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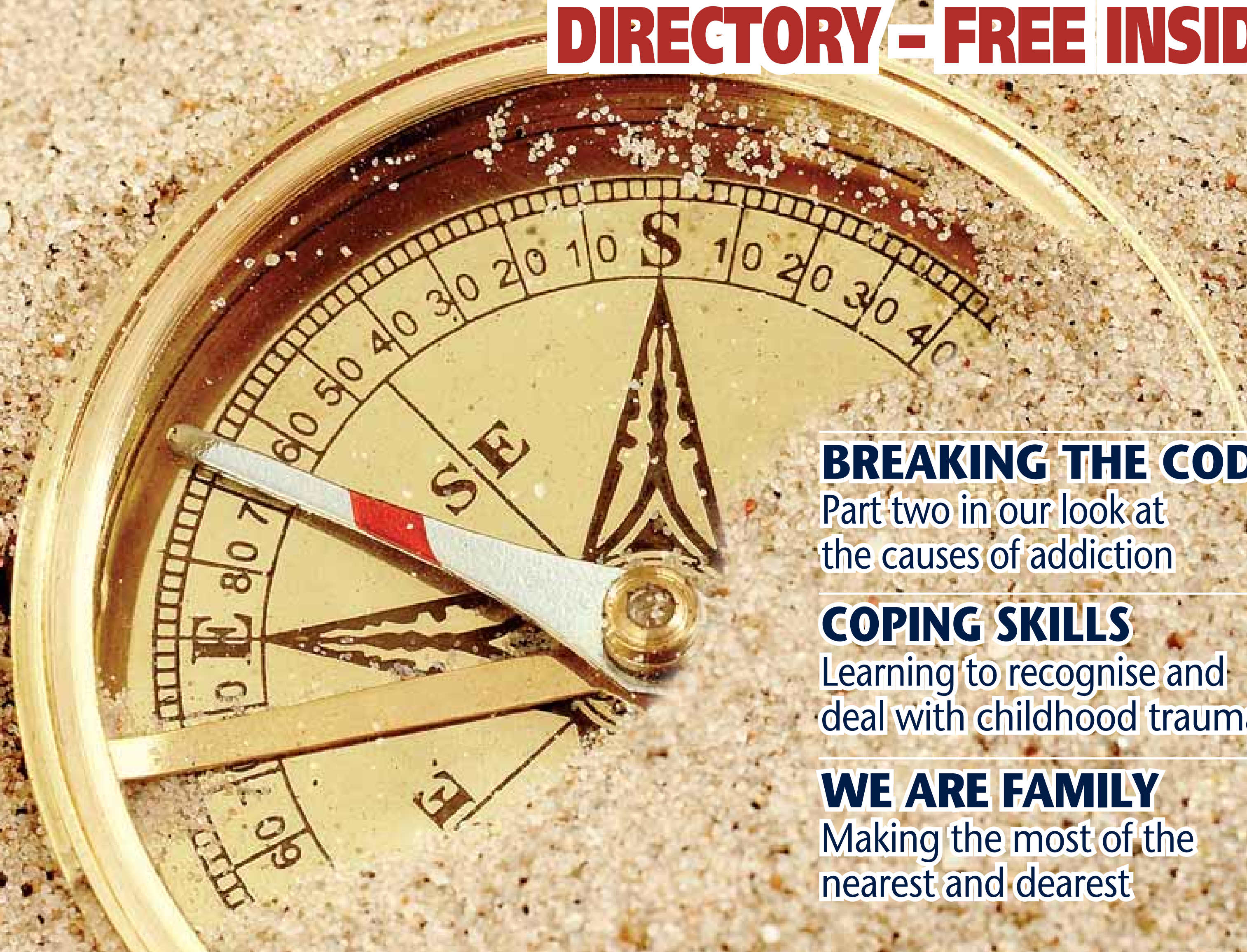
DDN
Drink and Drugs News

RESIDENTIAL TREATMENT DIRECTORY – FREE INSIDE



BREAKING THE CODE
Part two in our look at the causes of addiction

COPING SKILLS
Learning to recognise and deal with childhood trauma

WE ARE FAMILY
Making the most of the nearest and dearest

THE ROUTE TO REHAB

The right directions are essential on the journey to recovery

Your fortnightly magazine | jobs | news | views | research

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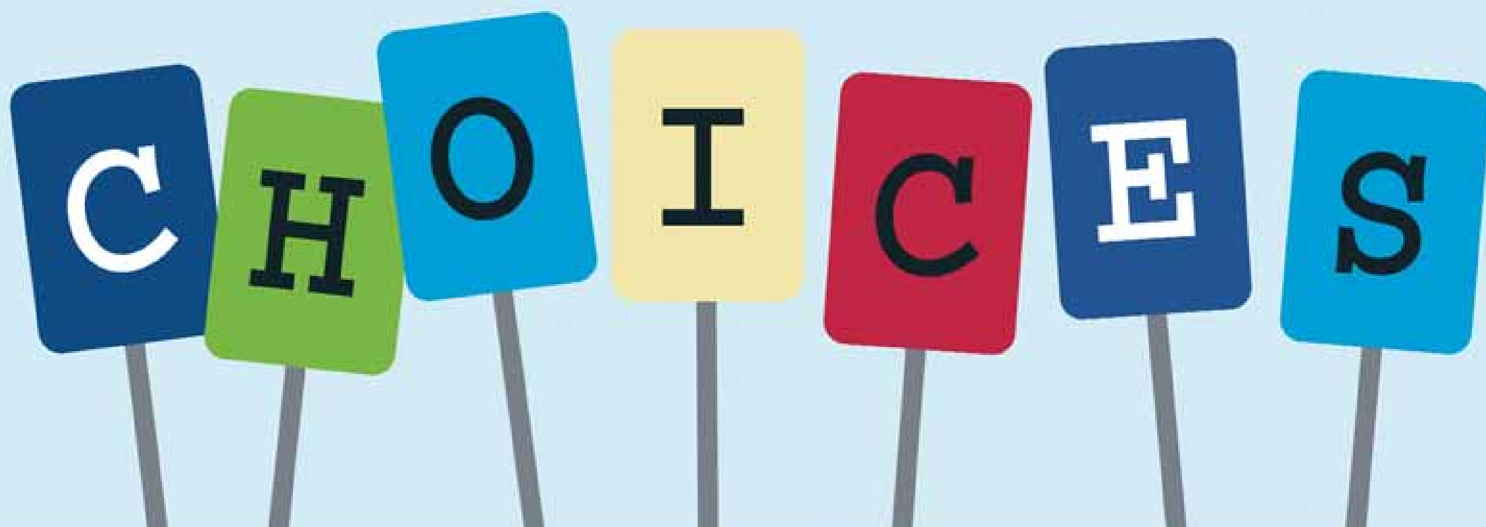

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Voices for Choices Conference

Meet us as the Voices for Choices conference in Birmingham on 29th January. Building on the success of last year's 'Nothing about us without us' DDN/Alliance national service user involvement conference, 'Voices for Choices' will bring together policymakers, DAAT coordinators, treatment providers and drug and alcohol service users from all over the country for essential dialogue. Our team are supporting the exhibition and will be available on the Concateno stand to answer any questions.

choices

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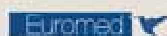

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Editorial – Claire Brown

On the lookout

Can we always see the obvious routes to improvement?

