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Drink and Drugs News
23 February 2009
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Editorial – Claire Brown

New ideas for old

Try something new... but remember what already works

Hunting through the woods blindfolded while pretending to be a wolf sounded pretty daft at first to me, but I would be an ideal candidate for nature awareness therapist Geoffrey McMullan, who says the more sceptical his clients are, the better (see this issue's cover story). Reading the interview made me think that actually, there's nothing wrong with a totally novel approach – and a lot right with having your conditioned behaviours turned on their head. What better way to demonstrate how we instinctively react and illustrate the work you would need to do to change? If you've tried this kind of therapy I'd be really interested to hear from you. Did the experience of a day in the countryside help you relate in a meaningful way to your behaviour in the urban jungle?

From the shock of the new to the shock of the old. Why do we research only to reinvent? Nick Barton gently reminds us on page 10 that the discovery that meaningful employment can be beneficial is a decade behind some highly practical and effective back-to-work schemes. The issue here is not just the income, but the restoration of self-esteem. With the slogan 'working recovery is a recovery working' he makes a vital point – that support groups have their role, but for many people they do not offer a path away from addiction and into self-sustaining long-term recovery.

We're grateful to Sharyn Smiles for tackling a difficult subject on page 11, through an account of her own relapse. When you've been a drug worker and lecturer it's not easy to face the fact that you're not immune to falling off the wagon, particularly when you fear losing your job as well as being accused of hypocrisy. But this story does have a satisfying outcome in that Sharyn tested the drug treatment system and found it worthy – not just of her clients' confidence, but of her own.

This issue

News in Brief

Captive audience

A countrywide prison radio service is being launched by the National Offender Management Service (NOMS) and the Prison Radio Association. The station, which will be available to prisoners in both cells and communal areas, will allow information slots on issues like drug awareness to be broadcast to the entire prison estate, says the Home Office, with those prisons that already have radio stations noting an 'increased positive engagement with the regime and staff'. Prison radio is also seen as a useful pathway into education, particularly for younger prisoners.

Gateshead gateway

A new online resource for drug users in Gateshead has been launched in response to concern at the number of drug related deaths in the area. The website, which has been designed in consultation with drugs staff and clients, was commissioned by the Gateshead Drug Treatment Partnership to link drug users with local services – six people died from drug related causes in the area last year, only some of whom were already known to services. The website contains information on services available, different types of treatment, and how to go about accessing them. 'There is a lot of information about drugs available both locally and nationally,' said service user involvement officer David Brady. 'Gateshead's new website pulls all this information together in one easily accessed and readable site, concentrating on the local picture.' *www.gatesheaddrugs.co.uk*

Red star rap

The makers of the spirit-based Red Star Plus drink, Intercontinental Brands, have agreed to change its packaging to make it clear that the drink contains alcohol, following a ruling by the Portman Group's independent complaints panel. 'Producers must be mindful that their packaging does not cause consumers to buy alcohol when they actually want a soft drink,' said Portman Group chief executive David Poley. The government announced in last year's Queen's Speech that it intends to introduce a mandatory code for alcohol retailers, following the widely perceived failure of self-regulation (*DDN*, 12 January, page 5).

Government ignores ACMD advice – again

Ecstasy will not be downgraded to a Class B drug, despite the recommendations of the Advisory Council on the Misuse of Drugs, the Home Office has stated. The announcement has raised questions in the media about what role the council usefully plays, as its recommendation not to reclassify cannabis as a Class B drug was also rejected (*DDN*, 1 December 2008, page 5).

Chair of the ACMD, Sir David Nutt, had said in a letter to the home secretary accompanying the report that while 'the use of MDMA is undoubtedly harmful' it was a public health issue and criminal justice measures 'will only have limited effect'. 'In reviewing the evidence of the harmfulness of MDMA to individuals and society, the council's collective view is that the balance of harms most closely equates to that of other substances in Class B,' he wrote.

The council's report, *MDMA ('ecstasy'): a review of its harms and classification under the Misuse of Drugs Act 1971* recommends that more research is carried out into the effects of the drug on the brain and that parents, carers, teachers and criminal justice staff should be better informed about the risks and how they compare to those associated with other drugs. It also wants to see a continuation of the harm minimisation approach, better data on the constituents of seized MDMA and improved data on the use of the drug among those under 16.

There was widespread support from drugs agencies for the report's recommendation that the drug be reclassified. 'The advice is based on a thorough, objective and independent review of the latest evidence,' said DrugScope chief executive Martin Barnes. 'Previous reviews of drug policy, not least a Home Affairs Select Committee report in 2002, have questioned the classification of ecstasy as a Class A drug. It would be regrettable if we reached a situation where, for political reasons, drugs can only be placed within, or moved up, the classification system, but cannot be moved down regardless of the evidence.'

The home secretary's failure to take the ACMD's advice was 'further indication of the government's refusal to base drug policy on evidence,' said Release. Professor Nutt's comparison with the risks of taking ecstasy to those of riding a horse in an article for the *Journal of Psychopharmacology*, meanwhile, led to strong criticism from the Home Office and sections of the press for 'trivialising' the harms associated with the drug.

However, the ACMD's recommendation for reclassification was not suggesting it was a harmless drug but 'making an accurate judgement on it being less harmful than substances such as crack cocaine and heroin,' said executive director of Release, Sebastian Saville. 'Sending this message to young people should be more important than satisfying illogical political agendas.'

Report available at *drugs.homeoffice.gov.uk/publication-search/acmd/mdma-report?view=Binary*

Cocaine – 'Balkanisation' of the market

THE AMOUNT OF COCAINE ENTERING THE UK through the Balkans has increased significantly, according to a new report from the International Narcotics Control Board (INCB). This has contributed to the continuing falling price of the drug, says the *Report of the International Control Board 2008*.

Europe remains the second largest market for cocaine in the world, it says. While large amounts of cocaine are still being smuggled through West Africa (*DDN*, 3 November 2008, page 5), the total amount of cocaine seized in Eastern Europe 'increased dramatically' in 2007, with the growing number of shipments from South America to countries in Eastern Europe representing 'a new development in cocaine trafficking.' The drug is then distributed via the Balkan route more commonly associated with the smuggling of opiates.

Smugglers were targeting these countries partly because of weak governmental structures, says the report, and the INCB is concerned that the government of Bosnia and Herzegovina has 'still not established a body at the national level to coordinate the fight against illicit drugs'.

The report also raises concerns about the role of the internet in supplying drugs – prescription and otherwise – and is 'alarmed that rogue pharmacies are encouraging drug abuse among vulnerable groups' as well as advertising and selling counterfeit drugs.

'Drug regulations are not a panacea,' says INCB president Hamid Ghodse in the foreword to the report. 'Regulations alone cannot eliminate illicit drug trafficking and abuse.' He could understand why the question of whether it would be better to do away with regulations was often raised, he writes, but it was the 'wrong question'. 'History has shown that national and international control of drugs can be effective and it is therefore the choice to be made.'

Meanwhile, the International Harm Reduction Agency (IHRA) has sent a letter to Ghodse, in collaboration with other harm reduction networks, calling on him to restate the INCB's position on harm reduction, after a member of the INCB secretariat is thought to have questioned the legitimacy of harm reduction interventions and the INCB's support for them at a meeting of a working group of government delegations. 'There is an urgent need for the board to make a public statement reaffirming its support for harm reduction as a pragmatic and evidence based approach to addressing drug related harm,' says the letter.

Report available at *www.incb.org*

NTA talks up new tool: personal maps

A NEW TOOL TO PROMOTE CHANGES IN BEHAVIOUR in drug dependent clients has been endorsed by the NTA. The mapping tool – which allows professionals to visually represent their clients' thinking in a series of personal maps representing the journey through treatment – has been found to improve engagement and motivation in pilot studies.

Originally developed in the US, the approach can be used as part of a range of psychosocial interventions – 'talking therapies' – says the agency. The 2007 *Clinical guidelines* endorsed mapping techniques, stating that they could also increase the client's 'memory and understanding of therapeutic session'.

The NTA sponsored tests in Birmingham, London and Manchester based on US findings and involving more than 3,000 service users and staff. Along with improved levels of engagement, the tests found better rapport with key workers, better peer support and improved psychological functioning. An NTA report, *Routes to recovery*, states that the full benefits of mapping are achieved combined with a focus on how services are organised.

'We need a broad approach to treating drug dependency, providing a range of interventions for different clients with a range of problems,' said the NTA's director of quality Annette Dale-Perera. 'These pilot schemes demonstrate that the combination of mapping and management significantly contribute to an individual's progression to recovery, and put psychosocial interventions at the heart of delivery of drug treatment.'

The Birmingham study, the Birmingham Treatment Effectiveness Initiative (BTEI), found that the approach improved treatment continuity and helped build planning and momentum into the recovery process, increasing the motivation of staff as well as service users.

