DDN
Drink and Drugs News
20 November 2006
www.drinkanddrugs.net

CONFERENCE REPORTS
FDAP debates the future as the NTA go 'full and frank'

COMPETENCE ROUTES
Meeting targets is straight-forward with DANOS

COMMENT
Back-to-work challenge for service providers

GETTING IT RIGHT

Drug education in schools – a more effective approach

Your fortnightly magazine | jobs | news | views | research

Alcohol Concern
Making Sense of Alcohol

NATIONAL PROBATION SERVICE

"Improving local alcohol provision for offenders under probation supervision"

Treatment Providers Consultation Event

7th December 2006 @ The Selfridge Hotel, London

Alcohol Concern in partnership with the National Probation Service (NPS) is holding a consultation session with treatment providers who work with offenders under probation supervision with alcohol misuse issues.

The aim of the session is to gain a clearer picture of the issues providers face in working with offenders and to hear from providers how objectives from the NPS Alcohol Strategy can be met.

The session will explore:

- What's happening on the ground? Are Alcohol Treatment Requirements working? What provision currently exists?
- What are the challenges and obstacles that providers face when working with offenders?
- What recommendations can be made to meet the aims and objectives of the Probation Strategy?

Representatives from Alcohol Concern and NPS will make presentations and facilitate workshops to enable providers to give feedback on their experience of treatment provision for offenders under probation supervision.

This event is free, with lunch and refreshments provided.

To book a place for this event, please contact:

Email: alison.graham12@homeoffice.gsi.gov.uk
Tel: 020 7217 0686
Fax: 020 7217 0693

The closing date is Friday 1st December 2006.

NOMS National Offender Management Service
Working together to reduce re-offending

Published by

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Drink and Drugs News

20 November 2006

Editor's letter

What are the most significant challenges facing drug and alcohol services? Who would you like to see interviewed in DDN – and what questions would you like us to put to them? What issues would you like to see us cover in the magazine in the New Year?

Please visit our website and fill in our readers' survey, so we can plan ahead. (And yes, there's a prize..!) We want to know what you find interesting, which issues you want to debate and what you need us to challenge.

There's been plenty of challenging debate over the past fortnight. The FDAP and Alcohol Concern conferences in London (pages 4-7); Reducing Drug-related Deaths conference in Manchester (coverage to follow in our next issue). The NTA tell us the key issues they identified from 'full and frank debate' with commissioners and service providers at the 'Squaring the Circle' conference in Leicester. Read the next steps relating to Tier 4 commissioning on page 6.

On the back of widespread conclusion that most drug education in schools is proving ineffective, I was interested to hear about Dr Niamh Fitzgerald's opportunity to reconstruct the approach with Glasgow schools (this issue's cover story). With pupils saying they'd heard it all before, it was crucial to tune the curriculum to make it interesting and at the right level. Apart from keeping lessons lively with modern interactive resources, it proved just as important to make sure teachers understood the lesson plans so they had confidence in working with the material.

Dr Fitzgerald highlights the opportunities of schools and outside agencies working more closely together to give pupils (and families) different levels of support. It's as logical as making sure adults have aftercare when they come out of an institution; why wait until young people have been disconnected from one supportive environment before they need to be picked up by the next?

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In this issue

Alcohol Concern calls for service agreements

Health service commissioners are failing to address the harmful impact of alcohol misuse according to Alcohol Concern chief executive, Srabani Sen.

Addressing the charity's annual conference, Ms Sen said: ' They all recognised that alcohol misuse is a big problem, yet three-quarters failed to make any attempts to address the health harms and damage caused by alcohol'.

In a bid to make alcohol problems a genuine priority, Alcohol Concern will call on the Treasury to fund a public service agreement with the Department of Health and Home Office, to give more people access to brief interventions as well as alcohol treatment.

It was not AC's intention to criticise the practice of drinking, but to: 'raise awareness both among the general public and policymakers of the real impact that alcohol misuse causes to public health', said Ms Sen.

The government's emphasis on drunken crime and disorder is not enough, according to Ian Gilmore, president of the Royal College of Physicians. 'There are people binge-drinking in their houses,' he reminded the conference.

Head of alcohol harm reduction for the Home Office, Alex Lahood pointed out that the sole responsibility could not just be passed to the Department of Health as the health issues associated with alcohol needed support from all departments. 'We are working across the government and looking at a new strategy of harm reduction,' he said.

Director of the social marketing centre, Dr Jeff French, said focusing on the 'sensible drinking' message would encourage long-term behavioural change. 'We need to get inside people's heads to find out why they will do something, what they need and what will work,' he told delegates.

'Better policy drivers combined with a citizen focused approach' would get people working together for change.

Professor David Foxcroft, of Oxford Brookes University, called for education on alcohol to target the whole population – the groups perceived as lower risk who might have three or four drinks a day.

'Targeted prevention is the tip of the iceberg', he said. 'We have to work with the whole body of water to get the most activity done'.

Professor Christine Godfrey of the University of York, added that tax was the most cost-effective way to reduce alcohol related problems, to counter increased affordability and accessibility through off-licences.

Alcohol Awareness week will be held from the 7 – 14 May 2007. For more information visit the Alcohol Concern website on www.alcoholconcern.org.uk

New guidance for youth challenges

Youth workers are being offered guidance on dealing with challenging drug issues and providing support for young drug misusers.

The new document addresses practice and policies in youth work settings, and offers help on managing drugs issues in outreach work, coping with drug incidents and working with young people with problems.

Head of the education and prevention team at DrugScope, Dr Jenny McWhirter, said it would 'equip youth workers to face these challenging issues with confidence while retaining important contact with the young people they work with'.

Drugs: Guidance for the youth service is launched this month by The National Youth Agency and DrugScope www.drugscope.org.uk

Mentor sets early lessons on alcohol

The relentless rise in alcohol related deaths have provoked calls for more educational work to be aimed at children.

Alcohol project manager for Mentor UK, Derek Ferguson, said: 'recent statistics showed that the current government strategy to tackle alcohol misuse was simply not working'. He called for greater funding for prevention and educational work to reach children at an early age.'

Alcohol-related deaths have more than doubled between 1991 and 2005, with men accounting for two-thirds of all fatalities, according to the Office for National Statistics.

The death rate of women in the 35 to 54 age group had almost doubled within the last 14 years.

Ley Community patron, David Cameron, appeared moved as he heard graduation speeches from former residents that demonstrated their willpower and commitment since completing the programme. Pictured with Steve Walker, programme director (left) and Paul Goodman, chief executive, he acknowledged the courage needed to participate in the treatment. All 12 graduates have continued to abstain from drugs since leaving the community programme nearly a year ago, and are now in employment. They were congratulated as excellent role models for current residents battling to overcome their problems.

Drug money given to family support groups

Families affected by substance misuse are being helped through support groups funded by money recovered from drug trafficking.

The project, by Clouds Families Plus, uses the Home Office's recovered assets fund to provide 14 free weekly groups for families across the South and West of the UK.

Family members who attended the sessions have reported a reduction in stress and an improved ability to cope. 'I have put some boundaries in place and no longer cover up for the behaviour of the user,' said one.

Chief Executive for Clouds, Nick Barton, said it was good to think that the ill-gotten gains of drug traffickers were being used to help some of their victims, especially as the results were so encouraging.

'Hopefully, in time, as a result of this project, more families and communities will come to benefit from this type of intervention,' he added.

Experimenting starts 'as young as 13'

Almost 80 per cent of children have had their first experiences with drugs by the time they reached 16, with 39 per cent experimenting as young as 13, according to a new survey.

Clients from prison, residential care and community services across England and Scotland participated in the survey, by Phoenix Futures. The charity aimed to understand more about why people turn to drugs and alcohol, the recovery barriers and the urge to become abstinent from addictions.

Responses show 58 per cent of children ranking 'fun' as the main reason for trying drugs, while 31 per cent said they helped them to cope or block out a previous abuse.

Among the findings, nearly half of all clients were under 16 when they first tried heroin.

There were encouraging messages on recovery, with 75 per cent of respondents saying they were motivated to build a better future for themselves and 80 per cent wanting to gain employment and a decent income.

Chief executive of Phoenix Futures, Bill Puddicombe, commented: ' In contrast to the picture often painted of drug and alcohol misusers, this survey shows that, despite our clients having led lives in extreme social exclusion, they still want to enter the mainstream of society with the same opportunities to participate and contribute that the rest of us take for granted.'

FDAP Drug and Alcohol Professionals Conference, London

Tipping point reached on drinking culture

'It was brave of Health Minister Patricia Hewitt to try and raise taxes on alcohol – but it's unlikely to happen,' commented Don Shenker of Alcohol Concern.

Alcohol is 15 per cent more affordable than it was 50 years ago, he pointed out. 'We're a nation of binge drinkers. It's harmful to health and to the community.'

The nationwide picture of dependent alcohol users drawn by ANARP (the Alcohol Needs Assessment Research Project) showed 'staggering figures', even at the bottom of the league table of regions. While government 'has recognised the need for treatment because of hazardous and harmful use', there was a distinct mismatch between level of need and level of service supply: only one in 18 alcohol users was receiving the support they needed.

'We get stuck in a rut between the criminal justice and treatment agendas, but we need to make a link and not see the two as separate,' said Mr Shenker. Screening and brief interventions were among the most effective ways of reducing harm, he said, together with linking alcohol to cross-cutting Public Service Agreements on conception rates, crime, accident and emergency and domestic violence to form more coherent public health policy.

MOCAM had given a full range of interventions across Tiers 1 to 4. It was important to train the workforce to respond and to build capacity for service users with their involvement, he emphasised.

The Department of Health had confirmed it would be giving PCTs £15m to allocate to alcohol treatment in 2007-8. 'It's up to us to say how it should be used,' said Mr Shenker.