A story in the papers this week reported that surgeons would be required to read out a two-minute checklist in the operating theatre, before operating on patients. Among other things, they would need to check they had got the right patient and were operating on the correct part of their body. How obvious, I thought – aren't they doing that already? Apparently not. A trial had showed this simple measure could cut deaths by 40 per cent and avoid hundreds of botched operations.

Which leads me onto our cover story. You might think that paving an easy path to rehab is a straightforward process that happens as a matter of course. But a drug worker's version of easy routine can be very different to someone who has been passed from pillar to post, is required to trail from one site to another when arranging transport is difficult, and who is finding it difficult to seek help and coordinate the recommended options. The obstacles can add up to be simply prohibitive. Caroline Sutton and Brendan Georgeson gained a picture by talking to some of their clients at Walsingham House and share some observations and recommendations that make very obvious good sense. Some simple measures make a huge difference – such as having someone take a real interest and keep in contact with them through every stage.

We have talked often in *DDN* about what help and support families need from drug services, but on page 10, family support project worker Alison Sadler gives another perspective – how drug services can themselves benefit from families' input. Seeing the family members as allies in treatment, and not just as obstacles to be dodged, can accelerate the treatment process and enhance chances of sustained recovery. It's all a part of using resources imaginatively, and families' in-depth knowledge of your client can be an invaluable asset. And finally... hope to see you at our conference in Birmingham on Thursday 29 January!

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News in Brief

Ban for 'Speedball' beer
The Portman Group's independent complaints panel has upheld a complaint against a beer called Speedball, brought by Alcohol Focus Scotland. Named after the practice of combining heroin and cocaine, the beer is marketed as a 'class A ale' with a 'vicious cocktail of active ingredients.' The beer's producer, BrewDog, was 'seriously misguided in its claim to be educating and preventing people from misusing drugs,' said Portman Group chief executive David Poley. Shops will be asked to remove the drink from sale until its marketing is altered to comply with the group's code of practice.

Aberdeen treatment boost
The Scottish Government is to contribute nearly £940,000 to a new integrated treatment and rehab facility in Aberdeen city centre. The Timmer Market project is a joint venture between NHS Grampian, Aberdeen City Council and Grampian Housing Association. 'The city's drug problem is somewhat different from those of other areas in Scotland so extra resources are desperately needed,' said deputy council leader Kevin Stewart.

Binge drinking HIV risk
People who binge drink tend to have more sexual partners and are putting themselves at increased risk of contracting sexually transmitted diseases including HIV, according to a report from the New York City Department of Health and Mental Hygiene. Among gay men, drinking also reduced the chances by more than 20 per cent that a man engaged in receptive anal intercourse, the highest risk act, would be protected by a condom, according to Alcohol use and risky sex in New York City. 'Heavy drinkers are more likely to have multiple partners – increasing their risk of HIV, other STDs and unplanned pregnancy,' said the city's health commissioner Thomas Frieden. Little research has been done into the links between alcohol use and HIV outside of developing countries, says the International Harm Reduction Agency (IHRA). Report available at www.nyc.gov/html/doh/downloads/pdf/survey/survey-2008alcohol.pdf

Drugs coordinators for every job centre district

New funding worth £9m has been announced by the Department of Health to fund the placing of drugs coordinators in every JobCentre Plus district in England. The move is designed to build links between the job centres and local drug treatment services to both support drug users into work and get those in the benefits system into treatment, as set out in the controversial *No one written off* white paper published last year.

The money – to be allocated over the course of 2008-09 to 2010-11 – is designed to help people overcome drug dependency by developing skills, training and employment prospects, says the NTA, and develop a 'drugs pathway between JobCentre Plus and drugs partnerships.' Seventy three new posts will be funded across England – recruitment for which has already begun – with the aim of having all posts filled by 1 April.

The JobCentre Plus drugs coordinator role will raise awareness of treatment services among job centre advisors, make sure two way referral systems are in place, participate in treatment planning and help map provision and build relationships with other drugs agencies. It will focus on the delivery of drug strategy commitments and would only involve client contact in exceptional circumstances, says the NTA.

The initiative is a key step towards helping reintegrate problem drug users into the community, says the NTA. According to a recent report from the UK Drug Policy Commission (UKDPC), however, many employers are reluctant to recruit problem drug users even if they have the right competencies for the job and urgent action is needed to address employers' concerns and tackle stigma (*DDN*, 12 January, page 4). The *No one written off* white paper has been widely criticised by organisations across the drugs sector as unworkable and unnecessarily punitive (*DDN*, 3 November 2008, page 4).

Guidance to support drugs partnerships will be issued shortly, says the agency, which has also asked partnerships to 'ensure that strategic summaries submitted to the NTA regional teams as part of the treatment planning process for 2009-10 include high level objectives to support the development of the employment and drugs pathway.' This should include liaison with JobCentre Plus representatives, it says.

'About two thirds of the 330,000 problem drug users in England are on benefits, but only half of the problem drug users on benefits are in drug treatment,' said NTA chief executive Paul Hayes. 'Getting drug users on benefit into treatment is the first step to helping them regain control over their lives so they can overcome their addiction, be safer and healthier, and reintegrate into society. Drug treatment services and JobCentre Plus will work together to persuade employers to give drug users in treatment a real opportunity to achieve this, and to make sure that those who need treatment can get it.'

NTA report dispels young drug myths

The number of young people receiving treatment for substance misuse problems is rising, according to a new report from the NTA – but as a result of the expansion of specialist services rather than increased prevalence of drug use.

Addiction problems among those under 18 are rare and drug use is falling, according to *Getting to grips with substance misuse among young people*. Of the 23,905 young people helped with drug and alcohol problems in England last year, four out of five received counselling based services for issues around cannabis and alcohol use, such as emotional and physical wellbeing, family relationships and school attendance. Fifty one per cent were primarily seeking help for cannabis use, and 36 per cent for alcohol. Children's services are markedly different to those for adults, says the report, and those accessing services are not concentrated in any particular location.

Very few young people were treated for Class A drugs – 3 per cent each for heroin and cocaine as the main drug of misuse, and less than 1 per cent for crack. The figures were based on National Drug Treatment Monitoring System (NDTMS) data collected since 2005 as well as previously unpublished figures for the numbers of young people provided with interventions for alcohol misuse.