'Mapping isn't a new technique but BTEI introduced a more systematic use as part of the initial assessment, detailing a client's past and present circumstances,' said Sian Battle-Welch, team manager at Swanswell, which piloted BTEI. 'Maps are used throughout treatment and successful examples are shared as best practice to motivate and inspire other workers. Overall they provide the mental and physical space for clients to systematically process their sessions and reflect, and become a memory aid for clients and keyworkers.'

Findings from the Birmingham Treatment Effectiveness Initiative (BTEI), available at *www.birmingham-dat.org.uk/birmingham-treatment-effectiveness-initiative-btei*

NTA report available at *www.nta.nhs.uk/areas/workforce/psychosocial_tools.aspx*

Government gets FRANK about cannabis

A NEW CAMPAIGN focusing on the mental health harms associated with cannabis has been launched by the government's drug information service FRANK. Aimed at 11-18 year olds, the £2.2m campaign will run for the next six weeks on terrestrial and satellite TV during programming which targets that age group, as well as on commercial radio and the internet.

The TV advert features a teenager smoking cannabis with its effects illustrated by neon signs spelling out words like 'talkative' and 'happy' followed by 'paranoia', 'panic attacks' and 'memory loss', while a voiceover says ' the more you mess with cannabis, the more it can mess with your mind'. Cannabis, the topic most callers to the FRANK helpline ask about, was controversially reclassified from a Class C to Class B drug last month (*DDN*, 9 February, page 4).

'Cannabis is the most commonly used illegal drug in Britain, and 'binge smoking' to achieve maximum effect may be putting people's mental health in serious danger,' said FRANK spokesperson Chris Hudson. 'There is evidence of a link between cannabis and mental health problems such as schizophrenia, and those who first use it at an early age may be more at risk.'

Ten per cent fewer 16-24 year olds are using cannabis than 10 years ago, but the government says it is concerned about the mental health risks associated with stronger 'skunk' cannabis – the reason given for reclassifying the drug. 'Cannabis is a destructive drug,' said public health minister Dawn Primarolo. 'What can start as a few giggles and being part of the crowd can have serious and long-term health problems. Young people need to know cannabis isn't a soft drug.'

Some commentators were unimpressed with the new adverts, however. 'No one is expecting Jamesian subtlety in a 40-second government health ad – but neon signs above people's heads? Really?' wrote Lucy Mangan in *The Guardian*. The adverts, she said, displayed a 'dismal, deadening literalness that I suspect won't even cause its target demographic to lift an eyebrow, never mind a phone.'

Fragile gains in Afghan opium struggle

THE AMOUNT OF OPIUM PRODUCED IN AFGHANISTAN this year is likely to lower than in 2008, according to a new report from the United Nations Office on Drugs and Crime (UNODC). Eighteen provinces are likely to be opium-free, and seven – including the largest opium-producing province, Helmand – to reduce cultivation, according to *Afghanistan opium winter assessment*.

Government pressure and higher prices for other crops are partly responsible for the decline in these provinces, says the report, with cultivation remaining concentrated in unstable areas in the south and south-west of the country. Prices, however, are continuing to fall as a result of overproduction in previous years – 2007 saw the country's opium cultivation reach the largest scale ever (*DDN*, 5 May 2008, page 4).

The drugs trade is still a major source of revenue for insurgent forces and organised crime in Afghanistan, says UNODC. Last week emails from a UK official in Helmand province obtained by the BBC estimated that 60 per cent of police in the province use drugs themselves, and that police corruption was widespread.

Drug money was 'a lubricant for corruption' said UNODC executive director Antonio Maria Costa, which meant that counter-narcotics efforts needed to be integrated into the wider process of economic development. 'Success cannot only be measured by reducing opium hectarage,' he said. 'It depends on improving security, integrity, economic growth and governance. There is no point winning a Pyrrhic victory against opium if we lose Afghanistan in the process.'

Report available at www.unodc.org/documents/crop-monitoring/ORA_report_2009.pdf

News in Brief

Tackling Drugs 09

This year's *Tackling drugs* week will be held from 8 to 12 June, the Home Office has announced. The week is seen as an opportunity to raise public awareness of treatment and increase confidence in efforts to tackle drug related crime. 'This week will build upon the success and momentum generated by previous national *Tackling drugs* weeks and is a reflection of our commitment to respond to community concerns about drugs,' says the Home Office. The government will release details of the week's events soon.

New man at the top

Stephen Rimmer has succeeded Moira Wallace as director general of the Home Office's crime reduction and community safety group. Previously governer of Wandsworth and Gartree prisons, and the Home Office's director of policing policy, his brief will be to 'support the home secretary and other ministers in the Home Office in reducing crime, tackling drugs and alcohol abuse and building confidence in the police service,' according to the Home Office. 'I look forward to working with colleagues within the Home Office and with external partners to deliver responsive policing that has the confidence of the public and meets the pressures of a tough economic climate,' he said.

Get briefed

The Department of Health's *Identification and brief advice* e-learning module for alcohol has now gone live. Part of the Alcohol Learning Centre, the free online course for healthcare professionals – which takes around two hours to complete – covers alcohol facts, alcohol units and a section on structuring brief advice. It also includes interactive assessments, video and a podcast. The website, which does not require users to register, was designed by e-Learning for Healthcare and is backed by the Royal College of Physicians, the Royal College of Nursing and the Royal College of General Practitioners, with all the tools supported by the DH policy guidance in Safe, sensible, social.

www.alcohollearningcentre.org.uk/eLearning/IBA/

‘I had a counsellor say she’d tried every possible way of intervening with a client with no success, until she went on nature awareness – it was an integral part of her recovery that focused on the here and now. A consultant psychologist told me it helped clients respond to more traditional treatment methods, and counsellors have also told me that it works on the spiritual side, which can be hard to deliver.’

Seeing the wood AND the trees

David Gilliver hears how nature awareness therapy has been helping clients with substance misuse issues not only re-connect with nature but also with themselves

'I didn't understand how trees and nature could be so powerful. I felt something I never felt before – I can't really explain it. I felt happy, got in touch with my feelings for the first time. I started to feel spiritual as well – it was amazing.'

Lucy is talking about her experiences of nature awareness, an intervention for people with addiction issues using nature-based games. It's designed to build trust, increase self-awareness and self-confidence, boost creativity and promote communication, problem solving and relationship skills. It is also based on the theory that connecting with nature – and stepping outside of yourself – can help change established behaviours and encourage people to take responsibility for their actions.

Nature awareness therapist Geoffrey McMullan used the method with clients from Kent-based 12-step centre Promis, as well as a Christian rehab centre, as part of research for his MA in addiction psychology at Southbank University. 'I'd been involved in nature awareness work for around 10 years, but when I ended up working in rehab I had no prior knowledge of working with addictions,' he says. 'It was like a blank sheet of paper.'

The games include 'meet a tree', the aim of which is to locate a specific tree while blindfolded, and 'the drum stalk' in which participants move through the trees to the sound of a drum beat. The games are based on Native American ideas, but have been modified through use with substance misuse clients – they also incorporate elements of 'wilderness therapy', which challenges people by removing them from their comfort zones.

So how does it work? 'Nature awareness is very much about going into nature but allowing the events to unfold before you,' he says. 'There's no set procedure other than the games I use. If a situation arises, we go for the intervention there – we sit down and work as a group.'

Rather than an alternative to traditional treatment methodologies, however, he sees nature awareness as a means of helping people get more from mainstream treatment. 'I had a counsellor say she'd tried every possible way of intervening with a client with no success, until she went on nature awareness – it was an integral part of her recovery that focused on the here and now. A consultant psychologist told me it helped clients respond to more traditional treatment methods, and counsellors have also told me that it works on the spiritual side, which can be hard to deliver.'

He cites the example of equine assisted psychotherapy (EAP), which uses interaction with horses to boost emotional growth and non-verbal communication skills. 'Nobody really understands how that works, but it does work,' he says. 'A horse is part of nature – we're not separate from nature, we do have that connection, and it's about firing that up. I say to people 'I'm going to help you remember what you already know'.'

With some clients, the therapy also seems able to put them back in touch with aspects of their character they may have lost touch with. He describes how a woman with an eating disorder felt intense frustration after becoming caught up in brambles during one game. She persevered, however, and later said that the frustration she felt was the same as when she started to binge, but the fact she had managed to get out meant there was hope for her. Another said that for the first time in her life she listened to what her body was telling her. 'That could only be achieved by being outside in nature,' he says. 'You couldn't achieve that within four walls. So it's not a stand-alone intervention, it's very much a complementary one.'

Another client, now a counsellor himself, described the 'drum stalk' game as being like steps one, two and three of the 12 steps. 'The person being blindfolded was him in his addiction, going through the forest blindfolded was him recognising that he's powerless over that situation, his sight guide represented his sponsor and the drum beat was the higher power calling out to him,' he says. 'That was a good analogy.'

