From FDAP in association with WIRED

DDN
Drink and Drugs News

23 October 2006
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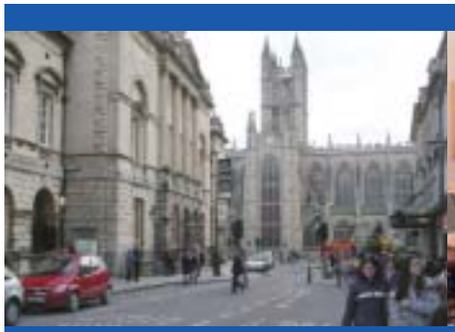
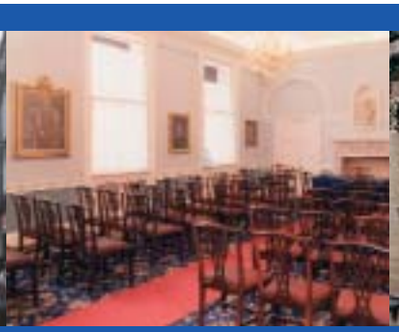
BUILDING CAPACITY
Reversing the decline of residential rehabs

SHARP COMMENT
DDN attends the national conference on injecting drug use.

FIREWALK WITH ME
Unconventional therapy over a pit of hot coals

CRISIS OF COMPETENCE

Knowledge gaps and inappropriate training? What's going on?

Interesting issues, interesting people speaking, new aspect of addiction (Hannah Hage Ali, Phoenix House, Copenhagen)

UNHOOKED THINKING 2007

THE ADDICTION CONFERENCE

"LOVE AND BAGGAGE"

THE GUILDHALL, BATH, UK

MAY 9-11TH 2007,

The second international multi-disciplinary and iconoclastic enquiry into the vary nature of addiction in Bath's Guildhall with its much better acoustics, better breakout facilities, and stunning Georgian architecture.

THEMES FOR EACH DAY:

RELATIONSHIPS	MAY 9TH
LOVE AND CONFLICT	MAY 10TH
FAMILY	MAY 11TH

WE WILL EXPERIMENT WITH OPEN SPACE ON THE 10TH. FILM DIRECTORS WILL INTRODUCE THEIR ADDICTION-THEMED MOVIES ON THE 9TH AND 10TH.

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SPEAKERS INCLUDE:

Prof Bruce Alexander, Dr Linda Blud PhD, Terry & Daisy Bogg, Doug Cameron, Tom Carnwath MA, Prof Robin Davidson, Prof John B Davies, Sonia Douek, Kirby Gregory, Laurence Guinness, Anthony Hewitt, Rachel Heywood, Danny Kushlick, Tim Leighton, Eleanor Lohr, Trevor McCarthy, Gillies MacKinnon, Ron McKechnie, Dr Gordon Morse MD, Dr Marian Naidoo PhD, Shaun Naidoo, Prof Jim Orford, William Pryor, Dr Alan Rayner PhD & Ray Sheath.

I had an absolute ball and would love to attend further events. I go to rather a lot of conferences and usually wish I was going home by the end of the first day: not the case with Bath (Dr Phil Delgatto)

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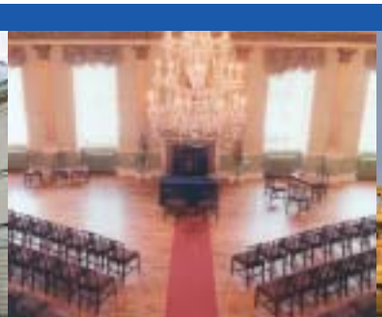
You can submit papers/presentations relevant to the conference themes through the website.

I thoroughly enjoyed the conference. I profited from most of the plenary sessions, but was also pleasantly surprised by the quality of the breakout sessions. I wound up taking 17 pp of notes (Professor David Courtwright, University of North Florida)



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Drink and Drugs News

23 October 2006

Editor's letter

There's so much going on at the National Conference on Injecting Drug Use that it's difficult to know which session to go to next. You'd need a few weeks to do the two-day programme justice – and then another few to debate the issues in satisfactory detail.

What's particularly interesting about this event are the different perspectives on very specific issues heard from service users, GPs, those running services – and those who have become activists because things aren't working as they should, or because obvious harm reduction messages still aren't getting through.

Our feature on page 12 is a taster of what went on, but I'm quite sure each delegate would be able to write a very different report of the discussions they participated in. What matters is that these discussions are taking place between all parties; it's a shame more events aren't as interactive. It would save a lot of time and heartbreak if the dialogue on better drug services and safer practice was ongoing in different areas of the country.

Our cover feature opens a subject that many of you will feel strongly about, depending on your route into the drug and alcohol field and your career plan. Do you see qualifications as a ladder to career advancement, or as reasons to trip you up and take no account of your wider skills? Does keeping a professional portfolio offer a valuable opportunity to translate experience to DANOS units – or is it all just an elaborate money-making scheme?

Tim Morrison and Kevin Flemen open the debate by giving their perspectives on how we should arrive at a competent workforce (page 6). There's no dispute that knowledgeable and skilled workers are essential in dealing with vulnerable clients – the question is how we get there.

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

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

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
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In this issue

News Round-up
Youngsters shown bleak side of alcohol • Winchester Prison alcohol survey • RAPt graduates reunion • West Lothian targets pub-going men • Home Office calls off drug class review • SDF calls for quick response to cocaine rise • New treatment services and centres • **4**

Features

Cover story

Crisis of competence?
Basic gaps in knowledge are undermining drug and alcohol professionals and have to be addressed, says Tim Morrison. Are we cutting off valuable expertise from the wider field by insisting on DANOS qualifications?, asks Kevin Flemen. **6**

Residential futures
Richard Phillips joins the debate on the future of residential rehab with some constructive suggestions on how we can build capacity through funding, commissioning and performance management. **10**

Getting to the sharp end
This year's National Conference on Injecting Drug Use invited service users and providers to look at how far we've come and what we could do better, as DDN reports. **12**

Fired for change
David Griffin shares his UserActive group's experience of firewalking – a successful experiment in alternative engagement. **15**

Regulars

Letters and comment
Statistical anomalies; thoughts on education; alcohol, MOCAM and AA; better commissioning; and a plea for reintegration. **8**

Post-its from practice
Prejudice continues and must be challenged, says Dr Chris Ford.

Q&A
Advice for Sarah on not losing her job. **14**

Background Briefing
Prof David Clark explores conditioning models of addiction (part 2). **16**

Jobs, courses, conferences, tenders **17**

DDN diary

RAPt celebrates graduates' new life

DDN shares the joy of a graduate reunion with the Rehabilitation of Addicted Prisoners Trust.

It's a sunny Saturday, 7 October, and a bunch of blue and white balloons waves jubilantly at the entrance of Fulham Town Hall. Inside, 200 people listen intently to each person that steps up to the microphone.

The occasion is the Rehabilitation of Addicted Prisoners' Trust graduate reunion, when previously addicted prisoners celebrate maintaining recovery.

'I was taking drugs at 11, because I wanted to follow my dad's example. By the time I was 16 I was drinking at school, filling a pop bottle with whatever alcohol I could find in the house. I was pregnant by 17… I had my son taken from me…'

The personal stories speak volumes. Everyone waits for the turning point in each catastrophic diary of drink and drugs misuse. Just as the worst happens and the scene shifts to prison, in comes the CARAT team and chance of a different life through following RAPt's 12-step programme.

The old outlook on life – 'I left my kids because they got in the way' – changes to a feeling of empowerment never experienced before:

'I make the decisions now. The drugs don't make them for me.'

RAPt graduates remember their despair ('I thought my life was just going to go round and round, in and out of prison'); their delusions ('I thought I was a gangsta. Then I was nicked by a female security guard at 8am in Tesco's, with toothbrushes and deodorant') and their realisation that they'd met people who cared for them when they didn't care for themselves… 'RAPt helped me to live instead of just existing.'

After each person shares – and there are many different turns at the microphone – their fellow graduates roar approval. At the close of the afternoon senior manager Dave Mulvaney leads the clean-time countdown: graduates stand up and are applauded for their achievements in staying sober, starting with 30 years and counting down to just a few weeks.

There are smartly turned out suited professionals; there are mothers with babies; and there are groups of friends who are enjoying the chance to catch up over the buffet. But what unites every single person in the room is the discernable pride that they are now in control of their own future.

Youngsters shown the bleak side of alcohol

A £4m government advertising campaign is urging young people to know their limits by showing them taking dangerous risks when drunk. Already launched on tv, the 'Know your limits' campaign will spread to cinema, radio, magazines and online throughout next month.

Young people are shown behaving as if they think they are invincible after excessive drinking – with the consequences of falling off high scaffolding, running into a busy road, walking home alone and getting into fights.

Joining forces to target 18 to 24 year-olds, the Department of Health and Home Office aim to help young people 'still have a good time but to know their limits and take responsibility for the amount they drink', said Public Health Minister, Caroline Flint.

Half of all violent crime has been related to alcohol, with 70 per cent of peak time A&E admissions blamed on drink. A third of men in this age group have been shown to drink more than eight units on at least one day and almost a quarter of women drink more than six units on at least one day. Many regularly drink above the daily recommendations.

Home Office minister Vernon Coaker said government needed to get the responsible drinking message across, as 80 per cent of pedestrian deaths on Friday and Saturday nights were drink related.

'I want people to continue enjoying their nights out but urge them to drink sensibly to avoid situations that could involve police involvement, injury or worse,' he said.

Alcohol Concern's chief executive, Srabani Sen, welcomed the campaign as 'an important starting point in changing young people's attitudes to binge drinking', but said there was a 'great deal more to do' in tackling their relationship with alcohol.

Prisoners would respond to treatment – if it were available

A survey of inmates at Winchester Prison has revealed that the prison has ten times as many hazardous or dependent drinkers as the rest of the population.

The prison's population of 697 were asked about their drinking habits before entering prison, of which 405 prisoners returned the questionnaire.

