that we've got on the go at the moment will make it much clearer to partnerships what value they're getting from their investments.

All we can do at the moment is count people who are in Tier 3 and 4 treatment, and make on average £2,000 per head available for that. And if an area is going to receive less in 2007/2008 than it got in 2006/2007, it can get more money again in 2008/2009 if it increases its activity.

In relation to overall value for money, the three strands we've got working together are the treatment outcomes project, work we're doing to establish unit costs for treatment interventions, and the needs assessment to help partnerships understand the treatment demand in their area.

So going forward, partnerships will have a much better idea of what their drug misusing population consists of. They'll have an idea which of their treatment interventions are actually delivering – not delivering through proxies such as waiting times or retention, but how many people are getting off drugs, how many people are stable, how many people are back in work, whether people are or aren't breaking into other people's houses. Real concrete outcomes – and that will put us on a very different playing field from where we've been up to now.

Will this help areas to be more focused about identifying poor areas of treatment?

Very much so, and I think it will dramatically strengthen commissioners' hands. The commissioner will be able to say: 'We're giving you half a million pounds a year. And although the numbers in treatment are good and waiting times are low, we don't seem to be getting as many people who are becoming abstinent, we don't seem to be getting as many people who are getting into work, or we don't seem to be getting as many people who are happy with their treatment and see their lives are improving, as they're getting in the next town down the road. So what's going on?' **DDN**

Do you have questions, concerns or comments about the new budget system?
Email the editor, claire@cjwellings.com
Questions on specific regional technicalities should be sent to the NTA regional teams.

Learning to fill their free time was an essential part of staying clean that Tim Sampey and Terry Swinton needed to master. They found a solution that went beyond their own recovery, as **Michael Clarke** explains.

Get set for the weekend!

Tim Sampey (right) and Terry Swinton (second right) with fellow Saturday clubbers

If Tim Sampey and Terry Swinton had been asked in December 2003 what they would be doing in three years' time, neither could have imagined that they would have just celebrated the first anniversary of a Saturday Social club they helped set up.

At the time they were both still hooked on heroin and desperately trying to kick respective 28 and 10-year heroin habits.

But after getting involved with the Blenheim Project in Kensington, the pair began a journey of recovery which culminated with the former drug users not only beating their addictions, but also giving something back to the community.

Sampey and Swinton now co-ordinate the running of the clubs as members of the Service Users Drug Reference Group, for Kensington and Chelsea Council's Drug Action Team.

The Saturday Social Club at the Blenheim Project drop-in centre in Portobello Road provides service users with a relaxed, friendly environment on Saturdays where they can listen to music, take part in art workshops, use the Internet, play games, and get hot food and refreshments.

They can also chat, make new friends and build up a support network with people who can completely relate to their situation. The pair have also just set up a weekly gym and swimming club.

It is a far cry from the situation they were in several years ago. Sampey, 45, from North Kensington, started using illegal substances as a teenager.

He says: 'By the time I was 19 I had had my first heroin habit – that lasted until I was 42.' On 12 January 2004 he flew to Spain and tried a private naltrexone detox programme. It was a date that ended up having enormous significance for him, as that was the last day he used heroin.

He remembers returning to London and visiting the Blenheim Project: 'People think that once you are off the drugs that life will be fine – but it isn't like that,' he says. 'The Blenheim Project were very supportive. It is the best place I have ever come across.'

Then he met Terry Swinton, who was on a methadone programme having stopped using heroin on 5 May 2004. A 37-year-old from North Kensington, Swinton began using heroin when he was 26. He came off all drugs in July 2006 and has been clean ever since.

After being advised to attend the Blenheim Project, he was offered counselling and complementary therapies and attended the drop-in centre every day for a year.

When he met Sampey, Swinton was involved in trying to set up a Service Users Drug Reference Group so they could advise professionals on what worked and what didn't.

'I asked to attend a service users' meeting at Kensington Town Hall and found I was listened to, he explains. 'Tim came to a meeting and we chatted about the idea that service users could do some good if we were given the right opportunities.'

Sampey had talked him into playing badminton and at a following Service Users Drug Reference Group meeting they suggested setting up a badminton club for people in recovery. They were given £500, bought some rackets, hired courts and started the club.

'We felt strongly that the treatment system of the borough was very good, says Sampey. 'However at the time there was no aftercare – and aftercare is vital.

'When you come off drugs you have a life to rebuild. If you are abandoned at that point you are bound to go back onto the drugs. You have time to fill and we wanted to come up with something that would fill that time.'

The pair wrote a business plan and negotiated rental space with the Blenheim Project, and the idea of a Saturday Social Club was born. They celebrated their first anniversary of the club last December, attended by Mayor Tim Ahern.

'The club provides a very relaxed environment where people won't feel judged,' says Sampey. 'There are no professional workers and so visitors know they are with people who have had the same problems as them.'

'This gives them inspiration to continue their own journey of recovery,' adds Swinton.

As well as the social club on Saturday afternoons, there is the new gym and swimming club on Saturday mornings, a badminton club on Sunday lunchtimes, a women's group being set up for Monday evenings and a cinema club for Friday nights – all designed to fill the time between Friday and Sunday when services are shut.

They are also putting together training courses for service users and volunteers involving life and work skills, assertiveness, self-esteem and communications.

'This whole thing has done the world of good to me,' says Sampey. It's given me a huge buzz to have helped design, build and organise these clubs. I've never been responsible for an organisation before.'

Swinton agrees: 'I've now been involved in project management, accounting, group facilitation and communication. It's changed my life.'

Michael Clarke is at the Royal Borough of Kensington and Chelsea.
Visit the Blenheim Project's website at www.theblenheimproject.org

'As methadone maintenance is now firmly established, we are going to get an ageing population of opiate/opioid dependent people who will get conditions that require an opiate-based painkiller. This fills me with dread, so I was relieved to see Dr Ford's article... and that as a GP, she was willing to prescribe them. '

In our latest website poll we asked: Do you believe the Drug Intervention Programme has been a worthwhile initiative? Yes it has, say 63 per cent of you, including this DIP case manager:

Proactive partnership promotion

I have worked within the DIP project for the last year at Harlow, Essex. I am convinced the project is worthwhile when it operates in a proactive manner with its partners.