'We have reached a tipping point on drinking culture and need to change public opinion,' he added. 'We need to have good existing models of service and back-up from government policy.'

Harm reduction must be flexible

'Options on harm reduction have improved enormously over the last few years, and we're getting better at supporting people. But we still need to recognise what works,' Danny Morris of the UK Harm Reduction Association told conference.

Principles of harm reduction were pragmatic, goal-orientated and built on a public health approach, but the rights and dignity of service users had to lie at the heart of this, he said.

The Health Protection Agency's *Shooting Up* report highlighted that half of drug users in the UK had hepatitis C. Dangerous levels of ignorance had to be tackled, according to Mr Morris.

Many drug users had a casual attitude to 'lending' needles, not realising that they were passing on blood borne viruses. 'We know there aren't enough needles out there to cover the number of injectors,' he said.

Young people were associated with the biggest increase in BBVs and were 'a group that many of us feel we've failed', he said.

The NTA had started to introduce more consistency, and the recent NTA needle exchange survey had found many needle exchanges to be addressing safe injecting. But there was need for more flexible services, equipment for injecting drug users, and debate around harm reduction relating to young people and parenting.

'We have to overcome the divide between criminal justice and other treatment interventions,' Mr Morris emphasised. 'We need to develop services to meet needs.'

Rehabs need better commissioning

Rehab should be made available for more of the population, but this depends on more effective commiss--ioning and better alignment between DAT commissioners and community care teams, said Annette Dale Perera of the National Treatment Agency.

The NTA would not respond to calls for a national funding system for rehabs as this was not within its remit, she told delegates. While some rehabs were having difficulty – 'we reckon six or seven out of 120 residential rehabs in the country' – others were not, she said.

Recent problems in filling places had been 'more cock-up than conspiracy', and could be addressed by more transparency between service providers and commissioners; better consultation with service users on the appropriate provision for them; service level agreements with providers to ensure quality; and block pricing offered by rehabs to ensure value.

'We don't want rehabs going under,' said Ms Dale Perera. 'We might want some to modify and we need to meet market need better. She urged all rehabs to submit their data regularly to the National Drug Treatment Monitoring Service (NDTMS) so the NTA could get a more accurate picture of occupancy levels for commissioners. Last year more than half of rehabs had failed to do so.

Ms Dale Perera was also keen to emphasise that Tier 4 provision was not seen by the NTA as the only option, but one essential component of every local treatment system. Cautioning rehabs against 'unhelpful comments in the media', she said: 'We need community-based services. It's not helpful when rehabs say "we're the only way".'

Get basic competency in place

Fears about qualifications are misplaced, said Simon Shepherd of FDAP. 'We need to make sure anyone in the field is competent to work with vulnerable clients and that they're suited to do their role.'

While DANOS and qualifications offered substantial frameworks for competence, 'the real world' was some way behind, said Mr Shepherd. 'Everyone should have a role profile based around DANOS. We're a long way short of that.' People were not doing work profiling, because they hadn't a clue how to do it, he said.

However we should not run before we can walk, he cautioned. 'It's no good getting people to demonstrate their competence when they're not competent.'

Mr Shepherd had been involved in setting up the Competency Group (COG) to give managers guidance, including through e-learning and workshops.

'Let's get the first stages in place,' he said. 'Responsibility lies with frontline managers to get this right.'

DEBATES

Do workers need qualifications? Should coercion be used to get people into treatment? Do talking therapies work? DDN heard the debates.

'This house believes you shouldn't need qualifications to work in this field.'

Proposing the motion: Kevin Flemen, KFx

Being competent shouldn't be entangled with being qualified.

We need to clarify what is meant by the 'drugs field'; it includes drugs workers, peer educators, youth workers, housing workers and teachers. So we need a community centric approach to drugs work.

There's a belief that by having a group of workers who are qualified, they are competent. There's also a belief that treatment can only start when you come into contact with workers who are accredited.

Some qualifications don't qualify anyone for anything. They show someone's attended something for the day and managed to stay awake.

When we demand accreditation, we start to restrict and exclude. I would be saddened by a field that lost its diversity. People need different interventions; I don't want everyone to be judged by the same yardstick.

Opposing the motion: Caroline Frayne, Central and NW London Mental Health NHS Trust

It's important to look at the quality of workers, at workforce strategy and at the range qualifications – NVQs, degrees, diplomas and FDAP accreditation. We should think of qualifications as an equaliser, helping people to acquire skills.

Throughout huge changes in the NHS, staff are being supported through the training process. DANOS gives clear standards and our workers deserve support – we should be working to the highest possible standard.

We have to ensure people have done enough hours of training, as the safety of users and carers is paramount. How does a manager know their worker is working safely?

We have a duty of care. Would you want a member of your family entrusted to someone without qualifications?

From the floor...

For: 'People with qualifications can baffle you with science. What I wanted as a service user was people who'd walked in my shoes already and could inspire me. Those people had no qualifications whatsoever.

Against: 'This is a crucial issue for the field. We are going to have to find a way of upskilling the field, giving service users the service they need, without excluding valuable people.'

Result: Motion carried

'This house sees no place for coercive treatment.'

Proposing the motion: Danny Kushlick, Transform Drug Policy Foundation

Coercive treatment is a product of prohibition.

Treatment should be available for all who need it, not just through the criminal justice system. Should there be coercive treatment for people who use tobacco, alcohol, tranquilisers? How far do you want to go with this?

Prohibition creates a Hobson's choice. It forces people to stop using and supplying drugs by giving treatment as a choice to prison.

It's time to look at ethics. Do we want to collude with prohibition? Or do we want to take a principled stand and replace it with a public health approach?

I'd like to see regulated control – coca leaves available from grocers, heroin from specialist pharmacies.

Against the motion: Brian Arbery, Adapt

My natural inclination is not to be coercive. But drug treatment always has an element of coercion.

Treatment is defined in so many different ways, but I don't consider receiving maintenance to be

The way forward for Tier 4 commissioning

The National Treatment Agency met with providers and commissioners at the 'Squaring the Circle' conference in Leicester earlier this month to tackle the future direction of Tier 4 commissioning. Here the NTA tell us about their next steps following a 'full and frank debate'.

As has been raised in *DDN* over the past couple of months, the residential sector has not yet benefited from the improvement in capacity and quality experienced by community based treatments since the launch of the Drug Strategy in 1998.

The Department of Health and NTA see the solution to the long-standing structural difficulties that have impeded growth and failed to guarantee income streams as the creation of a managed market in which an increasing proportion of Tier 4 provision, including residential rehabilitation, is commissioned rather than spot purchased.

The catalyst to bring about this structural change and enable the sector to expand to meet unmet demand is the Tier 4 capital programme, being rolled out across the country. The rationale for this approach was ably set out by Richard Phillips in his article 'Residential Futures: how do we build capacity?' (*DDN*, 23 October, page 10).

As part of this process, the NTA and the Centre for Public Innovation hosted a national conference in Leicester on 2 November to discuss with commissioners and providers what a managed market would look like and how we could make it work.

Results from the NTA's examination of the commissioning activity of all 149 partnerships in England were also fed back to the conference delegates. Findings show that while there have been examples of DAT partnerships spending less than planned within the first six months of this financial year, there has also been overspend in other areas. In addition, analysis of the national picture did not show any discernable correlation between occupancy and cost; so it does not appear to be the case that commissioners have started to fund Tier 4 treatment simply on the basis of cost.

What has become increasingly clear is that there is no one specific reason as to why a number of providers (between six and eight on the basis of reports so far) have experienced a downturn in referrals. Similarly, there was no one reason why individual partnerships have invested less than they planned in the first half of 2006/07.

Key issues identified

One of the main activities of the conference was to consult with delegates on what a more sophisticated and robust model of Tier 4 commissioning may look like. The event itself was interactive and lively with a full and frank exchange of views and invaluable information and ideas were forthcoming as to how to

treatment. It's giving people something that'll make them more likely to reoffend and 'top up'.

There is over-criminalisation of drug users on one hand. But friendly persuasion is a better way than coercion. There are right ways of administering treatment where criminality is involved.

I'm not taking a stand against people's human rights. But to give people opportunities you may need to push them. Can they make the decision to go into treatment when they are in that frame of mind? They often can't make that decision on their own.

There's a lack of joined-up thinking and a rigid adherence to treatment modalities that makes this issue less than clear cut.

For: 'We spend all our time trying to gain trust... So a Drug Rehabilitation Requirement may have an effect, but not necessarily the one government wants.'
Against: 'I don't just see coercion as coming from the criminal justice system; I was coerced by family and friends. And It worked for me.'
Result: Motion defeated

'This house believes talking therapies don't work with drug and alcohol users'

Proposing the motion: Dr Michael Farrell, National Addiction Centre
I am not arguing that treatment doesn't work; I am arguing that the evidence base for certain talking therapies is very weak.

Studies on smokers are very useful as the outcomes are clearest. A study on motivational interviewing with smokers saw no increase in their ability to quit. People change for far more complex reasons than the therapy. A similar study showed those who quit smoking suddenly in an unplanned manner did better than those undergoing treatment.

Talking therapies don't work. Treatment works when you look at the whole and work on developing people's lives, as well as providing throughcare and aftercare.

Opposing the motion: Simon Shepherd FDAP:
There is no evidence of one therapy being more effective than another. What is important is how good the therapist is and how they relate to people.

An Australian study on cannabis smokers showed that the group receiving cognitive behavioural therapy for the longest had the best outcomes, and a RAPt study, showed those receiving treatment did slightly better than those who did not.

Unfortunately there have not been enough proper controlled trials. However the small amount of evidence we do have is broadly supportive.