Of the 65 per cent of prisoners who said they didn't have a drinking problem, average consumption was 43 units of alcohol a week. Those who did say they had a problem averaged 157 units a week.

A strong link emerged between alcohol consumption and violent crime. Almost half of the prisoners surveyed said that alcohol was linked to their criminal activity, with half again citing violent crime.

Half of those who believed they had an alcohol problem said their offence was for violent crime.

When asked if they would use an alcohol service located within the prison, 49 per cent said they would. However 37 per cent of these were unlikely to be eligible for a service to treat their alcohol problem alone, as they had not used drugs in the previous year.

From their survey, Winchester concluded that many prisoners were unaware that they had an alcohol misuse problem – but of those that were aware, a high proportion would like to access an alcohol service, if one were available.

The survey was carried out with Hampshire DAAT.

Targeting pub drinkers on cue

West Lothian DAT are taking a direct approach to male binge-drinking through distributing their pool table cover, funded by the Scottish Executive. Research and development officer, Hilary Smith (left), says the campaign will target men to raise awareness of the dangers of heavy drinking, alongside promoting local support services. Manager of West Lothian Drug and Alcohol Service, Margot Ferguson (right) added that the campaign, whose slogan is 'if you want to see your balls again, drink sensibly', was 'a fun way of getting a serious health message across to men during their leisure time'.

Home Office calls off drug class review

The government has decided not to proceed with a review of the drug classification system in this country, stating that the current system is effective in categorising drugs and determining penalties for their manufacture, possession and supply.

'I have spent the last few months meeting frontline police, victims of crime, drug addicts and others involved in the criminal justice system. None of them have raised the classification system as a concern that affects them with me,' said Home Office minister, Vernon Coaker.

DrugScope reacted to the announcement with disappointment. 'Concerns about and criticism of the classification system will not go away and are likely to be repeated time and again when the current ten-year drug strategy is reviewed before it ends in 2008,' said chief executive, Martin Barnes. 'There is no ideal system, but the government should not be afraid to lead a debate as to whether there are better alternatives,' he added.

In the same announcement, the Home Office confirmed plans to reclassify crystal meth, moving it to a class A drug 'in recognition of the harm it can cause to individuals and society as a whole'.

Mr Coaker also announced that proposals made earlier in the year to introduce a threshold for the amount a person could possess without being charged with dealing, would be put on hold following consultation. Responses to the consultation had produced no consensus on whether to introduce the threshold, and the levels at which it should be set.

Drug stats show stability

Results of a Home Office statistical bulletin, based on British Crime Survey data, has shown a significant decrease in overall drug use, including cannabis. Class A drug use has remained stable in young people since 1998, but has increased among 16-59-year-olds since 1998.

Cocaine use has shown an increase since 1998, but is shown to have stabilised since 2000.

Illicit drug use among 16 to 59-year-olds was shown to be highest in the South West, with class A drug use highest in London.

Cocaine rise calls for more and quicker response, says SDF

More specialist treatment services are needed to halt the growing trend of cocaine use in Scotland, according to the Scottish Drugs Forum.

SDF director David Liddell told the charity's conference in Glasgow that an urgent response was needed to target recreational use, as well as support for those who have gone on to develop a problem.

Education campaigns should be realistic he said, and make people snorting cocaine aware of the risks of contracting hepatitis C and HIV from traces of blood on shared equipment, such as rolled-up banknotes, straws, razors and mirrors.

He called for services to respond specifically to different types of cocaine users. Those using just cocaine, 'many of whom are working professionals' would need services geared to their lifestyle for them to respond. Those using cocaine on top of heroin would need services to be clued up about cocaine's ability to destabilise heroin treatment and increase paranoia in people using both drugs.

The Scottish Crime Survey carried out two years ago showed at least 45,000 people in Scotland between the ages of 16 and 59 had used cocaine in the previous year – a huge increase in the 12,000 users recorded in 1993.

New treatment services and centres

Integrated services in Hounslow

Cllr Pamela Fisher opens Pharmacia House, an integrated drugs centre in the London borough of Hounslow that will offer treatment, support and education under one roof.
NTA chief executive Paul Hayes praised the borough for its high performance record in making sure all clients in treatment have a care plan. Congratulating all the agencies involved in forming the new centre, he hailed the project as 'a template we will be recommending'. The centre will be run by Crime Reduction Initiatives (CRI) and provide a base for other agencies and groups helping people deal with addictions.

Up-to-date in Port Talbot

Welsh Assembly Minister Edwina Hart opened a new treatment centre in Port Talbot this week.
The £600, 000 centre, funded by The Big Lottery, Welsh Assembly Substance Misuse Capital Fund, Neath and Port Talbot Community Safety Partnership and the West Glamorgan Council on Alcohol and Drug Abuse, will be run by WGCADA and will provide modern, purpose-built facilities for drug and alcohol addiction in Wales. Director of operations, Ifor Glyn said substance misuse services had been delivered from ill-equipped and unsuitable premises for too long. The new centre would help WGCADA deliver effective services for the future.

Stabilisation at Friends Road

A drug programme to help people stabilise their chaotic drug use will open in East Croydon this week. Friends Road will be run by Equinox Care and is the result of investment from Futurebuilders England. A six-week stabilisation programme will be tailored to hard-to-reach and socially excluded groups, with referrals expected from other London boroughs and local authorities in the South East, as well as the immediate area. Chief executive Brian Watts said the centre would offer 'a flexible, yet rigorous programme' to many people who would see it as their last chance of getting help.

Luxury in Spain

Luton quasi-residential treatment centre PCP will double their capacity to 60 people, when they move to new premises down the road. The new centre will have better facilities, more parking, and larger meeting rooms. PCP Spain is opening a larger residential clinic this week in Granada, with 23 beds and a swimming pool.

Birmingham online

Birmingham's DAT and Community Safety Partnership have launched an online directory of local treatment services to provide up-to-date information on services across the city, through one easy access point. The site also includes contact details for needle exchange services, many operating through pharmacists, where clean injecting paraphernalia and disposal units can be obtained free of charge. Visit www.birminghamdatdirectory.nhs.uk

Crisis of competence?

Knowledge, practice and development

For all our talk of workforce development there are basic gaps in knowledge that undermine practice in the drug and alcohol field, says trainer Tim Morrison. He shares his perspective from behind the flipchart.

In 2003, a vast Training Needs Analysis was published by the NTA on the whole workforce. It suggested that large numbers of us had major training needs about some of the basics of providing care. Since then the workforce has expanded considerably, new jobs have appeared and one can assume (always dangerous) that any needs that existed in 2003 will be more extreme by the end of 2006.

My experience as a jobbing trainer (have flipchart, will travel) bears this out. Now admittedly, I meet people who have a training need – there is an acknowledgement that people who come on courses need to do something to develop their skill base and, necessarily, this skews my experience – so sometimes I don't get to meet the most skilled people.

But there are many types of issues that come up again and again in the training room that I find very concerning.

I regularly hear about examples of practice that appear extreme, dangerous and frankly unethical. Often these would be unacceptable with any other client group, but are routine in parts of this sector. Examples include withholding prescribed medication and thus forcing people into withdrawal. First contact takes place in the client's home without any risk assessment, and dispensing decisions about controlled drugs are being made by people without necessary training or qualifications.

The essential skills (and note these are not attitudes) that underpin care are often not followed through. These skills establish a relationship with the client where change can take place and determine the quality of the intervention and involve unconditional positive regard, empathy and the ability to be giving the client full attention. There may be a good theoretical grasp of what these concepts mean, but the ability to demonstrate them in practice is often missing.

How can a client be engaged in the assessment process if workers find it hard to distinguish between open and closed questions and the appropriate use of paraphrasing, summarising and reflective skills?

Most people have heard of the key theoretical models that should influence practice – but do they know what they mean? Nearly always, when I ask people who are already familiar with the cycle of change to talk me through the model they will say something like 'pre-contemplation means that they have started to think about their drug or alcohol use as a problem'. But that's the contemplation stage – 'contemplation' means 'thinking'; 'pre-contemplation' means 'before thinking'.

Some very basic knowledge issues are at stake. Again, everyone has heard of the alcohol unit measuring system – but applying it? How many workers know how many units there are in a normal bottle of supermarket wine, how many are in the large glass bought from Ikea, and what constitutes a binge. The myths that 'one glass equals one unit' and that 'binge equals bender' are as prevalent in the treatment sector as they are elsewhere. If this is the extent of common knowledge, then a lot of people are not competent to screen someone for an alcohol problem.

The opportunity for people to engage in reflective conversations that look at their reasons for doing things, hold them accountable and develop their skills, seems to be limited. A consequence of this is a willingness to

Mandatory qualifications: a step too far?

Training is all well and good, but how did we get to a situation where entry to the drug and alcohol field is being controlled by DANOS, asks Kevin Flemen. Are we limiting our pool of expertise?

The drugs field is becoming qualified – but I for one am not buoyed by enthusiasm for this. In fact quite the opposite; my heart sank when DANOS was launched. And unfortunately it has been sinking constantly since then. Maybe one day it will hit rock bottom.

I should make it clear that my dislike of the qualification framework is not specific to DANOS; I would have had a similar reaction to any similar framework. I will however except some aspects of drugs work from this, such as prescribing. My opposition is not merely because of the mechanics of the current qualification model. It is more the overarching principles at work here.

I want to address drugs as a social problem – not simply a health problem, or a legal problem. I want to see communities that are responsive to and understanding of drugs, and, most importantly not intimidated by them. I see a role for teachers, youth workers, housing workers, employers, parents, peers, partners – the whole of society to engage with, support and assist people who use drugs.

The advent of qualifications undermines this community-centric approach. It reinforces the illusion that the 'treatment' of people with 'drug problems' is some sort of science that can only be undertaken by those who have the qualification. It disempowers the many others who could, and should, be making a real difference.