I do feel it still has a lot of growing to do and the opportunities for this to happen are there – I see this as a very positive element of the scheme.

DIP has had to create its own identity. This is starting to be recognised and appreciated by most of our partners, but there is still work to be done in this area. The rapid intervention ability of DIP has had an effect on the more chaotic offending clients and the variety of intervention services strengthen the project's ability to be effective.

DIP will continue to develop in the future as long as the partnership ethos is continually promoted.

Clive Emmett, DIP case manager

R.E.S.P.E.C.T.

I would like to applaud Dr Chris Ford for her article 'No pain, all gain' in the last issue (*DDN*, 29 January, page 9). It has been a growing concern of mine that opiate dependent people are not given opiate-based analgesics when needed, to relieve them from pain.

I have witnessed too many times people on methadone scripts in chronic pain go through a process (depending on their condition) of NSAIDs such as Ibuprofen, Naproxcen *etc*. Then if they are still in pain the doctor may try drugs for neuropathic pain, such gabapentin and amitriptyline, mentioned in Dr Ford's article. It seems that opiate dependant people in severe pain are given every analgesic under the sun except opiate-based pain killers.

We had a client who is undergoing palliative care for Aids. They were in severe pain so we fixed them up with an appointment with the pain management team at our local hospital. This person was on a small methadone script from the specialist service. The pain management team wrote to his GP saying he needed Sevredol, which the GP had no problem with prescribing.

However the specialist drugs team told the GP not to prescribe it, as they would not be able to tell if the person was using street heroin! We were dumbfounded and arranged a meeting with all the aforementioned teams; the patient was also present at the meeting.

Getting this meeting together took over three months because of the politics and ethics of the situation. In that time the person did start to smoke heroin as they felt they had lost the battle, plus they could not stand the pain anymore. I am pleased to say that the meeting was over quickly and the patient was prescribed a morphine-based painkiller, which did the trick. He has since stopped using street heroin.

I highlight this case because if it takes all this 'red tape' to get an opiate-based painkiller for someone who is dying of Aids, imagine what will happen if we have someone in severe pain who has not got a terminal illness!

As methadone maintenance is now firmly established, we are going to get an ageing population of opiate/opioid dependent people who will get conditions that require an opiate-based painkiller. This fills me with dread, so I was relieved to see Dr Ford's article highlighting that opiate dependent people do sometimes need opiate-based analgesics – and that as a GP, she is willing to prescribe them.

I applaud Dr Ford for this and hope that the message gets across to people in the medical profession. Also, I hope that drug users read this and that it will give them the confidence to push until they get opiate based painkillers when necessary – or at least get someone to advocate on their behalf.

Well done Dr Ford – respect.

A freelance South Wales Drug advocate, name and address withheld

Notes from the Alliance

Do hospitals, custody suites and prisons realise that withholding methadone could be grounds for legal action?, asks **Daren Garratt**.

At the inaugural Methadone Alliance Conference on 22 March 2000 at the Purcell Rooms in London, Professor Gerry Stimson delivered a speech entitled 'Blair declares war' or 'The unhealthy state of British drugs policy', in which he raised concern around the government's then new Drug Strategy, which clearly prioritised the reduction of crime over the promotion of public health. The knock-on effect of this, Gerry feared, would be the development of a new unhealthy drug policy that would both disregard and have adverse effects on the health needs of drug users. He said: 'More drug users will be detained: in police cells, on remand in prison, sentenced to imprisonment, and returned to prison. There will be more drug use in prison and more risk of death from overdose around after release.'

How right he was. In 2006, the inability of the prison system to respond effectively and appropriately to the health needs of an increasing population of detained users previously maintained on substitute medication, resulted in an unprecedented test case that highlighted the practice of involuntary withdrawal of methadone from prisoners. The Home Office was forced to compensate 198 prisoners on the grounds of clinical negligence and assault, but what are the implications for the continuation of this practice beyond the prison system?

The Alliance receives many requests for advocacy from users who have found that, following admission to a general hospital ward, they have had their maintenance script reduced or even fully withdrawn because of seemingly arbitrary decisions of ward doctors who call into question, and frequently override, the clinical assessment of a patient's own prescribing GP.

This is unjustified, inexcusable, discriminatory, and I would suggest, possibly even illegal. Under the Disability Discrimination Act (1995) it is unlawful for a contractor to discriminate against a disabled person – 'a person has a disability if he has a physical or mental impairment, which a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities' – by failing to comply with a duty, in which the effect of that failure is to make it impossible or unreasonably difficult to make use of any services provided. Further the DDA also states that a provider of services discriminates against a disabled person if

(a) for a reason which relates to the disabled person's disability, he treats him less favourably than he treats or would treat others to whom that reason does not or would not apply; and

(b) he cannot show that the treatment in question is justified.

Now I'm no lawyer, but it would seem to me that any hospital ward, custody suite or prison that knowingly withholds or alters an individual's legally prescribed prescription is in breach of this act, and there could be a whole new clutch of test cases and undisclosed payouts just round the corner. I wouldn't bet against it, would you?

Daren Garratt is executive director of the Alliance

In our recent **DDN** survey, we asked: What are the most significant challenges facing drugs and alcohol services? What changes would have the greatest impact on services and service users? Here's a selection of your comments.

'The lack of ring-fenced funding for alcohol treatment is unacceptable.'

Comments reflect that alcohol-related harm is not taken seriously, and the damage that binge drinking does is not reflected in funding or policy – particularly compared to funding for drug services.

'Dedicated funding for primary alcohol clients at Tier 2 and 3 levels' is called for.

'We need recognition of alcohol as a major factor in drug-related crime,' says one reader.