From the floor...
For: 'Some therapy works, some doesn't. It is the participation of the client that makes the difference.'
Against: 'You need to deal with the reasons behind the drug taking. If you don't use talking therapies how do you find out?'
Result: Motion defeated.

improve Tier 4 commissioning and provision. The conference helped to clarify the following issues:

- The interface between local authority community care teams and local joint commissioning is poor in some areas and requires improvement.
- DAT partnership-level commissioning would not appear to be the most efficient model in the majority of cases. Rather, 'cluster-commissioning' where a number of partnerships in a region or sub-region act jointly to commission treatment from common providers may be more effective.
- A move to local partnerships tendering for and commissioning preferred providers of known quality is recommended.
- A mixture of block contracting (with payment in advance) and spot-purchasing may give more security to providers and improve access for service users. Timely payment should be the norm.
- Providers will need to be more compliant in submitting monitoring data including NDTMS and occupancy data, and more transparent about the quality of programmes they provide.

Next steps
Two sets of guidance launched at the conference (*Models of residential rehabilitation* and *Commissioning Tier 4 drug treatment*) are designed to assist partnerships in focusing their thinking on current activity, as well as planning for the coming financial year. The guidance was sent out with a covering letter, the day after the conference, to DAT and commissioning group partnership chairs and heads of adult social services, flagging up the importance of Tier 4 Commissioning for the Treatment Effectiveness Strategy. It signalled a clear direction of travel towards regional or 'cluster commissioning' models.

NTA regional teams will have an additional focus on Tier 4, with a case-by-case approach being taken to examine local partnerships and establish the reasons behind any shifts in funding where they have occurred. The regional teams' objective is to ensure that individual clients receive the level of service appropriate to their need, not to ensure that certain providers are funded. NTA staff will also liaise with particular providers who report they are having difficulties.

It is the DH and NTA's intention to work towards more coherent and efficient models of 'cluster commissioning' during 2007/08. The NTA will now convene a national steering group made up of commissioners (at both a strategic and community care level), providers from all sectors and service users to help future commissioning models. We hope to build on the excellent steer we got from this conference, which was robust throughout but remained positive and focused on solutions.

The NTA will issue a conference report shortly. The new guidance documents are on the website at www.nta.nhs.uk

FDAP News in brief

Services for stimulant users
How can existing drugs services engage better with stimulant users?, Michael Bird from South London Drugs Project, a specialist crack and amphetamine service, challenged delegates. Approaches using stress relaxation techniques, acupuncture, offering dietary advice, as well as round the clock telephone support are all useful to support this particular client group. It was concluded that while not all services could offer all of these things most could offer at least some of them.

Young people's needs
How do you fully address the needs of young substance misusers?, Dr David Bee from Middlegate asked. For many young people, drug-taking is part of natural youthful risk often exacerbated when the young person's parents are themselves substance users who may not be providing a clear role model. More resources are required to tackle the problem and increase the amount of young people's rehabilitation facilities as well as a clearly defined protocol for prescribing methadone to this vulnerable group.

Clients with co-occuring gambling problems
What are the differences and similarities of people addicted to gambling to those addicted to drugs?, asked Kevin Farrell Roberts from Gordon House. Both need the buzz, whether on gambling or drugs; both groups enjoy the rituals surrounding their addiction; and each suffers withdrawal symptoms when it is not available. The one big difference is that there are no physical limits stopping a gambler feeding their addiction, and as a result many find it easier to keep hidden and deny the problem.

Self-help groups
What are the great benefits of the self-help fellowships movements?, discussed Peter Smith from Broadway Lodge and Simon Shepherd of FDAP. They are free; there aren't any waiting lists, entry requirements, referrals or bureaucracy. There is just one criterion: the desire to change and stop using. The problems lie in people's perception that these groups are religiously motivated and a dislike for the self-labelling that is part of the programme: 'My name is ... and I am an alcoholic'. While these groups do not work for everyone they do work for many as attested by the large number of groups meeting all over the world, and the longevity of organisations such as Alcoholics Anonymous.
Presentations and contact details for some of the speakers are available at www.fdap.org.uk/fdapevents/conf2006.html

Drug education in schools: getting the **basics** right

Glasgow's 29 secondary schools are located in communities that range from severely deprived to fairly affluent and none are immune from issues relating to substance misuse by pupils or their families.

Recognising this, the local council and NHS health promotion department have established a record of providing training, support and up-to-date resources for school staff. The curriculum is described in a comprehensive policy on drug, alcohol and tobacco education, which includes guidance on parent and outside agency involvement. The area has also developed the 'Glasgow's Health' curriculum pack, which gives advice to schools on all aspects of health education, including that associated with these substances.

Over the course of 2002 to 2004, all Glasgow City Council secondary schools were provided with four new teaching packs on substance misuse and alcohol, and offered two days' training for up to 12 staff through the Scotland Against Drugs Secondary Schools Initiative. While this was a good foundation, it was not known what changes had been implemented in practice in schools.

Doubts arose during the training courses when some staff seemed unaware of the new teaching packs and it seemed that older, out-of-date resources might still be in use. Some reported that they did not know where to start in making decisions about selecting appropriate and effective teaching activities for each age and stage, or did not have time to sit down and 'plough through' the new resources to incorporate them into current teaching plans.

'There were few specific learning outcomes, leading to repetition of many general drug lessons and a lack of progression across year groups. Information was not being tailored to meet the specific needs of pupils...'

Old familiar complaints about drug education were still surfacing: 'The pupils say that they're tired of it, they've done it all before'; 'we're never really sure if what we're doing has any effect'; 'it feels like we're teaching the same old thing, year after year' and paradoxically, 'it seems to need constant updating'.

In an effort to get to the heart of these issues, the council's Education Improvement Service and NHS Greater Glasgow's Health Promotion Department (now NHS Greater Glasgow and Clyde) got together in 2004 and developed an outline of a consultancy service for schools, 'to provide support for individual mainstream secondary schools in Glasgow City to improve the quality of drug and alcohol-related education in line with national best practice guidelines and "Glasgow's Health" local curriculum guidance'.

Later that year, having founded Create Consultancy, I was awarded the initial contract to provide the consultancy service to 15 secondary schools over 2004 and 2005. I had previously investigated the practicalities of achieving good practice in secondary school-based drug education during my doctorate at The Robert Gordon University in Aberdeen. Following the success of the first year of the project, Create was commissioned to extend the service in 2005 and 2006 to all other mainstream secondary schools in Glasgow City and to Jordanhill School, bringing the total number of schools supported to 30. Under the terms of the service at each stage, each school was entitled to five days of support from Create Consultancy.

I initially asked schools to provide me with details of their current drug and alcohol curriculum, which I followed up with a meeting with school representatives. At this meeting I reviewed current provision using a specially developed audit discussion guide based on best practice and research evidence. The audit also focused on the specific needs of each school in terms of the profile of substance use in the local community and in any school drug incidents, and the time available in the curriculum at each year stage for drug education. I then provided the school with a confidential audit report with recommendations for action and a package of support for implementation was agreed. This support was delivered over three to five months, followed by a final report of outcomes and recommendations for future action for each school.

The reviews of current provision were surprising in that despite the excellent support provided by the

Reviewing the state of drug education in Glasgow's schools gave Dr Niamh Fitzgerald a clear idea of what needed to change. She describes her plan of action and shares ideas for more a more effective approach.

authorities to schools in the past, the drug curriculum in the majority of schools still needed extensive revamping.

A number of key issues arose regularly. In too many cases there were few specific learning outcomes, leading to repetition of many general drug lessons and a lack of progression across year groups. Information was not being tailored to meet the specific needs of pupils in terms of the most commonly used substances, and teachers showed a lack of understanding about how to do this. The materials in use often provided poor guidelines for teachers on how to lead lessons and often invited staff to discuss an issue without providing any notes or back up information to guide them. Outside agencies were not being used appropriately or consistently and teachers tended to over-rely on non-interactive methods such as videos and worksheets.

In all cases, schools used most of the time for support to improve the content of their drug curriculum, though many still had time for staff training or other options. Over the course of the consultancy, more than 100 lesson plans were developed and tailored to individual schools' requirements, using various combinations and adaptations of existing school lessons, available teaching packs and in some cases completely new teaching activities.

This project led to significant improvements – and in many cases a complete revamp of the content and coherence of the drug and alcohol curriculum in the schools involved. Many of the recently-provided resources were added to the new curricula, which many schools needed a lot of help to find. Specific learning outcomes were devised to avoid repetition in lessons, with an emphasis on progression and continuity. A balance between alcohol and drugs needed to be ensured, with input on alcohol strengthened in most cases. The teaching programme was expanded, particularly for older year groups and additional attention was paid to specific substances of concern such as cannabis and ecstasy. Clear, concise and comprehensive lesson plans and guidance notes were provided to teachers supporting delivery of the curriculum.

As well as developments relating directly to the content of the curriculum, schools made use of the consultancy service to liaise with outside agencies to ensure that the new material made best use of their expertise. The service also helped with pupil consultation on what issues and proposed lesson content were most interesting and relevant.

Finally a number of innovative pieces of work were completed, including an evaluation and monitoring toolkit for drug education and a two-level differentiated programme (see case study). All support was in line with best practice guidance and relevant research evidence.

The project was independently evaluated in April by CCL Associates, who found that teachers felt it had 'led to recognisable improvements in the way staff and pupils experience drug and alcohol lessons'. Among direct impacts identified by teachers were clearer key messages; more coherent topic coverage; more varied teaching methods; up-to-date knowledge and materials; and boosted staff confidence. Teachers also felt the format and style of lessons could be applied to other Personal and Social Education (PSE) subjects.

A health education co-ordinator at one of the schools commented: 'It would have taken us years to do what you've done.'