It also tries to take a primarily humanistic intervention and turn it into a set of replicable, mechanical steps which, if followed correctly achieve a set outcome. This may work for some tasks; it is a misguided approach when working with drugs. It also reinforces the dominance of a 'treatment paradigm,' wherein the 'sick' addict can only 'recover' through the intervention of a suitably qualified practitioner. How arrogant! How controlling!

Rather than bundling up this power, the drugs field should be demystifying, inculcating wider society with the skills and confidence to work with drug users. But we are doing the opposite.

Worse still, we're creating closed shops. Employers once felt able to recruit people who had the right personal attributes, and could learn the drug-related aspects on the job. It's how I, and many others, entered the drugs field. But increasingly posts will demand DANOS-qualification, reducing access for many who could bring many skills to the field.

Unfortunately, this is going unchallenged by key bodies – who instead can profit from DANOS by 'accrediting' people as qualified, and thus gaining entry to the field. As gatekeepers, who see membership

blame the client when things go wrong – 'it's because they are chaotic, not ready to engage, are like that anyway, everyone knows that clients are manipulative' – rather than reflecting on how the worker is impacting on the client, the type of response that this would invite and how all of what is happening can be useful material for the change process.

Responding to this level of training need is an incredibly complex problem and solutions must have three elements.

Flexible learning opportunities associated with qualifications are useful, but only as part of a solution. Belbin said that a qualification tells you that someone has had an opportunity to learn, not that they have learned. Everyone knows qualified workers whose practice is terrifying – and highly skilled unqualified people.

Our qualification structure must establish that people can demonstrate effective practice in a range of situations and their understanding of the knowledge and skills that support it – 'competence' in other words, and the implied use of DANOS.

To be real professionals we require a commonly held ethical base. As a sector, the debate must continue about what constitutes decent practice. FDAP has started this process with its code of ethics and we need to resolve many issues about what happens in the treatment process, information sharing, confidentiality, boundaries, coercive treatment, and what constitutes client-centred care.

The final element is effective management practice through performance management, appraisal and supervision. Workers must be allowed to flourish in a culture that supports accountable, competent and ethical practice.

For this to happen, managers must be involved in both what their staff are doing and how they are doing it. This should not be something to be endured, but an empowering experience where workers are enabled to solve problems themselves, identify learning opportunities and improve their practice continuously.

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

and profits increase as a result, there is no reason to kill the chicken that keeps laying golden eggs.

We're already starting to see the negative impact of this – workers in other disciplines who no longer feel able to engage with drug users (or are being told not to engage with users) because they have not been assessed as DANOS-competent. For example, I've met housing providers who are being told that they need to achieve DANOS competence in order to provide supported housing to drug users. If we ever wanted to create a disincentive to provide appropriate services, this is it.

As with QuADS before it, we're watching resources pour out of client-facing services and in to servicing the qualification work. Bought your DANOS framework tools, paid for your DANOS-specific training, the NVQ assessors, the industry-body membership? How much did it all cost?

I am not convinced the outcome has been worth this outlay. Despite all this professed competence, we have a large number of people who are routinely under-prescribed. There are many workers who will only promote a single treatment modality rather than looking at the many interventions available. Patients are still discharged from treatment for the most superficial reasons – all by organisations who are, ostensibly, DANOS-competent.

I know that there are many others who question the worth of the qualification framework. I hope that I am still in the field to see its exit. But, for me, DANOS is all too likely to be the thing that finally pushes me out of the field.

Kevin Flemen runs the drug consultancy KFx at www.ixion.demon.co.uk
He will be proposing the motion 'this house believes you shouldn't need qualifications to work in this field' at the FDAP conference, London, 8 November. Book your place at www.fdap.org.uk

'Without support, many schools struggle to deliver accurate and credible drug education. Health education does not have the status of mainstream academic subjects... Staff may be inexperienced or unwilling to teach it as an add-on subject, curricula may be structured to undermine progressive provision, and planning processes can be haphazard and uncoordinated...'

Educational gaps

As an organisation that specialises in supporting schools to improve their drug education, we agree wholeheartedly with many of the comments in your recent article (*DDN*, 25 September, page 10). There are a number of points that were missed out that we would like to highlight:

The vast bulk of research which suggests that drug education may have little effect on drug use has been carried out in the US and evaluations have focused on whether levels of drug use in the general youth population targeted, have fallen as a result of drug education. There is little evidence to show what effect drug education has on overall harm due to drug use, progression from experimentation to problematic drug use, or help-seeking behaviour. This is a key gap in evidence and reflects the zero-tolerance culture of the US.

Drug education in schools is recommended by education departments in all parts of the UK and few would disagree with the recommendation. Young people will inevitably come across drugs (both legal and illegal) as part of life and ought not to be ignorant about the effects and circumstances of, and reasons for their use. (See *DrugLink*, 17(4), page 18-22, 2002, for some good discussion on this.) Recent media stories about young girls smoking while pregnant in a futile attempt to reduce labour pains only serve to reinforce this. Drug education also forms a key part of a bigger picture of action to contribute to long-term culture change in our attitudes to alcohol and drugs.

Without support, many schools struggle to deliver accurate and credible drug education. Health education does not have the status of mainstream academic subjects and can be de-prioritised accordingly in terms of time and staffing. Staff may be inexperienced or unwilling to teach it as an add-on subject, curricula may be structured to undermine progressive provision, and planning processes can be haphazard and unco-ordinated. In many cases, those planning the provision have had little or no training on what they should be aiming to provide. In our experience the best provision is achieved, not surprisingly, in schools where a small, dedicated team of teachers are involved in planning and delivery. (See reports on www.createconsultancy.com under 'Schools' and 'Research' for more information on our findings from Scottish schools.)

There is a need for greater awareness among all frontline staff (*ie* non-specialists in addiction) of how to support individuals who may be using drugs before things get to a crisis stage. Our experience is that many such staff do not currently feel able to take on the kind of role, excellently described in the Home Office's document *First steps in identifying young people's substance related needs*.

This is not to say that teachers or schools should not deliver drug education. On the contrary, we believe that teachers are well placed to understand and be sensitive to the needs of their pupils, but that they are currently inadequately supported to do this and that the system works against good provision. Some local authorities have put in place excellent services to support schools and these can make a real difference to quality.

In addition, tailored approaches are needed for young people who are experimenting or at risk, and in non-school settings, to sit alongside quality universal drug education.

Dr Niamh Fitzgerald,
director, Create Consultancy
(www.createconsultancy.com).

Questionable comments (in defence of MOCAM)

I would like to comment on some statements made by Mary Longley, in the article 'Does MoCAM pass or fail?' (*DDN*, 11 September, page 11).

First of all, I would question the statement about the numbers of young women in their 20s and 30s who have 'developed cirrhosis within two or three years of regularly drinking marginally above sensible limits'. In my view, if cirrhosis has set in so swiftly at the age mentioned and with no previous history of alcohol misuse, then young people are drinking far more than 'marginally above the limit' than they care to disclose to either a researcher or to a clinician.

As a psychologist working with alcohol misusing clients in both the NHS and in the private sector, 'dependent and non-dependent' has less significance for psychologists and therapists than it has for prescribing doctors or nurses administering a community detox.

For example, a client can be severely psychologically dependent on alcohol and drink daily, every evening after work. He or she may have a high-powered job and a house in a good part of town but a bottle or two of wine in the evening has now become 'a must'. The client craves alcohol after work like a smoker craves a cigarette. In certain cases, the alcohol exacerbates prior anxiety and depression but the client carries on drinking. The partner points out that the client is drinking too much and the children hate the arguments that ensue when the client is irritable and psychologically 'craving'.

The fact that the client is not a candidate for a detox (and therefore not physiologically dependent) has little relevance to the current stressors fuelled by alcohol dependence. The client's psychological obsession with alcohol, the cognitive distortion due to the effects of alcohol on the neurotransmitters in the brain and the fear of facing reality without a drink, fulfil the criteria for 'dependency' but of a psychological, rather than of a physical nature. At some level, such thought distortions can be seen as comparable to eating disorders when individuals cannot stop seeing themselves as overweight no matter how skinny they appear to the rest of us.

In defence of MoCAM, I wish to take issue with Mary's point about 'moderation as a goal with problem drinkers for whom abstinence would usually be advisable but for whom this goal is not currently acceptable'. Most adult clients know full well that they have 'lost control' over their drinking when they come into specialist alcohol services. Initially, very few want abstinence as a goal.

Unless there are serious physical health concerns which indicate that abstinence has to be continually reinforced, as a team we work towards reaching the client's goal of controlled drinking, at least in the early days, when it might appear viable to the client. But many change their views over time and acknowledge that achieving control may well involve a period of abstinence, whether long-term or short-term. The process is not static but moves with the client around the cycle of change as new goals are set or reset, abandoned or achieved.

Finally, I wish to address the point made about Alcoholics Anonymous in the last paragraph of the article. Many Tier 2 Clients benefit from AA because they are cognitively able to engage well in a 'talking group' unlike some of the Tier 3 clients with impaired cognition. Discrete definitions of 'dependent' and 'non dependent' categories are of little value in a self-help group where one of its leading traditions states: 'The only requirement for AA membership is a desire to stop drinking'. This applies equally to the social drinker as well as to the desperate individual in need of an in-patient detox.

Jane Benanti, chartered counselling psychologist and lead psychologist in substance misuse at Sandwell Mental Health NHS & Social Care Trust

Please don't let me be misunderstood

With reference to John W's letter (*DDN*, 25 September, page 9) nothing in my article was meant to denigrate AA or deny its value in the arsenal of weapons available to address alcohol problems. On the contrary, I have huge admiration for the nature and extent of the support it offers to its members, and the 'sponsor' system offers a service, which is, I believe, unparalleled by any statutory or independent provider.

What I did say though was meant to be carefully crafted: while I accept what John W says about the only official criterion for admission being a desire to stop drinking, my understanding is that custom and practice encourages new members routinely to announce 'hello, my name is x, and I'm an alcoholic'. If I am wrong I apologise, but in any case this issue is not central to my argument.