'Alcohol is a bigger problem than drugs!' is typical of the frustrations voiced. Some readers who work with young people highlight a dangerous lack of awareness of the dangers of alcohol among clients, and a lack of meaningful education being delivered on the subject.

Existing alcohol services are not attractive or comprehensive enough to encourage clients, and alcohol problems among drug users are not being picked up and treated as a matter of course. 'Lack of alcohol strategy with targets' is a typical complaint, which suggests documents like MOCAM are not always reaching their audience.

Many of those who run alcohol services feel neglected and misunderstood, listing among their biggest challenges 'getting government to realise those with alcohol problems need more support' and making sure 'the perception of alcohol is challenged in the wider community'.

'We need more control of alcohol retailers,' states one reader. 'Stop sports sponsorship by breweries,' adds another.

Lack of communication between services is hampering progress in many areas of the country.

There is 'poor communication between different agencies and professionals' and 'failure to involve clients in service design'.

As well as 'better interagency co-operation', readers want 'better joined-up working between services and professionals', and 'joined-up thinking to help people move away from drug culture'. A reader in Ireland is among those advocating 'incorporating drug

and alcohol services together' and 'maintaining them under the mental health umbrella'.

'Private and government agencies need to work together more closely to meet service users' needs better', is one of the many comments, alongside a plea for 'no more silo working'.

'We need greater service user involvement in decision-making' is echoed by both services and service users.'

Service users feel they have much to offer in developing relevant services, but want barriers to be broken down.

'Don't treat us like lab rats, give us care, respect and trust… we're not objects to provide a pay packet,' says a frustrated service user.

'We need a system where service users can access treatment at the right time'… 'listen to users' views and think more out of the box in terms of treatment options' are other comments. 'Put service users in charge of the NTA,' says another, alongside: 'Make joint commissioning groups made up of 50 per cent service users and 50 per cent officials.'

Lower waiting lists and 'a non-punitive approach to service users' are among top priorities. Service providers and users both want more funding for user involvement.

A senior manager comments on the challenge of 'keeping the service user at the heart of developments when the system is often the focus of attention'.

Service users need more help in moving on and accessing employment and housing, say many readers. 'We have to have a variety of meaningful and effective interventions, rather than just healthcare, available for service users to effectively reintegrate with their communities,' comments one.

There are calls for 'greater emphasis on holistic approaches', the need 'to find good housing outside the area service users used to live', and 'greater links between prison and community'.

Better housing options are needed, including improved supported housing, alongside 'proper progression routes into paid employment' and 'being resettled in the community'.

'There needs to be a radical rethink and increased range of permitted medical interventions' is typical of comments calling for more flexibility. Rapid prescribing, shorter waiting periods, more nurse prescribers and easier access to prescribing GPs are all high on the list. Service users also call for access to better detox facilities, increased availability of counselling, and more effective services for relapse prevention.

'Fast track scripting' is mentioned as an essential option, especially for those released from custody, as well a more out-of-hours services and longer opening hours to catch service users' times of real need.

'Keep harm reduction at the heart of the work we do', says a service manager. 'More needle exchanges', 'more prescribing of diamorphine', and 'provision of consumption rooms' are among specific harm reduction initiatives mentioned by others.

'Make the promotion of drug paraphernalia illegal' demonstrates (predictably!) that all readers are not all in agreement.

'Greater choice around abstinence programmes', 'less polarised attitudes to treatment' and 'there should be government promotion of abstinence – the best form of harm minimisation' are some of the comments. 'We need the abstinence versus methadone debate from both sides,' is another.

'Give clients easier access to residential treatment' states one reader, representing others of the same view.

'We need to rethink the nature of addiction' and 'develop critical thinking' say others, wanting new options.

'We need a better trained workforce' sums up many of the comments on competence. 'We need consistent training nationally', 'more emphasis on life skills' and 'improved career development… not everyone wants to be a manager,' others suggest.

'We want better commissioning, more consultation with frontline staff', and planning cycles that go beyond one year, say readers.

'Simplified and standardised funding paths' and 'treatment budgets for young people more closely aligned with need' are among suggestions on funding and planning. 'Security of funding' surfaces regularly, alongside other practical concerns such as 'less emphasis on where people live in order for them to access services'.

Standard of care is as important as availability: 'We want consistent treatment available nationally'.

'Increase the funding to increase the team… so you can do more one-to-one with the client' is one among many suggestions relating to how money impacts day-to-day practice.

'There has to be an honest rethink of drugs classification'… 'decriminalise drug use'… change criminal justice led legislation.' There are many calls to change the relationship between drugs and the law. 'Repeal the 2005 Drugs Act', says one reader, representative of the lobby – alongside suggesting various policy-level sackings.

'There needs to be more education about addiction in school and colleges', represents many of the comments about young people.

'We need more funding for young people's treatment'… 'We need appropriate services to cover the gap between 18 and 25, no longer youth, not yet adult' comment readers. Another suggests more funding for outward-bound activities, including resources for writing, making music and playing sport. There are calls for more resources and training on working with drug-using parents.

Thank you to all readers who returned our annual survey. Your views are essential to us, and we will use them to plan our forward feature programme and interviews in future issues.

Please keep letting us now what you think: email the editor, claire@cjwellings.com **DDN**

What you want to see in DDN

You gave us lots of ideas on what you want covered in future issues...

- New treatments
- Treatment successes and failures
- Innovation in the field
- Bringing research into practice

- Housing provision for drug users
- Ideas on working with 'revolving door clients'
- Successful prison drug interventions
- Progress to work interventions

- Impact on the family, and family support
- Developments in children's services
- Education and prevention

- More on dual diagnosis
- Drugs' and alcohol's effect on the brain
- GPs' views on methadone prescribing
- Buprenorphine prescribing

- Compare other countries' initiatives
- Politicians' views on drug treatment
- The politics of drug use

- MOCAM, theory to practice
- Binge drinking and extended opening times
- Developing alcohol services

- Review of training available
- Managing stress in the workplace
- Why commissioners get it right or wrong
- The role of DATs

- More service user feedback
- The value of peer support
- More interviews with clients and recovery stories

- Services for stimulant users
- Drug updates, eg crystal meth
- Motivational techniques

- Using CBT and 12-step treatment side by side
- Profiles of therapeutic communities
- Looking at funding shortfalls for non criminal justice services

Navigating the future

'Aftercare was always seen as something separate to treatment,' says Darren Worthington, chief executive of the treatment agency, Smart. 'More often than not, people would be catapulted across into aftercare without any real planning. The two should be working in conjunction with each other.'