Established behaviour patterns are challenged through asking clients to 'become' animals and completely lose themselves in the role. 'I had a group of guys blindfolded, holding hands, who took on the role of a pack of wolves,' he says. 'They were hunting someone who was a rabbit, and one of the guys broke away from the group. We challenged that, asking him why, and he suddenly realised that that's what he does when he wants to go and use. That wasn't picked up within the four walls – it wouldn't be, he's not breaking away from the group there. When you get them to take on the role of an animal, after a while people drop the barriers they've put up – there's no need to hide anymore. It's quite amazing what comes from that, because they're not them, they're the animal.'

He's now used nature awareness with around 100 clients with substance misuse issues, covering a broad range of addictions. Does it work with certain age ranges better than others? 'Nature awareness works from a very young age all the way up,' he says. 'Children up to about 12 respond very well to nature-based activities. After that it becomes a little bit more difficult and for me that's where the wilderness aspect kicks in – taking them out of their environment and into a wilderness where they can't just pop down to McDonald's. You're putting them in a challenging situation where eventually they have to do something about it.'

As yet no one else seems to be using this in substance misuse treatment. Are people usually open to the concept or are they likely to be suspicious or cynical to begin with? 'Cynical, totally,' he says. 'But I kind of encourage that. I give them very little information because I want to challenge them. Some people will claim that they know everything about nature and there's nothing I can teach them, some will be suspicious but curious and others will use it as a reason not to go to group or counselling sessions. But then they take part in the game and suddenly get challenged. It doesn't work with everyone – I've had one or two people just walk away and not engage at all.'

Once clients have overcome their initial reservations the feedback is usually positive. So does any one group seem to get more out of it than another? 'What I did find with the research is that women tend to perform better than men because they tend to be more organised. Nature awareness is about getting people into that 'heart' space, rather than the 'head' space, which is all factual and statistical, and once men do that they perform just as well as women. One man who was on detox came back a year later and said it was still having a profound effect on his life.'

He's now in the process of setting up a workshop to teach nature awareness to other counsellors. Clearly, however, a lot of people will take a good deal of convincing – what would he say to the sceptics? 'A consultant psychologist asked me if she could come and observe and my answer was the same as always – 'yes you can, but only by taking part. If you want to stand on the sidelines you're not going to have that experience.' She came and was very cool about it, looking at it from a professional point of view, and at the end she told me that it created a bridge that traditional methods couldn't. I'm more than happy for anyone to challenge me. You can get lulled into a false sense of security about what you're doing, and that's wrong – I'm always open to change.'

And would he like to see nature awareness ultimately becoming a part of mainstream treatment? 'That's in my heart of my hearts,' he says. 'I'd love to see it used throughout the country and for the evidence to be built up. Ultimately I want to set up my own wilderness centre working with people from all different backgrounds, not just addictions, and I'd also like take the research further if anyone's interested. One of the problems with the alternative or spiritual-based side of things is that there's not enough evidence, because the other side – the scientists – don't want to go there. I do believe that nature awareness can close that gap – not entirely, but a little bit. I've had real sceptics come along and I've just thought 'great, the more sceptical you are, the better.'

Contact Geoffrey McMullan at pathfinder777@btinternet.com wild-tracking.blogspot.com

Online opinions

A taster of our website forum at www.drinkanddrugsnews.com

Been watching the user group movement for some time and have come to the inevitable conclusion that it is as self-serving as many other aspects of addiction treatment. Why are they all funded by DAATs? Why are some of the founders of the various groups salaried? Why are these so called 'voices of users' all self-appointed? And why do they seem so irrelevant to the average user on the street? Why are they having the head of the NTA at their conference? All that does is allow him to pretend to be listening. Why do they do cheap research for trusts, DAATs etc? Why have they become such an integral part of the system that they were supposed to shake up?

I remember when I first joined UKHRA users being impressed with the 'punk' spirit of the whole thing. Now it just seems like practically everyone involved has a vested interest in not rocking the boat they are sailing in.

This conference was a joke. I'd love to see it organised and have a random selection of users sent, rather than the self-appointed elite. I'm sure it would have been a very different event.

Posted by Jon of Arc

Obituary

Alex Georgakis

Alex Georgakis may not be a name you will find in the pantheon of addiction treatment researchers. Had he lived longer than his 46 years, I am sure that that is where this name would have come to reside. Our field lost an important colleague and friend when Alex Georgakis died of cancer in a London hospice on St Valentine's day.

Alex took a psychology degree at Goldsmith's College, following this up with a Masters in Counselling Psychology at City University. As part of his studies, Alex undertook various assignments for Broadreach House, where he had earlier undergone treatment for addiction. He monitored treatment processes, analysing the variables that appeared to affect outcome and providing management with valuable information. He increased understanding of the effect of particular inputs or approaches and, as a result, refocused training.

Around this time he gave evidence to the then government's task force looking into drug treatment, including his discovery that waiting times appeared to have an impact on completion and longer term outcomes. This finding helped influence the National Treatment Agency to promote the reduction of waiting times.

I met Alex in about 1994. Long before it became fashionable to do so, he raised the challenging question of outcomes. I managed to persuade the trustees that we ought to submit the outcomes of Clouds House to independent evaluation, to bridge the gap between belief and evidence, and informed them that I had found just the person to undertake the study. We agreed that for the study to be credible, whatever it revealed, Alex's independence must be preserved. His designs and protocols were approved by the National Addiction Centre and what resulted was a 30-month follow-up study of 166 people admitted to Clouds House in a six-month period in 1992.

At least one highly respected researcher described Alex's evaluation as one of the best naturalistic studies he had ever seen. The unusually high response rate must have had something to do not only with Alex's persistence but his engaging way with the research subjects.

With his beautifully constructed report, we set off around the country on a road show in which Alex starred, delivering the presentation of his findings in his own distinctive style – a mixture of a somewhat rumpled boffin and a charming raconteur. Speaking in his immaculate, yet deliciously Greek-accented English, he engaged audiences from Southampton to Manchester, making the material accessible and digestible.

Alex undertook other evaluations, including a study of the effects of the Clouds brief residential family programme for adult family members. He applied a set of standardised tests to participants prior to the programme, at its end five days later and then again 12 months after completing the programme. Another compelling report was written, with a literature review into the relationship between families and the treatment of substance misusing family members following much later.

Using similar instruments, he also measured the changes people experienced over the six week treatment episode at Clouds House.

Alex also embarked on an evaluation of SHARP, a structured day treatment run by the then Chemical Dependency Centre in London. His interim report on the factors predicting completion or early discharge were illuminating but sadly he never got to complete his analysis of the data and write the report.

Even when reports had been compiled and put to bed, which was sometimes a struggle for a man with self-confessed unmanageable tendencies, Alex could not resist returning to dig away at the data to see if there was some nugget he might have missed.

Alex set up Telos (which I believe is the Greek for 'outcome') a small independent practice encompassing psychotherapy, evaluation and consultancy services, before returning to Broadreach to work to oversee the treatment service.

Despite his own experience and painful personal insight into addiction, Alex was reassuringly dispassionate when it came to research. He simply wanted to find things out, to understand what things meant and what would make a difference. As he wrote, 'effective treatment can only evolve through systematic evaluation and a reciprocal partnership between research and practice.'

Nick Barton, chief executive, Action on Addiction

'From inside the prison it is often difficult to verify the dose being given... A simple solution would make my life a lot easier.'

Insider blues

Martin Roberts proposes an easy solution to the problem of continuing appropriate methadone doses for people being admitted to prison (*DDN*, 9 February, page 9). As a prison substance misuse doctor I wish it were that simple. The courts and prison service do not always send people to the prisons that one might expect. I do not know how outside doctors would know who to contact.

From inside the prison it is often difficult to verify the dose being given, and taken. We are given details of drug teams/doctors only to be told on contacting them that the client has not been seen for weeks or months. There can be a discrepancy between the dose prescribed and the dose taken if the methadone is diverted. We are also often presented with people on high doses but who have then spent several days in police cells on a few tablets of dihydrocodeine and who have a reduced tolerance.

I spend a significant proportion of my time reducing methadone doses because people are over-sedated after being given the dose ostensibly taken outside the prison, although I spend more of my time increasing inadequate doses. The national guideline for prescribing in prison states 'the standard maximum recommended maintenance dose of methadone prescribed in prison is 40mg per day'. This is too much for some and too little for others but very safe, if titrated to this level, for the majority.

A simple solution would make my life a lot easier, but I suspect that it will be elusive.

John Belstead, prison substance misuse doctor

Survey request

You published my article on creative writing as a therapy in recovery from addiction (*DDN*, 21 April 2008, page 12).

I'm now doing a survey on creative writing in addiction for a project as part of the MA in Creative Writing and Personal Development at Sussex University and would very much like *DDN* readers to participate.

To take part, please phone for a survey and SAE (on 01883 713388) or email me – fiona@friendandco.com. All replies will be confidential if so requested.

Please send replies back by 20 March to meet my project deadline.

Fiona Friend, Friend & Co Copywriting, www.friendandco.com

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity.