My point is, that whereas other Tier 2 services appear to aim to target non-dependent drinkers who seek a 'controlled drinking' goal, using brief interventions, AA is clearly focused on those seeking ongoing support for abstinence, and it seems incongruous for the NTA, in seeking to rationalise service provision, to house these two very different approaches in the same silo.

Finally, I don't understand why John W imagines I am critical of AA's fierce independence. Nothing could be further from the truth; I heartily approve. What I am saying is, 'what sort of control-freakery inspires the NTA to suggest publicly that it might exert any sort of influence on such a well-established and proudly independent organisation as AA?'

Mary Longley, non-executive director, Broxtowe & Hucknall PCT, director SASSI Direct Ltd.

Yell for reintegration

With reference to 'A Road to Nowhere', (*DDN*, 9 October, page 6) I would like to add my voice on the need to prepare those in recovery for the economic workplace.

The Yeldall Lodge Resettlement Programme is aimed specifically at reintegrating clients into the community. The Lodge is an abstinence-based supported housing project for men who have previously undergone a programme of rehabilitation. It provides a safe environment where newly acquired skills can be consolidated and practised. When combined with a rehabilitation programme at Yeldall Manor or elsewhere, it provides a total treatment package, including an aftercare floating support service on completion.

In an area such as ours with low unemployment, it is important that residents enter the employment market on a level playing field. Their employment road begins with work experience placements at local businesses, where they continue to adapt to the structure and routine of a working day. Their confidence and self-esteem will invariably increase, and such work experience can also produce a much-needed reference, something that some men have not had before. In some cases, full-time work will also arise directly from the placement.

With discretionary funding from the Berkshire Learning and Skills Council, residents are able to undertake basic work-related courses such as food hygiene, manual handling, health and safety and fire warden training as well as ongoing training in job-search skills. Vocational courses are also encouraged, ranging from forklift or HGV licences to certificates in tree surgery or Portable Appliance Testing, which all increase employment prospects.

It is essential that ongoing support is available throughout this difficult re-adjustment time, and learning how to obtain and retain employment is vital to a sober and meaningful lifestyle. If this important link in the chain is under-resourced, then much time effort and money in rehabilitation will have been of little value.

Mandy Stevens, resettlement manager, The Yeldall Lodge Programme

Commissioning complex

To join the debate on residential commissioning (*DDN*, 25 September, page 9 and *DDN*, 9 October, page 8): This is a complex area, with not enough data to determine what is going on. Commissioners are currently blaming providers and providers are blaming commissioners; the only people losing out are the users and carers. Funding for the residential sector has always been a problem since I was a regional commissioner in London in the early 90s. I saw residential services fold then too.

This is a great opportunity to bring the residential sector into the mainstream, as it is not currently integrated and is seen as very marginal. Regional commissioning might help ensure co-ordinated commissioning clusters to help ensure quality and outcomes. It is also a key opportunity to move towards an outcome based commissioning and contracting framework to help providers, commissioners and service users make decisions about what works.

At times like this, there is a need for short-term measures, once we understand the problem and then a longer-term more measured approach that will secure longer-term solutions. This will require commissioners and providers to work together in an open and transparent way for the benefit of service users.

It is quite right that the new funding is spent to modernise and 'future proof' the system – but the real debate is how we can work together so that these services deliver improved outcomes for service users.

Peter Mason, chief executive, Centre for Public Innovation

Comment

Statistical anomalies:

What's more important: producing a good report, or helping people to become drug free?, asks Peter O'Loughlin.

The first thing that strikes one about the NDTMS latest statistical report (on the NTA's website www.nta.nhs.uk and reported in *DDN*, 9 October, page 4) is that data from the North West has been excluded. We are informed that the reasons for omitting such a large area are that 'details of drug use are missing for a large portion of clients registered in this region'. We are further informed that where such details have been collected that 'they may be subject to systematic bias'.

In marked contradiction to this, it is that area that researchers from John Moores University of Liverpool concluded was the only area in the UK that had consistently collected treatment outcome data between 1996 and 2004/5. Further, that no less than 8 per cent of all clients in structured drug treatment services in England are resident within that area.

A further significant difference in the report from John Moores, and that of the NDTMS, is the former considered the numbers 'Discharged Drug Free' (DDF) which is defined 'as a planned discharge from treatment following cessation of drug use and treatment completion'. Such a vital statistic is a valid measure of the cost effectiveness of the services provided.

Given that numbers emerging DDF from treatment was only 3 per cent, a figure well below the universal average, one could conclude that either the current strategies are ineffective, or that offering treatment to enable clients to become drug free is unimportant since it is not included in the 'principal objectives' listed on page 4 of the NTDMS report.

Yet on a number of occasions, we have been informed through the columns of *DDN* that various surveys indicate that 70 per cent of those using drugs would like to become drug free. This raises the question as to whether the surveys are wrong – and if not, are the wishes of service users being ignored? Given that the powers that be abandoned the goal of abstinence because they concluded it was too difficult to achieve, we can draw our own conclusions.

The fact that the number who completed treatment with a planned discharge as DDF is excluded from the NDTMS statistics, could lead to the conclusion that their report is either incomplete, or sufficiently biased to permit facile claims that both the strategy and services provided are a success. Predictably, the latter is exactly what Caroline Flint and Paul Hayes have hastened to do.

A further inconsistency in the NDTMS report leading to suspicion that the statistics have been sanitised, is the definition given to what constitutes 'discharge'. The NDMTS have chosen a broad interpretation. We are informed that if a client fails to turn up for 'treatment' the 'discharge' date is that of the 'last face-to-face contact.'

A more realistic description for such cases is to be found in the John Moores report under the definition of 'drop outs'. The inclusion of those figures in the NDMTS report, together with the number who were discharged as DDF, would have created a more realistic, but politically unacceptable report.

Peter O'Loughlin is a drug and alcohol recovery specialist at the Eden Lodge Practice.

Residential Futures:
how do we build capacity?

The residential sector is facing a challenge that no other major area of drug treatment has faced: a gradual and long-term decline in the availability of adequate funds to run their services. Community care budgets appear to have reduced in real terms over the last few years and only small amounts of pooled treatment money have been used to fund residentials. Many services have also lost Supporting People money.

Getting paid for providing this service is Kafkaesque in its complexity. Providers quote a gross price to local authorities, but actually invoice an amount based on calculations that can only take place after admission. Some funders refuse to sign an assurance they will pay the full amount if the benefits system, for some reason, fails to pay their share. Occasionally care managers sign confirmation of funding agreements that are not then honoured by finance departments, even after the client has spent months in treatment. The amount charged for a client can change many times during an episode of care – and so on. All these procedures create time-consuming administration for every admission, bringing increased risk of late payment, poor cash flow and bad debts. Providers have been passing on at least some of these risks and costs to purchasers, increasing the risk that their prices will outstrip community care budgets and translate into yet fewer referrals.

Residential services are expensive to run and most costs are fixed. You cannot reduce staffing levels if you get fewer admissions, so services quickly haemorrhage cash if occupancy falls below budgeted level.

To turn to the commissioning framework, the behaviour of purchasers and providers can be understood in economic terms by looking at the incentives to behave as they do. The incentive structure of the current purchasing model does not seem to be in the interests of clients – perversely it is often in the purchaser's interests to minimise referrals, to make placements as short as possible and to not provide feedback and work collaboratively with providers if there are problems with a specific referral. This is not their fault (and providers might remind themselves of that occasionally). It is just the structure of things.

In a perfect market, rational consumers (purchasers) shift their patronage when they are unhappy with a particular producer. The worst performing producers go out of business and new entrants to the market vie for business, driving down prices and pushing up quality. The residential rehabilitation sector is a profoundly 'imperfect market', quite unlike this ideal of classical economics; both providers and purchasers have poor market knowledge and the costs of entry to the market are high and margins so low that new entrants do not set up new houses to replace those that close.

The current purchasing model for the residential sector is not 'fit for purpose'. Instead of driving down prices and pushing up quality, it damages the ability of providers to invest in their services and risks further reductions in the availability of services, even as the level of need increases.

One of the biggest problems with the commissioning framework we have at present is its inability to effectively performance manage residential provision. Providers should be held accountable for the quality of the service they provide to clients. The purchaser-provider split is in principle a good way to embed this accountability: commissioners act on behalf of clients and the public purse in setting and monitoring performance standards for providers, who should feel under pressure to meet performance and quality targets that will benefit their clients.

The current care management system appears ineffective at performance managing residential services. Individual care managers cannot fully monitor and review the quality of all the residential services they use – and some do so for none of them. They rely to some degree on the regulatory framework provided by the Commission for Social Care Inspection (CSCI), which does a good job but provides no oversight of the quality or appropriateness of the treatment itself.

In place of a robust performance management framework, the current system relies on the abilities of care managers to generalise from the experience of individual clients to create demand side pressure that then translates into improvements in quality and new capacity from the better providers. This is largely ineffective as providers also have poor market information (they get insufficient feedback from purchasers) and because the supply side of the market is so inelastic.

Targets for DATs do not actively promote the treatment outcomes that are best achieved through structured residential rehabilitation; there is thus little incentive for them to commission lower tier services with a requirement to provide pathways out to tier four services. There also appears to be a serious lack of strategic coherence between the management of the pooled treatment budgets and the community care budget.

Solutions must be found that strengthen each of the 'pillars' that shore up the residential sector.

Improved commissioning framework:

We should disentangle care management and move to a commissioning rather than a purchasing model. Care Managers would still be needed to assess, support clients and ensure effective throughcare; they should also record and feed back to a lead commissioners any compliments or concerns they have about the provider. It is not entirely obvious who should be this lead commissioner; one option

The steady decline in availability of residential rehab has contrasted starkly with the NTA's recommendations that the sector should lead the way in effective, evidence-based treatment, and has led to heated debate in DDN and elsewhere. Richard Phillips examines the key 'pillars' of funding, commissioning and performance management, and offers some solutions.

would be a regionally based structure, to commission capacity for only that region.