Setting up the Access 2 programme, the agency aimed to provide those leaving treatment and prison with the chance to gain recognised qualifications, which they can then take into the workforce or continue onto further education.

People accessing the programme will have the opportunity to learn a combination of skills to help them handle everyday scenarios, such as dealing with emotions and improving communication skills. They are also prepared for employment by helping them with interviewing, CV writing and how to use a computer.

Those who are referred onto the scheme are contacted at around six weeks before they are due to leave rehab or prison and are provided with a mentor and a care plan. Once they start the aftercare programme a

Back on track...

Danielle, 27, is currently working as a mentor for Smart. She started using drugs at the age of 13 and at 15 was addicted to heroin and crack. She has been clean for seven years.

'Before doing the Smart mentoring course I had never been to college, passed an exam or even written an essay. Going to college and doing the Access 2 course made me realise that the only thing I knew about drugs was how to take them. The programme has given me the confidence to do the job that I am doing now at Smart. If it wasn't for the mentoring programme I wouldn't have even got past the interview stage.'

Paul, 38, completed the Access 2 course and progressed to become a mentor to help those with a similar background to himself. He now gives talks to police and probation about his experiences.

'I was involved in a fairly hard-core London criminal scene – a lot of it to do with drugs. Without the support of Smart I would be back in London and back to my old way of life, so thankfully I have stayed positive and persevered, listened to good advice and stuck with like-minded people. I know I now have a great deal to give back to the community and people in similar positions to myself.'

Donette, 43, completed the Access 2 programme last year and now has links with the social services' children and family teams. She is able to help those who are in the same position she was in a couple of years ago.

'Two years ago I was sitting in a cell. My kids had been taken away from me and I had just about lost hope. Smart sorted me out somewhere to live and things started to improve. It's still one day at a time, but I've won the kids back and feel like I'm alive again.'

For an ex-substance misuser with a criminal record, finding employment can be a daunting task. Prejudice, learning difficulties and confidence issues are just some of the demons they have to face. Darren Worthington tells **DDN** how Smart's Access 2 programme is helping people in Oxfordshire make the transition to work.

case manager sets a long-term goal that identifies three key options: education, training or mentorship. When the clients feel confident enough to start working, the team will identify local employers and help them to fill out application forms. If they want to continue their education, they will be able to access courses and training through Ruskin College in Oxford.

Another route from the programme is towards becoming a mentor, where clients can use their own experiences and additional training to support others in services throughout Oxfordshire. This has proved a successful part of the course, according to Worthington, and 27 out of 200 members of the mentoring programme have moved onto full-time employment during the three years that the programme has been running.

'Of the 200 [mentoring members] you have to appreciate that not everyone wants a job in the field. Some are just taking up the programme because they feel a social duty to offer something back before they finally move on.

'We encourage mentors to take clients out to the cinema and social events. At the moment it seems to be pool that they have brushed up on!'

Clients employed as mentors will have experience of a working environment – providing them with confidence and skills they can demonstrate to future employers.

Throughout the course a training facilitator is on site to offer tutorials and provide support for those having difficulty. Clients can also attend weekly learning support groups where they can discuss any difficulties with recent graduates. 'It's a confidence issue. They've been away from classrooms for about 20 years and just the thought of getting back into a learning environment scares them rigid. Having someone who's actually done the course can act as a motivator,' says Worthington.

Many of the clients have been accessing the service, as a means of support, for over a year. 'People are still coming back to see a caseworker because they feel they need it and we wouldn't close the door on anyone,' he adds.

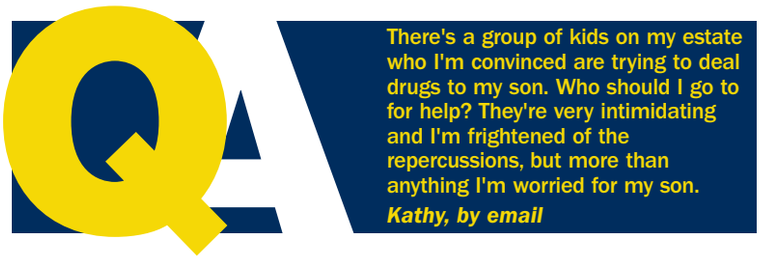
The Access 2 programme is in partnership with Ruskin College and all courses are equivalent to NVQ level three. Everyone attending will need to have a basic standard of reading, writing and arithmetic. Those who are not yet ready for the courses can brush up through the classes that the college provides.

'Presently, we have placements in the drug support field but we are looking to extend that to other employers this year,' says Worthington. 'I'm also talking to the Open University at the moment about developing the NVQ further.'

According to Worthington, there is a community centre feel among the clients, with people free to come and use the facilities as they please. As well as the Access 2 courses there are many alternative therapies available such as reflexology and acupuncture. 'We are in a period of experimentation and it feels great. It's quite rare in the drugs field today that you've got a little freedom to experiment,' he says. 'I'm not going to rest on my laurels and say we've cracked it, but I think we're a little bit further down the road than most people.' **DDN**

Darren Worthington is chief executive of Smart.

The Access 2 programme covers the Oxfordshire region and is available to ex-substance misusers. For more information visit the website, www.smartcjs.org.uk



There's a group of kids on my estate who I'm convinced are trying to deal drugs to my son. Who should I go to for help? They're very intimidating and I'm frightened of the repercussions, but more than anything I'm worried for my son.
Kathy, by email

Frankie

Dear Kathy
I thought I would ask the government's well publicised 'Talk to Frank' website about your dilemma at www.talktofrank.com. This was their offering:

'FRANK understands this is a worrying time for you.