Post-its from Practice

Hidden menace

Don't forget hepatitis B, says **Dr Chris Ford**

Eddie registered as a patient a few weeks ago. He was jaundiced and looked very unwell. He had lived in the area for a while but hadn't registered with a GP because he hadn't yet had a reason to. At 24 years old, he was still enjoying his drug use. He had discovered the right combination of injecting heroin and cocaine which allowed him to stay in work and out of debt. Following a few days of pale diarrhoea and vomiting, that morning his eyes had gone yellow, prompting him to go the doctor.

After examining him I decided that he needed to go to hospital but he refused, even though I explained there were guidelines for care of drug users at our local hospital. So I set about trying to make a diagnosis and provide him with the appropriate care. It was obvious to me that he had acute viral hepatitis and as he injected, although denied sharing equipment, I thought it would most likely be hepatitis B or a rare case of acute hepatitis C.

I took some blood tests and explained the treatment was rest, a good diet, pain relief as required, and no alcohol. Eddie had come with his partner so I offered her a hepatitis B vaccination, which she accepted. Eddie's results confirmed acute hepatitis B and over the next six weeks his symptoms settled and his liver function tests returned to normal.

Hepatitis B is a potentially fatal liver disease caused by the hepatitis B virus (HBV). Acute hepatitis B, like Eddie had, results in liver inflammation lasting one to six months and can very occasionally lead to liver failure. Chronic hepatitis B (CHB) comprises a lifelong infection characterised by liver inflammation and damage that can lead to cirrhosis and liver cancer. HBV is second only to tobacco as a human carcinogen, causing 50 per cent of primary liver cancer in the world. Patients with CHB are 100 times more likely to develop hepatocellular carcinoma than those not infected.

It is estimated that 180,000 people (0.3 per cent of the UK population) have chronic hepatitis B infection. Around 1,300 new cases of acute hepatitis B and 7,700 new cases of chronic hepatitis B are reported in the UK each year.

HBV is transmitted in a variety of ways and is more infectious than HIV. The virus is found in the blood and other bodily fluids, and may survive in dried blood for up to a week. The main route of transmission in the UK is via unprotected sex and injecting drug use. Worldwide the most common route of infection is transmission from mother to child at birth. Other routes of transmission include needlestick injuries in healthcare professionals, transfusion of infected blood products in countries with inadequate screening, and piercing or tattooing with unsterilised equipment.

There is an effective vaccine to prevent HBV and the World Health Organisation recommends routine vaccination of all infants against HBV infection. The UK does not offer this vaccination at birth or in childhood purely for economic reasons, apart from to high-risk groups – but as in Eddie's case, it is not a catch-all.

Acute hepatitis B is often self-limiting and usually only requires relief of symptoms. Treatment of CHB aims to prevent progression to hepatocellular carcinoma or cirrhosis. There are now a number of drugs licensed for the treatment of CHB including peginterferon.

Eddie successfully cleared his acute hepatitis B and is back at work. He and his partner Janet have remained patients and now use the surgery for general medical care, needle exchange and counselling. Janet has completed her hepatitis B vaccinations but as yet neither of them wants substitute medication. Eddie and Janet have managed to have their immediate healthcare needs met, can continue to stay in contact with us and are making the changes they want.

Supporting and encouraging people while respecting their own choices and timescales is one of the many reasons I love being a GP.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP.

A referenced version of this Post-it is on our website, www.drinkanddrugsnews.com

Working recovery

The 'discovery' that work can have a positive effect on recovery is nothing new, says **Nick Barton**, who looks back over a decade of helping clients into rewarding employment

When the world catches up with you it is difficult to know whether to indulge in a bout of somewhat resentful self-righteousness ('what on earth took you so long?') or bathe in the more noble sentiment of relief that others are recognising an important way forward. Let us settle for the latter – improved understanding should result in more people receiving the help they need to sustain their journeys out of substance dependency.

What am I referring to? Well, I recently attended a gathering at Barclays' 'global HQ' in Canary Wharf at which the UK Drug Policy Commission (UKDPC) presented findings of its review on getting problem drug users into employment. UKDPC commissioner Jeremy Hardie delivered an eloquent introduction to the report, *Working towards recovery: getting problem drug users into jobs* – a review that has roughly coincided with the national drugs strategy, and which also emphasises the need for recovering drug users to build recovery capital beyond treatment in the form of employment, housing and education. You may remember that a few years ago the Audit Commission also made much of this angle to the recovery journey.

The initiative in whose historical slipstream these important developments follow is called Working Recovery – a project that has been in business for ten years, having been officially opened by Keith Hellawell, the then 'drug czar'. Its longevity is certainly something to celebrate given that it has survived on charitable giving and lottery funding, apart from a very small annual grant from the local authority. But longevity alone is not the point. The project has now helped nearly 700 people to get a real start on what is rather turgidly referred to as social reintegration, and in so doing brought benefit to the local community.

In 1997 I got a call from a former client of one of our residential services who was living in Boscombe, an area of Bournemouth that regularly appears among the most deprived localities of the South West region. He wanted me to visit a project he had started off his own bat. Intrigued, I found that John had set up a workshop in a dilapidated back street garage that someone had loaned him. In this unlikely venue John, who had been a very skilled joiner in his time, had managed to collect some tools for carpentry and other jobs like painting and decorating. He explained to me that he had decided on this course because he feared that boredom and lack of direction would lead to relapse. Sitting around in cafes talking about recovery and going to anonymous fellowship meetings – while providing him with essential support – were clearly not, on their own, going to lead him further forward along the path of a self-sustaining recovery over the long term. He needed to get a life, and a working life at that.

'When the world catches up with you it is difficult to know whether to indulge in a bout of somewhat resentful self-righteousness... or bathe in the more noble sentiment of relief that others are recognising an important way forward. Let us settle for the latter.'

It soon became clear that John was not alone. As this new venture began, other people in recovery appeared, drawn out of curiosity to what became known as The Recovery Project. They began to ask John how he did this or that, and he began to teach them. Word got around and more people appeared. It was a social hub, but one with another purpose as well. The Recovery Project began to undertake small commissions to make or repair.

It was impossible not to be impressed by this service user-led initiative. It was clearly meeting a need. However, it was also not difficult to be alarmed at the health and safety nightmare that was looming. Having reflected for a while on how Clouds (as we were then) might help, I returned to John with the following proposition: the charity would absorb the project, raise enough money to put it on a proper footing, and train him in both basic counselling skills and management. It was important to me that it should not lose its beneficiary led spirit. I proposed the new name Working Recovery and the slogan 'a working recovery is a recovery working', both of which John readily accepted.

A major appeal resulted in our being able to rent part of a warehouse for a fully equipped woodworking workshop. This was made accessible to people who had received treatment and who had managed to establish some basis of recovery. Under the watchful guidance of skilled and caring trainers, they learned to use simple tools and quite complex equipment to make and repair things. Attendance was expected as if it were indeed a workplace.

One aspect of the original initiative we were keen to retain was for the project to generate income through real work done for real clients in the surrounding community. There was little to compete with this when it came to filling clients with pride and building their confidence. The realisation that real people wanted to pay for things they had produced or

work they had done was a tremendous boost to self-esteem. Not only would this benefit clients and the project, it would help the local community to recognise the value of investment in projects promoting recovery.

The first commission was to make replacement furniture for an old people's home. A wide variety of others have followed, including such highlights as constructing and installing a replica of a Victorian umbrella seat in Stourhead gardens – one of the National Trust's most visited sites – along with garden seats, work benches, picnic tables, bird boxes, coffee tables, bookshelves, children's outdoor play furniture and a signposted local nature trail. It is particularly heartening that a couple of other treatment providers have commissioned items from the Working Recovery workshop. Early on, Clouds House commissioned three garden cabins, which are used to this day.

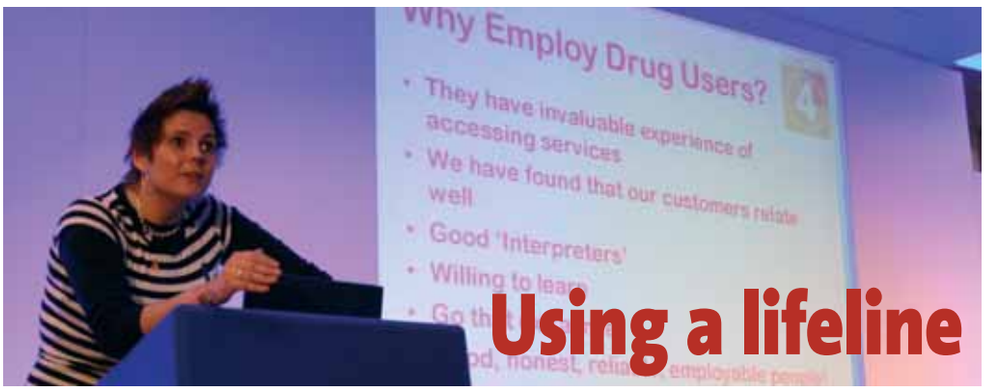
While the woodwork programme continues, we have added an IT suite, basic skills training – including literacy and numeracy – work experience and a creative skills programme. Most recently the clients have played a significant part in producing the local community newsletter. A productive relationship has been built with local colleges in Bournemouth and Poole. Opportunities for volunteering are taken up and former service users encouraged to provide mentoring support.