The ongoing debate about the effectiveness of drug education often overshadows and distracts from the real need to address the practicalities of the provision of good quality drug education on the ground as highlighted by this project. Culture change has to be at the heart of reductions in alcohol and drug related harm, and while interventions such as increased price and reduced availability may be more effective for reducing alcohol consumption for example, support for these interventions is unlikely to exist without public education.

The bottom line is that drug education is being delivered in schools throughout the UK – and that in many cases it could be better. This is true regardless of whether it is fundamentally viewed as education or as a means of prevention; of drug use or of drug-related harm; or whether it is a life skills, social influences, or other programme 'type'. This project illustrates the many practical issues that affect the quality of drug education that exist far outside such philosophical debates and that good drug education is about coherent planning, relevant and as far as possible evidence-based content and teaching methods – and confident delivery. These skills need to be nurtured and developed in schools.

The final project report identifies 16 recommendations to improve the quality of drug education in schools relating to models of delivery and staffing, outside agency inputs, monitoring and evaluation, resource management and areas for further support. Similar projects are now being implemented by Create for Additional Support Needs secondary schools in Glasgow and for primary and secondary schools in East Renfrewshire.

Case Study – Hightown Secondary School

This school was located in a deprived suburb of Glasgow and has a population of approximately 800 pupils. The initial audit included a review of written materials and a discussion with the principal teacher of pastoral care and deputy head teacher with responsibility for health.

The main issues then identified were: Out of date materials; greater input needed on alcohol and cannabis issues; lack of teaching plans for S5 and S6 pupils who receive drug education together; no differentiated materials for pupils of varying ability; variations in knowledge, confidence and enthusiasm of the large group of staff involved in teaching; and little evaluation or monitoring of provision.

A programme of work was agreed with the school which included the following outcomes:

- Existing lessons were reviewed to clearly identify learning outcomes for each one and to ensure progression from S1 to S6.
- New lesson plans were developed to maximise use of modern interactive activities and resources.
- A two-level curriculum was developed for S1 to S3 to allow greater differentiation according to pupil ability and support needs.
- A rolling programme of drug education was developed to be taught to S5 and S6 pupils, which avoided repetition.
- A training session was provided to staff to give them greater confidence in delivering new lesson plans.

The school was provided with a ring binder and CD-ROM containing an overview of the new curriculum and all materials required to deliver the lessons.

The Drug and Alcohol Education Consultancy Service was jointly funded by: Glasgow City Council using the Scottish Executive Drug Education Grant; Greater Glasgow NHS Board Health Promotion Department (now part of NHS Greater Glasgow & Clyde); Greater Glasgow Alcohol Action Team.

Dr. Niamh Fitzgerald is director of Create Consultancy. She would like to thank the staff and pupils of the schools involved for their co-operation and the welcome they extended to her over the course of implementation of the project.

For further details of the project or a copy of the final report, contact: Create Consultancy; Tel: 0141 445 5858; email: niamh@createconsultancy.com; website: www.createconsultancy.com

Have you got yourself an occupation?

I was very interested to read the article 'From addiction to work... A road to nowhere?' (*DDN*, 9 October, page 6). I am an occupational therapist working in forensic mental health services with a specialist interest in drug and alcohol misuse.

The article highlighted several issues for me: Firstly, the many benefits to drug users from engaging in employment, including developing relationships and a 'non-addict' identity. Secondly, the gap between specialised interventions offered by drug treatment services and employment services and a difficulty to recruit staff who are expert in both domains.

Also, the problem of individuals who are 'not ready' being referred for work programmes was explored, with the suggestion that drug users in later stages of their treatment may need to undergo a process of re-socialisation into the world of work.

Occupational therapy aims to enable people to achieve health, wellbeing and life satisfaction through their occupation, and in my view, has a valuable contribution to make to the field of substance misuse. There are close links between the need for individuals to use their time purposefully and the occupational deficits of those who misuse substances, specifically in the areas of self-care, productivity and leisure.

Self-care can be affected by substance misuse, as the compulsion to use a substance can supersede awareness of nutrition, health, cleanliness, safety or responsibility for finances. Chaotic lifestyles can result in individuals becoming de-skilled in coping with day-to-day household activities and basic time management. Occupational therapy intervention includes individual or group work promoting independent self-directed functioning in such skills as structuring the day, developing a routine, cooking, budgeting and healthy living.

Jobs are often negatively affected or lost once substance misuse patterns become established, resulting in unemployment or high anxieties around returning to work. Indeed, maintaining a drug or alcohol habit can become 'work', using up many of the user's energies. Occupational therapists have traditionally been involved in encouraging individuals to identify, develop and apply their potential work skills and with facilitated, graded (re)entry into employment.

Work preparation schemes are designed to encourage people to identify, develop and apply their potential work skills, with transition to full employment. However, clients can be unsuccessful in attaining their goal of maintaining employment due, at least in part, to their lack of work-related skills. Focus needs to shift in order to concentrate on involving individuals in training opportunities to develop such skills.

Involvement in a work preparation scheme involves making an occupational choice and a deliberate commitment. However, many individuals who misuse substances are not ready to make such a commitment and could be helped by occupational therapy focusing on such basic issues as developing communication skills, increasing confidence, and motivation by providing opportunities to make everyday choices.

Inability to fill time with meaningful activity, boredom and social pressure are associated with health risk behaviours and relapse. Many individuals engage in no, or few leisure activities outside their drug use. Occupational therapists attempt to engage users in leisure activities which are perceived as possessing several benefits, such as integration into mainstream society, increases in social networks, development of new, more socially accepted routines and experience of pleasurable substance-free time. This is particularly important as repeated drug use often results in decreased ability to feel pleasure or satisfaction in normal activities, and the ability to find employment in a drug-free state is a factor determining rehabilitative success.

Occupational therapy intervention involves enabling individuals to identify and engage in leisure occupations of their choosing that are then graded in order to enable success and enhance personal growth and functioning within an appropriately challenging environmental situation.

I would suggest that occupational therapists may be the professionals best placed to be able to meet those needs identified by Neil McKeganey and James McIntosh in their article and should perhaps be borne in mind when recruiting staff for drug and alcohol services.

Heather Gourley, senior occupational therapist, Caswell Clinic, South Wales

Please don't let me be misunderstood

Yet again I find myself rebuked for views I do not hold. In an original longer draft of my article (edited for space reasons), I ventured an opinion that it was a pity MoCAM had not used and promoted the use of the standard internationally recognised definitions of dependence, the WHO's ICD10 and/or the APA's DSM IV – especially for non-specialist SM workers needing to make triage decisions on the basis of dependency, I think it would have been helpful for MoCAM to have given and maintained a more accessible and consistent definition.

It would surely have made it easier too for commissioners to ensure the presence of the 'clear and standardised screening and assessment procedures and processes across all agencies' which MoCAM advocates. Ironically, both the ICD 10 and the DSM IV offer classifications of dependency which can be based entirely on psycho-social symptoms; a conception which Ms Benanti erroneously believes I do not appreciate (*DDN*, 6 November, page 9).

The increase in incidence of liver cirrhosis among young women (not young men) drinking marginally above sensible limits was conveyed to me independently by two hospital hepatologists; I cannot vouch for it. I do have in my possession a copy of a QC's opinion of professional liability where a controlled drinking goal is endorsed in the face of permanent organic damage – but in the absence of a test case it remains only an opinion.

I did not maintain that an interim goal of 'controlled drinking' was always detrimental; but I did question the received wisdom that it is always therapeutic. I am sure that Ms Benanti's specialist service is very sophisticated and careful in its informed consent practices and interventional strategies; unfortunately though I know that some other services are not.

And while the Medical Council on Alcohol, the UK Alcohol Forum, and the Scottish Intercollegiate Guidelines Network offer consistent general guidance on the relationship of assessment findings to goal setting, (both UK AF and SIGN citing 'alcohol-related organ damage' as an absolute and independent indicator for abstinence), it is a source of regret for me that MoCAM, which doesn't shrink from offering guidance criteria for in-patient detoxification, does not offer similar guidance with respect to goal setting.

Beyond this, I am very happy to re-iterate a personal opinion that MoCAM generally has much (as previously articulated) to recommend it.

Mary Longley, by email

The hardest part

I am an addict and alcoholic, and although I am in recovery on a daily basis, I have seen many things I do not want to return to. I have loads of affirmations – one of which I always have on the front of my diary 'remember the pain'. This helps me to recall the physical, emotional and mental pain that I went through when I was using, having been in hospital over 30 times and in two rehabs.

Two weeks ago I lost another friend to our horrendous illness. She had been sober for 18 months but hopefully has found peace at last. Although there are many rehabs, very few offer an aftercare programme with second stage support in all directions, including re-housing and ongoing counselling and groups for those who need it.

Vale House stabilisation services in Hertfordshire offers all these services to clients and sets an individual programme to meet their needs. The staff have a full understanding of addiction and voluntarily put themselves out to go to meetings as and when required with other professionals, to support the sufferer.

What frustrates me and makes me angry is when Vale House puts their concerns to teams about clients, but they fall on deaf ears through lack of knowledge, training and little understanding of addiction. Teams are told that if they don't put an emergency programme out this person will be dead by Monday – and sadly this happens only too often.

My friend was the seventh to have died; like myself, she had eating disorders (though hers were as severe as anorexia) and Vale House tried so

hard without her knowing to get funding for her to go into a special unit for this addiction and be looked after. I only found out last week by talking to the director (a loving and caring individual) that the system failed both of us once again.

My own experience is that drug and alcohol teams just want to write you off their books once you have gone through rehab with no further support. For the majority of us, the real hard work comes when we leave rehab and start living in the real world and have to deal with sober emotional feelings.

Having been an addict for three quarters of my life it's like a full-time job, and when something comes along that would seem perfectly practical to a non-addict, it just brings me down as I have no balance in my life yet.