You may benefit from an in-depth confidential chat with an advisor about your concerns. Please feel free to phone the helpline to discuss your concerns with an advisor. The helpline is confidential and available 24 hours, seven days a week.

You may wish to search for free local help via the following link : www.talkto frank.com/multimap.aspx?id=278

If you want to know any more, or would like to talk to one of our advisors about this, call 0800 77 66 00 and tell them you've been asked to ring for more information. Alternatively, you can get more information at www.talktofrank.com Hope to talk to you again soon.' FRANK

I have to say I was disappointed at the standard automated response, but I'm passing it on in case you want to call them or follow the local link. Good luck,
Caitlyn, Stirling

My generation

Dear Kathy
I can understand your concern for your son but you have to be very careful about jumping to any conclusions. You say that you find these kids intimidating but you don't say in what way they are intimidating you. Is it possible that it is a generation thing? Remember in the 1960s older people found hippies and lads with mop top haircuts intimidating!

You also say that you are convinced they are trying to deal drugs to your son, have you spoken to him about this? You seem to be implying that he has no choice in the matter when he obviously does; he has the ability to say no! The problem seems to be not with the kids on the estate but with the lack of communication between you and your son. He probably has a far better understanding of the situation than you give him credit for. Talk to him, he may surprise you.

Good luck
Jeremy, via email

Hanging around

Dear Kathy
I appreciate your dilemma; groups of young people hanging around can be intimidating even if they don't mean to be. I'm sure that hanging about on the estate is not their ideal thing to be doing but it is usually caused by boredom and a perception that there are no alternatives, and often lead to drug taking.

Have a look at what schemes and opportunities there are for young people in your area and maybe get involved in the running of one of them. If there aren't any maybe you could get together with some of the other residents and start one!

You have the power to take action in your area and be part of the solution. If you get involved and interact, and get to know these kids as people, you might no longer find them intimidating.
Raj, Milton Keynes

Reader's question

I run a house for four people recovering from Drug and Alcohol problems. They all attend treatment during the day and I offer support in the evenings. I would like to offer more help and in time work on the treatment side. The Organisation I work for have offered to put me through training. Could anyone advise me on the best route or suggest appropriate counselling courses to get me started?
Thank you
Chris Gibbons, by email

Email your suggested answers to the editor by Tuesday 20 February for inclusion in the 26 February issue.

Blooming at work

What do you need from your organisation to keep you functioning properly? **Tim Morrison** offers some suggestions.

Few follow a typical route into drugs and alcohol work. For me, after completing an irrelevant degree, being unemployed and having a vague desire to give something back to society, I took up sessional work with vulnerable young people.

No-one tested my skills, suggested training or was in anyway involved in checking out what I was doing. The employer was relieved that someone was daft enough to come in the morning and keep the young people relatively occupied. Not surprisingly, things didn't always go that well.

That was a long time ago, but my experience is still common. Rob Kenyon of the Institute of Health Sciences and Public Health Research, speaking at the 2005 FDAP conference, reported the results of a survey over nine DAT areas. He found that:

- 64 per cent of employers always recruit at interview even when candidates are not competent.
- Only 57 per cent test competence at induction and regularly thereafter.
- 40 per cent of employers were unsure or dissatisfied with the calibre of their staff.

If I am going to start a new job, I want to be developed and expand my areas of competence – I wouldn't have moved job unless there were going to be some challenges as well an opportunity to try something new. The organisation and my manager in particular, have a role in helping me do this – but many are failing.

So what do I have the right to expect in terms of support from my organisation – especially when I am taking a risk working there and they may be taking a risk employing me when I am 'not yet competent'?

At the most basic level, I need to be provided with the physical and intellectual resources to do my job and the safest possible environment in which to do it. This should be integral to the induction process.

Induction is the process of being enabled to get embedded in my new role. According to Skills for Care (the body responsible for training in the social care sector) if I work in residential care, within the first 12 weeks I must have covered the content of six 'induction standards' published by Skills for Care that are also a good idea for practitioners throughout the rest of the sector. The units cover: understanding principles of care; the organisation and role of the worker; maintaining safety at work; communicating effectively; and recognising and responding to abuse and neglect.

It is not unreasonable to expect to be managed by my manager. The Chartered Institute of Personnel and Development argues that performance management has three distinct elements: performance improvement, development and managing behaviour. If I am being managed well, again according to them, I should: know and understand what is expected of me; have the skills and ability to deliver on these expectations; be supported by the organisation to develop while being given feedback; and have chance to contribute to individual and team objectives.

Performance management takes place informally, but also requires regular structured meetings between those managing and being managed as part of the appraisal framework. Normal topics of conversation in these meetings will include how objectives are being met; emphasising and developing skills; problem-solving; the size and demands of the workload; and training and development issues.

Clinical supervision is involved with the mechanics of the care relationship and case management. To work, it is dependant on the ability of the worker and the manager to engage in and develop reflective practice; at its most basic it is concerned with ensuring that the client is being worked with in a competent, effective and safe way.

Another element of supervision is to help the worker to reflect on their emotional responses to the client and so develop empathy (the ability to be with someone in a difficult situation without being overwhelmed by it).

All workers who are dealing with situations where people are using listening skills, and where there is emotional risk or distress, need some form of supervision to help relieve both stress and distress.

Depending on skills, clinical supervision may take place in meetings with the manager, with an internal practice supervisor, with colleagues (peer supervision) or with an external supervisor.

And if I am not getting support within the organisation..?

Not getting the management support to which I am entitled is a very serious situation. It puts me at risk of stress and burnout. It also means that I am not accountable in my practice and so the client has few safety mechanisms.

In the first instance, the situation needs to be discussed with my manager. If he or she is not forthcoming then it may be necessary to pass it further up the chain. If this still does not work then the trade union may be the best option. If this doesn't work, it's time to start looking at the job ads.

Tim Morrison is a freelance trainer and part-time senior university lecturer and can be contacted through the website, www.alcohol-drugs.co.uk.