'Young people receiving substance misuse interventions cannot be described as addicts in the same way as adults in treatment are, but are vulnerable to lives damaged by drugs and future dependence if they are not provided with relevant interventions early enough,' said the NTA's director of delivery Rosanna O'Connor.

Much of the concern around young people and drugs – particularly among parents – is fuelled by the media, the report states, with 'little in the way of reliable evidence' to support claims that drug use and drinking are becoming more widespread among young people.

Adfam chief executive Vivienne Evans said 'Adfam receives regular enquiries from parents worried about the possibility, and the reality, of their children using drugs. It is encouraging to see that the NTA's report challenges some common misconceptions, dispels myths and provides a positive picture about the outcomes of the increased investment in treatment for the relatively few young people who need it.'

'We know that, unfortunately, a minority of young people will need help to overcome problems with drugs or alcohol, and to get to grips with other problems that may have led them to use substances in the first place,' said DrugScope chief executive Martin Barnes. 'Whenever a young person does need help, it is vital that they are able to access age appropriate support in their local area in as short a time as possible.'

Full report available at *www.nta.nhs.uk/areas/young_people/Docs/NTA_young_peoples_report_2009.pdf*

More service cooperation needed to protect vulnerable children

Closer working between drug and childcare services is needed to protect vulnerable children, according to a report from the Drugs Misuse Research Initiative (DMRI). Early intervention services for the vulnerable children of problem drug using parents need to be embedded into mainstream service provision as a priority, says *Interventions for children and families where there is parental drug misuse*.

Children of drug misusing parents should be seen as 'children in need' unless there is evidence to the contrary, says the Department of Health funded document. Closing the gaps between childcare services and adult drug services is a key priority, and there is also a need to 're-think bureaucratic approaches to record keeping'. Policy makers should also 'engage more forcefully with the impact of fear, stigma and labelling,' it says.

The needs of these children are not being met in the way they should be, says the document, which calls for the development of 'twin training' programmesfor professionals in one specialism to allow for dual purpose intervention – such as specialist drug misuse midwives or child care trained drug workers. Joint visits by childcare and drugs workers should also become standard practice, it says.

The study – in a rural area of South West England – was based on interviews with children and young people aged between four and 20, as well as parents, health, drug and social care professionals, and case file analysis.

'It was apparent that the culture of denial and secrecy that characterised these families had significant consequences for intervention,' says the document.' 'Most young people said they rarely felt supported, listened to or understood. At times they were invisible – in case records, to some of the professionals they encountered and to their parents.'

Report available at *www.lshtm.ac.uk/research/dmri/pdfs/Kroll%20summary.pdf*

Scots look local with treatment cash

Every health board in Scotland is to receive a funding increase of 13.5 per cent to support the implementation of the national drug strategy, the Scottish Government has announced.

Subject to parliamentary approval of the overall government budget, NHS health boards will receive the 13.5 per cent increase in their ring-fenced budget for drug services in 2009-10 – totalling £27.98m across the country, compared to £24.66m in 2008-09. The government had decided to 'retain as little of the drugs budget as possible for national projects' in order to maximise the amounts given to the boards to deliver frontline services, said community safety minister Fergus Ewing.

'It will also help health boards and their partners increase their funding to voluntary organisations,' he said. 'The extra cash will help get those seeking help the treatment they need and quickly.'

More than 97 per cent of seized herbal cannabis grown by intensive methods

More herbal cannabis on sale

The proportion of herbal cannabis available has increased in recent years, according to the *Home Office cannabis potency study 2008*. Based on samples confiscated from street level users, herbal cannabis represented more than 80 per cent of the drug seized. Just over 15 per cent of samples were cannabis resin while the remainder were either not cannabis or 'indeterminate.'

The figure points to a continuing increase – 55 per cent of the drug seized in 2005 was herbal cannabis, compared to 30 per cent in 2002. The figures are based on samples from 23 police forces across England and Wales. Examination of the samples for the 2008 report found that more than 97 per cent of the drug had been grown by intensive methods – with a median potency of 15 per cent, similar to other years – while the remainder was 'traditionally imported herbal cannabis.'

Regional variations were also found in the 'market share of herbal cannabis,' says the report, with proportionately more found in the Metropolitan, Avon and Somerset and Essex police force areas.

Report available at *drugs.homeoffice.gov.uk/publicationsearch/cannabis/potency?view=Binary*

News in Brief

Ketamine concerns

More young people are taking ketamine, in higher doses, and more people are injecting the drug, according to a survey by DrugScope's Druglink magazine. High doses of ketamine can potentially cause heart failure or respiratory collapse and long term use is associated with kidney, bladder and urinary tract damage. 'These trends are concerning,' said DrugScope chief executive Martin Barnes. 'Ketamine has been increasingly common on the club scene but there is worrying evidence that people are experimenting with larger amounts or are even injecting the drug. Ketamine's harms increase considerably at high doses and injecting users risk exposure to blood-borne viruses such as Hepatitis C or HIV.'

Drugs offences up

Drugs offences recorded by the police during the third quarter of 2008 increased by 9 per cent compared with the same period in 2007, according to the Home Office's new quarterly crime statistics. The report attributes the rise to use of police powers to issue cannabis warnings. The figures represent the most up to date statistics based on two sources – the *British Crime Survey* and police recorded crime. According to interviews to determine public perceptions of crime, the proportion of people who perceived high levels of drunken anti-social behaviour showed a 'statistically significant' increase from 25 per cent to 26 per cent, it says. *Crime in England and Wales: quarterly update to September 2008* available at *www.homeoffice.gov.uk/about-us/news/quarterly-crime-stats*

'Scope for development

DrugScope is holding a number of forums throughout the UK in 2009 to support development of good practice, update people on policy and make sure that local concerns reach the relevant bodies. Details are available at *www.drugscope.org.uk/ourwork/national-and-regional-fora/index.htm*
The organisation is also mounting five regional workshops for anyone who works with young people on drug and alcohol issues. The themes will be alcohol and young people (Cambridge, 2 March), working with families (Nottingham, 9 March), effective interventions and complex needs (London, 10 March), mental health and sexual health (Bristol, 18 March) and criminal justice (Newcastle, 1 April). Details at *www.drugscope.org.uk/newsandevents/ukevents/*

The route to rehab

Talking to residents at their rehab highlighted to Caroline Sutton and Brendan Georgeson that, for some, the journey to get there was needlessly difficult. They share their insight

NTA guidelines state that to ensure effective and consistent service delivery across the country, the maximum waiting time for access to rehab should be three weeks. As managers of an inner city rehab, experience has shown that many service users have a long and often arduous road to rehab, and that frequently, these guidelines on waiting times are not met.

We wanted to gain more insight into service users' experience of accessing our service, so we decided to conduct research, through interviewing service users and recording their comments.