Over the years Working Recovery has become a key component of integrated services offered by the charity in Bournemouth that now includes pre-treatment, structured day treatment and continuing care programmes. Working Recovery can, subject to assessment, now be accessed by people at different stages, under the SHARP (Self-Help Addiction Recovery Programme) banner.

Working Recovery clearly plays a key role in helping to build the personal and social capital that will support individuals in the ongoing process of self-managed recovery. This in turn helps the local community as it leads to productive citizens keen to give something back. It plays a role in reducing drug-related crime and increasing community safety. Given that much of the generous three year funding from the Big Lottery and charitable sources is coming to an end, the question is whether those charged with investing public money will also recognise this value and ensure that this project survives for another ten years.

The value of this model project was most vividly brought home during a visit to Working Recovery from the then drugs minister Caroline Flint. A man, who had made full use of what Working Recovery had to offer, had developed sufficient skills and confidence to launch his own joinery business. As a result, he no longer needed to be on benefits. He had become independent in every sense of the word – a fine example that a working recovery is a recovery working.

Nick Barton is chief executive of Action on Addiction



Using a lifeline

Sharyn Smiles **– MA, drug worker, trainer, lecturer, PhD student, daughter, sister, friend, drug addict and alcoholic says off with labels and on with the reality of relapse**

The sleeves on my jumpers get lower, along with the tracks on my arms. I'm sitting down because I'm in agony from the abscess on my leg. Baggy clothes hide the fact that I'm desperately underweight. Make-up hides my deteriorating complexion and sunglasses hide the pain in my eyes. This is the worst pain – the pain no one can see, feel or understand. The shame, the guilt, the hurt, the desperation, the sheer mental torture of my reality – where can I find a drug that could take away the plague in my head, polluting every cell in my body, a cloud with no silver lining?

I was a person lost in a sea of self-hatred, a representation of shattered dreams, anguish, pain, distress and self-ridicule – all shielded in a veil of secrecy. It preoccupied my days and haunted my sleep. I survived in complete despair – seven and a half years of abstinence. Little did I know my addiction was sitting waiting to detonate, finally exploding like an atom bomb, and I found myself back in the middle of chaos, deep in the heart of what I can only describe as a hellish nightmare.

The first problem for me was even considering treatment. How could I possibly tell people what had happened? Surely I should know better – I've been there and done all that before. I see the devastation caused by addiction every day, the damage and destruction to families, coupled with the sheer waste of human life.

I work in the drugs field, I can recite almost every theory of drug treatment known to man. I've seen the figures and done the maths – how did this happen? Where did it all go wrong? How will I ever live with the shame, humiliation, guilt and embarrassment? Perhaps more importantly, why can't I apply the mass of knowledge and theory to my own life?

Then there's the question of my colleagues who were already working under massive pressure. I didn't want to lumber and burden them with my problems. The secrecy and dishonesty I had used in an attempt to protect my addiction and maintain a professional image were about to be revealed. I was about to approach a service I worked for and helped to build.

Panic and anxiety overwhelmed me as I thought about the possibility of losing my job, house and the last threads of security I had – not to mention the respect of my colleagues and the reputation of an entire company. I didn't know how to tell my colleagues, who had also become my friends, what I had done and what I felt I had become.

It could be argued that drug treatment is at its pinnacle. But when I couldn't trust myself, or those I hold dear, how could I trust a system? Did I have the faith that this system could salvage the debris of a broken life? Could I or would I trust it with my life?

Entering treatment this time was the most challenging and arduous thing I have ever had to do and I was doubtful it could really salvage the remains of my broken life. I arrived in a comfortable waiting room where I saw a drug-related magazine – it sported my name and an article I had written, and seemed to sneer at my hypocrisy, which I felt was a representation of my life.

A nurse took me to my room where I started a drug and alcohol detoxification. Forever the cynic, I waited for something to go wrong, for judgement, for mistakes, for miscommunications, for broken confidentiality, for poor treatment, for being treated like a number. It didn't happen – drug treatment has changed. The empathy, patience, kindness, compassion and professionalism were without parallel. What began was a new journey, a new beginning, a place of safety to explore and discover who I was.

What have I gained from this experience? Peace of mind and pleasure in the small things I had became blind to. Contentment and a harmony I'd long forgotten. Friends from across the globe who come to England for the sole purpose of drug treatment – now that's telling in itself!

The joy of genuine laughter, learning to care for me again and the beginnings of a reconciliation with myself. I gained a restored faith and belief in drug treatment and a new way of looking at things.

Ultimately it was my colleagues who believed in me, when I couldn't believe in myself. I consider myself privileged to work for an organisation that practises what it preaches. I feel no pride and I feel no shame in sharing my truth – if it helps one other person it's been worth it.

So would I trust drug treatment with my life? I just did.

Safe haven

In the fourth of our series on the aetiology of addiction, Melody Treasure **argues that the concept of therapeutic respite could make 'Every child matters' more than just an empty slogan**

As a contributor to this series of articles I need to state from the start that I am not going to offer a theory of addiction – I have many problems with the word addiction, especially when applied to young people. Too often I have young people referred to me and am confronted with 'little Jimmy' in his baseball cap, hoody and varying degrees of 'bling', earnestly informing me that he has been referred 'cos I'm an addict'.

A shudder goes down my spine and the thought 'there's a title to live up to'. Invariably, I discover that Jimmy does smoke too much weed – he says he can't sleep without it, it chills him out and stops him being hyper. It's true he may also be causing a problem to his family, school and community, often because of his weekend alcohol binging sessions with his mates. But addict? No.

More often than not I discover that Jimmy is a deeply unhappy boy, who is in so much trouble all over the place and has so many appointments with so many different professionals that he hasn't had time to stop and think about why he does what he does. But somebody gave him as good a reason as any other – he's an addict. And therefore he can't help what he does.

As an experienced practitioner in young people's drug services, I am aware that many of the young people we work with are simply going through an episode in adolescent life. For many their early dabbling or recreational use is something they will grow out of, learn to manage or be helped to stop. Many of these young people view their experimental drug use as a rite of passage and they are often more perplexed by the professionals' interest in it than they are bothered about why they do it.

'Often the biggest barrier to a young person gaining access to any... provisions is that, even before they get there and before they have escaped their chaos, they are expected to sign up to the "gold seal" of recovery – life time abstinence... At age 15 is that appropriate? Could any of us have signed up to that as teenagers?'

However, there are a few young people that we come across whose use is more problematic. I am not referring to the drug of choice – some troubled, anxious, traumatised young people are using any drug to mitigate their emotions or numb their pain, and therefore it's not just an issue of dependence, health or legality. The real problem for these young people is that they are simply not coping with their lives without drugs, and often their lives wouldn't be easy for anybody to cope with. These are young people who, for example, have been bereaved, bullied, suffered abuse, have low self esteem, don't feel that anyone loves or cares for them, are in the care system, have been neglected or are young carers themselves.

Their inability to make changes is often nothing to do with the drug, aetiology or genetic disposition – it is because they are trapped in a cycle of trauma and chaos. It is these young people that I believe present challenges to us, because we have to look at other ways of enabling them to make changes and we have to face up to the fact that, in many ways, drugs are the least of their problems. But because drugs are there, and everybody surrounding them is focused on that – often because of their own fears and lack of training or awareness – they send them to us.

So how do we help these traumatised young people? Traditionally our concern has been the drug – can we substitute it, can we reduce it, can we stop it? But how do we hope to do this when nothing else around them changes and they are surrounded on a day-to-day basis with all the stresses, strains, expectations, trauma and chaos that make up their lives.

We can of course try to engage them in a therapeutic relationship, but even this has to be carefully measured and managed. Can we really ask a vulnerable young person to 'open up', relive their traumas and admit their fears when they are not in a safe place? Because we know that when we have finished our hour-long session with them they return to the chaos of their lives and, of course, to the thing that has helped them cope with this – mind and mood-altering substances.

If we are to truly realise the ideals, aims and outcomes of *Every child matters*, we need to develop ways in which these children and young people can be healthy, stay safe, make positive contributions and achieve economic wellbeing. Because if we don't it is these young people who will populate our adult dependency services in the future, not little Shaz, Baz and Caz who are simply enjoying a bit of weed socially at the weekend.

It is these unhappy young people that I believe we fail – we write them off and we describe them as immature. The few services that we do have to cope with their diverse needs are often staffed by workers from adult services and young people are expected to engage in an adult referral route – despite everything else that is going on, they are somehow supposed to keep appointments in surgery-type venues. The programmes devised in many of these services are adult programmes, or a relive-creation of the school structures they have already rebelled against or deemed to have failed.

These programmes are often proud of challenging philosophies, attitudes, behaviours and beliefs. Has it ever occurred to anybody that perhaps the greatest challenges you could give a young person are choice, unconditional respect for them as a human being, serenity and an opportunity to make informed choices and actions?

