DDN
Drink and Drugs News

15 January 2007
www.drinkanddrugs.net

INSIDE:

Residential Treatment Directory

JACK OF ALL TREATMENTS
Sharing expertise to offer a variety of choice

NEW YEAR CHALLENGE
Connecting treatment with service users

THE RIGHT REHAB
Deciding the best placement for clients

THE ALTERNATIVE HIGH

How do you replace the buzz of drugs with the buzz of achievement?

Your fortnightly magazine | jobs | news | views | research

DDN / FDAP workshops

Healthy eating for a better life

14 February
Central London

Helen Sandwell
Nutritionist
MSc NutMed

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

£110 + Vat per delegate

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

Drug & alcohol courses

Professional development training 2007

the TRAINING exchange

One day Courses (£110 + VAT)

Appraisals	*17 Jan*
Loss & change	*19 Jan*
Effective communication	*24 Jan*
Service user involvement	*31 Jan*
Monitoring & evaluation	*1 Feb*
Engaging and assessing drug and alcohol users	*6 Feb*
Introduction to drugs work	*7 Feb*
Alcohol & poly drug use	*15 Feb*
Difficult & aggressive behaviour	*26 Feb*
Steroids	*2 March*
Women & drugs	*23 May*
Working with diversity	*2 Oct*
Bins & needles – safer injecting & harm reduction	*14 Nov*

Two day courses (£195 + VAT)

Motivational interviewing	*28 Feb-1 March*
Training for trainers	*7-8 March*
Supervision skills	*12-13 March*
Brief solution focussed therapy	*14-15 March*
Young people - mental health & emotional support needs	*21-22 March*
Relapse prevention	*28-29 March*
Introduction to management	*30 April-1 May *(£235)*
Groupwork skills	*4 & 11 May*
Dual diagnosis	*15-16 May*
Key working & support planning	*20-21 June*

All courses take place in Bristol

All courses mapped to DANOS

Call or email us for more information
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk

Visit our website

www.trainingexchange.org.uk

Find out more about us, our trainers, our courses

10 years of providing consistently high quality training, learning and professional development opportunities

Published by

CJ Wellings

In partnership with

fdap
Federation of Drug and Alcohol Professionals

WIRED
Empowering People

Drink and Drugs News partners:

Adfam

The Alliance

ANSA

drugsandalcohol today

EATA
European Association for the Treatment of Addiction

THE FEDERATION

LDAN

Mentor

RELEASE

SMMGP

Drink and Drugs News

15 January 2007

Editor's letter

Welcome to our first issue of 2007! I hope you've found it easier to get back into routine than we have... After all that Christmas excess it seems appropriate to carry articles with titles like like 'alternative high' and 'New Year challenge'.

To tie in with our latest treatment directory (centre pullout) we've looked at different ways of doing things. The Windmill team make the most of team skills to give a valuable variety of options on page 11; could you share good practice with other inpatient teams?

Paul Goodman shares experience from the Ley Community on page 12. Their recent research on client outcomes leads him to caution against looking just at completion rates as a gauge of success in rehab. He urges those involved in weighing up the suitability of a placement to look at the longer term picture, and whether clients make it back to being part of society.

Jim McCartney takes us back to basics on page 10, reminding us that people, and not just systems, should be the beating heart of services. In place of the usual exhortation to go to the gym at New Year, he recommends a 'mind gym' as part of rehab, where clients 'stretch the mind muscles into new realms of thinking', with the aim of 'tapping into new resources at the core of their being'.

Our cover story describes a strong opportunity for lifelong change. I wonder what inmates of Hindley Young Offender Institution thought, when they learned they would be taught how to scale walls. But the outcome of their outdoor skills and initiative course certainly seems to have woken inspiration in many of its participants. The story is in itself a challenge to perceptions: some of those on the course were nervous about trying the activities, but confident when given the skills to achieve a 'legitimate' high. It's an interesting illustration of how instilling a little positive self-belief can take someone a long way.

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

Editorial assistant:
Ruth Raymond
t: 020 7463 2085
e: ruth@cjwellings.com

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

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
Website maintained by wiredupwales.com

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ
Printed on environmentally friendly paper by the Manson Group Ltd

Cover Montage: JellyPics

In this issue

New alternative to methadone launched in UK

An alternative treatment to methadone and buprenorphine has just been launched and is available immediately for maintenance treatment of opioid dependence.

Suboxone, manufactured by Schering-Plough, is buprenorphine hydrochloride and naloxone hydrochloride. The combination of naloxone alongside buprenorphine (whose formulations include Subutex) is designed to limit the potential for misuse, as well as lowering its street value.

The drug is prescribed to be taken sublingually (under the tongue), which renders the naloxone component ineffective, because of its poor bioavailability through this route. If the drug is injected however, the naloxone is activated, causing withdrawal symptoms.

Suboxone was approved on the basis of a year-long clinical trial, comparing it with buprenorphine and a placebo. It had similar efficacy and safety to buprenorphine and had similar side effects to this and other opioid agonist treatments.

Dr Michael Farrell, consultant psychologist at The National Addiction Centre said the medical community would welcome new treatment options.

Daren Garratt, executive director of The Alliance, said the patient community also welcomed the addiction of new treatments for heroin addiction. 'More choice for people trying to control or stop using opioids can only be a good thing,' he added.

New chief exec for Phoenix Futures

Karen Biggs will join Phoenix Futures as their new chief executive on 5 February, taking over from Bill Puddicombe. Ms Biggs, who is 38 and has a social housing management background, previously worked for Stonham and the Home Group over the last 15 years, leading both organisations through key organisational changes. Commenting on her new role, she said she was passionate about delivering services to the most excluded people in society and incredibly excited about the opportunity of working with Phoenix Futures.

'I see my role as leading the organisation to meet the very real challenges present within the sector, while protecting the high quality of the drug and alcohol services currently being delivered,' she said.

Healthcare survey shows a patchy picture for drug service users

An inconsistent picture of care standards across England has been revealed by a national survey of substance misuse services.

The joint report from the Healthcare Commission and the NTA, who assessed services in 149 drug action teams, including all 56 mental health trusts within those DATs, showed that most services had improved.

But weaknesses were exposed across all areas of commissioning, prescribing, care planning and service user involvement. Thirty-eight per cent of local drug partnerships were scored as 'weak' at commissioning prescribing services, with 37 per cent 'good'.

Methadone prescribing for heroin users was patchy across the country, with some services failing to prescribe high enough doses to maintain users and prevent them from using street drugs. Only 30 per cent of services recorded giving a mean dose above 60mg. As well as inadequate supervision at early stages of methadone treatment, the report highlighted that many services were prescribing a standard dose, rather than tailoring it to the needs of individual patients.

Almost half of DATs were found to be weak at care planning, with a further 32 per cent 'fair'. Common mistakes were failing to find out about service users' overdose history, and not asking about their alcohol use. Thirty-five per cent of people in structured services said they did not have a care plan.

Although 72 per cent of services reported keeping clients in services longer, on average, than in 2004/5, some DATs had a smaller number in treatment for the recommended 12 weeks.

Service user involvement showed variation across the country, with 27 per cent of DATs scoring 'good' or 'excellent' and 7 per cent 'poor' at involving service users in design and development of treatment. Twenty-three per cent did not have local user forums, 31 per cent could not offer service users access to strategic planning groups, and 40 per cent did not offer training or mentoring to help them participate in service planning and monitoring.

NTA chief executive, Paul Hayes, highlighted that twice as many people now had access to drug treatment as in 1998, and said that for most people the experience of treatment was improving. But he acknowledged that the review demonstrated that 'in some places, local partnerships and health providers are failing to deliver the high quality of care needed to help people turn their life around'.

Mr Hayes said the findings of the review 'have enabled the NTA to focus its work on the areas which are failing their populations, to ensure that the worst performing areas match the quality of delivery elsewhere'.

'Beerhead' tackles young Scottish men

Men in West Lothian are being targeted with the equivalent of the DAT's well-publicised 'pink handbag' alcohol awareness campaign for women.