I have heard through recovery chat rooms across the country of similar situations where the welfare of the client is not paramount at all. The funding mechanism sounds like a lottery and when you are sick with this illness, the whole process can be too much.

I endorse user advocacy as I have seen many give up and go back into their illness, as this option is far easier than trying to fight the system, which really needs a shake-up.

I do not know anybody who has managed to recover on their own. The ones who come through – and also the ones who sadly don't – are all loving caring and sincere individuals. We didn't ask for this illness, yet when professional staff like those at Vale House can see what the individual needs are but they are not met, then the system is failing lock stock and barrel; just another number crossed off the books.

Professionals in the field should listen much harder to staff in rehabs – after all, they are the ones who live with them for 24 hours a day. Have you tried getting a drug and alcohol member of staff on a Friday afternoon? And most teams seem to have their weekly meeting on a Monday morning, so for us individuals who are in addiction that is three days without support.

This isn't written as a complaint, but I am compelled to point out flaws as I see them, in a bid to improve the system for others.

Sean Rendell, Hertfordshire

Comment

Back to work, not back to addiction

As an enthusiastic employer of former service users, **Andy Winter** throws down a challenge to other service providers.

Several years ago a brilliant British academic was asked to give a presentation to a conference in the Netherlands. He was happy to accept the invitation and he and one of his carers (he had motor neurone disease) made the trip to Amsterdam. He required someone to repeat his words so he could be understood by a larger audience.

At the start of his lecture his carer had to ask him to repeat what he had said as he couldn't make out the words. He had to ask again, and for a third and fourth time, until someone in the front row said, 'he's speaking Dutch'.

The lecturer then said: 'There are two lessons there about disability. Never underestimate a disabled person. Secondly, most people with disabilities are limited mainly as a result of the resources available to them.'

How true this is when considering attempts by people leaving treatment to gain employment. We should never underestimate them, but their progress is often hindered by the resources, including treatment, available to them.

I write as someone who has been involved in the management of alcohol and drug services for almost 20 years, but also as the head of an organisation employing around 200 men and women, a number of whom have themselves successfully completed treatment.

From these two perspectives I was disheartened by the article 'From addiction to work: a road to nowhere?' (*DDN*, 9 October, page 6). A study in Scotland found that just 10 per cent of drug users interviewed 33 months after they started a new episode of drug treatment were in paid employment.

The benefits of paid employment were well described and are commonly recognised. Yet there remains a gulf between addiction and treatment on the one hand, and employment on the other.

As an employer, Brighton Housing Trust (BHT) welcomes and encourages job applications from men and women who have used our services. We have work and learning programmes to assist people to gain employment.

BHT recently publicly committed itself to ensuring that by 2008, 15 per cent of our staff in all services will have been former service users, and we have similarly ambitious targets for future years.

We have made this commitment for two reasons. Firstly, it is the right thing to do, to improve the opportunities for legitimate economic activity, to develop relationships beyond current or former drug users, and to create a further span on the bridge to normal living.

> **'The world of work is harsh. We demand high professional standards from our workers, and we will not take avoidable risks.'**

Secondly, we do it because as an employer in an area with high housing costs and relatively low wages, people applying for work in Brighton and Hove often cannot afford to move here. We need to ensure that there is a pool of applicants with the appropriate skills and experience.

But the world of work is harsh. We demand high professional standards from our workers, and we will not take avoidable risks with vulnerable men and women who are still using our services.

That is why, while encouraging applications from former service users, I would expect to see real progress in terms of recovery. I would expect that they have moved well beyond methadone maintenance scripts.

Frankly, my view is that someone who remains on methadone may well be 'topping up', may well continue to socialise with others who may still be using, and who have yet to fully come to terms with their addiction. I would be very unlikely to employ them. I would even question how effective work and learning schemes might be for those who may still have one foot in the drug scene.

I have seen some schemes where the prospect of employment is floated but the reality is that some participants, even though they may be engaged in treatment, remain 'unrecruitable' because of ongoing use. For them it may seem a cruel hoax.

I am saying this as someone who has committed resources and reputation to making this work. How much harder will it be, then, for those completing treatment to gain work in an employment market that can pick and choose, with prejudices that 'once a junkie, always a junkie', that can't distinguish between crimes committed in active addiction and other offences.

Those completing treatment are hindered by what is available to them. Harm minimisation, as practiced in BHT, is an essential intervention for those in active addiction. It is not an intervention that will lead to work, and will restrict learning. That is why BHT is committed to achieving continuous progress, that harm minimisation is just a start, that abstinence is just an opening, and that recovery from addiction is possible.

We know it can work. For this article, we reviewed 21 individuals who completed treatment at our Recovery Project, who have been abstinent for between 12 months and 30 months. Five are in employment and the remainder are engaged in education, training or employment schemes, such as our own Learning Links Project.

Unless treatment providers stop underestimating an addict's potential for recovery, until full recovery is promoted, then the promise of employment will remain a cruel hoax.

Andy Winter is Chief Executive of Brighton Housing Trust. BHT provides a range of services for homeless and insecurely housed men and women in Sussex, including several substance misuse services that embrace both harm minimisation and abstinence based approaches.

Post-its from Practice

Invisible enemy

Never forget HIV among injecting drug users, says Dr Chris Ford

Matthew registered with us so he could have his blood tests before going into rehabilitation. We knew that the local community drug team (CDT) was providing him with a methadone script and monitoring his hepatitis C infection. However, as he was also a heavy drinker, he had not been offered any further intervention.

We discussed with him what tests might be worth doing and he agreed willingly to have an HIV test among others, although he thought a positive result unlikely as he was under both the CDT and the hospital hepatitis C clinic. Despite this, I gave the usual pre-test discussion before taking his blood for hepatitis A, B and C, HIV, as well as liver function tests, full blood count *etc*. We were both surprised to find his HIV test was positive and even more surprised at his CD4 count of 290, suggesting that he had probably been positive for several years.

How could this be? He has been in both community and hospital care for over 20 years. Have we have forgotten HIV in drug users? We do so at their peril.

Shooting Up, a report recently released by the Health Protection Agency, shows that there has been an increase in HIV among injecting drug users. Today, 1:50 Injecting Drug Users (IDUs) in the UK are infected with HIV. This is around twice the level seen at the beginning of the decade. In particular, the HIV prevalence has been rising since 2002 among those who have been injecting for less than three years. Increasing evidence suggests that injecting crack cocaine is a major factor.

The report also found that while levels of HIV remain high among current IDUs in London, with around one in 25 infected, the recent increase in the number of cases has been greatest outside of London (data relating only to England and Wales) where it has risen from approximately 1:400 in 2003 to about 1:65 in 2005.

Elevated levels of reported needle and syringe sharing have been seen since the late 1990s, with around 3:10 IDUs currently reporting this. The underlying factors for these differences are not clear, but they are a cause for concern.

Matthew reacted to the diagnosis with commendable insight. He informed his parents and his kids of the result and explained that treatment was available. We have an excellent HIV service down the road and he is about to start treatment less than two months after his diagnosis.

So my plea to you all is to regularly screen all people who use drugs, whether they are in drug treatment or not, for HIV and hepatitis; to provide sufficient injecting equipment so that people don't have to share; and to never forget HIV infection -– it hasn't gone away.

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP Proforma for undertaking BBV screening can be obtained from the RCGP website www.rcgp.org

Shooting Up is available online at: www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm

Q A

As a worker in the drugs field I sometimes suspect that clients may be behaving in a way that poses a risk to themselves and to others – behaviour that could mean that they or I do not have the protection of our confidentiality policy. For example, I suspect that at least one of my clients has hepatitis C and may be sharing their works, or is sexually active in a way that may put his partner(s) at risk. Can readers give me any advice as to whether I should be reporting this to someone, and if so, who? Please don't say 'my manager' as I'm sure she would have the same question.
Jane, by email

Harm minimisation

Hi Jane
I think you're right to worry about the effect your client's behaviour is having on others but unfortunately I don't know of anyone you could report this to – and even if there were 'Risky Behaviours Police' it wouldn't necessarily stop your client from participating in unsafe sex or sharing works.

All you can do in this situation is support your client by delivering harm minimisation, such as introducing him to needle exchange services which I am sure you are already doing. If you can get him to take some responsibility for his own health and behaviour, you then can stop others from being at risk.

Although others may be at potential risk, we have to remember that for many we are talking about consenting adults. If two adults choose to take part in risky behaviours then no crime is actually being committed. We can only provide services to those who we come into contact with, but if we educate and support them we minimise harm to those in the wider community.

There was a case where someone who was diagnosed with HIV intentionally infected others and I think one of those affected brought legal action; however your case is very different to this.

I think your client needs education so he can make informed choices and help to raise his self-esteem so he can take care of his own health therefore decreasing his risk to others.

If you suspect he has hep C symptoms, I would suggest you talk to him openly and honestly and ask him if he would like to be tested. Showing you care for his health may encourage him to care for himself as he too is at risk from his behaviour.

Harm minimisation and sexual health are the answer and I am sure you are already doing this. Keep up the good work.
Mel Riley, drugs worker and counsellor

Safety first

Dear Jane
I read your question with interest. I am a burnt out social worker and addict and have spent most of my years working with young people in vulnerable positions.

I feel that us addicts are like children when we finally take the step and choose to do something about their addiction. It is similar with the young people I have worked with: they all had challenging behaviours and to initially gain their trust and confidence, the team and I sat them down and, with my support, let them write out a contract of their expectations.

We always agreed that confidentiality was very important and high on the agenda. However, I always pointed out that if they disclosed anything that would be against their own welfare, which is paramount, or if it were harming friends, family, police or whoever, we would obviously talk about it and for everyone's safety, pass this information on.