But often the biggest barrier to a young person gaining access to any of these provisions is that, even before they get there and before they have escaped their chaos, they are expected to sign up to the 'gold seal' of recovery – lifetime abstinence. When these young people are trapped in the chaos of their lives, how can they possibly contemplate the one effective coping mechanism being taken from them? And at age 15 is that appropriate? Could any of us have signed up to that as teenagers?

While abstinence is an admirable achievement for many people, and an acceptable goal for others, it cannot be a condition for these young people to get the support and help they need. If, after they have gained some balance in their lives, learned to cope and learned to be the happy young people they should be, then lifetime abstinence – if freely chosen by them – may be an appropriate lifestyle choice.

There is also the possibility that these young people could be sent to something called 'brat camp', a residential environment offering them a 'therapeutic' programme. How do therapists seriously imagine that the way to therapeutically engage with a troubled, stigmatised unhappy child is to start the process by naming them a 'brat'?

It is because of these concerns that I have, in partnership with other dedicated youth workers and a group of ex-using young people, looked at what else could be done. We have come up with the idea of 'therapeutic respite', a 12- week residential that incorporates fun, calmness and therapy.

Our initial ideas began when we realised that many of these young people are so caught up in their own chaos that they have no space or time to see the wood for the trees. We believe that time out in a therapeutic environment – that will require them to be drug free for the time that they are there – will give them the safe place from which they can explore their issues. They can begin to regulate their emotions, understand their hyper-arousal, develop self-esteem and, with therapy and positive youth work interventions, be enabled to express their emotions in appropriate ways. They can develop resilience to stresses and they can enjoy life, feel safe and have a sense of achievement.

We believe that this can be done, in a supportive, person-centred, therapeutic manner, by using non-invasive therapies that help rebalance the nervous system, by positive psychological interventions and by focusing on these young people as the unique and wonderful individuals that they are, not by bullying or behaviour modification type regimes. When these young people have reached calmness, then they can make informed and rational decisions about their lives for themselves.

As well as therapy and calmness, this centre should also have access to other activities, whether creative, sports or IT. Whatever it is, it should be an opportunity for these young people to achieve their own diverse and unique potentials, rather than the self-destruction they have experienced in the past. These activities will enhance their self-esteem and give them practical and achievable diversionary opportunities for the rest of their lives.

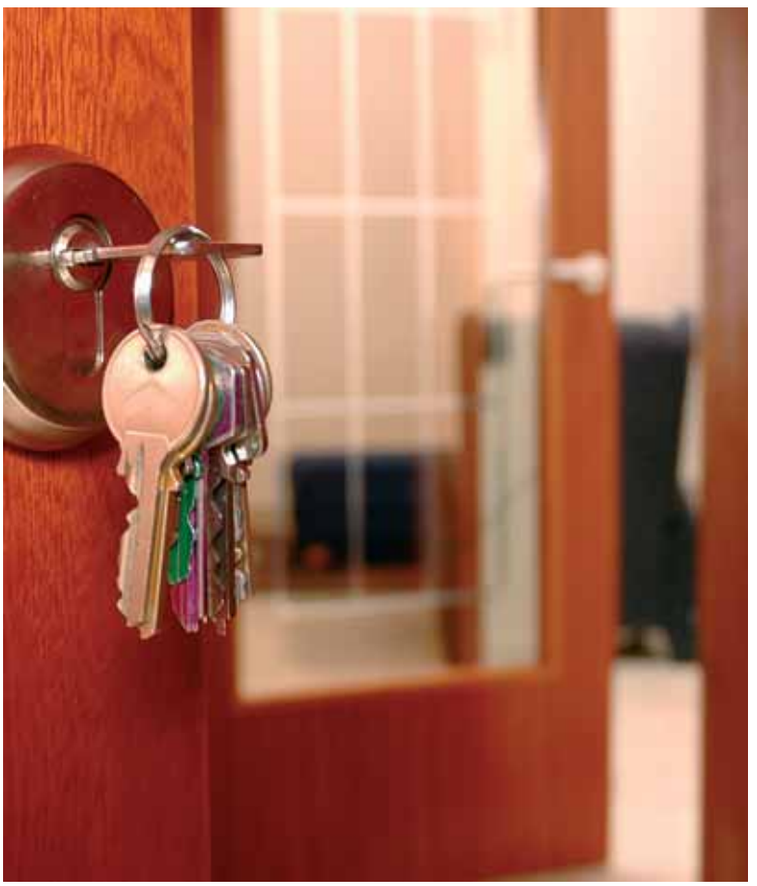
An essential element to the success of this is that young people should also be allowed and encouraged to continue to enjoy their normal activities, such as listening to, making and enjoying their music, even if it is hardcore or drum and base! They can't be denied in recovery the activities that they will take part in when they get home, because part of what we, and they, need to do is to prepare for their relive-entry to normal teenage life.

Cooperation and partnership with families, communities, schools and other professionals and services is also an important element. It's not appropriate to simply remove a young person, 'fix' them and put them back – they are not cars in garages. So constant dialogue, involvement and an integrated approach with other carers throughout the process should be encouraged.

Family work and therapy should also be a part of the process, as many of these young people come from families where intergenerational dysfunction has been a pattern, and to enable them not to replay this in their own futures they need to understand the process. And effective, planned after care should be an essential element of the process. All of this can only be achieved with consultation, participation and cooperation of young people.

I have written this article as a means of opening this discussion and would welcome suggestions, particularly on how to progress this idea, from others.

Melody Treasure CQSW, melodytreasure@btinternet.com



Opening doors

With the high cost of homes putting job candidates off living and working in Sussex, the local DAATs have been helping prospective employees to find affordable housing. **Jackie Campbell** provides the details

FINDING AND KEEPING ENOUGH HIGH CALIBRE STAFF is always a challenge, and can be especially so for certain job roles in the substance misuse field. In Sussex we've made significant progress in providing good quality training pathways and helping managers to use competencies to support recruitment and development processes. However, one of the issues that's been holding back our workforce planning in Sussex (which consists of East Sussex, West Sussex and Brighton and Hove), is the high cost of housing. At least a quarter of employers have told us that it is a significant barrier to recruitment.

Traditionally, low cost housing initiatives in the South East have been aimed at a defined list of public sector 'key workers'. Last year the Sussex DAATs decided to commission a piece of work that looked at ways of maximising the benefits of any housing initiatives for workers in the drug and alcohol field. One of the issues for drug workers has been that many of them are employed by voluntary organisations which are not eligible for key worker status – despite the fact that their post is likely to be funded by the public sector. In fact, over recent years, the consensus from an array of reports and studies has been that the traditional definition of key workers is overly restrictive and that housing initiatives should be targeting the needs of individual workers. A growing trend seems to be to focus on housing need in general, rather than on narrow definitions of key workers, and this is reflected in the latest government-funded affordable housing products.

Despite this move, general knowledge of affordable housing and eligibility for it is low. In fact there is now a wide range of housing options for those who cannot afford to buy a suitable home on the open market, including shared equity schemes and shared ownership schemes. Successful applicants can purchase a property using a mortgage plus an 'equity loan', or part buy and part rent a property.

MyChoiceHomeBuy, New Build HomeBuy, HomeBuy Direct and Open Market Homebuy are all products offered through housing associations where the eligibility criteria is based on applicants' ability to afford to buy a property that suits their household needs without assistance.

The main thrust of the recommendations coming out of our project has been to inform potential candidates and existing workers of the range of housing initiatives that are out there. The Sussex DAATs have already developed a website aimed at sharing information between service providers and job seekers. Sussexdaatjobs.org now holds a wealth of information on living and working in Sussex, with explanations on the range of affordable housing schemes such as the HomeBuy range of products, as well as useful information and links for anyone moving into the area. The website is still growing and there are plans to add real case studies to illustrate how the various schemes have helped people to enter the housing market.

As well as the website, our DAATs have produced leaflets which can be handed out at recruitment events and open days. We have developed a working relationship with Moat Housing, who are the government's appointed HomeBuy agent in Sussex and co-ordinate all the affordable home ownership schemes in the region. Many of the affordable schemes are also available in other parts of the South East, London and across England. Elizabeth Flegg, the workforce development manager for Sussex DAATs, commented: 'Moat Housing have been key to helping us get the information out there and have been able to attend one of our stakeholder days to help get the message across that there is help for people who are not necessarily defined as key workers.'

Of course in recent months much has changed in the housing market, and despite prices coming down, mortgages are just as hard, if not harder, to access. The advantage of using our website is that it is easy to post the latest news and changes to the various schemes on offer. Although Sussex is still seen as an expensive option in terms of housing, giving information on all the help available can encourage candidates to take the next step and submit their application.

Details of the appointed HomeBuy agents for other regions can be found on the communities.gov.uk website.

Jackie Campbell is HR consultant for Sussex Daats

Thinking outside the box

A new type of worker is needed in the post treatment phase, says **Jim McCartney**

IT IS NO LONGER VIABLE for us to merely rehabilitate people – we must also help them grow. Think of a bicycle – rehabilitation is the chain-set and pedals that keeps the person moving through a programme. Development is the back wheel that helps you move faster and more effectively and reach your destination. Rehabilitation has a time limit – development is limitless.