'The adventures of beerhead', developed in partnership with West Lothian Drug and Alcohol Service, NHS Lothian and 360 Degrees Communications, is a Sin City-style comic book, aimed at educating young men in an innovative and fun way.

This latest campaign reflects West Lothian's key priority of tackling excessive alcohol consumption, seen particularly in a rise in binge drinking in young men.

'Statistics indicate that one in three men exceed weekly recommended guidelines for alcohol,' commented Hilary Smith, research and development officer at West Lothian DAT. 'We know that young people are starting to drink at an earlier age and 16 to 24 year-olds are the most likely to drink heavily. West Lothian DAT is keen to promote a responsible attitude towards drinking and this resource will target young men and provide them with factual information and advice relating to alcohol.'

Margot Ferguson, general manager at West Lothian Drug and Alcohol Service, added that the resource had been market tested with the target audience before production, and highlighted the support services available to young men.

Westminster DIP Conference

DIP 'achieving aims'

With more than 800 offenders a week entering treatment – double the number two years ago – the Drug Intervention Programme is achieving its aim, according to Peter Wheelhouse, DIP programme director.

More than £500m ploughed into the programme had resulted in a 22 per cent reduction in recorded acquisitive crime, he told Westminster City Council's DIP conference this week. Drug testing now took place in 175 custody suites, with drug workers to hand in most of them. There was better integration with CARATS staff, and more Drug Rehabilitation Requirement (DRR) commencement and completions than ever before.

With a target of getting 1,000 offenders a week into treatment, Mr Wheelhouse said he wanted to make sure these were the 'right people', who would receive the right treatment regimes. Research that had identified that 20 per cent of offenders were responsible for 60 per cent of convictions for trigger offences had shown the value of targeting the 'high crime-causing user'. Mr Wheelhouse said there would be tougher responses to breaches, and closer working and information sharing with probation and prisons to prolific and other priority offenders (PPOs).

There was still a need to align DIP and PPO schemes more closely with more routine cross-referencing, to make sure people who tested positive got rapid access to treatment. 'There are still people at the core of this who are making a disproportionate impact,' said Mr Wheelhouse. 'We need to use all tools to work with them.'

Hungerford open access support

The Hungerford Drug Project, a Tier 2 and 3 service, had supported Westminster Drug Project with a range of open access services, said Monty Moncrieff, DIP team leader at HDP.

Taking clients at arrest referral stage and from single point of contact, they had been able to link them to a range of services, including keyworking and drug treatment, liaison with providers, needle exchanges, referral to housing, and help with ID and benefits.

The intensive support and case management approach by the DIP throughcare team had given better flexibility for clients as well as better interagency work across the borough, according to Mr Moncrieff. Services, such as prescribing, could now be extended to weekends to target prisoners released on a Friday.

Improvements were visible, but there were labour intensive challenges ahead, he said – not least locating clients once they had been released from prison and maintaining their interest in treatment.

'They will say yes to everything when they are in prison,' he pointed out. It was often a different matter when they were released.

Testing increases pressure

Since the introduction of test on arrest in April 2006 there has been more pressure on treatment services, said Wendy Ryan, DIP programme manager at Westminster.

With a 50:50 caseload of housed and homeless clients, the team was focused on improving retention and increasing effectiveness. Needs assessments had shown that a substantial number of Black and Asian people were not accessing services, and many women who had been assessed through the triage system were not coming back.

As well as the key challenge of improving housing, Ms Ryan said other priorities were developing an equality and diversity strategy and a multi-agency harm reduction strategy, as well as 'engaging service users and carers in everything we do'. Targeting hard to reach groups like sex workers would be done by 'looking with police and partners at what we can achieve'.

The borough was gearing up for the requirement of follow-up assessments for people who test positive for drugs – an element of the Drugs Act that would be 'switched on' in April 2007. There were resource implications, as many people tested in Westminster were not from the borough. Would they be providing the follow-up elements for other boroughs, asked Ms Ryan, who suggested that their partners in the police would need a small team of case progression clerks to manage this new element.

Despite these concerns, Ms Ryan emphasised that Westminster were committed to DIP and aware of the reasons for its coercive approach.

Our job is to get more drug users into treatment,' she said. 'We're very confident we'll get it right.'

Partnership a success despite slow start

With a successful DIP partnership testing 500-600 people a month and bringing about a steady decline in crime, Westminster's DIP champion chief superintendent David Morgan said the borough was now looked to for guidance and advice.

But he admitted that Westminster had 'not made the best of starts and took a while to work out what DIP was about'. Under pressure from the NTA, Home Office and Police Service, they had set about visualising a chain with links from arrest, to court, to prison. Having been set a target for reducing crime by 20 per cent, they were now on course to achieve this in two years instead of three.

Strong partnerships had been essential, with agencies meeting regularly and working closely together, he said. Focus had to be on individuals and their care plans, 'and not just on processes', and it was vital to make more accommodation available to create a drug-free environment and break the cycle of drugs and crime.

Westminster Drug Project's DIP project manager added that the Tough Choices Programme, which had introduced testing on arrest rather than testing on charge, had given drug workers the opportunity of offering support to drug users who might not otherwise come into contact with services.

Many recreational drug users saw themselves as in control of their drug use, so DIP offered the chance of more gentle intervention through offering harm reduction information that they could take back to others in their community. Those perceived as 'angry drug users' had benefited from having drug workers on hand to talk to them in custody.

Voice of experience

The conference heard from Jonathan, who had been a drug user for a long time before being 'captured' in a cell in Paddington Green. He was using £500 worth of drugs a day.

'I was an angry drug user, just interested in the next bit of gear,' he said. 'My default system through life was lies. I'd had the support of my family, but they'd washed their hands of me and said go and sort your life out.'

He had heard of treatment, he said, but didn't know what it meant. But it turned out to be his 'way out' and he was 'very grateful to those people at DIP'.

'I was never going to deal with life on life's terms,' he said. 'But now I've had Westminster Drugs Project's support, I will help anyone else I can.'

LDAN Annual Conference

Call for creativity and education to improve alcohol services

Professionals dealing with alcohol dependent clients should use creativity in offering support, rather than focusing on the lack of government funding for services, according to a nurse consultant.

Speaking at an LDAN annual conference, Claudia Salazar of Central and North West London Mental Health Trust, said: 'We have to be creative and focus on what we can do. This means highlighting the health risks through health education.'

Ms Salazar told delegates that the government's 'sensible drinking' levels of 14 units a week did not necessarily relate to people with hepatitis C, mental health problems or the young and old and risked seriously compromising their health. ' We need to be more specific with the information we are giving,' she said.

Calling for more empathetic brief interventions in place of lecturing the user, Ms Salazar said that having one person in charge of alcohol brief interventions in hospitals made a huge difference, as this person could teach and train other nurses.

There was also evidence to suggest that giving people small amounts of support over a long period of time was more effective than giving 'huge support' over a short length of time. John Podmore of Rugby House, and a former governor of Brixton prison, said that a holistic approach 'without silos' was a simple and cost-effective way to provide better services: 'We tend to get wound up as practitioners with what the client's dominant problem is or what came first,' he said: 'It doesn't really matter. What matters is [being a practitioner] who can appreciate all the issues.'

Matt Bradby from The Drink Aware Trust said that reducing alcohol misuse also depended on working with the drinks industry. The recent launch of Stella larger at 4 per cent, rather than 5.2 per cent was a 'move in the right direction'.

Alternative high

How do you replace the buzz of taking drugs with the buzz of achievement? Hindley Young Offender Institution took the brave step of teaching their inmates how to climb, use their initiative – and learn to survive outside.

Last October, professional instructors arrived at Hindley Prison and Young Offender Institution and began to teach a group of teenage inmates how to climb a wall. The idea might seem unlikely, but two months later, staff were celebrating the success of a scheme that has brought new skills and confidence to its participants. Perhaps more significantly, it is opening up opportunities outside prison, to give former inmates a chance of flourishing in the community.

The concept was to combine physical activities with essential life skills, explains Chrissy Hutchinson, group manager for the substance misuse service, who introduced the programme to Hindley, in consultation with youth work consultant Kate Clements.