We ran our study over a period of six months. During this time, we conducted semi-structured interviews with seven residents, documenting their journey into rehab, and including any obstacles they encountered as well as positive experiences.

Five men and two women took part in the study, and they ranged in age from mid 20s to late 40s. All had been assessed and were being funded by Bristol City Council. Of those interviewed, three had used drink predominantly (one woman and two men) while the remaining four (one woman and three men) had mainly used illegal drugs.

We asked them questions about their journey before coming to Walsingham House:

What were you using and for how long, when you made the decision you wanted to go to rehab?

Most residents had begun using drink or illegal drugs in their teens. Two had started at the age of 12.

Of the drug users, most started by using alcohol and cannabis before experimenting with a range of drugs such as ecstasy, LSD, amphetamine and mushrooms. All the drug users had then moved on to using crack cocaine and heroin, a process which had usually taken several years. Drug use had usually started as what was seen as recreational use – with peers or as part of the 'rave scene' – and had gradually become more of a solitary experience.

Had you been in treatment before?

All those who took part in the study had been misusing drugs/alcohol for several years before thinking of starting a structured treatment programme.

Of those who had been in residential treatment before, two said they had found it a helpful experience. The memory of residential treatment had stayed with them and had been a motivating force in their seeking such treatment again. The other interviewee who had been in residential treatment before (for five weeks only) said he had found the regime 'harsh' and it seemed that little of benefit had remained with him from the experience.

Of the four who had not been in residential treatment previously, two had misused drink only. Both these residents had attempted to detox with professional help on several occasions but had relapsed after only a few days. As one resident said, 'The temptation was too great. There are lots of pubs between the Robert Smith Unit and where I live.'

Both those who had misused mainly illegal drugs had moved away from home in an attempt to stay drug free and for both, this had failed to stop them using drugs. Both had received some form of counselling over several years before making the decision to enter residential treatment and both indicated they had been in denial about their drug use for many years.

What was the process of deciding to come to Walsingham House, including influence by family, friends and other agencies?

For all residents, the decision to come to rehab was the result of years of drug/alcohol abuse and a growing understanding that their life was out of control and their health in jeopardy.

The main 'triggers' for deciding on rehab were a breakdown in relationships with family and friends, failing health, and pressure by authorities (social services, prison). In several cases, a combination of these had led to a sense of desperation. To quote

two residents: 'I became very fed up… I was exhausted' and 'I decided I'd had enough… I asked to go to a rehab – any rehab.'

For two (both drinkers) failing health was a major motivation rather than the influence of family and friends. For another (woman) drinker, the threat of losing contact with her daughter was a deciding influence and for another (drug user) the realisation that time spent using drugs and/or in prison meant loss of contact with his child – 'I am missing out on his growing up'. In both these cases, intervention by a statutory authority (social services or prison services) had played an important part in their decision-making.

Another resident's wife had delivered an ultimatum but had remained supportive and this had been a turning point in his recovery.

The following comment from a long-term drug user encapsulates the experience of many residents: 'I was not able to work. A relationship had broken down and relationships with family and friends were becoming increasingly strained. I felt I had lost everything… I had no feelings of self worth or esteem… and I knew I had to get away from the lifestyle I'd got into.'

What did you have to do to get here?

Three of the seven residents reported having to do very little to get a place in rehab. One of these had been in prison and said that following discussion with a drugs worker – who he described as very helpful – in prison, the move to rehab was arranged for him.

Another (female) resident had been helped through the process by a social worker, following a court appearance at which her daughter had been taken into care. This resident recalled being given a choice of two rehabs and getting the one she chose almost immediately.

The third resident, who said they had done very little to arrange rehab, was a long-term alcoholic who was well known to drug and alcohol workers. He had been near home when a doctor who had worked with him before saw him staggering along the road, near home. He said this doctor had arranged an admission to hospital and a move to rehab was arranged from there.

For the other four residents, securing a place in rehab was more complicated and took much longer. In general, those who were using alcohol reported finding a place in rehab more easily than did drug users.

Of the four drug users, one had come straight from prison. The remaining three described a protracted and sometimes difficult route to rehab, that included the following process:

- First meeting with social worker at social services
- Second assessment meeting
- Requirement to attend eight-week programme in the community
- Detox
- Admission to rehab

The following aspects of the process were perceived as difficult:

- A lack of coordinated response by social services. Residents were required to attend interviews in different parts of the city and with different staff, and they were inclined to feel they were unnecessarily repeating information in interviews. This led to a sense that their case was not known or understood.
- Problems with attending groups. While the rationale behind the requirement to attend groups was recognised and accepted, residents' discussions were hampered by practical difficulties, but they felt that they would be penalised or excluded for not attending. They perceived that the reality of their drug use was not being acknowledged, in that their lifestyle was too chaotic to ensure regular attendance at group meetings. In one case the group meeting was held just around the corner from where a resident's child went to school and this resident said he felt apprehensive about attending meetings because people would know where he was going.
- Having to arrange their own detox. Two residents said this had been very difficult for them – in both cases, they were helped by someone outside the system (for example the Salvation Army).

'Most of the people I deal with tell me what they don't want, so the first thing is to identify exactly what it is they do want and not to be apologetic about it… when you identify what you want, you step out of victimhood.'

We asked residents how the process affected them, and responses varied widely. From the three people who described having to do very little to secure a place in rehab there was, not surprisingly, very little comment. One of these people – who came from prison – said 'it was all arranged for me', and another said 'quite honestly, I was a bit shocked by the speed of things'.

Of the other residents, two expressed a high level of frustration with the process. Both said it took too long, with one commenting, 'I thought I might be dead by the time I got to rehab.' The other said, 'the whole process took too long, and I was not given any indication of how long it would take'.

The second complaint was about the attitudes of those managing the process and the quality of service. Residents felt they were not kept informed about the process and its timing. Comments were as strong as: 'I was disgusted by the ineptitude. You have to ask who trains these guys. I wasn't treated like a person and there was a complete lack of respect.' However, one resident that expressed frustration with waiting times also suggested that her lifestyle and attitude may have had some bearing on her perception of the process: 'I was so chaotic at that time… I can't remember parts of the process… you have to be determined. It was a drawn out process… but I prolonged it to be honest.'

Our research highlighted that there needs to be a balance between the road to rehab being so easy that it is taken for granted and so difficult that it is unattainable. The preparation process could certainly be streamlined to set people up for success, and it would be helpful to acknowledge that people do not need to be totally stable to go to rehab.

We found that those with the smoothest journey into rehab had had someone show a personal interest in supporting and encouraging them to go. Some of those we talked to had had a perception of rehab being a bit unknown and mysterious, so it would be beneficial to encourage commitment-free visits for those interested in abstinence recovery.