He is running two DDN/FDAP events: a 'Supervision, appraisal and DANOS' workshop on 28 February and 'The essential drug and alcohol worker' five-day course on 23-27 April. For details and to book, visit the 'training' section at www.fdap.org.uk

Stages and processes of change: Part 3

Professor David Clark completes his look at the Transtheoretical Model of Change by considering the different dimensions of change and their interactions.

The Transtheoretical Model identifies dimensions of change that describe a similar path into and out of a variety of problematic behaviours or addictions, including problematic drug/alcohol use and addiction. The model comprises four broad dimensions of change and their interactions.

I have previously described how the process of change can be divided into distinct segments, the stages of change (the first dimension). These stages are Precontemplation, Contemplation, Preparation, Action, Maintenance and Termination.

Each stage entails a series of tasks that must be completed and goals that must be achieved if a person is to move forward from one stage to the next. While the model describes these stages in a linear sequence, the vast majority of people move back and forth through the stages, even those that finally overcome their problematic behaviour.

The processes of change, second dimension, represent the internal and external experiences and activities that enable a person to move from one stage to the next. These processes involve a broad strategy employing any number of techniques, *eg* psychodrama is a technique used for emotional arousal.

The extent to which each of these processes is used depends on what state of change the person with a problematic behaviour has reached.

In fact, effective change depends on doing the right things (using the right processes) at the right time.

Consider these inappropriate ways of trying to change:

Some changes rely on processes that are best suited for the early stages – consciousness-raising and self re-evaluation – while they are moving into the Action stage. They try to modify behaviours by becoming more aware of them. However, insight alone does not bring about lasting behavioural change.

Other people begin with processes most effective in the Action stage – reward, countering and environmental control – without having gained awareness and readiness from the early stages. However, overt action without insight is likely to lead to only temporary change at best.

Engaging in these processes provides the means by which a person can accomplish the stage tasks and move along the stages of change.

The third dimension is the markers of change; signposts that help identify where a person is in two key change-related areas.

The first of these areas is decision-making about the change, which is called the decisional balance. This involves the weighing-up of the pros and cons of change.

'Effective change depends on doing the right things (using the right processes) at the right time.'

For any change that is contemplated, the person has his/her own set of pros and cons for both the current (*eg* cocaine use) and the new behaviour (abstinence from cocaine). The resulting decisional balance will help the person take action or not.

The second of these markers of change concerns the strength of a person's perceived ability to manage the behavioural change, measured by the self-efficacy/temptation status.

Self-efficacy is a term used to describe a person's confidence about performing a specific behaviour. Efficacy evaluations can represent a person's confidence to abstain from a problematic behaviour, as well as to engage in a desired behaviour.

Efficacy evaluations are typically measured across a range of situations or cues connected with engagement in the problem behaviour. Temptation represents the strength of the desire or inclination to engage in the problem behaviour in a particular situation.

Temptation is often negatively correlated with a person's self-efficacy or confidence to abstain, but this is not always the case. Some people have strong temptations to drink in certain situations, but are confident that they can resist the temptation.

The fourth dimension concerns the context of change – areas of functioning that complement or complicate change. The context consists of five broad areas of functioning that represent the internal workings of the individual and important interactions with environmental influences.

These broad areas of functioning are: current life situation; beliefs and attitudes; interpersonal relationships; social systems, and enduring personal characteristics.

Obviously, any individual pattern of behaviour occurs in the context of an individual's entire life. A holistic approach is therefore required to help people overcome problematic behaviours. Resources and liabilities in these five areas of functioning can promote or hinder movement through the stages of change.

Most often, the behaviour change target is in the foreground of focus, with the contextual areas in the background of the person's attention. However, if, for example, family problems escalate, it can become pertinent to bring this matter to the foreground to try and address the problems.

Earlier, the importance of using the right processes at the right stage of change was emphasised. In summary:

People moving through the early stages of change must shift decisional considerations. In order to foster these shifts, Precontemplators and Contemplators appear to increase use of experiential processes, particularly those that increase information and re-evaluate the behaviour and its consequences.

Increasing commitment to change appears most critical during the Preparation and Action stages. Effective planning is also key.

Increasing use of behavioural processes that modify the actual behaviour and reinforce the change are most important in the Action and Maintenance stages, along with a growing sense of efficacy to perform the behaviours necessary to quit the problematic behaviour.

The lessening and ultimate disappearance of temptation to engage in the problem behaviour, along with a strong self-efficacy to abstain, seem to mark the termination of the process of change.

Carlo DiClemente (2003) How Addictions Develop and Addicted People Recover. The Guilford Press.