'Young offenders would be given the opportunity to experience new and exciting activities that would act as a diversion to taking drugs,' she says. 'In addition it would be a basic course equipping them with life skills such as team-building, communication and problem-solving.' Skills would give a strong foundation for other schemes and qualifications, such as first aid and the Duke of Edinburgh's Award.

The young person's substance misuse service (YPSMS) staff talked to experienced instructors at Hill Climb Activities to design a programme of outdoor pursuits. The activities needed to be challenging, with the purpose of giving the participants an 'alternative high'. Instead of relying on substances, they would feel the adrenaline rush of taking a calculated risk, or achieving an unexpected goal.

'Young people are natural risk-takers. They have little sense of their own mortality,' says Graham Smith, Hindley's principal officer for whose role includes co-ordinating work with the voluntary and community sector. Activities would give them the skills to assess risk, make judgements, and consider possible consequences – transferable skills that would stand them in good stead in the outside world.

The programme is also designed to link to other initiatives – the government's 'Youth Matters' agenda, which advocates providing young people with 'things to do, places to go'; the Youth Justice Board's requirements that they are helped to find positive leisure interests within the Resettlement and Aftercare Provision (RAP) system; and 'Positive Futures' activities, being piloted within some youth offending institutes. So whatever the individual experiences and 'highs' for those involved, it also fitted with the strategic direction of the institute.

The course was set for half a day a week over eight weeks, with each session lasting two hours. When Andy Hill and Innes MacDonald arrived with climbing equipment – including an eight metre portable climbing wall – they found some of the lads nervous about the task ahead. After the mandatory health and safety instruction, they were taught how to scale the wall.

In the second week, Paul Hunterdale arrived to introduce problem-solving activities, supported by Innes MacDonald, and by Jenny Evans from the substance misuse team. The 16 young people were divided into two teams, to play team-building games. Each team had to complete six challenges as efficiently as possible, and with as few errors as they could. Every completed challenge earned points, and used different

skills such as thinking and listening, communication and strength, and groups were moved around the site so they could not see their opponents' tactics.

'Two contrasting teams emerged from the outset,' Jenny Evans observed. 'One team was a very dominant mix of young people, who were all very vocal, all trying to take the leadership role in their own right. The second team was a much quieter group on the whole, but they developed excellent communication skills as they listened to what each individual had to say. Through this they supported each other magnificently.'

A log sheet, which participants completed at the end, encouraged them to think about what they had enjoyed or disliked, as well as the outcome. Some of the lads told Evans, after the event, that they had enjoyed this session even more than the climbing, joining in the challenge and the feeling that 'the race was on'.

Weeks three and seven introduced all the skills for attaining an HSE accredited first aid certificate. The course covered conscious and unconscious casualties, bandaging and resuscitation and taught practical advice on dealing with situations such as asthma attacks, heart attacks and diabetic incidents.

'The benefits of these skills may be obvious in relation to outdoor activities, but from a substance misuse point of view the benefits fall in neatly with the harm minimisation ethos,' comments Phil Stuart of the YPSMS, who supported Andy Hill and Innes MacDonald in delivering the training. 'With the nature of our clients' lifestyle and the risks they put themselves at, the skills they have learnt may help a peer who has used illicit substances.' He added that 'it was refreshing to see them showing genuine benevolence to their mock casualties'.

More advanced climbing skills and rope work followed in week four, when they were noticeably more confident with the whole activity. By week five they were ready to learn the basics of navigation. The were shown a video from the Duke of Edinburgh's Award Scheme, taught the basics of map reading with the encouragement of Roz Ashworth from the YPSMS, and set loose within the grounds to carry out some orienteering exercises.

The sixth week had a survival theme, and included building a shelter and pitching a tent blindfolded – 'a fun activity that had both students and teachers in fits of laughter', says Graham Smith.

At the final session in December, the lads had a recap on all the subjects they had covered, and were then presented with certificates of achievement by Emily Thomas, Hindley YOI's head of reducing re-offending, who said: 'This is an excellent initiative for Hindley that will have very positive benefits for the young people we care for.'

While longer outcomes of the programme will need to be monitored, the staff at Hindley are satisfied that the two-month programme fulfilled its aims.

'We can say with some certainty that as the programme has progressed, each individual has gained confidence and developed new skills, says Graham Smith. 'Their progress becomes evident to them when they read their own weekly accounts of their experiences.' **DDN**

The lads' verdict on their 'alternative high'

Ben
'It showed me ways of enjoying myself without taking cannabis or cocaine'
I found it really exciting. It was interesting learning new skills and I liked the teamwork. I feel I've achieved something and learnt things I wouldn't have done before. It showed me ways of enjoying myself without taking cannabis or cocaine.'

Daryl
'Physical and enjoyable at the same time'
I enjoyed the rock climbing best, as you were doing something physical and enjoyable at the same time.

Dean
'It taught me how you should speak to people'
My favourite bit has been the rock climbing and I also enjoyed the camp craft. I didn't know any first aid before, but now I would know what to do if something happened. I found the team building good as it taught me how you should speak to people.

Lee
'It's improved my confidence'
I learned different things like rock climbing and team work. I feel glad that I've done it as it's improved my confidence. When I get out I would definitely do something like that again if I got chance, but before doing this I wouldn't have wanted to.

Bradley
'It gave me a buzz'
I thought it was an enjoyable activity and it gave me a buzz. I learned new things so I'm glad it gave me this opportunity. It also involved team work which was good.'

Lee
'It gave me the chance to learn new skills'
I loved it. It's not everyday you get a chance to do something like this. I wouldn't have thought of doing it before, but I got the opportunity, went for it and loved it. It gave me the chance to learn new skills like first aid. My favourite bits were all the team building exercises and the wall – basically all the ones you had to think about. They really got you going.

Ian
'It has given me ideas'
'It's a great opportunity for people inside. I loved the rock climbing with my mates as it then became a challenge – it showed me how to work as a team. It has given me ideas to take it up when I get out.'

Karl
'I loved it all'
'Great, fantastic. I loved the rock climbing – in fact I loved it all.'

Sean
'I'd recommend it to others'
It was good – pretty cool. I'd recommend it to others. It gave me a chance to learn new skills.


Home detox:
a step too far?

No to unsupervised detox, say readers

In our last issue of 2006 we asked on our website poll: Should medically unsupervised detox be allowed? Of 116 readers, 63 per cent voted 'no' against 37 per cent 'yes', and some of their reasons, thoughts and concerns about home detox are given below.

This fortnight we want to know:
Do you believe the Drug Intervention Programme has been a worthwhile initiative? Partners in Westminster City Council's DIP gave their verdict so far at a conference this week (page 5). Please visit www.drinkanddrugs.net and give us your vote. More detailed comments are welcome for the letters page; write to the editor at the usual email or address on page 3.

Qualified agreement

I voted yes… BUT, I think the drugs that are given for this should be carefully chosen as well as the families that are given this 'home detox' option.

Every addict, during heroin withdrawal will use any means necessary to get medication to stop the sickness. (I speak from experience here.) Giving these drugs to an addict's parents to administer 'when needed', whereby a combination of them could kill the patient, is slightly reckless in my opinion.

A parent might have a very hard time saying 'no' to a desperately sick and pleading son or daughter. And that addict could possibly have a stash of pills to add to the mix, 'just in case' the symptoms got bad. Addicts lie… a lot.

Giving the sole responsibility of a home detox (to administer the drugs and 'watch the patient 24/7') should not be given to an addict's parents. The responsibility should be shared by a home nurse, a case worker or even another addict who has been through it themselves… someone who could help the parents say 'NO, your next dose is in three hours and NO I won't give you all of them at once!'.

A comment on Dr Brewer: Thinking outside the box is a good thing when it comes to treatment. I believe Brewer meant well but just went way too far in what and how much he prescribed. It was almost as if the good doctor just couldn't say no, giving his patients whatever he or she wanted in whatever amount they could tolerate.