Our study participants reported that they needed to be at a low ebb and desperate to access rehab, so proactive welcoming initiatives would help many towards recovery at an earlier stage.

Caroline Sutton and Brendan Georgeson are managers at Walsingham House, Bristol

FDAP Feedback

DDN reports from the recent FDAP conference

COMMUNICATION IS KEY, heard delegates at the FDAP conference in London last week. 'We need to focus on changing the public's perception – things are getting better but the perception is that they're worse', said Pamela Spalding of the Home Office. 'People who fear drug use and crime are less likely to engage as citizens and until we improve people's perceptions we can't see the strategy as a success.'

She explained the Home Office's intention to communicate the good work being done in the drugs field on a regular and targeted basis. Young and middle-aged people with children in urban areas were most concerned about drugs, and these were the people that it was essential to communicate with – getting the message across that treatment was working.

The high levels of stress an individual's drug use causes his or her family was something that could sometimes be ignored, Alex Copello, consultant clinical psychologist at Northern Birmingham Mental Health Trust, told delegates. Using recognised stress tests, most family members scored as high on the scale as individuals receiving treatment for stress for their own reasons. 'Family members are heavy users of the healthcare system through stress, depression and anxiety,' he said. Drug services needed to recognise this and offer support and information for their own needs, to support drug using family members in treatment. The need for family services had been recognised in recent policy documents which was a good start, said Copello, but there was still a long way to go. 'It is not stand alone family services that are needed – all services need to be more family focused, as opposed to just focused on the individual in treatment.'

'We live in a wet culture – drinking and drunkenness are commonplace in our media,' said Mike Shiner of the London School of Economics. This set social norms and expectations and it was important to understand that decisions around youth drinking were taking place within this context, he explained. Britain had always had a culture of binge drinking, so comparisons with Mediterranean cultures were unfair.

However there were still real worries surrounding the increase in youth drinking, especially among young girls, Shiner told delegates. Young people tended to use alcohol to express their independence in the transition into adulthood, and do most of their drinking in a social context – in pubs and bars in their late teens or parks and streets at a younger age. This is where society as a whole must take a share of the blame, he said, as the new pubs and bars that were the staple of regenerated city centres were unlike the old-fashioned intergenerational hubs of the local community with customers operating informal social control. Instead they were 'drinking factories' with limited seating, loud music and bar promotions, designed to maximise revenue. It was important to shame the behaviour, not the individual, he said.

Nicola Singleton of the UKDPC presented delegates with feedback from their research on the importance of employment to recovery. Employment was not just an end goal but important to consolidate recovery and reintegration, she said. There were barriers to employment on both sides, and it was crucial not to rush people back to work too quickly before they were 'job ready'. This involved meeting primary needs first, such as treatment, health, housing, personal support and motivation. When these needs are met, you can then address training, skills and qualifications, she said.

On the other side of the coin, the challenge was tackling employers' prejudices around employing former opiate and crack users. These were both genuine concerns surrounding managing relapse, criminal record issues and integration with current employees, as well as perceived concerns around punctuality and trust. Interestingly, while 80 per cent of employers with no experience of current or former opiate or crack users said they would not consider employing them, those with experience were overwhelmingly positive and reported highly on issues of trust and honesty.

We cannot consider an individual drug user in isolation – he or she is part of a community and their drug use needs to be considered in that context.

Fiddling before the flames

For reasons that are obscure to me, you have published yet another article by Professor Neil McKeganey promoting the idea of abstinence and dismissing the harm reduction approach to drug treatment (*DDN*, 12 January, page 12). Surely we know Prof McKeganey's views by now? There is nothing new here, and for a professor of addiction research to advocate a treatment for a highly selected group of patients when he himself acknowledges we do not yet know – if we ever will – the criteria we would need to select thses patients, seems farcical to say the least.

Prof McKeganey makes several valid points in his article. Yes, the 12-step movement has a wealth of experience in supporting recovery, and an evidence-based track record in delivering it, and yes, it would make sense for addiciton treatment services to work in partnership with them.

But to suggest that all services focus on recovery, treating only that minority of patients who would be deemed to benefit, to the exclusion of all else, and presumably abandoning the majority of drug users to a period without treatment, is both logically flawed and dangerous. Logically flawed, because he ignores the infectious nature of drug misuse – drug users learn to use drugs from each other, they buy and sell to each other and on occasion they actively promote relapse in the abstinent. We cannot consider an individual drug user in isolation – he or she is part of a community and their drug use needs to be considered in that context.

And it is dangerous, because – as Prof McKeganey well knows – the risk of death in an untreated drug user is seven times that of the non-user, whereas on treatment this risk returns almost to that of a non-user. The evidence can be seen in his own backyard – Scotland has for several years had a consistently higher rate of drug-related deaths than the rest of the UK (three times higher in 2005). The numbers have risen for the last three years, and doubled over the last ten, according to the Scottish Government's *Reducing drug users' risk of overdose*.

While we are about it, shall we also consider the exponential rise in deaths due to alcoholic liver disease in Scotland, now the highest in Western Europe (*Liver cirrhosis mortality rates in Britain from 1950 to 2002: analysis of routine data*, published in *The Lancet*, vol 367, issue 9504).

One could be forgiven for gaining the impression that Scotland is drowning in a sea of drink and drugs, and Prof McKeganey's leadership on the issue is like that of Nero – fiddling while Rome (Scotland) burns.

Dr Susi Harris, clinical lead in substance misuse, Calderdale

Time for change at the NTA?

Neil McKeganey puts his finger on what should be the real priority at the NTA (*DDN*, 12 January, p10). Growing numbers of addicts 'in treatment' – far from being a reason for self-congratulation – are a result of the failure of 'treatment' to procure recovery in those 'entering treatment'.

However it seems clear from the NTA chief executive's own published statements that his agency does not expect treatments to actually cure anyone, as the NTA considers it necessary to provide continuing but different treatments throughout the life of an addict.

In October 2008, Paul Hayes stated: 'the NTA believes in a balanced treatment system, in which a range of treatment options are available from which addicts can benefit at different points in their lives.'

But any former addict who has become drug-free no longer needs or wants any further treatment options!

Yet we have Hayes publicly proclaiming that 'this means methadone is available as the standard clinical treatment to start the process of getting heroin addicts off drugs.'

With the proven fact that only 3 per cent of methadone-treated addicts become drug free, and with the 1999 Big Issue in the North revelation that 45 per cent of those in treatment had been on methadone from over five to more than ten years, how can the NTA go on to say that it makes no apology for standardising on methadone?

And does the NHS and the government not know that when their NTA makes such appalling admissions of failure and proclaims as standard policy the continuation of such failures, the UK is in deep trouble as regards government drugs policy? The Conservatives know it, but instead of investigating why, the NTA hits back verbally.