Improved funding streams:
Pooled treatment budgets and community care budgets should be merged entirely, and work to a single set of performance targets for the DAT and local authority. A robust block contracting mechanism should be developed where providers are commissioned to make a certain number of beds available rather than invoice payment for each bed night provided. Removing the need to have contractual relationships with dozens of local authorities would save money, cut down on paperwork, improve cash flow, reduce bad debt and improve financial planning. Most of all, occupancy fluctuations would not result in a long term loss of capacity to the whole sector.

Improved performance management:
By having a single commissioner for each service it would become possible to deliver an integrated performance management system. This would collate data relating to each individual placement and information from inspections. Commissioners would use this information to monitor, support and review the contract with a particular provider. A pilot by the London Purchasers Group several years ago demonstrated how such a monitoring system might work. Commissioners also need performance management, with performance targets for DATs to develop services that successfully route appropriate clients through to the available residential capacity. The whole incentive structure should be rebuilt such that it serves the interests of clients, including those who want to be drug free.

We also need clearer specification and information about the treatment being provided in residential services. In many areas of the drug and alcohol field it has become common, if not standard, practice for service level agreements to be linked to manual based treatment programmes, with clearly specified outcome targets and demonstrable links to staff skills development and competencies. The residential sector has developed without these, or has initiated such work outside the gaze of commissioners. A 'trade-off' for providers in getting the security of block contracts must be to accept greater oversight of what they do. We must be prepared to demonstrate that what we do is effective, accept the need to show how our everyday practice is supported by evidence and be able to demonstrate staff competence to deliver. The simplest way of achieving this would be an accreditation framework alongside block contracting, perhaps along the lines of the system in place within both the English and Scottish Prison services. Only accredited programmes would be commissioned and inspection would look beyond the CSCI limitations to ensure the programmes being run is of a high quality and run in line with the agreed specification.

The residential treatment sector is providing an excellent range of services that are being under-used to an extent that threatens to undermine the National Drug Strategy. The sector is run to a market-based mechanism that is currently failing to deliver the benefits that should accrue from a purchaser provider split. In the interest of clients, we should establish a new future for residential services; a restructured market that is viable to providers who urgently need stability and agreeable to commissioners, who quite rightly demand value and accountability.

Richard Phillips is director of services at Phoenix House.

Is rehab in crisis?

The NTA has invested in a number of helpful pieces of work that suggest a real commitment to the residential sector, though they have also questioned whether the problems facing the sector constitute a crisis. (See Paul Hayes' letter in *DDN*, 9 October, page 8.)

Official figures show a 50 per cent increase in DAT planned spend on residential treatment this year. Without wider context this is misleading. Only a very small proportion of residential rehabilitation is funded by DAT pooled treatment budgets – it is community care funding that counts. While any increases are to be welcomed, starting from such a low base even a 50 per cent increase in DAT expenditure means little. This would not represent an 'increase in funding' if the overall community care pot shrinks faster, or if most of this money was going into other forms of residential treatment such as NHS inpatient units.

The NTA has also quoted figures supplied by providers, suggesting a 5 per cent fall over the last year, with average occupancy reducing from 85 per cent last year to 80 per cent this year. These figures may be correct (though we do not yet know their providence), but should be considered in the context of a 7 per cent reduction in the previous year. A house that is budgeted to break even at 85 per cent but only fills 80 per cent will run a deficit of some £35k on the year – sufficient to trigger closure for many organisations. If 5 per cent is the average, half lost more than this; it is reasonable to assume that many lost 10 per cent this year. For some this would be in addition to the 7 per cent last year, leading to deficits of as much as £100k per year.

By any account, this is a crisis.

Getting to the **sharp** end

This year's National Conference on Injecting Drug Use invited service users and providers to look at how far we've come and what we could do better. DDN reports.

Dominic started injecting drugs in the 1960s. 'It was so easy to get heroin, methadone, anything you cared to mention. Injecting took place in toilets in Piccadilly, using water from the toilets,' he remembers.

'I would sell excess drugs for food and syringes. I'd keep a spike behind my lapel, until it was worn out.'

He saw clinics introduced at the end of the sixties – and watched as the tide turned against drug users at the beginning of the eighties. 'I remember watching *Pebble Mill* and they were talking about outlawing needles and syringes,' he says.

Why did attitudes change so drastically? Edinburgh GP Roy Robertson looks back to early eighties' Edinburgh, where an active cohort of drug users was enjoying a plentiful supply, alongside scarce injecting equipment.

The number of drug users was unknown, he says. They were out there somewhere, but were a criminal justice or domestic problem, not a medical problem. Hepatitis C was known but not readily identified; HIV was 'present but invisible', with no routine test available until 1985.

Suddenly the UK woke up to the stunning fact that 250,000 American and several million Africans were affected by HIV, with prevalence rising rapidly. Closer to home, the first HIV blood sample was taken in Edinburgh in 1982. Everything became urgent – to explain the epidemic, prevent transmission and provide screening.

Then came the bombshell for drug users: the conclusion in 1985 that drug injecting, with its needle-sharing culture, was an identifiable cause.

Since the Thatcher government's squeamish attempts at public health campaigns on Aids and HIV, there has been significant progress on harm reduction in many parts of the world. Gerry Stimson of the International Harm Reduction Association points to significant developments in syringe exchange, social marketing on safer drug use, and expansion of methadone prescribing, outreach services and peer advocacy.

But progress is still not as fast or as wide-reaching as it should be. 'Public health thinking has been lost,' he says. 'We need a Public Health Agency, not a National Treatment Agency.'

Colin Stewart, drugs advisor at Release, points out that prejudice still gets in the way of progress. 'Addicts are still regarded as self-inflicted,' he says. 'Needle exchanges have a very negative image… many pharmacists are unwilling to have them on their premises.'

We need to address the postcode lottery around treatment services, he suggests, as well as the inbred culture of bad injecting ('you see usage till the needle is blunted') and we should look at the potential of peer education.

So what are the acute problems of 2006? The diamorphine shortage has dominated for those who suddenly found their prescribed supply interrupted 18 months ago, without any explanation – a situation that still drones on without resolution.

'No information was passed from the manufacturer, to supplier, to pharmacy. How can the service user know what's going on?', complains Paul Murphy, who has become an activist in Rochdale. There are still no 100ml ampoules available in this country – only 500ml ampoules – 'so if you are on the smaller dosage, there is no dosage for you at all'. There are different stories about the reasons for the shortage: problems with freeze drying; problems with the ampoules.

But the stark truth for those maintained on the drug was that there was no information before going for their script and 'getting a ridiculous answer from the pharmacist that there's none in the country'.

Other diamorphine patients express their distress at how the situation has affected them:

'[Suddenly transferring to methadone made me feel] emotionally weird, like going round with a bucket on my head. Before this situation I had held down a job for 20 years.' Another says 'Subutex is alright, but I don't feel well. And if I don't feel well I will go and score.'

Those who need the diamorphine cannot understand why politics are blocking solutions and conclude that they, the service users, are just not important enough. 'Such a small number doesn't justify the bureaucracy,' comments one woman whose life was transformed by her diamorphine script. The debate is confirmation that many service users do not feel listened to – despite all the talk of service user involvement.

Our natural inclination towards stigma and stereotypes does nothing to help matters, says Tony Birt, a current methadone patient whose public responsibilities include advocacy on behalf of the Alliance and serving as public governor of a mental health trust.

'Would you want someone to look after your flat if they were a crack user or a heroin user?,' he asks. 'How do we feel about the mythical two-year rule [preventing prospective employees from taking a job until they are two years 'clean' from drugs]? How do we feel about the DVLA not allowing methadone maintained drivers? How do we feel about the negative language of drug 'abuse' in the workplace?'

Media, colleagues, friends and family all contribute to the wall of stereotypes, he explains. 'My family still think I have recovery to do because I'm still on methadone,' he says. 'I'm sick and tired of being told I've not recovered yet.'

For those who are homeless, problems are often compounded. Peter Anderson is support team manager at Street Work UK in Edinburgh, and

spends his time working out how best to engage with rough sleeping injectors.

'The homeless population is service resistant and hard to find,' he points out. The way in which drugs are prepared can match the 'horrors of the lifestyle'. So workers need to be practical and carry paraphernalia, water and swabs when they're out and about with the service. They have a 'make it happen' culture, looking out for every opportunity to provide cinbins in hostels and graveyards; reaching out to people who feel they have 'lost their house and their whole life'.

Outreach can be equally important in a clinical setting, as Prof Graham Foster, a consultant hepatologist demonstrates. Through setting up an outreach unit to treat patients with hepatitis C, he found he was able to break down the barriers between drug users and treatment.

'We mother them through treatment with text messages and emails… putting energy into people and telling them they're worth it has worked,' he says.

Prof Foster has a positive message for many hep C sufferers: 'It's a very curable disease in about 60 per cent of the people I see.' But he argues vociferously for early treatment, both to limit the spread of the disease – as he points out, 'people with infectious diseases tend to be friendly and pass them on' – and because younger people tend to respond better to treatment.

'Treat a 20-year-old and they have a 70 to 80 per cent chance of cure. Every year they delay, there's less chance,' he says. 'We know early treatment is effective. The longer you delay, the more clients you are generating.' As if these reasons are not compelling enough, the disease is explosive, with symptoms getting much worse after ten years. 'So why wait?', asks Prof Foster.

A lot of people have other priorities and may not be ready for treatment, he acknowledges. 'But all have a right to be treated when ready,' – an obligation on PCTs that is stipulated in National Institute for Clinical Excellent (NICE) guidelines to the Department of Health, regardless of an area's perceived budgetary constraints.