I feel for some of his patients, now that Dr Brewer's services are no more… these poor addicts with these 'huge' habits to maintain. Who will take them on now?
Ceane DeRohan, by email

It depends…

I was about to vote on your detox survey, but the answer depends upon what drug the person is requiring a detox from:
Alcohol – no
Opiates – yes
Benzodiazepines – possibly.
Derrick Anderson, mental health/ addictions specialist, Clouds

No supervision is dangerous

Our response to the debate is that a medically unsupervised detox is potentially dangerous. Though the unsupervised client will begin detox with the best intentions to strictly follow his or her doctor's instructions, we know the very nature of this disease can make self-detoxing almost impossible due to the addictive nature of many detox medications and behavioural patterns.

The weapons necessary in the earliest stage of the battle against this disease (the detoxification period) are in themselves a danger to the addict if not properly supervised. Further, friends and family members, even those with the strongest desire to help the client, generally do not possess adequate knowledge of addiction and certainly do not have the necessary medical training to act appropriately in emergency situations. However, due to the lack of financial and human resources in the NHS, statutory and voluntary sectors, most of the drug and alcohol users in this country are required to detox with very limited medical supervision.

The NHS is overstretched on budgets for substitute prescribing and for drug and alcohol workers to monitor the volume of clients on their caseloads. It is the age-old question of does one sacrifice quality for quantity? Having worked in the drug and alcohol field for over 20 years I am aware of the dilemma the statutory sector faces. It is because we ultimately believe that drug and alcohol detoxification should be medically supervised by trained professionals that my business partner and I founded Detox At Home Ltd, a private home detox service for people wanting a safe means to end their habitual intake of addictive substances. Our model ensures clients are supervised 24-hours per day and that detox medications are maintained and administered only by nurse specialists.

We did not set up the service in opposition to traditional treatment centres – quite the contrary – but we also understand that for some people this cannot be the only answer. Many of our clients have repeatedly attended treatment centres and feel that they a) cannot afford the time or money to repeat this process or b) have recently lapsed and simply need to reconnect with their support services once detoxed. We actively seek to re-engage clients with all their supports, including therapists, treatment facilities, community services and the fellowships. Our belief is that if we can supervise a safe detox, the client is then in a better mindset to absorb the vital therapeutic input they receive thereafter.

We also believe that the home environment – the client's family and support system – are critical elements in starting and keeping the client on the road to recovery. The in-home aspect of our model

allows our professionals to provide care and support not only to the using client, but also to the family and others involved in the client's life. Many times clients leave treatment in a good state of recovery, only to return home to the stressors that contributed to active addiction in the first place. Frequently, these stressors include the damage sustained by significant others during the client's using history. These stressors can result in feelings of guilt, shame and ultimately to relapse.

By providing support to the family during the detox period, work can begin immediately to alter dysfunctional patterns and dynamics. Having worked in many treatment centres I am aware that some family members find it difficult to address their roles in the addiction, believing it not to be their problem. We provide these family members with compassionate support, while educating them in addictive disorders.

Analysis of the most recent data from the National Drug Treatment Monitoring System estimates a 113 per cent increase in individuals making contact with structured drug treatment services between 1998/99 and 2005/06. This report states that 181,390 drug misusers sought help in England in 2005/06 and this data excludes the prison population. (Data from Manchester University, National Drug Evidence Centre.) These staggering statistics clearly indicate the need for a wider scope of detox and treatment services overall. The high morbidity and mortality rates make it particularly important that drug misusers remain in regular contact with treatment services.

In September 2004 the Department of Health published *Management of Medicines*, which is intended to support medicines management within the national service frameworks. Its main focus is on the involvement of the patient, family and carers in prescribing decisions and subsequent concordance with those decisions. Services such as ours recognise the critical importance of involving client, family and carer in building a solid foundation for recovery by beginning recovery in the environment that will need to sustain recovery: the home.

Moira Rothery, clinical nurse specialist, Detox at Home. www.detox-at-home.com

Issues of trust

As an addict, I voted 'no' – the reason being that detoxing is not only hard but it can be dangerous, and fatal if not properly administered. I have learnt this from my own experience, as well as from many others, including on the professional side.

More importantly, when we are addicted, although we want a detox because of how the illness and affliction affects our state of mind, it is so common for us to lie, deceive and abuse the trust of any drug worker or supervisor. It is very common for the detoxer to have a double hit – taking what they are given to detox, yet continuing to use their drug of choice.

It would be interesting to know how members of the profession voted, compared to addicts. Maybe this would back up my concerns!

Sean Rendell, by email

Reconviction a crude measure

Peter O'Loughlin ('Does anyone care?', *DDN*, 4 December 2006, page 9) implies that high rates of reoffending for people given DTTOs are to do with reluctance to use abstinence-based treatment with this group. As measured by the proportion who are convicted of another offence, the two-year reoffending rate is high (86.3 per cent of those given DTTOs in 2003).

But reconviction is a crude measure. It fails to take into account the characteristics of the offenders being sentenced. DTTOs were targeted at persistent offenders with a high probability of reconviction – regardless of what sentence they received.

Also, reconviction figures do not recognise reductions in the frequency of offending.

In our research on DTTOs in the QCT Europe study (published online recently in the *British Journal of Criminology*), we found significant reductions in the frequency of offending for people on DTTOs. These reductions were comparable to the reductions reported by people entering treatment at the same centres who were not on a DTTO.

We also found that people on DTTOs found it very difficult to adapt quickly to the requirements of abstinence-based treatment, and so tended to drop out very early where services insisted on abstinence from all drugs. This backed up the experience of the original DTTO pilots on the risks associated with abstinence-based approaches.

Treatment can offer an effective alternative to imprisonment for drug dependent offenders. The success of this alternative can be enhanced when it is offered as a genuine diversion from imprisonment (and not as an extra condition for offenders who would not otherwise have been imprisoned), when workers have the time and skills to build strong therapeutic relationships and when treatment is provided on the basis of clinical need, and not just on the preferences of judges and professionals and the existing pattern of local commissioning.

Some people on DTTOs/DRRs may need abstinence-based treatment. But there is no reason to suppose that insisting on abstinence for all would lead to a reduction in reoffending. It would be more likely to lead to an increase in imprisonment, as people have their court orders revoked for failing to comply with such treatment.

Alex Stevens, University of Kent, and Tim McSweeney, Institute for Criminal Policy Research

Erratum

I would like to apologise to Iain Armstrong and to the Department of Health for wrongly attributing Mr Armstrong's letter in our last issue (DDN, 4 December, page 8). Mr Armstrong made it quite clear when submitting the letter, that he was offering his personal view in his capacity as a freelance workforce development consultant and asked that it be so attributed. Mr Armstrong made it clear that, while he contracts with the Department he was not, in this case, representing the views of DH.

Editor, DDN

Q&A is back next issue...

So you still have time to send a response for Terry's question, below. Please email answers to claire@cjwellings.com by 23 January, to appear in the next issue of DDN. New questions are also welcome from readers.

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

Terry, Parkhurst Prison

The challenge for drug treatment is how to connect with people, says *Jim McCartney*.

New Year challenge

One of the significant challenges we face within the drug treatment sector is how to connect with our service users in a socially intelligent way to transform strategic thinking. Target driven objectives encapsulate the way this government functions – yet despite their importance in setting the direction of strategy, we can run the risk of superficial box-ticking exercises replacing an actionable and dynamic plan that can radically transform human lives trapped within addiction.

The public sector is, by its very nature, driven by a contractual relationship with organisations and people, which can scar its ability to connect meaningfully. For example the contractual concept clearly evident within the Criminal Justice System, whose paramount function is to manage and control offenders and keep our streets safe, cannot solve the problems of an increasing prison population. Why? Because there is little consideration given to the nature of relationships and the factors that influence behavioural processes.

The 1990s saw the dawn of competitive tendering, with the public sector entering a new arena with the private and third sectors. This was further developed by the New Labour Agenda, yet little attention has been given to the harvesting of quality relationships. It resulted in highly effective systems of monitoring and a litany of new buzzwords – but do they have substance? The word 'quality' still has a weak voice within drug treatment strategy. This is because if we inflate its importance, it might contradict the very systems we have put in place to monitor our effectiveness.

There is no doubt we have come a long way in the last five years, mainly due to the creation of the National Treatment Agency, with its impact on service delivery and organisational design. Yet in many places there are still important parts of the jigsaw missing; a greater focus on holistic development and a move away from the domination of the clinical concept of treatment have to be addressed. We need to elevate the concept of human development to the forefront of strategic thinking.