NTA and DATS spend our taxpayers' money on these failures when they should, as Professor McKeganey indicates, be looking for 'where the experience and expertise in recovery is to be found'. The problem is that the NTA relentlessly ignores organisations which have such experience and expertise in recovery, because recovery so obviously reduces the need for 'treatment' and thus eventually the need for the NTA.

Kenneth Eckersley, CEO of Addiction Recovery Training Services (ARTS)

Passing the buck?

I welcome the letter from Annette Dale-Perera, the NTA director of quality, stating that they are 'definitely not on the fence' regarding innovative, evidence-based harm reduction tools such as naloxone (*DDN*, 12 January, page 8). However, I am disappointed that the emphasis appears to be placed on 'local areas to work out how best to make [these interventions] available given the barriers highlighted'.

If the NTA is, as their website claims, committed to 'ensuring that DATs are able to provide drug misusers with a full range of services' and 'promoting best practice in drug treatment', surely the onus should be on them to work around or remove these barriers?

Although I concede that some of the barriers that services face are outside of the NTA's direct remit – such as those relating to the Medicines Act or the UK paraphernalia laws – this surely does not prevent the NTA from strongly and centrally advocating on behalf of services and areas to overcome them?

Until they take up this mantle, unfortunately, they are going to be open to accusations of agnosticism – whether it be about naloxone, aluminium foil or any other innovative (and potentially life-saving) harm reduction tool.

Jamie Bridge, International Harm Reduction Association

Finding new horizons

A number of readers have expressed interest in our cover story from last issue ('New horizons', *DDN*, 12 January, page 6). To contact the therapist, Cathy Dixon, visit her website at energyroots.co.uk

Claire, Editor DDN

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

Post-its from Practice

Raising a smile

Dental pain needs recognising not ignoring, says **Dr Chris Ford**

I was sitting in my consulting room when I heard singing and guitar playing coming from outside. Going out to investigate I found Billy sitting entertaining the packed waiting room. He gave me an enormous grin, proudly showing off his new dentures!

When he began treatment about six months earlier, his primary goal had been to get his teeth fixed so he could sing again. For him, being homeless, having infected groin injecting sites and not receiving any benefits, were all secondary to getting his teeth done.

'Dental pain may only appear when starting substitute medication, and if not treated can lead to relapse'

It was a struggle to support Billy in his primary goal as many dentists in the area refused to register him and many others had left the NHS. But eventually with 'a little persuasion' from us and his supportive church (another largely unrecognised and underused resource) Billy started the process of having his few remaining teeth removed and preparing for dentures.

Drug-using patients frequently in and out of treatment have a high level of oral disease and on the whole a low uptake of dental treatment. Although users and workers alike blame methadone mixture as the cause, research shows that dental caries manifest themselves much earlier and it is a complex condition. A number of factors may play a part, including exposure to sugar, poor diet and poor dental hygiene, while the complex nature of dental pain may be masked by the analgesic effect of opioids before engagement in treatment. Dental pain may only appear when starting substitute medication, and if not treated can lead to relapse.

As Ruth Gray, dentist extraordinaire who did most of the research in this area states, it is '... vital that dental health is taken into consideration in the primary assessment of a new client and dental treatment made accessible.' Her research undertaken in Dublin showed that 99 per cent of subjects required some form of dental treatment and 30 per cent needed dentures. Ruth also found dental health (and hepatitis) were identified as main concerns for drug user support groups.

Dentistry has an important but largely unrecognised role to play in the recovery of people who use drugs – not only in the treatment of pain and disease, but also in enhancing people's appearance and self-esteem. Take care the need for dental treatment concurrent with drug treatment isn't a reason for people to drop out of treatment, and its importance needs to be acknowledged and included in planning.

Billy understood this and re-taught me an important lesson. I'm now off to listen to his CD of Christmas carols, two of which are his own compositions!

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

We are family

Families can be traumatised by drug use, but the family is a major part of most drug users' lives and can play an influential role in supporting the user in treatment, says **Alison Sadler**.

A service user sits in a consultation room with a drug worker. An assessment is done, a treatment plan agreed, and the next appointment is booked. Hopefully, during the session there has been some discussion about the service user's family – are they supportive, how are they coping and do they need support for themselves?

Valid questions. But how seriously are families' needs taken and how often dare a drug worker ask the question 'can we involve your family with this?' Perhaps if they did, they might discover what a powerful influence families can have.

When someone discovers they have a drug user in the family they are scared – understandable given the image most people have of drug use. They conjure up images of them overdosing, lying alone in a grimy bedsit or slumped in a city centre underpass.

Families are also scared about friends and family finding out. How can they face the neighbours or their colleagues at work? This is about blame and guilt, and protecting the family from judgements that will inevitably be made. It takes a strong family to say 'this is not our fault', because many are wondering if it is – asking themselves 'what have we done to deserve this, where did we go wrong?'

As part of protecting the family they may try to limit who knows, and extended family members are often kept in the dark. Some family members will opt to keep the discovery completely to themselves, believing that together with the drug user they can get through this with no one else needing to know and finding themselves plunged into a world of secrecy and censorship.

The family is angry and confused – they cannot understand what has happened to them and they certainly cannot understand what has happened to their relative. Gradually that considerate and caring person they have lived with for many years disappears, and in their place grows someone that is moody, irritable and withdrawn.

For years they deal with money and possessions being stolen, police at the door, court appearances and even prison visits. They are lied to and manipulated, with relationships put under immense strain as everything revolves around the drug user. But perhaps one of the hardest things to bear is that every family occasion is marred by shame and disappointment, as the drug user lets the family down once again.

There is a feeling of helplessness – the family has fixed its problems in the past but this one is beyond their means. To take some action is to regain some control, but this can lead families towards bizarre behaviour – trying their own version of a home detox, administering street methadone or attempting to regulate use by holding and dispensing drugs.

Some will go to extraordinary lengths and make incredible sacrifices in the misguided belief that they are helping. Family members find themselves paying off dealers' debts or remortgaging their house to fund the drug user, convinced that this will keep them out of trouble and off the streets.

Families are desperate for their drug user to receive help and time after time will do the work for them – phoning round agencies, driving them to appointments and sitting for hours in a waiting room. They expect it to be like a hospital where the drug user will receive treatment, everyone will be kept fully informed and the family will return home with clear instructions for the recuperation period. Gradually they realise it doesn't work like that – this is the start of a long and painful journey that threatens to tear the family apart.

When a drug user is in treatment, families frequently find themselves stuck in the middle, in conflict with the user and the worker. They want to know if the user has turned up for an appointment – a condition of them remaining at home – but they are unlikely to hear the truth from the user if they haven't.

It is daunting for drug workers to be faced with highly emotional families, but so much of this is fear and misunderstanding and if a little time can be spent helping them to understand, it can make so much difference.