It's a rallying cry to get hep C patients into treatment – because it needs to be. Just 2 per cent of those with the virus are being treated at the moment; a feeble dent in patient treatment numbers compared to the 90 per cent you would need to treat to make a difference.

'We need to challenge stereotypes,' says Prof Foster. There's no evidence that treatment doesn't work for drug users.'

Presentations from the full and varied programme of the 2006 National Conference on Injecting Drug Use will shortly be available on the website: www.exchangesupplies.org

Regional inspiration

Dynamic outreach
A needle exchange bus and outreach street work are used by NEON – Edinburgh and the Lothians' Needle Exchange Outreach Network – formed in 2002 to combat the rise in hep C cases. The service brings one-to-one tailored harm reduction advice, as well as clean needles to those not in touch with other services. Building rapport with clients and careful joint working with agencies has given a route to support services, including hostels, GPs, drug agencies and pharmacies. Close links with police have ensured that there is zero police presence at mobile clinics – essential for their success. The bus enables NEON to cover a large geographical region that was determined by looking at statistics on drug use within Lothian, and targeting areas with the most evidence of injecting drug use and the fewest established services.

Action on needles
Agencies joined forces in the Spider Bridge area of Sheffield to tackle an escalating problem of needle litter. Needle exchange outreach worker Emilie Taylor says her agency, Turning Point, sought service users' feedback – then involved them in the clean-up. After consulting with the job centre to make sure benefits would not be affected, they paid them £20 to join staff from the local DAT, the council's environmental health team, local Wildlife trust and the needle exchange. Putting a display about the clean-up in the service's reception afterwards generated discussion and encouraged a proactive response to the litter problem. A sharps bin has been ordered for the area by the DAT, 'but still hasn't arrived... perhaps one of the weaknesses of partnership working'.

Family support
With a high percentage of child protection cases linked to drug and alcohol using parents in their county, Kent agency KCA started a partnership project with social services. 'Historically there was a lot of suspicion between treatment and social services, but a lot of need to work together,' explains service manager Vanessa Cropper. 'Service users felt there wasn't much on offer.' Partnership working was found to be cost-effective in keeping families out of the social services system, and has proved beneficial to all parties by simplifying the referral route and instilling confidence in parents who previously experienced 'massive fear' in talking about problems with their children. The emphasis is on support, advice and helping parents to hold their family together.

Hep C pathway
An integrated care pathway for hepatitis C has now been published by the CAAAD project in Bristol, which navigates the client through expert support and medical interventions for screening, monitoring and treatment. Nigel O'Malley, CAAAD's hepatitis development worker explained that the pathway aims to make the journey much easier for clients, while improving consistency of services and making them more responsive to individual clients' needs. *(See DDN, 22 May, p10 for background to this project.)*

Post-its from Practice

No room for bigots

Prejudice continues and must be challenged, says Dr Chris Ford.

Joan, a longstanding patient of mine, died a few weeks ago. Like so many, she led a full life, juggling work with family commitments and although eventually divorced, was proud of her three children, two grandchildren, and her circle of good friends. Over the years, I shared some of her moments of joy and times of difficulty, and was happy to support her stable need for long-term injectable methadone.

Her death was unrelated to her drug dependence which, although it was one small part of her life, was often how she was defined. She dreaded going to hospital, fearing the reactions of the staff. Her concern was often well-founded – a typical example was when one doctor turned to her and said 'What's a nice lady like you doing taking those horrible drugs? You don't really need them, do you?' So before every admission, we 'negotiated' the continuation of her methadone maintenance and during every admission the hospital team would discuss reducing it.

She saw little of her family during her final illness but was supported and sustained by the daily visits of her best friend Alice, who also did her shopping, collected her prescription and generally cared for her. Alice is also my patient and takes maintenance methadone. Alice was understandably distraught when Joan died and phoned her eldest son seeking information about the funeral arrangements. Out of the blue, he demanded 'Are you taking methadone?' Taken aback, she admitted that she was and enquired why he wanted to know. Joan's son then informed Alice that she was not welcome and refused to tell her where the funeral was to take place. Despite all our best endeavours, Alice missed her best friend's funeral.

Charitably, we could say that both Joan's son and the hospital staff acted out of ignorance. Prejudice (literally to pre-judge) however, arises when ignorance unites with heartlessness and I am appalled that its foul influence led to humiliation for Joan when in hospital and distress for Alice over the funeral arrangements. No wonder those who take drugs alter their behaviour and their lifestyle, in order to minimise its ugly stench.

Now ignorance may be 'educatable' but prejudice is inexcusable and those of us who loath it need to confront it at every opportunity. We need to be wary of colluding with organisations that express prejudicial views about people who use drugs and politely challenge colleagues who also perpetuate them. We need to support others so that they feel strong enough to speak out. We need to be aware of our own prejudices and be ready to apologise when we get it wrong.

I will remember Joan as a wonderful, multidimensional person who deserved to be respected and treated with dignity. It is a basic human right and an expectation we all have and we forget it at our and our society's peril.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead of SMMGP

I read your article about tackling addiction alone last month, prompting this request. I'm 25 and I've been using base amphetamines and alcohol in increasing quantities for nearly two years. I want to give up now, so much. I'm sleeping badly, getting chest pains and losing my ability to keep a grip on my life. I'm also starting to experience paranoia which I never have before. I can't go to my doctor or attend a clinic. I would lose my (well-paid and respectable) job if they ever got a sniff of my drug use. I need to do this myself and I need to do it quickly. Is there, or has anyone, any specific amphetamine-oriented advice that can help me give up alone?
Sarah, London

Seek out support

Dear Sarah
Well done for admitting that your substance misuse has become a problem and well done for taking the brave step of asking for help.

It sounds like you're ready to give up your substance use but not yet ready to trust anyone to help you, as you fear losing your job. I would like to reassure you that if you went to your GP or a drugs clinic no one would ever dream of telling anyone about your drug use. Both drug workers and GPs will keep confidential what you tell them.

They would only breach confidentiality if you or someone else is at risk. Often appointments can be scheduled around your work with many clinics having a late night appointment system.

You don't have to do anything on your own; it can be lonely to have no-one to talk to or to share your hopes and fears with. We all need encouragement and support with whatever we are doing and it's also good to share your problems with someone who can help.

It may be helpful to explore why you are using substances and what alternative coping strategies are available, as often substance misuse is a symptom of other problems.

Sarah you can go to your GP, Drugs Clinic, Counsellor or any health professional and you can trust the services that are there for you. Let them help you to move forward with your decision to become substance free.

The only reason they may report your drug use is if you are under the influence at work and this causes a risk to you or anyone else – for example if you were driving a bus whilst under the influence of drink or drugs.

Get the chest pains checked out with your GP to make sure you're OK. Your GP may also be able to refer you to a counsellor. Drug clinics often have alternative therapies to help with relaxation, offering massage and acupuncture for free. These may all help to get your sleeping patterns back. I would suggest your own anxiety may be keeping you awake and talking to someone might help. Your GP may also be able to prescribe medication to help get your sleeping patterns back, although the best way to get a good night's sleep is to start dealing with the problems that cause the worry.

By writing to the magazine you have made the first step and are asking for some support and help; take one more step and speak to someone face to face. Most places won't insist on you giving an address or even your real name.

Get the help and support you need and deserve so that you can get a goods night's sleep and be ready for that well-paid job when you wake up each morning. Best wishes,
Mel, counsellor and drugs worker

Staying anonymous

Dear Sarah
You can't do this alone. You have to get help but this does not necessarily mean that you will lose your job, everyone will find out and you will be labelled with being a 'speed freak' for the rest of your life. There are organisations that will help you, where you can meet people who have overcome similar problems, and where you can work through a programme that has been proven time and time again to work. Maybe your first port of call should be Narcotics Anonymous – the clue's in the name, no one need know! By attending meetings and using the 12-step process that has worked for countless people before, you can reclaim your life and beat your addictions. Good luck,
Phillip, by email

Reader's question

I came across your magazine on the web and want some advice. I suspect my teenage son is taking drugs, something he vehemently denies. I need to know the truth and have heard about drug-testing kits (and seen them advertised online). Can your readers advise me if this is a sensible approach?
Ruth, by email

Email your suggested answers to the editor by Tuesday 31 October for inclusion in the 6 November issue of DDN. New questions are welcome from readers.

Fired for change

Service users often need support outside conventional services – which led Peterborough group UserActive to look for inspiration in a firewalk. David Griffin explains.

Only a decade ago both stable and chaotic addicts could expect to face a gamble on how useful their core treatment would be. We faced differing approaches in different locations; the relatively new centralised treatment units often under-dosed or bizarrely reduced methadone dose levels; there were different opinions on urine screening and user involvement beyond the 'suggestions box syndrome' was unheard of. So on many levels, because of hard work from grass roots and professionals alike, we've seen a vast improvement in the main focus of what treatment should be about.

Some issues continue to be raised at local level, in national publications and on various internet based forums. *DDN* recently featured a letter from a person wanting some sort of support structure not rooted in the 'drugs world' and for a long time ideas have been put forward to widen the scope of what the treatment community calls therapy, throughcare and aftercare. Because of the complex nature of addiction, stabilised clients (and perhaps service users generally) face a difficult conundrum in that the only area where they have some sort of structural support is often the treatment system itself – so they continue to be exposed to old patterns.

An article in the Summer 2006 edition of *Drug and Alcohol Findings* indicated when it's best for therapists to back off and allow some clients to locate a different approach:

'Non-directive therapeutic styles generally (in terms of substance use) work best for clients characterised by anger, defensiveness, or resistance, or who like to take control, while more structured and directive approaches may profit calmer clients, those who welcome being given a lead, and those already committed to the course of action being directed.'

It could be suggested that this works on a far broader level, depending on the individual and where they are on their treatment journey. Much of the process isn't about drugs or substitutes, but about gradually providing a platform for a person's control over their life. Addiction is a complex issue and so are the ideas we need to throw at it to 'fix' it.