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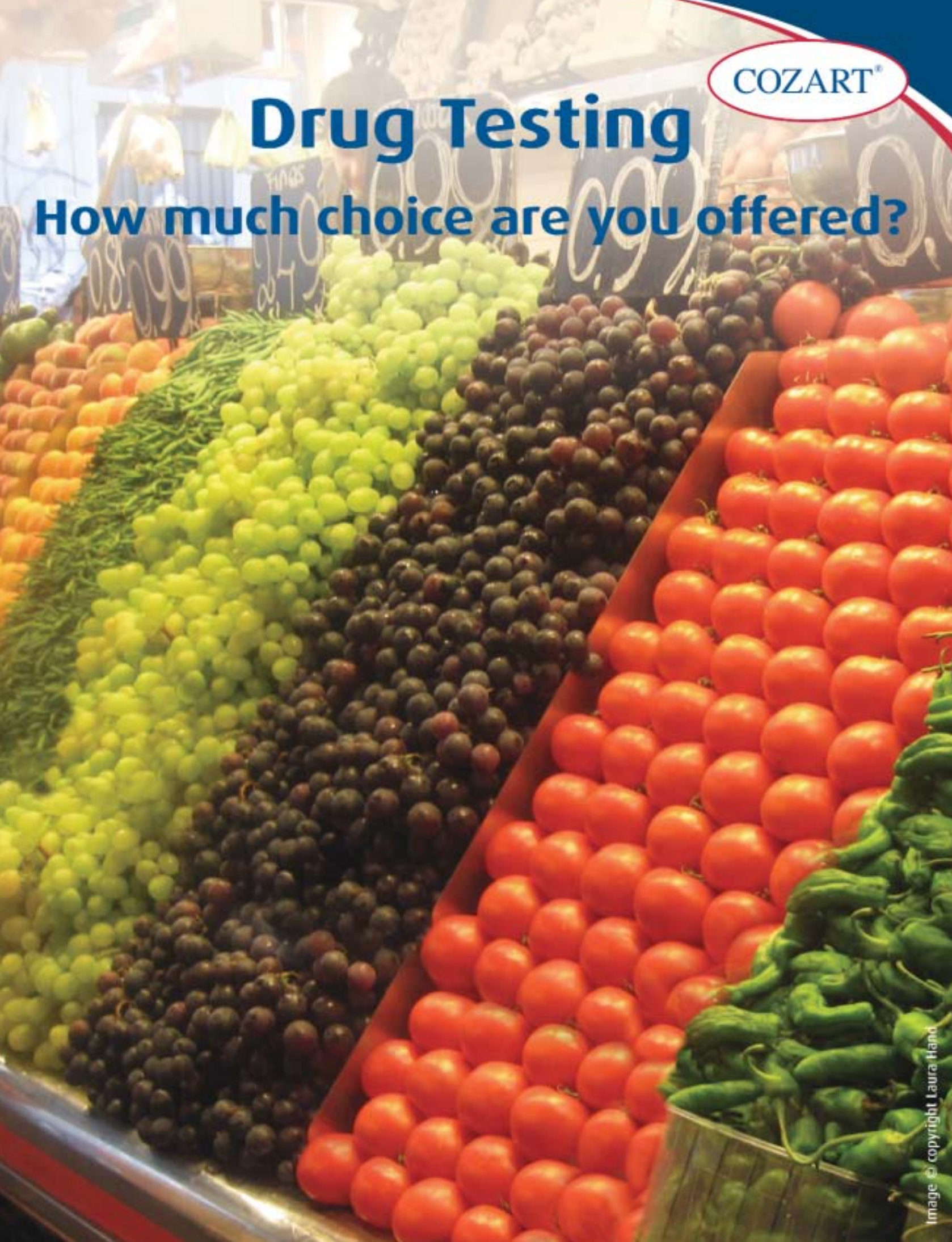

DDN / FDAP workshops

Qualifications, competence and government targets – making it work

26 February
Central London

Carole Sharma
Former NTA work-force development lead

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

£145 + Vat per delegate

Supervision, appraisal and DANOS

28 February
Central London

Tim Morrison
Former head of training and quality at DrugScope

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

£110 + Vat per delegate

The essential drug and alcohol worker

23-27 April (5 day course)
Central London

Tim Morrison
Former head of training and quality at DrugScope

Combining background information, theoretical discussion and the development of practical skills, this five-day course provides a full introduction to many of the elements of effective drugs and alcohol work. From learning 'the basics' to getting hands-on experience of some of the fundamental activities undertaken by drug and alcohol-workers (such as handling risk, assessment, harm reduction, care planning and reviews), participants will leave the training with a good grasp of many of the underpinning knowledge and skills required in drug and alcohol work. Developed in association with Drugscope, the course is mapped against four DANOS units and the accompanying book is based on the Skills for Health's document for induction, 'Knowledge and skills for tackling substance misuse'.

£645 + Vat per delegate

Specific services for stimulant users

29 March
Central London

Michael Bird
Community drugs services

This workshop centres on the difference between working with opiate and stimulant users, focusing on effective interventions. Interactive in nature, participation is encouraged through group work and open discussion. By the end of the workshop attendees will have a better understanding of the difficulties faced when working with this client group.

£110 + Vat per delegate

All workshops are located between London Waterloo and Vauxhall and run between 10.00am and 4pm. They include morning coffee and a light lunch. A 15% discount is available to FDAP members. Place numbers are limited on all of the workshops, so early booking is recommended.
For more information or to book your space please contact Ruth Raymond – e: ruth@cjwellings.com t: 020 7463 2085

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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 provide staff with a competitive salary, generous annual leave, support and access to training and development, and regular supervision.

REDBRIDGE AFTERCARE & RESETTLEMENT SERVICE (THE BRIDGE)

MANAGER (Ref: 06/16)

£30,043 for 35 hrs/pw

(funded to end September 2007, may be extended)

The Bridge aims to support people who have achieved abstinence from alcohol and/or drugs to maintain that state and access training, employment, housing and any other relevant services. You will establish and manage the service, ensuring it's flexible in meeting the needs of service users. Managing a small staff team, you will need to relate very well with service users and understand their needs, as well as those of the DAAT and other service providers in the Borough. A background in, and understanding of, working within the NTA's Models of Care framework along with proven ability in staff management and some management training will be required.

BEXLEY AND GREENWICH RESOURCE FOR ALCOHOL (BAGRA)

ALCOHOL ASSESSMENT WORKER (Ref: 06/20)

£10,515 for 14 hrs/pw

(1 year funding, may be extended)

You'll provide triages and Tier 3 assessments, developing care plans for access either into the structured programme for counselling and groups or external referral. Part of the provision will be for clients who are unable to access the service in the daytime and will involve evening hours. You will hold a relevant qualification in counselling, social work or a related discipline along with a proven track record of assessing for alcohol/substance misuse and an understanding of the Social Learning Model of dependence.

For an application pack:
w: www.dasl.org.uk, e: jobvacancies@dasl.org.uk, t: 0208 2573068

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

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Strategic Communities and Planning Officer

£32,487 - £36,636 pa Ref: 4636

Northamptonshire DAAT is responsible for the co-ordination of policy and action to tackle drugs and alcohol problems in the county. This important strategic policy post covers the combined areas of tackling drug markets, young people, and ensuring a community and neighbourhood approach.