A worker may have been told that the family is unsupportive, but this is rarely the case – it is more likely that they are feeling helpless and frustrated. Once again they see their relative relapsing, often before the worker is aware of what is happening.

Instead of being in conflict, families could be influential allies, working together with the user and the drug worker to make a powerful team. Recovery does not happen in isolation and if the user is serious about their treatment, many will welcome some input from the family. Confidentiality need not be compromised if some small shifts in attitude and approach are taken to enable families to be routinely offered a level of involvement.

Families recognise the expertise of drug workers and would not want to compromise that – they simply want to do something positive that might help the whole family survive.

Alison Sadler is manager of RODA (Relatives of Drug Abusers), a family support project based in Sheffield.

Desperately seeking guidance

The drug strategy promised guidance to improve drug workers' family intervention skills. **Steve Mills** argues that we need this guidance sooner rather than later

In the drug strategy *Drugs: protecting families and communities* the government set out its plan for drug services for the next ten years.

In the action plan that accompanies the strategy, under the heading of 'a new package for families', the government states that it will 'publish guidance to improve the involvement of family and carers and the development of family intervention skills of drug misuse workers'.

The guidance is not yet available but I have some suggestions as to what the family interventions skills of drug workers should include.

In my view workers are not receiving the training that would enable them to work as effectively as they need and want to, services are not as good as they should be and service users and their families are not receiving the standard of care to which they are entitled.

Certainly, family interventions training is not a panacea. It is, however, a fundamental aspect of substance misuse work and might be considered a fundamental aspect of health and social care work generally. Training in this area may be something we can no longer afford to ignore.

You might say 'if practitioners are for the most part working with individual service users why do they need to know about family interventions?' I believe that it will help achieve better outcomes. The simple fact is that we all come from a family (in the broadest sense) and we all remain connected (in the broadest sense) to one, whether we like it or not. We may choose to have nothing to do with it and it may choose to have nothing to do with us, but neither of us can make it mean nothing. We carry our families around with us. The influence of this on all of us – practitioners, service users, managers and commissioners alike – is profound.

The better our understanding of our service users and their context, the more likely we are to accurately hear them and provide them with what they actually need.

So what should family interventions training (FIT) include? There is quite a lot that is helpful in the suite of NVQ units but of course they are a set of competencies and not a training programme, and in my experience substance misuse workers can find the NVQ uninspiring. FIT training needs to inspire the workforce – not be a hoop through which practitioners are encouraged to leap.

A set of principles for family interventions work needs to be established with substance services, which should guide the nature of the interventions available.

FIT needs to include an exploration of what a family is and isn't – who we include and do not include and why – what holds a family together and what structures, boundaries, roles, rules and communications families use and why.

FIT needs to include as a minimum an opportunity to develop an understanding of different family systems as well as an appreciation of the influence of diverse ethnic, cultural and religious values on a family affected by substance issues.

It needs to include some exploration of the function of substance misuse in families as well as the different stages of children and young people's development, and how these stages can be affected by substance use.

Theories about human growth, identity and self-esteem, loss and change, conflicts and dilemmas, attachment, power and how it can be used and abused are a part of the NVQ suite and many workers will have covered these to a very limited extent. Because the NVQ only requires knowledge evidence to be covered once, this 'limited extent' can be very limited indeed.

FIT training needs to consider child protection issues and how substance practitioners and managers can work effectively and cooperatively with other professionals to share the care of families. This requires more than just training, but training could provide opportunities for a range of agencies to get together to share thinking and develop more whole family approaches.

As many children and young people in families affected by substance use can have early experiences of caring for both themselves and others (siblings and parents), an appreciation of the effects of this and what help is available would be of benefit.

FIT should include the development of an understanding of theory and practice around resilience and how to identify and develop this with families. Practitioners need to have time to consider the family life cycle – the emotional life of families and the stresses at different points in the cycle.

There is much that is good about substance misuse work but my experience of the field suggests that more time needs to be set aside for workers to develop a broader understanding of clients in their contexts. A deeper understanding of families seems a good place to start.

Steve Mills has worked in substance misuse services for the past 16 years (six of them as director of family services in a community-based agency). He is currently a DANOS assessor for substance workers in prisons, community-based agencies, statutory agencies and supported housing services. His website is at www.stevemillsconsultancy.com

Breaking the code

In the second of our series of articles looking at the aetiology of addiction, Dr Art O'Malley **looks at the neuro-psychological and biological aspects of trauma and the three stages of trauma recovery – safety and stability, coming to terms with traumatic memories and integration and moving on**

The first stage of trauma recovery is safety and stabilisation. In order to become actively involved in treatment, the client must first be taught to comprehend the effects of trauma – to recognise the common symptoms and understand the meaning of overwhelming body sensations, intrusive emotions, and distorted cognitive schemas (thought and behaviour patterns).

The achievement of safety and stability rests on the following:

- Establishment of bodily safety, such as sobriety and abstinence from self-injury.
- Establishment of a safe environment, such as a secure living situation, non-abusive relationships, a job or adequate support.
- Establishment of emotional stability – the ability to calm the body, regulate impulses, self-soothe, set healthy boundaries and manage depressive and post-traumatic symptoms triggered by mundane events.

The goal of this stage is to create a safe and stable 'life in the here-and-now', allowing the client to safely remember the trauma, rather than continue to re-live it.

The second stage is coming to terms with traumatic memories. The goal of this stage is to overcome the fear of the memories so they can be integrated into a personal narrative that helps the client appreciate, and have compassion for, the person he or she has become as a result of the trauma. In order to metabolise (not just verbalise) the trauma, the client may need to make use of EMDR (*DDN,* 12 January, page 14), hypnotherapy, or mind/body therapies at this stage. Throughout, he or she must be attentive to pacing so as not to become either stuck in avoidance of the pain or overwhelmed by memories and flashbacks – finding ways of coming to terms with the traumatic past without necessarily uncovering all of its details.

The third stage is integration and moving on. The client can now begin to work on decreasing the sense of shame and alienation, developing a greater capacity for healthy attachment and taking up personal and professional goals that reflect how he or she has made meaning out of having survived, and healed from, traumatic abuse. Overcoming fears of normal life, intimacy and healthy challenge and change become the focus of the work. As the survivor's life becomes reconsolidated around a healthy present and a healed self, the trauma is increasingly farther away – part of an integrated of self but no longer a daily focus.

In trauma processing, there are three levels of information to be processed:

1. Cognitive processing is the capacity for conceptual cognitive information processing, reasoning, and decision-making. It necessitates the ability to observe and abstract from the experience.

2. Emotional processing is the capacity for a full range of feeling and affect, and the articulation of that feeling and affect. Emotional processing adds emotional motivational colouring to sensory motor and cognitive processing.