The NHS perception of strategy is confined to the medical concept, and it runs the risk of becoming tunnel visioned and unable to grasp the developmental nature of people who often want to be set free from a life of prescribed drugs. The new drug treatment strategy post 2008 will need to focus more on the total and complete liberation of the addict, as well as focus on how to counteract the stigmatisation that still exists in our society, where people can be labelled according to their past histories. In addition it will need to look at the long-term development of some people who have never been accustomed to the employment market, who need a tremendous amount of coaching and managing as they prepare for the culture of work, and support when they enter employment. We need to open the door to specialist human developers who can influence strategic thinking and transform the clinical perception of strategy.

I have recently set up a 'mind gym' for graduates of our rehabilitation programme. This is a gym of excellence, providing opportunities for people to metaphorically stretch the mind muscles into new realms of thinking. Each member of the gym is professionally managed and coached as they tap into the new resources they are discovering at the core of their being.

This is part of the Kaizen initiative that I have introduced into post Tier 4 treatment. Kaizen is the Japanese term for 'incremental', and represents gradual continuous change and improvement. It is a management philosophy assuming that every aspect of our life deserves to be constantly improved.

The Kaizen philosophy lies behind many Japanese management concepts, such as 'total quality control'. Each member of Kaizen can be an asset to any business because they have radically transformed their lives; they have the essential strategies in place to succeed, and guard against failure. There is a strong marketing element to the initiative as we give people a new brand image to the wider community.

Kaizen becomes a place where therapeutic graduates can return and share their experience. It provides 'human capital', the accumulated stock of skills, experience and knowledge. Creativity is a useful process because it improves communication, promotes learning and helps to develop new ideas, solutions or alternatives. In this setting, group creative problem solving gives participants an opportunity to articulate their thoughts, perceptions and assumptions. Most of its associates are also ex-offenders and have invaluable insight into the complexities faced by both criminal justice and drug treatment sectors, so they are able to give a priceless consultation to the evolution of public sector reform.

This is all part of the 'whole person paradigm', and develops the premise that human beings are not things needing to be motivated and controlled; they are four dimensional – body, mind, heart and spirit. The challenge for us is to get the balance right and nurture the intellectual, emotional, spiritual and physical components that can equip the individual with the desire to discover their potential.

Jim McCartney is the Chief Executive of T.H.O.M.A.S. (Those on the Margins of a Society). For further information on Kaizen, email edges@globalnet.co.uk

Jack of all treatments

Clients have varying needs and are unlikely to respond to being pigeonholed, so why not offer them a variety of treatment options? *Stephen Donaldson, Robbie Corrie* and *Dr Marian De Ruiter* explain how they have combined their expertise to give a more responsive range of services on site and urge other teams to share good practice.

Inpatient treatment services can be seen by clients and professional groups as the 'must have' treatment package. In reality not all clients need an inpatient stay, so Tier 4 services should be aimed at those presenting with severe substance misuse problems, who require 24-hour care. This may include clients with a dual diagnosis, or those presenting with complex physical or psychological needs.

For many patients, a 'jack of all trades' approach to different treatment options benefits them well. Our Surrey-based Tier 3 adult substance misuse service, the Windmill Drug and Alcohol Team, is made up of staff from varying professions and offers a variety of community treatments. These include substitute prescribing; one-to-one key-working; home detoxification; individual counselling and psychotherapy; and addiction-related groups.

For clients needing more intensive treatment, we have the option of referring them to Windmill House, a specialist inpatient drug and alcohol unit. This ten-bed unit, dedicated to substance misuse treatment, is housed on a general hospital site. The community team is housed in the psychiatric unit, close to both psychiatric and general medical services, which allows inter-speciality working and benefits all involved.

Referrals to Windmill House come predominately from the community team, with our neighbouring Tier 3 team admitting clients to the two beds they purchase annually. The inpatient team comprises nurses of varying grades, doctors, occupational therapists, health care assistants and drug and alcohol workers, with both inpatient and community services having the same consultant psychiatrist as their clinical lead.

As an NHS service provider, the Windmill Team, including Windmill House, provides an inclusive service to a heterogeneous client group, which can accommodate for those with particular needs, such as learning disabilities or mental health issues.

In all cases, realistic expectations of what the client can achieve and participate in are important, and while goal-setting is in no way an exact science, the use of a multidisciplinary ward round to review clients' progress allows for open discussion of reasons to include or exclude clients from certain treatment options, according to the impact this may have on their recovery.

The philosophy of the unit is to provide clients with a supportive environment where they can begin to address their substance misuse and related problems, and they are offered a number of inpatient treatment options. These can be broken down into two main treatment modalities – detoxification and group-based intervention.

A six-week primary rehabilitation programme is offered either following detoxification or as a stand-alone intervention (for those using substances not requiring detoxification, or who have achieved abstinence in the community). The programme has both a cognitive behavioural and psychodynamic focus, which allows clients to develop positive coping styles while also gaining a better understanding of themselves and factors that have contributed to their substance misuse.

We offer various treatment options, which combine detoxification and the rehabilitation programme, to assist clients to achieve their goals. These include:

- Stabilisation/titration, for those whom abstinence is not a realistic treatment goal. Stabilisation prevents the continued use of heroin on top of prescribed medication.
- Day detoxification, which is offered when the client's carer is unable to be present during work hours. Day detox represents a combination approach and creative bed management, as the client is admitted while their carer is unavailable. They return home each night, therefore not occupying an inpatient bed but still accessing staff expertise.
- Inpatient detoxification, when clients are unsuitable for community detoxification. They are expected to undertake detox groups, aimed at increasing their insight into the nature of addiction and relapse prevention.
- Detoxification and programme, where clients join the six-week primary rehabilitation programme, undertaking three-weeks as an inpatient and the remaining three as an outpatient. This is designed to allow clients to reintegrate back into their lifestyle, without the presence of drugs and/or alcohol while still receiving intensive support.
- Programme only, where again clients undertake the six-week programme, initially as an inpatient, and then as an outpatient for the last three weeks. They are likely to have achieved abstinence in the community and need to develop insight and skills to maintain their abstinence or to break the cycle of use.
- Day detox and day programme, a combination of the above where the patient does both elements of detoxification and programme, but doesn't require admission.
- Naltrexone challenge, for those who are being detoxed from heroin on the unit as part of their detoxification process, or who may be reducing in the community and require a brief admission to commence on Naltrexone.

This 'jack of all trades' approach to treatment options is in no way used as a derogatory term. Rather, it allows flexibility to respond to clients' complex needs and gives a creative means of managing expensive and precious inpatient beds. Without the specialist staff base, clear review processes and dedicated environment, many clients most in need of therapeutic intervention may not be admitted. For example a recent audit identified a large number of dual diagnosis patients being admitted to Windmill House over a year period. This client population, and especially those who display self-harm behaviours, are often difficult to manage within therapeutic communities because of the therapy interfering behaviours they exhibit.

Is Windmill House unique? Probably not! However inpatient units can vary so greatly it's difficult to pin down how many units there are, let alone what services they offer. While the work by the NTA and others goes some way to suggest good practice for varying unit types, and DDN allows practitioners to share ideas for practice, it could be argued that there is a need for a national inpatient unit forum. This could be in the form of an electronic community, where inpatient teams can share practice, opinions, or ask other units for advice. After all, why reinvent the wheel?

Stephen Donaldson is substance misuse specialist and Dr Marian De Ruiter is consultant psychiatrist, at the Windmill Drug and Alcohol Team; Robbie Corrie is Ward Manager at Windmill House.

What improves the chances of a successful treatment outcome from rehab? *Paul Goodman* offers suggestions based on research of Ley Community clients.

The right rehab:

is it more than a hunch?

How do community-based drug workers decide where to refer clients for treatment? What are they looking for, and what do they have to take into account? How much will a placement be based on budgetary considerations, or the personal knowledge of drug workers of residential units they have used in the past?

Will a placement be influenced about knowledge of 'success' attributed to different treatment facilities? And if so, how does the community-based drugs worker get access to statistics about success that compare one residential treatment facility with another?