I find the concept of residential and structured day programmes unsound. It can become vague terminology, leaving a blind spot to the ongoing development that is needed when the treatment programme concludes and the funding terminates. They can provide a false hope of having reached the mountain summit, when in reality the climb has only just begun. It is especially the case for people with low cognitive ability, a chronic history of rebelling against the system, joblessness and a protracted pattern of criminality. Yet the right workforce with the right skills can help such people become empowered and liberated.

For over 20 years I have worked with people living outside society's norms. It's important for us to differentiate between those who are living in poverty and those who are the victims of a deviant lifestyle, resulting in behaviours and attitudes that have cut them off from the social systems that sustain most of us each day. There is considerable literature written by psychologists and experts on human behaviour, but not much written for the worker on the frontline. It does not help the project worker who has to motivate change.

For some time I have argued that there is a need for a new type of worker schooled in a multidisciplinary approach to developing people. The post treatment phase needs investment in a highly competent workforce equipped with motivational skills that transcend those of counsellor and psychotherapist.

Effective developers of people are few and far between, and this new type of worker needs to be a leader with knowledge of strategic coaching and cultivating growth. They need to be able to prepare the service user for the complex culture of a workplace made up of interpersonal dynamics that can make or break vulnerable people – especially those with a tendency to rebel against the social system.

Complex and hard-to-reach groups can provide the worker with a platform for personal innovation and an opportunity to develop new skills. However, this worker must be willing to embrace a journey of inner discovery that requires continuous learning – much of it taking place within an informal setting. They must also be prepared to change their mindset and be willing to think outside the box, as this is how innovation is created.

It's now a year since I set up the Academy within THOMAS and it has confirmed my belief that we need a tremendous amount of leadership on the frontline of service delivery. Service users need to be able to believe that the worker can cultivate their growth and development.

People are often encouraged to find work after treatment ends, but many service users have a limited history of work and need to be equipped with the necessary social and emotional intelligence to deal with the social system of the workplace. Over the years I have watched us tick boxes and get people into work only for them to relapse within a few weeks. The workplace is a social system that can make or break people.

Joseph Nye, the distinguished Harvard professor and political scientist, has written quite extensively on the theory of power. His concept of SMART power – a combination of 'hard' and 'soft' power – provides an interesting starting place for this new type of worker. Nye develops the view that hard power – the carrot and stick approach – does not always work and compares it to the Bush administration in its dealings with Iraq and Afghanistan. This type of power is harsh – but sometimes you get the result you don't intend.

Soft power can become more attractive – this is based on your powers of attraction, where people are inspired by what you have to offer and see that it's in their best interest to conform. With this approach you can get better results than hard power – but it's a different dynamic, demanding more from the worker, and can be a longer process.

Many people we work with in the drug and alcohol treatment sector have become the recipients of hard power – such as the police, the courts and the prison system. Drug and alcohol treatment programmes also exercise hard power with their focus on conformity.

Of course we need hard power, but at the same time we need a workforce skilled in the attributes of soft power and the charisma of leadership, where followers are convinced by the persona of the project worker so that the transformational process is able to continue.

One of the key challenges we face is equipping a workforce with these multifaceted skills.

Jim McCartney is the chief executive of THOMAS and can be contacted at james.mccartney@thomasonline.org.uk

Your Space – at our place

drinkanddrugsnews.com is the new home of DDN magazine. We have created a site not just for the magazine but for you to be a part of a new, integrated online community.

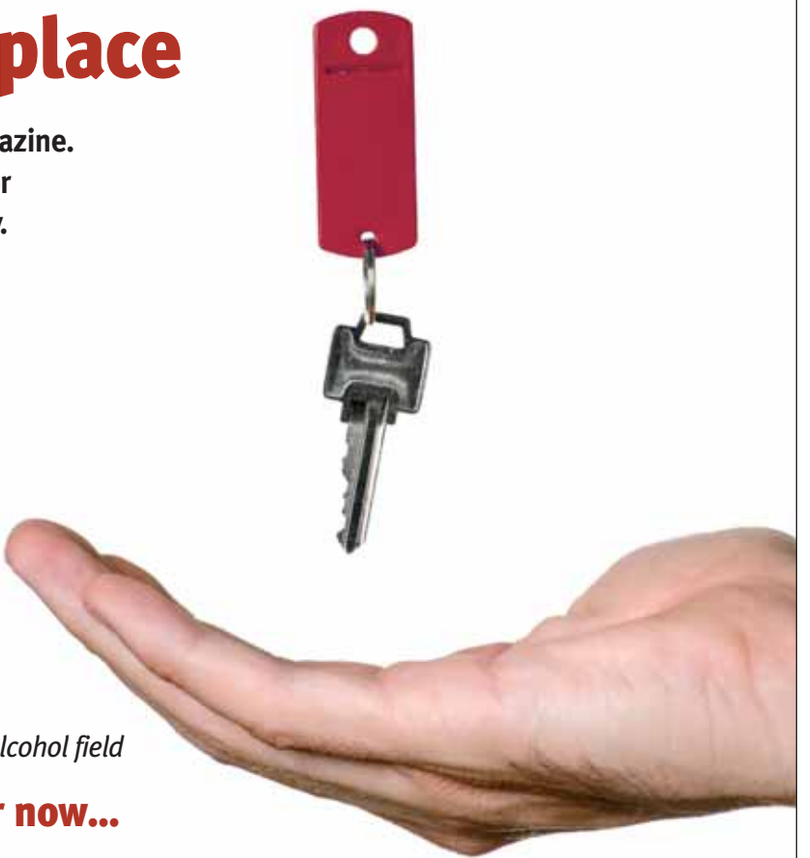
Magazine: *All issues are online, see the back issues for a full library of the last four years*

News: *More news more often, on the site and emailed direct to your inbox*

Jobs: *Enhanced options for recruiters and candidates*

Your Space: *A free page for you and your organisation to talk about the work that you are doing. Write, add videos, upload a photo gallery, this is your space to promote yourselves.*

Forums: *Discuss the key issues affecting the drug and alcohol field*



Don't just read – get read... Register now...

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Commissioned by Department of Health, HubCAPP is an online resource of local alcohol initiatives throughout England.

With funding from Comic Relief, HubCAPP is now including youth project and initiatives.

This is a great opportunity for professionals to:

- Promote and highlight youth alcohol projects and initiatives
- Share practice examples
- Learn from the successes of others

Help us achieve our aim of being a leading resource in the alcohol field by listing your projects today.

You can do this by:

- Emailing info@hubcapp.org.uk and a member of the HubCAPP team will contact you
- Or, create a project profile on the website by using the online submission form

www.hubcapp.org.uk

FUNDED BY COMIC RELIEF

Alcohol Concern
Making Sense of Alcohol

HubCAPP
Hub of Commissioned Alcohol Projects & Policies

CONFERENCE CONSORTIUM Presents...

Drugs Alcohol & Criminal Justice

Drugs, Alcohol and Criminal Justice

Interventions – how do we make a difference?

The Conference Consortium in partnership with DDN, CNWL Health Trust and Coventry and Warwickshire Partnership Trust announces the above conference on:

Thursday 25th June 2009 (10.30 to 4.30)

Venue: Friends House, Euston Road. London

The aim of the conference

The Conference will focus attention on Criminal Justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, looking at both 'what is working' and the 'pinch points' in the delivery of services.

Who should attend

The conference will be aimed primarily at DIP and Service Managers, Practitioners and Staff from arrest referral, courts teams, Probation Officers who manage the DRR's and those who run the programmes. Health Workers and Doctors who deliver rapid prescribing and triage interventions, Police Officers and Magistrates.

The cost – £145 plus VAT

info@conferenceconsortium.org
www.conferenceconsortium.org

rugbyhouse arp

Rugby House - ARP Residential Treatment Services

We provide evidence-based programmes that support people to gain an understanding of addiction and learn the necessary coping skills to enable them to reintegrate into the community with an increased quality of life. Using our stepped services we can coordinate an individually tailored treatment journey for clients. We believe in flexible treatment packages that support this goal whilst offering competitive pricing. We accept block contracts, detox + rehab packages at discounted rates and telephone assessments.

Agar/St Augustine's, NW1
T: 020 7916 7633/7634 E: lvassell@rharp.org.uk

Eleven-bed home that employs a highly structure programme that uses CBT and Solution Focused interventions to underpin a Psycho-Social programme. The diverse staff team have an excellent track record of working with members of the BME and LGBT communities.

Herbert Street, NW5
T: 020 7916 5013 E: rweller@rharp.org.uk

Nine-bed home with a purpose built bungalow for disabled clients and those with poor mobility. The theoretical model that underpins the programme is CBT, complemented by Systemic Family Therapy and structured relapse prevention education. 24hr staff cover ensures suitable care for residents with complex needs.