I never had a problem with this method and it empowered the individual to start taking responsibility for their actions and behaviour. Maybe your team could adopt a similar approach, as those who use the services are crying out for support and help and need to be guided like a child in many ways. I hope this is of some use.
Sean Rendell, Hertfordshire

Reader's question

I am a recovering addict of nearly five years and I am interested in becoming a substance misuse counsellor once I have completed the final year of my BSc in Psychology. Would anybody be kind enough to recommended pathways into this area as there are so many courses available it is hard to know which ones are effective, accredited by the relevant governing bodies, at the level needed in this field and so forth. Any help would be most appreciated.
Scott, by email

Email your suggested answers to the editor by Tuesday 28 November for inclusion in the 4 December issue of DDN. New questions are welcome from readers.

Straight route to **competence**

It couldn't be more straightforward to make sure you're competent as a substance misuse worker – or to help your workforce demonstrate the DANOS competence required by NTA targets, says Simon Shepherd.

The NTA qualification targets require most workers – apart from those qualified to practise as health and social care professionals (nurses, doctors etc) – to demonstrate evidence of their competence in four 'core units' from DANOS and at least four other units relevant to their jobs.

While health and social care professionals are assumed to be competent in the 'core units', they too are still required to demonstrate their competence in at least four other DANOS units.

One way for 'non-professionals' to meet these targets is through the NVQ in Health and Social Care, while those who are already professionally qualified can take a four unit 'development award' based on DANOS.

While many other qualifications claim to provide evidence of DANOS competence, most in fact do not – either because they do not include an assessment of workplace competence or because any assessment of competence they do include does not relate directly to the DANOS standards.

FDAP's Drug and Alcohol Professional Accreditation scheme has been designed to provide a way for people with other relevant qualifications to have these recognised as evidence of DANOS-competence, where they include a work-based assessment either directly against the DANOS standards or against other competence frameworks which map sufficiently closely to DANOS to provide at least indirect evidence of DANOS-competence.

It is relevant to workers across the field – including those who are already qualified to practise as a health and social care professional (as their qualifications are recognised as evidence towards Accreditation) – and is widely recognised as providing the externally validated evidence of DANOS competence required in the NTA targets.

Our Professional Certification Advisory Panel (PCAP) is responsible for identifying those qualifications which provide at least indirect (complementary) evidence of DANOS-competence, and against which specific units. To be Accredited under the scheme practitioners need to provide evidence of their competence against each of ten DANOS units (including the four 'core units') through one or more qualifications recognised by the PCAP – and where the qualifications concerned provide only 'complementary' (ie indirect) evidence of DANOS competence they need to be backed up by an internal workplace assessment directly against the specific units concerned.

Two examples of qualifications recognised as providing complementary evidence of DANOS competence covering all ten units required for Accreditation are Addaction's Core Competence Framework qualification (awarded by the Open College Network) and Clouds' Foundation Degree in Addictions Counselling (awarded by Bath University).

The Open University's suite of DANOS-related 'professional awards', developed jointly with FDAP, are based on a direct workplace assessment of DANOS competence and are recognised as evidence towards FDAP Accreditation in their own right. The ten unit 'Professional Award for Drug and Alcohol Practitioners' provides all the evidence required for FDAP Accreditation. While the smaller 'Professional Development Awards' cover individual units and a number of specified 'clusters', and can be used as 'top-ups' towards FDAP Accreditation, as well as for demonstrating ongoing professional development.

Workers who do not have all the evidence required for FDAP Accreditation can be Registered as a Drug and Alcohol Professional if they are able to provide at least a workplace assessment demonstrating their competence against the relevant DANOS units. Because it does not require these assessments to be backed up by qualifications, registration does not provide externally-validated evidence of competence. However, it does provide supporting evidence of competence, and is widely-recognised as a valuable first step towards demonstrating DANOS competence.

Almost 200 people have so far been Registered or Accredited by FDAP – and more than 50 have signed up for one of the suite of Open University awards. For more information about FDAP Accreditation and the Open University awards see under 'professional qualifications' at www.fdap.org.uk.

Simon Shepherd is chief executive of The Federation of Drug and Alcohol Professionals (FDAP).

Robert Clasper Todd, Head of Training and Development at Addaction

When DANOS was launched we already had our own competence framework at Addaction and a qualification linked to it which met our needs very well. We wanted to keep our scheme while also ensuring we complied fully with the NTA's targets – and FDAP's Accreditation scheme provided us with a way to do this. Otherwise we would have had to rip up what we had and start again. Instead, we worked with FDAP to develop our qualification to ensure that it provided complementary evidence against the ten units in their scheme – and incorporated line manager appraisals directly against the units themselves to provide the additional bridge FDAP required between our competence framework and the DANOS standards.

We are really pleased with how it has worked out – as are our staff, who now not only get a qualification from the Open College Network when they complete our training, but also get recognition as an Accredited Drug and Alcohol Professional too.

Mike Wheatley, Area Drug Co-ordinator, Prison Service High Security Estate

The Prison Service High Security Directorate covers eight prison-based drug teams and we have decided to base our workforce development strategy around the FDAP Professional Certification scheme. Our training and appraisal programme is being developed to ensure that all our staff become competent in at least the ten units in FDAP's scheme. From there, staff are being asked to work towards Registration as a Drug and Alcohol Professional, as a first step in demonstrating their DANOS competence. In the longer term, we want them all to become Accredited by FDAP – getting the qualifications they require (either covering all ten units or 'topping up' existing qualifications), through the Open University suite of professional awards.

Our staff have embraced our plans enthusiastically, and see them as an opportunity to develop their skills and knowledge, and demonstrate their professional competence to the wider world.

The Bureaucratisation of Misery

Why do we make clients conform to ready-made myths instead of letting them explore their own story? Have we all become slaves to measurable outcomes?, asks William Pryor.

Before I get too embedded in mythological quicksands let me underline my understanding of the word: a myth is a story that seeks to explain the inexplicable.

We take mood-altering substances to 'treat' the human condition, the pain of being. This 'treatment' releases a self-narrative with which we feel more comfortable, one that seems to prise us free from the vice-like grip of the tragedies of disappointment, frustration and unhappiness that would otherwise define us. Like all good myths, we mistake them for reality.

The myth segues into one of addiction when we want more and more of the ersatz liberation our psychosomatic stories seem to offer. As the lyric of one of Bob Dylan's songs on his new album, Modern Times, has it: 'I'm trying to get as far away from myself as I can'. It's the very self and its pain that are the inexplicable that require explanation. The myths of addiction and treatment that we tell ourselves not only give us identities, but seem to allow us to understand ourselves.

It's all very well me adopting an outsider, myth-busting position with regard to an industry that deals with the outsiders that are addicts, but myths make their own pressing demands to be seen as reality, to be treated. The junkie that's just mugged you to feed his habit is no myth, but a real person in the power of a myth; we've got to do something about him. We, society – liberal, caring, compassionate people that we are – have to respond. Maybe this imperative to respond is also part of the myth? He's telling himself and us an elaborate and scary story about his suffering, his misery. As long as he tells it in the way we need to hear it, we respond with our compassionate and overly bureaucratic treatment stories.

As an outsider to the treatment industry I am struck by how much energy is expended on trying to get clients to slip into something more comfortable, a ready-made story, rather than letting them find their own more authentic accounts of their unhappiness. As endless acronyms threaten to drown the humanitarian impulses of drugs workers, their compassion is corralled into the measurable bureaucratic outcomes with which adherence to such myths ends up.

One target that has been imposed on the service provider whose board I've just joined, is to attend a certain number of referrals in a particular police station. This has the Kafkaesque result that they fail to meet their key indicators if there aren't enough suitable arrests. I only just held back the suggestion that they send a worker out to urge more clients to get arrested, so they would get treatment and their indicators would be properly indicated.

'As the lyric of one of Bob Dylan's songs on his new album, Modern Times, has it: 'I'm trying to get as far away from myself as I can'. It's the very self and its pain that are the inexplicable that require explanation. The myths of addiction and treatment that we tell ourselves not only give us identities, but seem to allow us to understand ourselves.'

The government says to itself that it needs to know, us voters need to know, how successful they're being in treating addicts. But what on earth is this success, how can it be measured? How can we tell when an addict is no longer an addict? Is it when they stop being criminals, when they've had treatment, when they are abstinent, when they are on a script or all of the above?

The only answer to such questions that the medical, legal and social work establishments can give is a codifying and bureaucratisation of misery. Government has realised there is a connection between the taking of illegal drugs and law breaking. Not that the very illegality of the drugs might be the problem, but that, somehow, breaking the law has become a symptom of addiction, and as such, it can provide a useful measure of the treatment industry's success. The more offenders that can be managed at the moment when officialdom first comes across them – on arrest in police stations – the more addicts government can boast of treating.

Since alcohol is legal, ruining your life with booze rarely qualifies for the NHS or NTA help given for drug addiction, even though liquor kills thousands more than do all illegal drugs put together. In that police station, my service provider's outreach workers suggest to offenders, with a nod and wink, that their alcohol problem is really a drug problem, then, with story adjusted, they can get some caring attention.

As an ex-addict outsider, perplexed by this bureaucratisation of agony, I am in a quandary with regard to addiction and its treatment. On the one hand the whole thing – addiction, treatment and their explanations – is a huge catacomb of interweaving stories, a bucket of wriggling worm-myths, hopelessly intertwined.

The only way to move on is to move on, to find new and different stories to tell ourselves, stories free of dependence on the medical, social work and criminal justice professions and their dependence on a steady supply of addict-victims.

On the other hand we've been living with these mythic dependencies for over 150 years now. They are so ingrained in the way people express their alienation, grief, anger, isolation, frustration and world-weariness, that addiction has crystallised into a bureaucratic reality with which we are forced to deal.