And even if the community-based drugs worker is able to gain access to successful completion rates for different facilities, will the figures be comparing like with like? The completion rates for a six-week programme are likely to be significantly higher than for a six-month programme. And how do you take into account the differing seriousness of addiction problems that people have on entering treatment?

All this is further complicated by the fact that some residents who successfully complete programmes relapse, while others leave the programme early against advice, and then go on to make a success of their lives. Ultimately programmes must be judged by long-term outcomes after treatment is completed rather than completion rates. Yet for all their imperfections, successful completion and length of time in treatment remain currently the two best measures of effectiveness of treatment programmes. Research evidence (from De Leon and Simpson, for example) consistently confirms that the prognosis for positive long-term outcomes is linked to the length of time spent in treatment.

At present, it is difficult to get hold of data on 'successful completions' that compares one residential facility with another. It is, of course, difficult to follow up all residents when they leave residential treatment: the successful residents are likely to remain in touch, while many simply disappear. The only way to follow up everyone is through the police database that will provide information about convictions before and after leaving treatment. In 2001, Dr Marian Small, research psychologist employed at the Ley Community, replicated earlier research that demonstrated that the longer that residents remained in treatment at the Ley Community, the less likely they were to be convicted of subsequent offences. Table 1 below summarises the level of convictions in the two years before admission for treatment, and for the two years after leaving the programme, broken down into four tranches dependant on the length of time that they remained in treatment.

Small found that those residents who left within a month of admission committed slightly more offences in the two years after leaving the treatment programme than they committed in the two years before admission. The longer residents remained in treatment, the less likely they were to be convicted of an offence during the two years after treatment.

More recently, we looked to see what had happened to the 186 residents who left the Ley Community programme between 1 January 2004 and 30 October 2006. As indicated earlier, we had much more information on those who stayed for longer as opposed to shorter periods. The findings are shown in Table 2.

During the period covering just less than three years, 59 ex-residents (32 per cent) are known to be drug free. In view of the serious nature of addiction that residents had on arrival in treatment, this is a significant achievement. It is also possible that the figure is an underestimate. We have had a number of positive messages left on the guest book of the Ley Community website from ex-residents who 'disappeared' and were thought to have relapsed, but who

Table 1 – Reconviction

Length of Time in Treatment	Reconviction Rate
1 day – 1 month	104%
1 month – 6 months	58%
6 months – 12 months	31%
Over 12 months	8.5 %

Table 2 – Outcomes

Length of Time in Treatment	No. of residents	Outcomes
0 – 1 month	30	Outcomes not known, but likely to have relapsed
1 – 6 months	44	1 deceased, 5 relapsed, 39 unknown, but likely that a significant number will have relapsed.
6 – 12 months	28	7 drug free, 6 relapsed, 15 outcomes not known
12 months plus	84	52 drug free, 23 relapsed, 1 deceased, 7 unknown

have actually settled successfully away from the Oxford area.

We are aware that the Ley Community caters for a particular niche market in the substance misuse field: entrenched addicts who have had enough of prison and their chaotic lifestyle, and are desperate to change. They need to be very motivated to be able to abide by the rigid and demanding therapeutic programme. The issues that residents need to resolve cannot be sorted out in a few months. There will always be a number of entrenched addicts that require a long and intense treatment programme. The culture that instils in new residents that somehow the combination of 'tough love' and 'self-help' provides the basis of recovery is evident in the retention rates. 45 per cent of residents in the sample stayed in treatment for at least 12 months.

In a competitive market place, how are community-based drugs workers to get to know the variety of different treatment programmes available, and how do they select which facility is right for any particular client? The Ley Community is supported by a highly committed group of community drug workers who have seen previous placements work, and continue to refer. Their commitment to their clients is inspiring.

At a recent graduation ceremony at the Ley Community for 12 residents who have been clean and in employment for at least 12 months from completing their programme, community-based drug workers travelled to Oxford on a late October Friday evening from Edinburgh, Sheffield, Manchester, Stafford, Nottingham, Kent and Gloucester to celebrate with their former clients. It would be impossible to overstate the significance to the individual graduate of the long-term commitment to them of the drug worker who originally referred them into treatment.

It certainly underlines the fact that successful recovery is dependant on a close and collaborative relationship between the residential facility and drug workers employed in the community. We would only wish that the programme at the Ley Community is on the radar of community-based drug workers who have yet to hear about our programme that is aimed at a quite specific client group of seriously entrenched addicts who have simply had enough of using.

Related research:

- *De Leon G, Jainchill N, Wexler H (1982),* 'Success and improvement rates five years after treatment in a therapeutic community'. *International Journal of Addictions 17(4).*
- *Simpson D, Joe G, Rowan-Swal G, Greener J (1995),* 'Client engagement and change during drug-abuse treatment'. *Journal of Substance Abuse 7.*
- *Small M, (2001)* 'Two Year Reconvictions in a Rehabilitation Centre', *Therapeutic Communities 2001, Vol 22, No 2.*
- *Wilson S, Mandelbrote B (1985)* 'Reconviction Rates of Drug Dependent Patients Treated in a Residential Therapeutic Community: a Ten Year Follow-up', *British Medical Journal.*

Paul Goodman is chief executive of The Ley Community

Safer injecting practice

How much citric?

Exchange supplies are giving clients a chemistry lesson on DVD with their sachets of citric acid. DDN asks why.

Ever since we started distributing citric acid sachets, there has been a lot of debate about how much citric acid heroin injectors should use, says Andrew Preston of social enterprise, Exchange Supplies.

To resolve the debate, he asked Dr Jenny Scott, lecturer in pharmacy practice at the University of Bath, to demonstrate dissolving heroin with citric acid in the laboratory – and to talk him through the process.

Dr Scott takes 130mg of heroin and cooks it up with water. The mixture stays clumpy, where the heroin is not properly dissolved. She then repeats the exercise with 20mg of citric acid, adding it little by little, from a sachet. There are no clumps and no heroin left floating on the surface.

As she demonstrates this process on the DVD, Dr Scott explains that there is no visual difference between samples with more or less volumes of citric acid in them. The chemical composition is vital however: the more acidic the solution becomes, the more damaging it is to veins. The carefully weighed citric acidic she has just added to the heroin gives a reading of 2.55 acidity – enough to dissolve the heroin without tipping its acidity into the danger zone.

'Most injectors add too much citric acid to their heroin, and it causes major vein damage,' says Andrew Preston. 'Always err on the side of caution when dissolving citric. There's always a danger of knackering veins within a short time.

'Small amounts of acid will dissolve your drug – look for it going clear,' he advises. Too much acid causes chemical burns, inflaming the lining of the vein and causing clotting and scar tissue. Older injectors are likely to shift to deeper veins.'

Andrew Preston and his business partner Jon Derricot have been harm reduction activists since coming across more and more injuries associated with using lemon juice to dissolve the drug. They formed Exchange Supplies back in 2001 as an initiative to produce citric acid for needle exchanges to supply to drug users – but progress was in no way straightforward.

Despite the apparent logic of a harm reduction initiative, they were met with opposition from pharmacists who discovered that technically it was illegal to sell citric acid, according to the Misuse of Drugs Act. So they argued a 'crime prevention' case with the authorities, until the Crown Prosecution agreed that if pharmacies' only crime was to supply citric, it wasn't a disciplinary matter.

They visited pharmacies with a letter explaining this – and their supporters started to send letters to their own police force and pharmacies. Some pharmacies were adamant that it was still technically illegal; others saw it as an opportunity to take a practical stand for harm reduction.

Support from the field propelled Exchange Supplies into developing more paraphernalia, and advising needle exchanges throughout the country. **DDN**

For citric acid and copies of the DVD, or for more information on harm reduction, visit the Exchange Supplies website at www.exchangesupplies.org

Stages and processes of change: Part 1

Professor David Clark begins a description of a major influential model in the field, the Transtheoretical Model of Change, developed by James Prochaska, Carlo DiClemente and their colleagues.

In recent Briefings, I have been considering theories of addiction and factors that influence addictive behaviours and problematic substance use.