With this in mind, UserActive looked into setting up an event that would use therapy with a twist, by investigating what it would take to get both treatment staff and service users involved in some sort of event like a parachute or bungee jump. While looking around, the activity of fire walking popped up and we located a company that had a significant history of working with public sector and fund-raising organisations. With support from the local NACRO agency, who provided an indoor location for training and garden for the firewalk itself, an event was successfully staged at the end of last month.

This event broke new ground on several levels. Time4Change, who ran the event, have two approaches to event staging – one of which is a sponsored template that enables organisations to not only cover costs, but also raise funds themselves. We developed a system that let agencies or their individuals sponsor a client and let them do the firewalk cost free. In addition, the event offered a unique chance for the different cross-agency staff to come together and do something different.

By the time the event took place, we had representatives from the local NHS Community Drugs Team (CDT), NACRO, the DAAT and various support partners such as probation and arrest referral. The firewalking company operate an initial workshop based loosely on Neuro Linguistic Programming or NLP. Although to some this brings up ideas of hypnotism or mind control, really it is nothing of the sort, and is instead an effective way which helps the individual to take control of their own thought and language patterns and achieve things they maybe otherwise would not try. As the fire lane was prepared, the 25 participants went through a brief administration process for enrolment and into the training room with Cliff Mann, a qualified NLP tutor and hypnotherapist.

As it grew dark and a good crowd of supporters were in place the walkers came out into the large garden and felt the not inconsiderable heat from the red hot embers on the fire lane itself. What was interesting was the significant transformation in the group attitude and enthusiasm. People that walked in looking fairly apprehensive came out whooping. We saw GPs that we'd only seen previously sitting quietly in a surgery, bouncing up and down in anticipation! Time4Change had created a fantastic atmosphere by bringing a PA system with appropriate music and generally creating a safe but vibrant environment. One by one, under focused instruction from the trainer, users and staff took their turn to loud clapping and encouragement from supporters. That night the embers were apparently extra hot, but not a single person received an injury.

Events such as this don't offer an alternative therapy as much as a 'window' for personal change and control. They are an adjunct to treatment and work well where formal mechanisms may need additional input. This was evident from video interviews afterwards with a couple of service users – both of whom claimed it had given them a new way of seeing things.

On top of this it offers the possibility of self-financing small groups and giving a platform for differing agencies, clients and staff to interact on a different level. The UserActive/NACRO firewalk raised a significant amount for both the UI group itself and Peterborough Soup Kitchen.

David Griffin is chair of UserActive. Visit www.useractive.net for the firewalk video.Time4Change have written a short introductory document called 'Firewalking as an adjunct to therapy in Addiction Treatment', available from their site at www.t4c.org.uk

Conditioning models of addiction: Part 2

In this Background Briefing, Professor David Clark describes two of the three models pertaining to the involvement of classical conditioning in problematic substance use and addiction.

In my last Briefing, I described classical conditioning as a process that involves a neutral unconditioned stimulus, such as a coloured light, becoming rewarding and influencing behaviour because it has reliably preceded a reward such as food.

During a history of drug use, certain stimuli, such as environmental contexts or drug paraphernalia, reliably accompany drug administration. These stimuli, by virtue of their pairing with the drug effects, become conditioned stimuli capable of eliciting conditioned responses, *egg* drug-seeking behaviour.

There are three ways that classical conditioning may be involved in problematic substance use or addiction.

In the conditioned withdrawal model, proposed by Abraham Wikler in the late 1940s, environmental stimuli paired with drug withdrawal become conditioned stimuli capable of eliciting conditioned withdrawal reactions.

For example, in people dependent on heroin, withdrawal symptoms can occur and be paired repeatedly with environmental stimuli. At a later time, when the individual is no longer dependent, the environmental cues alone can be enough to elicit the symptoms of withdrawal.

The cues that trigger conditioned withdrawal can be both external (places or situations) or internal (moods). Conditioned withdrawal can play a role in relapse. In fact, the conditioned withdrawal model of addiction involves both classical and operant (or instrumental) conditioning. Repeated pairing of environmental stimuli with withdrawal results in these stimuli are capable of inducing conditioned withdrawal (classical conditioning).

The operant conditioning component involves the person taking the drug to alleviate an aversive state, the withdrawal symptoms, which can be regarded as a negative reinforcer. The second classical conditioning model involves the concepts of conditioned drug-opposite responses and conditioned tolerance.

Whenever a disturbance occurs in the body, such as produced by a drug, a physiological process known as homeostasis, in which the body tries to counteract the disturbance, comes into play.

For example, amphetamine enhances release of the neurotransmitter dopamine in the brain, but at the same time regulatory mechanisms reduce dopaminergic function in order to try and maintain the status quo – although the amphetamine still increases dopamine function overall.

Researchers believe that these compensatory mechanisms can eventually be triggered by stimuli and cues previously associated with drug administration, and this can happen even before the drug is taken.

'The cues that trigger conditioned withdrawal can be both external (places or situations) or internal (moods). Conditioned withdrawal can play a role in relapse.'

In situations where the predictive stimuli appear but no drug is taken, the body's compensatory mechanisms come into play and go unopposed because there is no drug effect. This can be expressed as overt physiological reactions and/or form the basis for the subjective experience of withdrawal sickness and craving.

Take for example a person who is drinking alcohol every evening to reduce the anxiety they have experienced from working in a stressful job. The clock at work approaching 17.00 acts as a conditioned stimulus to the anxiety-alleviating effects of alcohol.

If the person were to attend a school play one evening, without going to the pub, their body's compensatory mechanisms would come into play but not be diminished by the physiological effects of consumed alcohol. The person would experience the opposite subjective effects to those produced by alcohol, *ie* anxiety. According to this model, tolerance and withdrawal symptoms are intimately linked.

Tolerance – the gradual diminution of effect following repeated administration of the same dose of drug – is thought to occur because of the homeostatic processes that occur in the body to counteract the action of a drug. The homeostatic (or opponent) responses are thought to be strengthened by repeated drug administration, and the net effect of the drug is therefore reduced.

These processes are explained in more detail by the Opponent Process Theory of Solomon and Corbit (1973), summarised in Robert West's book *Theory of Addiction*. Shepard Siegel (1975) first proposed that a complete account of tolerance requires an appreciation of the role of environmental influences or cues. There is now abundant evidence showing that animals that are pre-administered a drug repeatedly in one environment and tested behaviourally in another environment, will not show as much tolerance as those animals given chronic drug and behavioural testing in the same environment.

An important consequence of this idea in relation to heroin overdose was illustrated by Shepard Siegel in the early 1980s. Tolerance develops to the effects of heroin, so that users face the possibility of overdose (and death) if they take much larger amounts of drug than normal.

Siegel reasoned that if tolerance to heroin was partially conditioned to the environment where the drug was usually administered, if the drug was administered in a new setting, much of the conditioned tolerance would disappear, and the person would be more likely to overdose.

In his study, many heroin users admitted to hospital suffering from a heroin overdose reported that they had taken this near-fatal overdose in an unusual environment, or that their normal pattern of use was different on that day.

The next Background Briefing will consider the third model involving classical conditioning, involving conditioned drug-like responses.

Recommended reading:
Robert West (2006) ***Theory of Addiction****. Blackwell Publishing. (Available at discounted rate from the DDN bookshop at www.drinkanddrugs.net.)*
Nick Heather and Ian Robertson (2001) ***Problem Drinking****. Oxford Medical Publications.*

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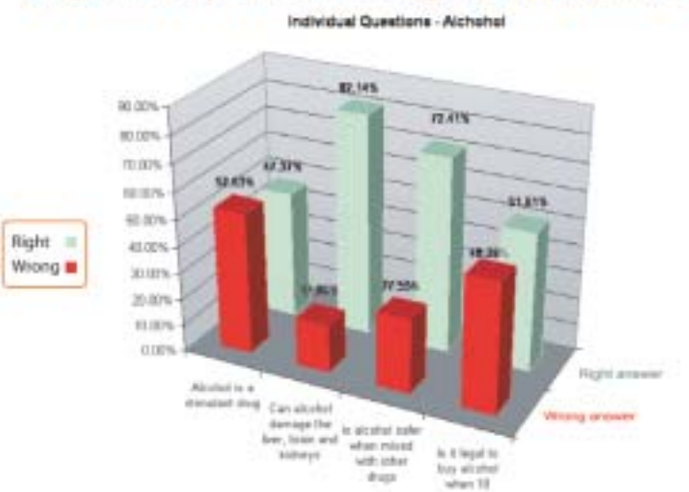

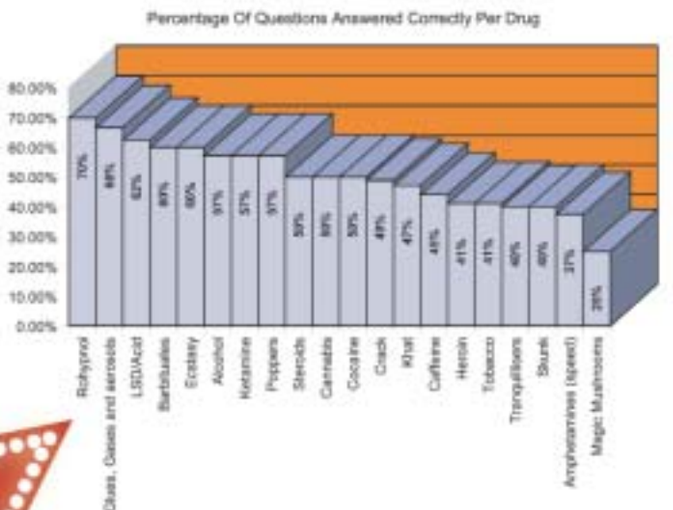

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We are seeking a manager with substantial experience of delivering treatment services to join our senior management team. Responsible for harm minimisation services in Bristol and North Somerset you will be passionate about delivering quality services that make a difference.