A dynamic, motivated self starter, you will have the energy and imagination to work with a wide variety of partners in communities, police, and young people's services to achieve high quality action and outcomes in these areas. Experience of commissioning or policy roles, and a capacity for strategic thinking are essential for this demanding and exciting role.

For an informal discussion please contact Robin Burgess on (01604) 236090.

Closing Date: 12 Noon, 1 March 2007.

For additional information about this role and to apply online or download an application pack, please go to www.northamptonshire.gov.uk/jobs

If you require an application pack in an alternative format, please contact 01604 237207/08.

Your local library has internet access, just ask if you need help.

Northamptonshire County Council

www.northamptonshire.gov.uk

KENWARD TRUST

NEW LIFE FROM ADDICTION

Chief Executive

Kenward Trust is a **leading specialist in drug & alcohol recovery**, giving people the opportunity to work towards a new life free from addiction.

The Trust is recruiting a Chief Executive following the retirement of the current Director. Reporting to the Trustees, **the CEO will play a crucial role in the future success** of Kenward.

You will be able to **lead a highly respected team**, providing clear strategic and managerial leadership to continue the Trust's development.

If you believe you could be the next CEO of Kenward, please send a letter of application with a full CV to:

Chairman of the Trustees, Kenward Trust, Kenward House, Yalding, Kent, ME18 6AH.

The closing date for application is **2nd March 2007**.

Further information about the Trust and a full role profile is available at **www.kenwardtrust.org.uk**

Kenward Trust is a **Christian organisation**, and as such it is a genuine occupational requirement that the CEO be a committed Christian.

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Drug and Alcohol Foundation

Counsellor/Dual Diagnosis Worker

(Personality Disorder Service)

12 month contract – 4 day a week post

Salary £25,000 – £28,000

The Drug and Alcohol Foundation is developing a new group work focused programme for people who have a psychiatric diagnosis of "personality disorder" and a history of abusing substances. The group work programme will run along side the other services at the Dartmouth Street Programme (DSP) that works with people who have dual disorders. The DSP has been working with this client group for a number of years providing both individual and group therapy.

This is an exciting opportunity for a self-motivated person with significant experience in the fields of substance misuse and mental health, to develop a structured programme for clients who are experiencing such difficulties. The post holder would work closely with primary care and substance misuse services as well as mental health services across London.

The post holder would be expected to conduct assessments, facilitate psycho-educational groups, psychotherapy groups as well as provide individual counselling to a caseload of clients. We would also expect the post holder to manage students and volunteers who work at the DSP. We would also be looking for someone who has an understanding of dialectical behaviour therapy, mentalization based therapy as well as treatment models for working with addictive disorders.

Ideally we would be looking to recruit someone who is a qualified Psychotherapist/Counsellor or Psychosocial nurse or professional equivalent.

If you have any questions about this post please call Malcolm Peterson (Project Coordinator) on 02072330400. If you would like to request an application pack sent out to you please call our administrator Lorraine Saunders on the 02072330400.

The closing date for applications is Monday 26th February 2007.

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HAMPSHIRE DAAT
Drug & Alcohol Action Team

Harm Reduction & Outreach Service

The Hampshire Drug & Alcohol Action Team are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of a Harm Reduction & Outreach Service to cover the Hampshire DAAT area. The service will form part of the pan Hampshire Harm Reduction Strategy and will be a mobile service providing outreach, harm reduction support and information and distribution and collection of injecting paraphernalia and will be required to commence in August 2007. A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Business and financial standing.
- Organisations experiences of the provision of substance misuse treatment services
- Service User Involvement
- Organisational capacity & capability to deliver this Harm Reduction & Outreach Service
- Price & Best Value

Process for application

1. Written Expressions of Interest must be received by the DAAT by **23rd February 2007**
2. Upon receipt a Pre-qualification document will be sent to **ALL** interested parties to be completed & returned by **12 noon on 16th March 2007**
3. The Hampshire DAAT invites **ALL** organisations expressing an interest for this tender to attend a consultation meeting at **2pm on 7th March 2007**
4. Following assessment of the Pre-qualifying document, **FIVE** organisations will be invited to tender for completion and return by **12 noon on 13th April 2007**

To register your interest please contact Richard Curtis, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL

Please Note this replaces the Previously advertised tender of the same name.

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Mental Health Partnership NHS Trust

Service Manager

Job Ref: 342-D5525-286
Salary: Band 8b £41,038 - £50,733 p.a. (R&R if applicable)

Over the past few years the Specialist Drug and Alcohol services have been working with commissioners and Bristol City Council to move towards the delivery of an integrated Health and Social Care Drug and Alcohol Service.

In early 2007 this work will be realised with the formation of the Bristol Integrated Specialist Drug and Alcohol Services.

As part of the process we are seeking to appoint a Service Manager to provide leadership and to manage the service. Initially your role will be to work with the Project Steering Group to finalise the transition from separate services into the new integrated service and then to operationally manage the new service.

The successful applicant will have appropriate, relevant experience in the health/social services field that would enable them to undertake the full duties of the post in a professional, confident and competent manner and/or a relevant professional qualification or degree.
An ability to work closely with other key stakeholders, providers and commissioners will be underpinned by management experience and an understanding of drug and alcohol service provision and legislation.

The service is provided from a number of sites across Bristol and South Gloucestershire. Under the integrated structure, there will be five team leaders and approximately 80 staff. Services include: specialist maternity services; Hepatitis project; rapid prescribing; criminal justice work; Community Care Assessments; prescribing and dispensing; services for sex workers; psychiatric/ psychological assessment and intervention and a Tier 4 inpatient unit.

For further information about this post, please contact David Colyer, Service Director, AWPT Specialist Drug and Alcohol Services, tel: 07771 764197, e-mail: david.colyer@awp.nhs.uk or alternatively contact Ian Dickinson, Clinical Lead on tel: 0117 918 6887, e-mail: ian.dickinson@awp.nhs.uk

To apply, e-mail: recruitment@awp.nhs.uk or tel: 01225 731602.

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