I will now look at the Transtheoretical Model of Change, which describes the stages and processes that occur when people change a problematic behaviour, such as substance misuse. This theory provides the basis for developing effective therapeutic interventions, and helps us better understand the problematic behaviours themselves.

The Transtheoretical Model has its origins in early research of James Prochaska who, along with a number of other psychologists, acknowledged that no single therapeutic approach had been shown to be more 'correct' than others. He recognised the necessity to 'unwrap' the various approaches to reveal the key elements that are required to help people overcome their problems.

Prochaska postulated that the hundreds of therapeutic theories could be summarised by a few essential principles which he called 'processes of change'. These processes were defined simply as, 'any activity that you initiate to help modify your thinking, feeling or behaviour ...'.

On the basis of his research, Prochaska and colleagues proposed nine major processes of change, which I will look at in the next Briefing.

They argued that all psychotherapies produce change by applying two or more of these processes. People who change their problematic behaviour without use of professional intervention (self-changers) also use these processes, or tools as they can be considered.

Prochaska and his colleagues went on to propose that people who successfully change their problematic behaviour use these processes only at specific times, choosing a different one when their situation required a different approach.

These different times seemed to be consistent from one person to the next, independent of their problem, *ie* smoking, excessive drinking, drug misuse, over-eating, mental health, over-exposure to the sun, and others.

Prochaska and colleagues proposed that change comprises a series of six stages that 'take place over time and entail a series of tasks that need to be completed before progressing to the next stage'.

These states of change are:

Pre-contemplation is the stage at which people have no intention of changing their behaviour. They may be at this stage because they are uninformed, or under-informed, about the consequences of their problem behaviour. Alternatively, they may have tried to change a number of times unsuccessfully and now feel demoralised.

People at this stage may be in denial. They tend to avoid reading, thinking or talking about their problem.

Their family, friends or work colleagues may see they have a problem, and may complain or pressurise the person, but they can't see the problem.

'Prochaska and colleagues proposed that change comprises a series of six stages that take place over time and entail a series of tasks that need to be completed before progressing to the next stage.'

Contemplation is the stage where people acknowledge that they have a problem and begin to think seriously about solving it. They may have difficulties in trying to understand the problem, seeing its causes, and may be unsure about solutions.

Contemplators are more aware of the pros of changing, but are also acutely aware of the cons. This can produce a profound ambivalence that can keep people stuck in this stage for long periods of time.

Preparation is the stage where people are planning to take action within the immediate future, usually the next month. They may be making their final adjustments before they begin to change their behaviour.

People at this stage need to have developed a clear, detailed plan of action, and have learned the change processes that are required to help them through to the later stages of maintenance and termination.

Action is the stage where people have made specific overt modifications in their behaviour and lifestyles.

Changes during the action stage are the most visible, and therefore receive the most recognition. However, there is a danger that the key processes required to get a person to action and to maintain the changes following action are forgotten.

Maintenance is the stage in which the person works to consolidate the gains that have been made during the action and other stages, and works to prevent lapses and relapse. This period can last from as little as six months to as much as a lifetime.

A variety of strategies are implemented during the maintenance phase to help prevent lapses and relapse.

Termination is the ultimate goal for all people changing their problematic behaviour. This is a stage where the former addiction or problem does not present any threat.

The behaviour will never return and the person has complete confidence that they can cope without relapse. There is no continued effort in maintaining termination.

It is rare that a person moves through the stages of change in a consistent and linear manner. Some people who initiate change move from pre-contemplation to contemplation to preparation to action to maintenance.

However, most slip up at some point, moving back to contemplation, and sometimes even pre-contemplation, before renewing their efforts to change. The average successful self-changer recycles several times.

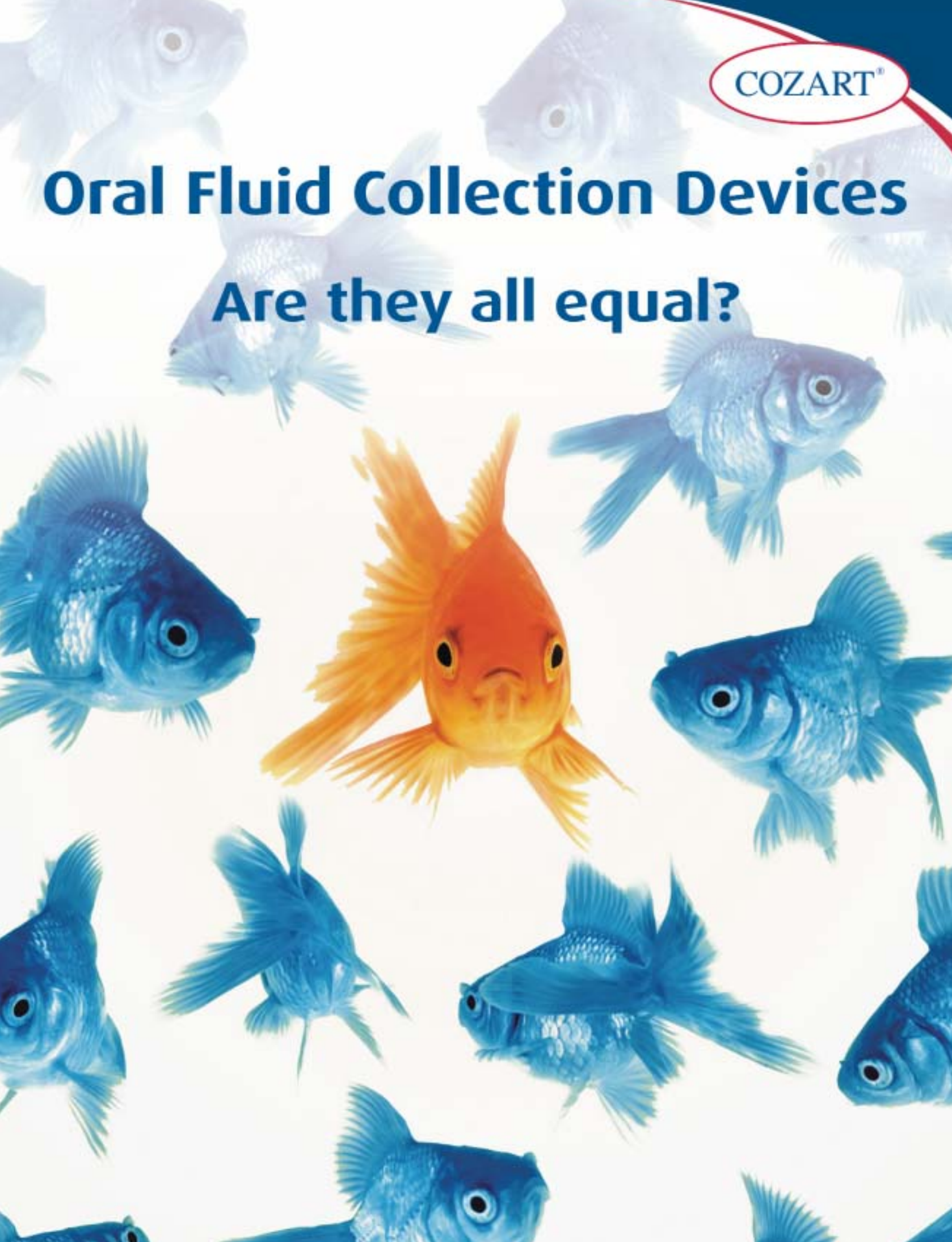
The next Background Briefing will look at the processes of change.

James O Prochaska, John C Norcross and Carlo C DiClemente (1994) Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. *Harper Collins. (Available from Amazon.)*

COZART®

Oral Fluid Collection Devices

Are they all equal?



COZART®

Is your oral fluid collection device...

- Free from animal products?
- Suitable for vegetarians and vegans?
- Free from stimulants?
- Collecting a known quantity of sample?
- Providing you with a visual indication of sufficient sample?
- Optimised for both on-site and laboratory drug testing?