Ravenswood Road, E17
T: 020 8521 4486 E: pcox@rharp.org.uk

Eight-bed modern home with disabled access. Ravenswood's core program uses Cognitive Behavioural Techniques to support clients via therapeutic groups and life skills workshops. The 24hr staff team can hold complex needs clients and have onsite support fortnightly from a specialist Mental Health worker.

PCP

a new beginning

Drug & Alcohol Teams, Social Services

LOOK NO FURTHER!

No waiting lists – immediate beds available

- 24hours, 7 days a week care
- 25 beds quasi- residential primary - £450 per week
- 12 week primary care and 12 week secondary care
- Detox facilitated
- 12 step and holistic therapy
- NTA & HCC Registered
- Monthly reporting to the NDTMS System

For further information please contact Darren Rolfe

CALL FREE 08000 380 480

Email: Darren@pcpluton.com
Web: www.pcpluton.com

Connections

Integrated responses to drugs and infections across European criminal justice systems

1st Conference of the Connections Project

'Joining the Dots: criminal justice, treatment and harm reduction'

25-27 March 2009
Kraków, Poland

www.connectionsproject.eu/conference2009

Camden

Camden NHS

LONDON BOROUGH OF CAMDEN DIRECTORATE OF HOUSING AND ADULT SOCIAL CARE TOGETHER WITH NHS CAMDEN

NOTICE FOR EXPRESSIONS OF INTEREST FOR THE PROVISION OF AN AFTERCARE AND SOCIAL INCLUSION SERVICE FOR PEOPLE WHO MISUSE DRUGS AND/OR ALCOHOL (EITHER STILL IN TREATMENT OR HAVING MOVED ON) AND FOR RESIDENTS OF CAMDEN'S HOSTELS PATHWAY

The London Borough of Camden and NHS Camden are seeking applications from suitably experienced providers for the award of a new contract. The contract is for the provision of an Aftercare and Social Inclusion Service. The service will support Camden's Community Strategy, Drug Treatment Plan and Alcohol Strategy. The contract will provide:

- access to a package of action, social care and support to help service users re-integrate and re-establish themselves in the community;
- enhanced support to access education and training, employment opportunities, social skills and peer mentoring support in order to improve their self esteem and support their recovery;
- the provision of treatment, relapse prevention, counselling and access to wraparound services;
- any other relevant service(s) that will improve the successful social reintegration and life chances of the client group.

The tender evaluation model will be based on a split of 50% price and 50% quality. The full evaluation criteria will be available in the Instructions to Tenderers. Camden Council and NHS Camden reserve the right to award the contract to the provider that submits the most economically advantageous tender.

The contract period is for 3 years, starting in summer 2009.

A briefing event will be held on Monday 2nd March 2009 at 10.00am. Please contact David Walsh on 020 7974 3535 for venue information. We can only accommodate a maximum of two people per organisation.

The Pre Qualification Questionnaire (PQQ) and draft specification can be downloaded from the internet by visiting the Camden website at www.camden.gov.uk/pqq

The PQQ must be returned fully completed in hard copy to the address below, no later than 4.00pm on Friday 20th March 2009. Late submissions will not be considered.

London Borough of Camden
Housing and Adult Social Care Department
Procurement and Contracts Team ATTN: David Walsh
79 Camden Road, London NW1 9ES
Email: david.walsh@camden.gov.uk

For details of all

Phoenix Futures

vacancies see

www.drinkanddrugsnews.com

Phoenix Futures
Ending dependency, transforming lives

my county council

Promoting Equality, Celebrating Diversity, Achieving Excellence

Treatment Commissioning Manager

£34,107 - £38,463 pa Ref: 23818

County Hall, Northampton

Fixed term contract ending 31 March 2011

Northamptonshire DAAT is seeking a dynamic, focussed individual to lead on the development, commissioning and delivery of treatment services for substance misusers. The role has a high degree of autonomy reporting directly to the strategy manager. Good communication skills and an analytical mind are essential.

This post is subject to enhanced CRB clearance.

For an informal discussion please contact Clive Jekyll on 01604 237604.

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

If you require an application pack in an alternative format, pleas contact 01604 237666.

Closing date: 12 noon, 12 March 2009.

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

Northamptonshire County Council

www.northamptonshire.gov.uk

Haringey Council

Policy Performance Partnership & Comms

Young Persons' Substance Misuse Commissioner

Salary:	**PO4 £25,842 - £38,463 per annum (under review)**
Closing Date:	**10/03/2009**
Reference:	**HMR/3850**
Hours:	**Permanent**
Location:	**Wood Green, London, N22**

We are looking for a Young Persons' Substance Misuse Commissioner to help drive forward our Young Peoples' Treatment Plan.

You will be experienced in commissioning and ideally have worked with young people. You will need to be able to work to tight deadlines and be excellent in partnership working.

We offer excellent training opportunities and career progression.

This post is exempt from the Rehabilitation of Offenders Act 1974. An enhanced disclosure check with the Criminal Records Bureau will be undertaken.

How to apply: Visit **www.haringey.gov.uk** where you can apply on line, or you can request a paper application pack by calling 0870 700 0205 quoting the reference at the top of this advert.

Substance Misuse Staff

For new 12 bed detoxification unit opening June 2009

caleb
alcohol & drug services

Are you...

- Passionate to see addicts recover
- Brilliant at keyworking
- Experienced at planning & leading sessions
- A team player
- Willing to work shifts

Salary between £20 & £24k depending on experience

Closing date: 13th March 2009

Contact Pat Johnson on 01274 720101 or info@calebbradford.org

www.calebbradford.org

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SUBSTANCE MISUSE PERSONNEL

PERMANENT - TEMPORARY - CONSULTANCY

Supplying experienced, trained staff:

Commissioning ❖ Service Reviews ❖ DIP Management ❖ DAT Co-ordination ❖ Needs Assessments ❖ Project Management ❖ Group & 1-1 drug workers ❖ Prison & Community drug workers ❖ Nurses (detox, therapeutic, managers) ❖ *plus many more roles..... call today*

NOW REGISTERING AND SUPPLYING NURSES

Register online www.SamRecruitment.org.uk

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Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust

The Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust is the major provider of mental health services across both counties. The Trust also provides more specialised treatments, both locally and nationwide. It is a leading Trust for teaching, training and research, with close links to both Oxford and Oxford Brookes Universities.

Specialist Addictions Nurse

Ref: 267-DW-SPEC-BA-6

Specialist Community Addictions Service, Buckinghamshire
Salary Band 6: £24,103 - £32,653 pa – Hours: Full time, 37.5 per week

The Specialist Community Addiction Service Buckinghamshire (SCAS B) is a dynamic and forward thinking community based service that works with people with substance misuse problems. The service is strategically developing drug/alcohol services across Buckinghamshire in both satellite clinics and primary care.

You will have experience in the treatment of drug and alcohol patients, or be an experienced community nurse willing to put the time and effort into becoming experienced in the treatment of drug and alcohol patients. You will key work and manage a clinical caseload of patients who have a substance addiction. As a senior practitioner you will act as a specialist clinical nursing resource within a community setting and other designated clinical areas.

We welcome applications from enthusiastic, dedicated and hard working individuals.

In return we can offer you: a friendly and supportive working environment, regular case management, individual and group clinical supervision, on-going training and personal development.

We encourage informal enquiries or visits. Flexible working and part time hours considered.

For an informal discussion please contact Anne Dolan on 07881476379.

Benefits we can offer include:

■ Single staff accommodation ■ Optional Pension Scheme ■ Flexible working arrangements ■ Key Worker Housing Scheme ■ Child care vouchers ■ Home Ownership Plan

To apply for this post please visit www.obmh.nhs.uk/jobs quoting the appropriate reference number.

Closing date: 8th March 2009.

We are committed to equal opportunities.

Please note that if this post involves the post holder having direct contact with, or unsupervised responsibility for, children or vulnerable adults then, they will be required to undertake a Criminal Records Bureau check before they can take up the position.

The average crack user spends £500 a week on drugs

Knowing the facts is one thing. Doing something about them is altogether more challenging — and that's where Worcestershire Druglink comes into its own. As the county's main non-statutory provider of drug services, we offer open access for crisis support and needle exchange, care-planned interventions, access to prescribing, structured day programmes as well as outreach work. Ready to join us?

Assistant Service Manager – Substance Misuse c. £31,500

Working closely with the Service Manager, you will be responsible for all aspects of service development, delivery and evaluation. This will involve much more than leading and developing your team. You will define outcomes, build stakeholder relationships, engage service users and ensure robust financial and data management systems. You will also explore ways to enhance efficiency and drive our process of continuous improvement.

This role calls for an experienced operational manager with strong leadership skills and the ability to grow and develop services in a social care or similarly regulated sector. You will certainly know how to involve service users and meet their needs in an increasingly complex commissioning environment. First class database, communication and organisational skills are also required – and you will demonstrate a high level of financial awareness. The willingness to travel across the county is, of course, essential. **Ref: N8710/28.**

To discover more about this influential role – and apply online – please visit **www.jobs-at-turning-point.co.uk**

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