For more information and an application pack visit our website: www.addictionrecovery.org.uk or telephone 0117 934 0844. For an informal discussion please call Peter Walker, Chief Executive, on 0117 930 0282.

We offer an attractive package including: 30 days annual leave; 35 hour working week; group pension; extensive training; good working environment.

Closing date for applications: 9.00am Monday, 30th October 2006.

ARA is working towards equal opportunities and welcomes applications from all sections of the community. Registered Charity No 1002224.

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Right Start Foundation

RIGHT START FOUNDATION

RSFI is an emerging complimentary therapy treatment provider in Birmingham, Serving the Drug users from the Ethnic minorities in particular the Pakistani/Bangladeshi/Somali and Yemeni communities, RSFI is seeking to fill the following 2 positions:

Substance Misuse Worker

RSFI - Birmingham - £20,421-£22,628 [Closing date: 10.12.06]
This post will provide substance misuse counselling/support, as well as advice and information, group work and assessments within a multi disciplinary team. A portion of the work may be carried out in GP surgeries. Some evening and weekend work will be required.

Senior Substance Misuse Worker

RSFI - Birmingham £23,724-£29,771 [Closing date: 10.12.06]
This is a high profile & challenging post that will lead, manage and develop substance misuse services for the Ethnic Minority groups in Birmingham. These services will be delivered to an accreditation standard that is recognised locally, nationally and internationally and the post holder will deputise in the substance coordinators absence. You will provide formal case management and day to day support, management and guidance to Substance Misuse Workers regarding their case work.

For an application pack please contact Shaukat Warraich on 0121-631-1679 or email: shaukatw@rightstart.org.uk

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INVITATION TO TENDER

NOTTINGHAM CRIME AND DRUGS PARTNERSHIP

Locality Based Assertive Outreach Service 2007/08

The Nottingham Crime and Drugs Partnership (CDP) invite applications from suitably experienced organisations to provide the above service.

This project is jointly funded through partnership regeneration and pooled treatment budget funding streams and commissioned through the CDP.

The role of this service is to provide a three-pronged approach to locality based assertive outreach. Delivery will be focused on 2 priority neighbourhoods within the City of Nottingham through:

- Assertive outreach with substance misusers
- A substance misuse resource and professional support for generic services, including non specialist GPs
- Brief interventions with substance misusers to maximise engagement and referral into structured treatment

The assertive outreach shall deliver provision to those unable or unwilling to access site-based services, including underserved groups.

The service will also provide appropriate professional advice and up-to-date information on all aspects of drug and alcohol misuse to all generic professionals in the localities.

It is anticipated that the service will be operational no later than the 1st of April 2007.

For an application pack please contact:
Naomi Roose, CDP 1st Floor Barrasford House,
Goldsmith Street, Nottingham NG1 5JJ.
Telephone 0115 915 6360 Email: naomi.roose@nottinghamcity.gov.uk

The deadline for formally recording your interest to tender is 12 noon on Friday 24 November 2006.

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WEST SUSSEX

The West Sussex DAAT is looking for an exceptional person to take up this newly created post, to shape the development of substance misuse services, to help reduce crime and increase community safety across the county.

Challenges in the first year include revising the delivery of the Drug Intervention Programme (DIP), overview of the friends and families project, reviewing the DAAT's Harm Reduction Strategy, and positioning the service squarely in the wider Criminal Justice arena with an overall view to reducing crime and increasing community safety.

This is an exciting role, which requires a good understanding of the issues we need to address with our key partners such as the local strategic partnership, crime and reduction disorder partnerships and the National Treatment Agency. As a senior member of the DAAT Officer Team, your enthusiasm, decision making skills and problem solving approach shall be essential in the ongoing development and consolidation of the treatment system. Good interpersonal skills are essential and the necessary self-motivation to achieve change and meet national targets locally.

This post is subject to a criminal records bureau check.

For an informal discussion, please contact Tony Toynton on 01243 777661.

For an application pack, please go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 642140 (24 hour hotline). Please quote reference number 60007826. Closing date 17th November 2006, Assessment Centre 30th November 2006.

Expression of Interest

Middlesbrough Council (on behalf of the Middlesbrough Children and Young People's Strategic Partnership, CYPSP) is inviting expressions of interest from suitably experienced organisations for the provision of an integrated young people's specialist alcohol and drug service.

The successful organisation will be expected to develop a service that has prevention and harm reduction as it's focus and is fully integrated into mainstream children and young people's services.

The service will form part of the CYPSP's response to alcohol and drug use/misuse by young people in Middlesbrough and will include the following components:

- Targeted work with schools
- Harm reduction services including needle exchange services.
- Rapid access to specialist drug and alcohol treatment services including substitute prescribing.
- Targeted work with the Youth Justice System

The indicative budget for this service is £328,000 per annum.

The contract is for a three year period commencing on April 1st 2007 and would, subject to satisfactory performance, be extended by a further year. Funding is, at this stage, only guaranteed for the first year and any continuation of the contract would be subject to funding being available for years two and three.

Expressions of interest in tendering for this contract should be submitted in writing by 27th October 2006 at noon and sent to: Harriet Booth, Young People's Joint Commissioning Manager, PO Box 69, Vancouver House, Gurney Street, Middlesbrough, TS1 1EL.

Completed tenders should be returned by noon on Friday 24th November 2006. Shortlisting will take place on 30th November 2006, interviews and presentations will be conducted on Tuesday the 19th December 2006.

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St.Helens Council

Criminal Justice Intervention Team (CJIT) Manager

SCP37-40, £29,010 - £31,653 pa • 37 hours per week

Ref: CHS31

Working with a range of partners to ensure effective service delivery and achievement of local and national objectives, you will be able to demonstrate strong project management and strategic planning skills.

An understanding of the issues around drug and alcohol misuse and the community benefits to be gained from effective drug and alcohol interventions is desirable. You should also have a proven track record in project management in a social care/criminal justice environment, as well as an understanding of the criminal justice system and the national drugs strategy.

Located within St.Helens Council's Safer and Stronger Communities Team, the post is grant funded and initially the contract will be up to the end of March 2008. Continuation beyond this date will depend on future funding of the programme.

For an application pack, visit www.sthelens.gov.uk/jobs Alternatively, email: C30@sthelens.gov.uk or call 01744 671733. Closing date: 3 November 2006.

St.Helens Council is committed to equal opportunities. The Council is committed to providing a smoke free environment. Flexible working practices are in operation.

For further information on the above job or to view a full list of current vacancies, visit our website at:

www.sthelens.gov.uk/jobs

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Effective management of staff, the day-to-day operations of the project and the activity of residents through:

- Implementation of all systems, policies and procedures
- Ensuring the assessment and management of risk
- Supervision and development of staff
- Liaison with key community organisations
- Working closely with Prospects General Manager to provide an effective, quality service
- Promotion of our belief in 'respect, rights and responsibility' for all.

You will have

- Outstanding interpersonal and team management skills and experience
- A focussed and dynamic team approach bringing out the very best in people
- Residential experience in a similar setting, particularly with vulnerable women
- Understanding of the issues facing drug misusers and interventions that support recovery
- A Social Work or Probation diploma, Nursing qualification (Grade G minimum), Housing qualification or equivalent experience.

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More information can be found on our website on www.kalyxservices.com Previous applicants need not apply.

The closing date for applications is 10th November. It is anticipated that the interviews will take place between 17th and 30th November.

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Kent Drug & Alcohol Action Team | Medway Community Safety Partnership | Kent County Council

PROVISION OF SUBSTANCE MISUSE SERVICES IN KENT AND MEDWAY (REF: Y700143)

The Kent Drug and Alcohol Action Team and Medway Community Safety Partnership are seeking expressions of interest from suitably qualified organisations for the provision of the following contracts:

In West Kent and Medway

The provision of Open Access Tier 2 specialist substance misuse (drugs and alcohol) community services for adults aged over 18 to include:

- Harm reduction advice and information
- Advice and Information Services.

The provision of a range of Tier 3 specialist structured substance misuse (drugs) community treatment services:

- Community Prescribing Services
- GP Shared Care Services
- Day programmes.

Tier 3 services are for adults aged over 18 with the exception of Community Prescribing Services, which includes young people under 18.

For Kent and Medway

The provision of structured Aftercare Service.

For West Kent Only

The provision of Tier 3 structured substance misuse psychosocial interventions service.

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

These are separate contracts and applications may be made for any or all the contracts.

These contracts have proposed commencement dates of 1st April 2007 up to and including 31 March 2008.

Those wishing to express an interest should e-mail ojeu@kent.gov.uk quoting reference Y700143 no later than: 1700 hrs, 14 November 2006.

Late applications cannot be accepted.

Annual Drug & Alcohol Professionals Conference 2006

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DDN Drink and Drugs News

PRIORY

The Priory Hospital Preston is an independent hospital which specialises in the treatment and management of mental health problems. The Priory Hospital Preston has established an excellent reputation for providing the highest standards of care together with an extensive range of medical and therapeutic services. We are now seeking to fill the following position:

Lead Addiction Therapist - Therapy Services

37.5 hrs per week
£22,340 to £33,510 (Grade 7)

Following restructure, an opportunity has arisen for a lead therapist with group experience to join our Therapy Services Team, offering a high quality service in our acute mental health setting.

We are looking for a therapist who will lead the Addiction Therapy Programme. We offer an intensive, abstinence based programme with high levels of individual, group and family therapy, with a strong emphasis on aftercare support.

The successful candidate must have practical experience of the principles and practices of abstinence based treatment and hold a Diploma in Counselling and NAADAC accreditation (or willing to work towards accreditation).

The Priory Hospital - Preston is a continuously developing service, priding itself in the opportunity to offer flexibility and full utilisation of specialist skills.

If you would like further information please contact Diane Ogden, Therapy Services Manager on 01772 691122.

Application packs are available from Becky Holroyd, Human Resources Administrator (01772 692016). beckyholroyd@prioryhealthcare.com

The closing date for this position is Friday 10th November 2006

www.priorygroup.com