If you answered NO to any of these questions

contact Cozart to discuss the Cozart® Oral Swab

Rapid, Simple, Accurate

Cozart plc
92 Milton Park
Abingdon
Oxfordshire
OX14 4RY

T: 01235 861483
F: 01235 835607
info@cozart.co.uk

www.cozartgroup.com

CRI

Bournemouth Assessment Team
incorporating Drug Interventions Programme (DIP) Team

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

Bournemouth Assessment Team Manager

(incorporating Bournemouth Drug Intervention Programme) *(Ref MP245)*

Salary: £28,742 – £30,415 • Hours: 37.5 • Project review date: 31 March 2010

The role is to manage, support and develop a team that is responsible for the Comprehensive Assessment, Care Planning and Care Co-ordination of individuals requiring structured treatment services for drug and alcohol addiction; enhanced drug arrest referral; through care & aftercare; support and assertive outreach services to substance misusers identified through a range of pro-active contacts in Police/Magistrate custody, prison or the community in Bournemouth.

Suitable candidates will be able to demonstrate experience of financial/budget management, have an excellent understanding of substance misuse and related offending, have sound knowledge of the criminal justice system and have an understanding of local Safe Guarding Children Board Policies and Procedures in relation to Child Protection. The suitable candidate will be able to demonstrate experience of leading a team effectively within a performance management framework.

Possession of or actively working towards a recognized management qualification in health and social care or a relevant professional qualification would greatly support your application.

Closing date: 29th January 2007

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

The successful candidate will be subject to a Criminal Records Bureau check at enhanced level. In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer

Safer communities through purposeful lives Registered Charity No: 1078077

RAPt

'Stopping Addiction, Stopping Crime'

COUNSELLORS & DRUG WORKERS WANTED

Starting salary £21,000 plus a generous benefits package

RAPt, one of the country's foremost providers of drug treatment services in the criminal justice sector are always looking for 12-step Counsellors and Drug Workers for their prison and community-based projects.

For more information, or an application pack, please send an A4 SAE and covering letter to:

Mandy Coburn, RAPt, Riverside House, 27 – 29 Vauxhall Grove, London SW8 1SY or email mandy.coburn@rapt.org.uk

RAPT strongly encourages applicants from Black and Minority Ethnic individuals and from those in recovery from addiction.

Registered Charity No. 1001701

Please mention DDN when responding to advertisments

---

www.commlinks.co.uk

Do you want to become part of an innovative and user-focused organisation?

Community Links Alcohol Support Service will open in Kirklees in 2007. We support people with alcohol problems to build independence.

Manager, Alcohol Support Service

£23,175 - £24,708 – 37 hpw **Ref: P15**

Previous management experience and substantial experience in the field of alcohol misuse and harm minimisation are essential.

Support Worker, Alcohol Support Service

3 full time and 1 half time posts **Ref: P16**

£18,450 - £20,235 – 37 hpw (half time post pro-rata)

Experience in the field of alcohol misuse and harm minimisation is essential.

We offer an excellent package, including generous annual leave and final salary pension scheme and work-life balance policies.

All posts are based in Kirklees.

For full application pack, visit our website www.commlinks.co.uk or write to Community Links, Regents Court, 39a Harrogate Road, Leeds LS7 3PD, fax: 0113 262 2294, or e-mail: maureenw@commlinks.co.uk

Closing date: 31 January 2007.

Interviews for the manager post: 15 February 2007; for other posts: 21 and 22 February 2007.

We aim for our workforce to reflect the varied and exciting region we serve. We particularly welcome applications from people from black and minority ethnic communities.

community links

NHS
Cumbria Drug & Alcohol Action Team

TACKLING DRUGS CHANGING LIVES

INVITATION TO TENDER

Adult Drug Treatment Services

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

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

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

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

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

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

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

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

KINESIS LOCUM LTD

Mental Health Professionals

- Continuing to provide for all recruitment needs of the Drug and Alcohol Services
- Does your service need staff?

Call Us **NOW!**

0207 637 1039

Because Good People are Hard to Find

www.kinesislocum.com

PCP

a new beginning

ADDICTION COUNSELLOR

Due to further expansion we are looking for a qualified counselor with 12 step experience and a minimum of 2 years experience within a similar environment (salary negotiable).

For further information and to apply for this position please contact Darren Rolfe, Treatment Director
Tel: 01582 730 113 www.pcpluton.com

Papa Stour Project

Full Time Support Worker

Papa Stour Project invites applications from experienced individuals (or couples wishing to job share).

This is a residential post. 37 hours/week fixed term appointment 01/04/07 - 31/03/08. In addition to food and board, a remuneration package worth in the region of £12k is offered.

We are looking for a self motivated and enthusiastic person able and willing to live as part of a small Christian-based supported housing service providing support for clients with alcohol/drug issues in a remote rural location in the Shetland Islands.

For further information and to obtain an application pack (closing date 16/02/07) please contact:
Sabina or Andy Holtbrook
01595-873238
sabina@papastour.org
www.papastour.org

EXPRESSIONS OF INTEREST

WILTSHIRE DRUG AND ALCOHOL SERVICES

WILTSHIRE CHILDREN AND YOUNG PEOPLE'S TIER THREE COMMUNITY SUBSTANCE MISUSE TREATMENT SERVICE

The Safer Wiltshire Partnership is looking for a suitably experienced Service Provider to deliver the Children and Young People's Tier Three Community Substance Misuse Treatment Service for Wiltshire.

The Service will enable children and young people up to the age of eighteen with substance misuse issues and complex needs to access a comprehensive community based tier three treatment service; and to help those using the Service to overcome their problems and live healthy crime free lives. In addition, the Service will be required to provide support to tier one and tier two Service Providers.

Service delivery is required across the whole of Wiltshire (excluding Swindon) and would need to ensure appropriate accessibility to treatment for Service Users and a responsive service to the requirements of referral agencies.

Expressions of interest must be submitted in writing or e-mail by 5pm on the 9th February 2007 to: Simon Jeffery, Contracts Manager, Department of Community Services, Wiltshire County Council, County Hall, Trowbridge, Wiltshire BA14 8JE or email: simonjeffery@wiltshire.gov.uk

Wiltshire County Council

LOOKING FOR HIGH QUALITY,SKILLED, SUBSTANCE MISUSE STAFF?

Consultancy, Permanent, Temporary

We Talk Your Talk…

- *A comprehensive database of specialist substance misuse personnel*
- *Providing staff for Public, Private, Voluntary and Charitable organisations*

We Walk Your Walk….

- *Recruitment consultants with many years experience in the substance misuse field*
- *Meeting all your recruitment needs for the substance misuse field: Criminal Justice; Treatment; Young People; Communities; Availability*

SAM Solutions in Action Management Recruitment & Consultancy

Contact us today: Tel. 020 8987 6061
Email: SamRecruitment@btconnect.com
Or register online

www.SamRecruitment.org.uk

Ceredigion Cyswllt Contact

SUBSTANCE MISUSE COUNSELLOR

Salary: *£18,000 up to £20,000 depending on qualifications and experience (Pay Review Pending).*
Contribution towards re-location costs.
Full-time position, 30 days per annum annual leave

An exciting opportunity has arisen to join the National Drug Team of the Year 2006 based in Aberystwyth and covering Ceredigion and parts of West Wales. It is essential that you have a counselling qualification and experience of working with the Minnesota Model. If you are in recovery you will have had three years of abstinence.

For an application pack please contact 01970 626470 or enquiries@recovery.org.uk, write to Contact Ceredigion, 49 North Parade, Aberystwyth, SY23 2JN or download the application pack from recovery.org.uk.

The closing date for applications is Monday 5th February.
For an informal discussion please telephone Maureen Fyffe on 01970 626470.

We are currently looking to expand our team of counsellors

Minsterworth, Gloucestershire

stepps

Applicants will need to be fully qualified, with a minimum of 5 years extensive experience within a residential setting.

The successful applicant will need to be proficient in group work, one – one counselling, abstinence based treatment and the delivery of workshops.

You will need to enjoy working as part of a multi-disciplinary therapeutic team. Set in the depths of the countryside Stepps offers the perfect supportive setting to work within.

Full Time Experience related salary.

Please contact Samantha Quinlan on 01452 750599 or info@steppsrehab.co.uk

www.steppsrehab.co.uk