Discuss these quandaries at Unhooked Thinking 2007, May 9-11, at Bath Guildhall. Booking now open at www.unhookedthinking.com.

Social Learning and Coping Models: Part 1

In the next Background Briefings, Professor David Clark looks at the relevance of social learning and coping models to our understanding of substance use and misuse.

In my last three Briefings, I looked at how learning or conditioning processes are involved in problematic substance use or addiction. This Briefing continues along a similar theme, but focuses on the role of higher forms of learning, and cognitive processes, in substance use and misuse.

Social Learning Theory (SLT), developed by Albert Bandura in the mid-1970s, has impacted strongly on this field. In essence, SLT describes the effect of cognitive processes on goal-directed behaviour. It considers the human capacity for learning within a social environment, through observation and communication.

Advocates of SLT describe the role of reinforcement, cognitive expectancies, modelling and self-efficacy in influencing substance use and misuse. SLT has generated a good deal of basic and clinical research in the field, and forms the basis for therapeutic interventions such as coping skills training and cue exposure treatment.

Reinforcement is a central principle of SLT. The learning element of SLT is the simple operant response, whereby a person will repeat any behaviour that leads to a reward. Thus, a person may continue taking cocaine because of the euphoric or pleasurable effects of the drug (positive reinforcement), or continue to drink alcohol because it alleviates the anxiety and tension they experience after a stressful day at work (negative reinforcement).

According to SLT, the more frequent or intense the substance-taking experience, the more habitual it becomes. SLT also recognises that different types of drug exert different effects and the effects will differ between individuals and their desires, depending on factors such as past history, personality and current life circumstances.

A person who is using a drug to cope with personal problems will face different issues in overcoming problematic use to a person who has been using a drug in a social environment where all his or her friends use.

When a person takes a drug or drinks alcohol, they form an expectancy of what they will experience when they take the substance again. While this expectancy may be confirmed on subsequent occasions, the effects produced by psychoactive substances are also dependent on the dose of substance, as well as other factors such as set (personal characteristics) and setting (environmental characteristics).

Thus, a person may experience different effects of a substance depending on their social setting or on their mood at the time. Of course, they will soon realise these more 'intricate' effects and their expectancies will be modified to take into consideration these other factors.

'Learning to drink occurs as part of growing up in a particular culture in which the social influences of family, peers and popular media shape the behaviours, expectancies and beliefs of young people concerning alcohol.'

Expectancies will also be derived on the basis of the presentation of conditioned cues (environmental or internal) that have been associated regularly with past substance use, as discussed in past Briefings.

Researchers have shown expectancies to predict the progression to problematic use of alcohol, for example, as well as the initiation of use. In fact, expectancy theories have their own place in this field, although not discussed here.

The social learning perspective also emphasises the role of peers and significant others as models. For example, learning to drink occurs as part of growing up in a particular culture in which the social influences of family, peers and popular media shape the behaviours, expectancies and beliefs of young people concerning alcohol.

Research has shown modelling to be a robust phenomenon, while modelling techniques are used therapeutically in skills training programmes for teaching general and substance-specific coping skills.

An important effect of both parental and peer modelling is the development of internalised expectancies for alcohol (or drug) effects. A young person may see their parents drinking a few glasses of wine to ease stress after a hard day's work, or to socialise at a party. The notions they develop can then be reinforced and generalised when watching alcohol-related scenes on television – and there are plenty of them on the soaps!

Stress has been defined as an 'adaptational relationship' between an individual and a situational demand (stressor). It can be viewed as resulting from an imbalance between environmental demands and an individual's resources.

'Coping' is an attempt to meet the demand in a way that restores balance or equilibrium. There are various forms of coping mechanism that people can use to deal with stress.

Problem-focused coping strategies are aimed primarily at directly changing or managing a threatening or harmful stressor. Emotion-focused coping is aimed primarily at relieving or regulating the emotional impact of a stressor.

One form of emotion-focused strategy is to use substances to manage the impact of a stressor. Since alcohol's effects are often quicker and more (superficially) effective in dealing with a stressful event than other, natural coping responses, alcohol becomes the preferred coping mechanism.

A person may become increasingly reliant on using alcohol to reduce anxiety in more and more situations, and they may forget (or not learn) other more beneficial ways of dealing with stress.

Of course, the amelioratory effects of alcohol are only transitory and the feelings of stress may resurface (and even be stronger due to a rebound effect) the day following a drinking session.

I will continue looking at these models in the next Background Briefing.

Alcohol:

the Forgotten Substance in Drug Treatment

Many drug users are problem drinkers but their care plans don't always reflect this. This one-day conference will assess the priority given to alcohol misuse by policy makers, commissioners and service providers when responding to clients with both drug and alcohol issues, examine where alcohol fits into key health and criminal justice drug strategies and explore how services can maximise the effectiveness of interventions to ensure all clients' treatment needs are met.

For further info or to book contact Shona on **020 7704 0004**, email **info@ldan.org.uk** or go to **www.ldan.org.uk**

LDAN Annual Conference

Wednesday 6 December 2006

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1 Shortlands
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LDAN LONDON DRUG & ALCOHOL NETWORK

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LLOYD'S

Derby Community Safety Partnership

Derby City NHS
Primary Care Trust

DERBY COMMUNITY SAFETY PARTNERSHIP

INVITATION TO TENDER – Adult Drug Treatment Services

Derby Community Safety Partnership, working with local agencies, has a reputation for the delivery of first class drug misuse services for adults and young people across the city of Derby. In order to maintain the highest standards and continue to meet drug treatment need, the decision has been made to reconfigure these services. As part of this plan, the Partnership invites expressions of interest from suitably experienced organisations to provide three adult services, either individually or collectively:

- **Tier 2 – Harm Reduction, Open Access, Information and Advice**
- **Tier 3 – Single Point of Entry, Key Working, Care Planning & Psychosocial Interventions**
- **Tier 3 – Specialist Mental Health Substance Misuse**

The services are commissioned through the Derby City Primary Care Trust. 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 to whom the final tender documentation will be issued.

An information pack and PQQ is available from:-

Karen Jones, Deputy Supplies Manager, Derby Hospitals NHS Foundation Trust, 4th Floor Education Centre, Derby City General Hospital, Uttoxeter Road, Derby DE22 3NE or email karen.jones@derbyhospitals.nhs.uk

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to these services. The aim is for the new services to be operational by 1st June 2007. The duration of the contract will be a minimum of one year and no longer than three years and subject to future funding allocations. The tender process will be running in parallel with public consultation.

The deadline for receipt of PQQs is 5.00pm on Friday 29th December 2006. Under no circumstances will late applications be considered. The formal tendering process will then follow within approx. 1 month.

Please quote reference : DH/470/T

Leicestershire County Council

Alcohol Strategy Officer

Ref: CC0580

£27,546 - £29,745 pa

Thurmaston

Initially until March 2009

This is a new post created to drive forward our partnership work in all areas where alcohol is an issue.

The post will ensure the implementation of the Leicestershire Alcohol Harm Reduction Strategy and the delivery of the Local Area Agreement indicators and targets. You will be working as part of Drug and Alcohol Action Team (DAAT) across a partnership of DAAT, County Council and Leicestershire Constabulary.

You will need strong partnership working skills, ability to work strategically and have an understanding of good practice in these areas.

www.leics.gov.uk/jobs

Application forms and further details are available from the Service Point, Main Foyer, County Hall, Glenfield, Leicester LE3 8RA or telephone (0116) 265 6253 (at any time). Please quote reference. Minicom available (0116) 265 6870 or use BT Typetalk or similar. Leicestershire County Council is registered with the Criminal Records Bureau and will undertake checks for certain posts.

Closing date: 8 December 2006

COMMITTED TO EQUALITY OF OPPORTUNITY IN EMPLOYMENT AND SERVICES

www.drinkanddrugs.net

Project Worker (Alcohol Misuse)

THE Space KC

Full Time: 3 year contract
Salary range: GLPC .26-31 (£23,994 - £27,807)
Start salary: £23,994
Funded by: Comic Relief

The Space KC provides a range of holistic support services for young people in the Royal Borough of Kensington and Chelsea aged 12-30 years. (*www.thespacekc.org*)

The project uses the Criminal Records Bureau disclosure service. An enhanced disclosure is required for this post. Registered Charity Number: 1003657

In this new post you will have the scope to develop activities for young people aged 13-17. In our drop-in facility you will provide information and guidance as well as deliver workshops in a range of venues.

Must have:

- At least 1 year's experience of working with young people (with knowledge of the alcohol misuse field)
- Ability to plan and deliver relevant programme of activity
- Excellent interpersonal skills

For an application pack call Libby Oakley on 020 7373 2335 or email info@thespacekc.org

Closing date: 7th December
Interview Date: 15th December

MimosaRecovery
MIMOSA RECOVERY LIMITED

Mimosa Healthcare Limited

Due to the expansion of our Alcohol Treatment Services into Yorkshire and the West Midlands we are seeking:

Residential Unit Managers **£28 – 32k**

The successful applicants will be responsible for all the day to day running of the units including Finances, Health & Safety. Staff Training and Programme Management. The successful applicants will be accredited by, or working towards accreditation by FDAP or equivalent professional body. Applicants with a First Level Nursing background may apply for roles within the Detoxification Units.

Addiction Therapists **£21 – 25k**

The successful applicants will be required to work in a multi-disciplinary team providing 7 day a week abstinence based treatment programmes, be accredited or working towards accreditation with FDAP or similar.

All applicants will be required to apply for a Disclosure at enhanced level from the Criminal Records Bureau.

To apply please email a C.V. along with a covering letter to SueAllchurch@lynwodemanor.co.uk

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Project consultant

CPI needs a new team member with current knowledge of substance misuse, joint commissioning, criminal justice issues. The successful candidate must have appropriate experience, be able to deliver consultancy services to the highest standard and also create opportunities for additional work.

Based in south London, with some travel.
Salary £32 - £38k.
Email egle.berruti@publicinnovation.org.uk for full details.
Deadline for applications Dec 8.

www.publicinnovation.org.uk

Welcome to a balanced approach

Safer Bristol Partnership – Users Feedback Organisation

Drug Service User Co-ordinator

£23,952 - £26,928 *Ref: 11169*

Fixed term until March 2008

Service user involvement in Bristol is developing rapidly. We have an active and focused range of current and ex drug users who are committed to improving standards of care and the experience of drug users in treatment in Bristol.

Safer Bristol Partnership and Users Feedback Organisation (UFO) are working towards developing an independent voice for user involvement. You will work with users to develop drug user input into service and strategic development.

You will play a key role in linking with Safer Bristol, service providers and national bodies, such as the National Treatment Agency (NTA). Based within the Drug Strategy Team, you will make strong connections with both service users and commissioners.

You will require:

- Strong commitment to the rights of drug service users
- Personal experience of drug services, either as a user or a worker
- Excellent communication skills to work with a wide range of stakeholders
- Good organisational and administration skills
- Good understanding of drug policy and service provision.

All staff enjoy: ■ An attractive final salary pension scheme ■ Competitive salary ■ Generous holiday ■ An award-winning work/life balance policy, including flexible working ■ Flexible retirement policy ■ Part-time, full-time and term-time only roles ■ Childcare vouchers ■ Great training and development

Apply Online at: www.bristol-city.gov.uk/jobs

Apply by Telephone: 0117 922 4499 quoting the reference number.

Closing date: 18th December 2006. Please note we cannot accept CVs.

At Bristol City Council, we value having a workforce as diverse as the city we serve. We therefore welcome, develop and promote people from all sections of the community. All jobs are considered suitable for job-share unless otherwise specified.

Welcome to BRISTOL

BRISTOL CITY COUNCIL

MANCHESTER CITY COUNCIL

TENDER

Manchester City Council are inviting companies to express their interest in tendering for the following Term Contract:

Drug and Alcohol Training Package for Supporting People and Housing Services in Manchester Ref: MH/0108

For further information, please email Carol Nolan at **c.nolan@manchester.gov.uk, quoting the reference MH/0108.**

Formal expressions of interest, need to be made by no later than 12 noon on Wednesday 6 December 2006, to the email address above, following which, passwords will be issued to allow interested suppliers full access to all tender documentation.

The appointed provider will be asked to design, plan and deliver a quality assured drug and alcohol training programme. This will include the compilation of a skills based manual, and a full evaluation report that would include recommendations for future planning.

For further information please go to: **https://b1.dmz.manchester.gov.uk/QuickPlace/datender/Main.nsf/**

MANCHESTER CITY COUNCIL

SHETLAND COMMUNITY DRUGS TEAM (CDT)

This is a re-advertisement.
Previous applicants need not re-apply.

Care Coordinator

35 hours. AP4 (£21,327 - £23,610)
Plus Island Allowance of £1,593

CDT is an independent voluntary sector agency dedicated to providing high quality treatment, support, information and aftercare services to those affected by drug use in Shetland.

We wish to recruit a care-coordinator to work with individuals seeking to address their drug related problems. You will be boundaried yet flexible, a first-rate communicator with good listening skills, a hard worker with excellent time-management skills, pragmatic and empathic.

You will be able to work to your own initiative but have a team-oriented attitude. You will recognize the value of working in professional partnership with a wide range of statutory and independent service providers. You will have 3 years experience of working in the substance misuse field and/or with individuals presenting with diverse complex needs.

For more information and/or an application pack please contact Mike or Agnes on 01595 696698 agnes.scdt@zetnet.co.uk

Closing date Monday 4th December 2006

THE SAFER MIDDLESBROUGH PARTNERSHIP

PROVISION OF A COMMUNITY SUPPORT SERVICE FOR PEOPLE WITH DRUG AND ALCOHOL PROBLEMS

Tender reference number: SS007/2006

The Safer Middlesbrough Partnership is inviting expressions of interest from experienced organisations to provide a community support service for people with drug and alcohol problems. The purpose of the service will be to support service users into accessing education, employment and training via services available locally. The service will be expected to have in depth knowledge and experience of working with this client group but also of the education, employment and training sector. The service will be based on a successful pilot scheme run locally, which involved supporting clients across the process from referral from treatment agencies, assessment of employment/training needs and referral on (with support) to appropriate services.

For inclusion on the select tender list, suppliers must obtain a pre-qualification questionnaire which will require amongst other things, information about economic and financial standing, ability and technical competency and other general information. The pre-qualification questionnaire can be obtained via the routes outlined below and must be returned no later than 15th December 2006. A shortlist of tenders will be obtained from the expressions of interest applications.

It is anticipated that the contract will commence on or shortly after 1st June 2007 and will run for a period of 3 years with a possible 2 year extension.

It is estimated that the Tender documents will be despatched to successful candidates on 5th January 2007. The contract will be awarded on the basis of the most economically advantageous tender in terms of price and quality.

Agencies who feel they have the necessary experience to provide the service should submit their PQQ by 12 noon on 15th December 2006 to Mr S. Ashley, Contracts Officer, Social Care Department, Middlesbrough Council, PO Box 234, Civic Centre, Middlesbrough TS1 2XH.
E-mail: simon_ashley@middlesbrough.gov.uk

MANCHESTER DRUG AND ALCOHOL STRATEGY TEAM

Manchester Drug and Alcohol Strategy Team are inviting companies to express their interest in tendering for the following Term Contract:

A review of the Eclypse service in Manchester Ref: 72.59.01

Companies interested in tendering should request in writing to Ian Jeffery, Senior Contracts Officer, Drug and Alcohol Strategy Team, 4th Floor, Heron House, Brazennose Street, Manchester M2 5EA, **quoting the reference (72.59.01). Tenders will be issued electronically therefore interested companies are required to provide an email address.**

Due to the nature of this contract, organisations and individuals who have a business relationship, or work in partnership with this service are ineligible to tender.

TACKLING DRUGS CHANGING LIVES

Applications will only be accepted up to Wednesday 6 December 2006.

MANCHESTER CITY COUNCIL

Lifeline Calderdale

Lifeline Project Ltd has a national reputation for effective and innovative interventions with people who use substances.

Lifeline Calderdale's Young Persons' Service works with young people and families affected by substance use, offering advice, information, harm reduction, prescribing and diversionary activities

Team Leader Salary: Pts 32 - 38, £25,437 – £29,859

Taking a lead on service development and delivery, you will have an interest in and an understanding of young people and substance use and a creative, problem solving-approach. If you have a good grounding in young people's substance use and think that you have the qualities to lead people in developing a flexible and exciting service model then we welcome your application.

Family Worker Salary: Pts 26-31, £20,895 – £24,708 (Pro Rata, 20hrs/week)

Developing a newly commissioned family service you will have experience of working with vulnerable adults or young people and you will establish provision for parents and young people affected by substance use. You will have the ability to engage, advise and support families and take the lead on developing a flexible programme of activities, group work and training.

For an application pack please send an A4 SAE with 2 x 1st class stamps to: Helen Newby, 9, Ferguson Street, Halifax, HX1 2EE
CLOSING DATE FOR APPLICATIONS: 9am Monday 27th November 2006 | Interviews will be held w/c 4th December 2006

Lifeline welcomes applications regardless of race, colour, nationality, ethnic origin, gender, sexual orientation, marital status, disability or age. All applicants are considered on their merits and abilities for the job.

Calderdale Drug & Alcohol Action Team

Cowal Council on Alcohol & Drugs

Counselling Practice Supervisor

Ballochyle House, Dunoon
17.5 hours per week
Salary Scale AP5: £23,739 – £25,857 pro rata per annum
dependent on experience.

CCAD is committed to providing high quality practice supervision to ensure that it continues to operate within a recognised ethical framework for good practice in counselling. Your duties will include attending standards meetings, providing individual and group supervision, client assessment, and you will be expected to carry your own case load.

You will be an accredited counsellor who has achieved a nationally recognised standard of competence in counselling supervision and have a minimum of one year's recent counselling supervision experience. Your training and experience must specifically include alcohol and drug counselling.

Please phone 01369 704406 for an application pack.
The closing date for returning applications is
Friday 1st December 2006.

Registered Charity No SC 021129
Ballochyle House, Dunoon, Argyll, Scotland PA23 7DP.

Operations Manager (London wide)
Salary circa £42K to £46K (including London weighting)

Westminster Drug Project is a leading drugs treatment service provider in London, working with a variety of partner agencies across twelve boroughs to offer a range of Tier 2 and 3 client-focussed interventions. We are a warm, supportive and diverse organisation which values our people and supports their professional development, offering a variety of career paths and learning opportunities.

Our continued expansion means we have a need for an Operations Manager who will have responsibility for managing, directing, and coaching a number of Project Managers and their teams, to support the achievement of performance objectives and targets.

Working closely with Senior Managers, and contributing to WDP's strategy, this important role will take a lead in creating relevant, high quality services, and devise solutions to operational challenges, to ensure services meet client need and commissioner requirements.

You will be able to demonstrate an impressive track record of leadership, working in partnership, and contract management, and a flair for bringing staff and service users together to create great outcomes.

To discuss the role informally, please call David Bamford on 020 7421 3103 or Stuart Campbell on 020 7421 3102

For full details of this exciting role and how to apply, please visit our website,
www.wdp-drugs.org.uk

Closing date: 6 December 2006.

Westminster Drug Project Ltd.

DDN Drink and Drugs News

Have you had your say?

Fill in the online DDN readers' survey 2006 and let us know the issues that affect you.

drinkanddrugs.net