3. Sensory motor processing is the capacity for processing through the body. It relies on a number of fixed action patterns or procedural behaviour patterns (startle reflex, fight-flight response, automatic reflexes) that often take precedence in traumatic situations. Sensory motor processing involves sequential movements associated with movement impulses, physical defensive responses and autonomic nervous symptoms arousal.

These different levels of processing relate to different levels of the brain. Sensations and movement impulses are governed by the reptilian parts of the brain, emotional processing occurs in the midbrain and cognitive processing occurs in the upper parts of the brain or frontal cortex. These parts of the brain interact with one another to gives us a coherent form of information processing.

Sensory motor processing is the foundation of the others, and includes the features of a simpler, more primitive form of information processing than its more evolved counterparts. With its seat in the lower, older brain structures, sensory motor processing relies on a relatively higher number of fixed sequences of steps in the way it does its work. Some of these are well known – such as the startle reflex and fight or flight response, as well as vegetative functions. The simplest sequences are involuntary reflexes such as the knee-jerk reaction, and these are the most rigidly fixed and determined.

More complex are the motor patterns that we learn at young ages and then put on automatic pilot, like walking and running. In the more highly evolved emotional and cognitive realms, we find fewer and fewer fixed sequences of steps in processing, and we find more complexity and variability of response. Thus, sensory motor processing is more directly associated with overall body processing – fixed action patterns, changes in breathing and muscular tonicity, autonomic nervous system activation and so forth. The 'bottom' is more associated with processing through the body, the 'top' less so.

The activities of very young children and those experiencing trauma are governed primarily by their sensory motor and their emotional systems – in other words, by bottom-up processes. A child's job is to explore their world through these systems, building the neuro networks that are the foundation for later cognitive development. Wired to be governed by somatic and emotional states, children respond spontaneously to sensory motor and affective cues. Traumatised people frequently observe how they are controlled by sensors and emotions, as they are unable to regulate these functions. For example someone who has experienced trauma will be dominated by the starter reflex, defensive or orientating responses.

Bottom-up and top-down processing represent two general directions of information processing – bottom-up is initiated from the sensory motor and emotional realms and has an effect on the processing of thoughts. The lower levels of processing are more fundamental and form a foundation for higher modes of processing – to set the limits within which upper levels of processing can operate. Top-down processing is initiated by the cortex and involves cognition – the higher levels monitor, regulate and often direct the lower levels.

The brain is known as one mind incorporating three brains. At the bottom you have the brain stem regulating emotional states; next up is the mid-brain, which incorporates emotional and sensory integration – the large and fine motor functions – and thirdly we have the limbic system, which facilitates socio-emotional relationships and governs teamwork, taking turns and sharing. Finally we have the cortex, which encourages abstract thoughts and processes, arts, language and humour. This triune brain develops and operates as a unit – the frontal lobes, limbic system and brain stem combine together in a holistic hierarchy, and the interplay between top-down and bottom processing hold significant implications for the treatment of trauma.

The crux of the problem in trauma stems from an inability to process sensory motor and emotional responses, and the disconnection of the frontal lobes for effective cognitive processing. Sequencing of responses are a necessary prerequisite for information processing – when someone experiences a traumatic

'In order to become actively involved in treatment, the client must first be taught to comprehend the effects of trauma – to recognise the common symptoms and understand the meaning of overwhelming body sensations...'

event the sensory motor systems become activated and often become overwhelmed in response to threat. When these functions are overwhelmed, sensory motor processing stops and further affective processing at the cortex level is blocked out, not only in the moment of the trauma, but also in the future.

Thus the interplay between top-down and bottom-up processing can hold these traumatic reactions in place. My unique approach is to integrate emotional and sensory processing with brain stem integration and information – I have called this Bilateral Emotional Sensory and Thought (BEST) therapy, or it can also be conceived as Thalamo Cortical Binding Therapy (TBT).

When traumatic memories occur they are burned into the limbic system with the associated distorted sensory information. They remain stored at this level and the thalamos is unable to relay information to the cortex. Careful sensory motor therapy integration enables the process of thalamo-cortical binding to occur so that the information transfers firstly to the right hemisphere and then to the left hemisphere where it is associated with language and meaning. The patient can now make sense of the traumatic experience. In my BEST or TBT therapy the medial, lateral and orbital prefrontal cortex are crucial to engage as there is a danger that during the trauma they will be offline and unable to process information.

The response to trauma is that an alarm bell is set off within the brain and the brain wiring is altered abnormally. There are different responses to threat depending on the type of reaction – in hyperarousal there is a classic flight response at the level of the locus coeruleus. This secretes adrenalin which increases the heart rate and occurs classically in older adolescents, especially males, and is linked to precipitation of aggressive instincts when the person's survival is threatened.

On the other hand, the disassociative response to threat involves freezing or numbing – the parasympathetic system is activated, causing the heart rate to decrease and the person to feel shut down or disconnected. It tends to be the response of younger children, often adolescent females, and is a result of painful inescapable trauma.

With trauma comes disorganised attachment. This is where the young person has contradictory behaviours at the same time. Movements are incomplete, mistimed and include freezing and moving slowly as if under water. They may behave fearfully towards their parents, with hunched shoulders and frightened facial expressions, and are often unable to regulate their emotions. Through my therapy, patients are more aware of their emotions, which are also developed through developing secure attachment relationships with parents, carers, siblings and peers. This has often been disrupted by exposure to trauma when attachment patterns are laid down.

Trauma means that you are unable to control your response to stress. You are also less able to interpret the body's signals in order to guide action, and this altered psychological sense mechanism may impair your sense of self and even your personal identity. In the future, trauma-focused therapy should involve a holistic approach to thought therapy and an awareness of the effects of trauma – the body, emotions, sensations, thoughts. My best therapy involves an integrated approach to reprocessing of all these aspects of trauma and leads to the development of mental toughness or resilience.

Dr Art O'Malley is a consultant child and adolescent psychiatrist

COPING SKILLS

Many adults in treatment have turned to drugs and alcohol partly as a result of childhood abuse and trauma, and yet most mainstream services have little in place to address these issues. **David Gilliver** hears about two new courses designed to give both managers and practitioners the knowledge and skills to help

According to Department of Health statistics, up to 60 per cent of both inpatients and outpatients in mental health services have been physically and/or sexually abused as children, and the DH cites substance misuse as one of the frequently reported long-term mental health effects of childhood abuse. In addiction treatment, however, these issues can either be overlooked or addressed by staff with no training in how to work with people who have been traumatised – people who may not necessarily be able to describe their problems clearly to begin with. The launch of two new courses in Bristol, however, aims to address this vital but oft-neglected issue.

Managing trauma and contributing to recovery is a one-day seminar aimed at service coordinators, directors, managers and team leaders while the two day *Abuse, addiction and disclosure – anchoring trauma* is aimed at the practitioners themselves. The courses are a joint venture between the Bristol-based Training Exchange and Southmead Project, a community support project that covers domestic abuse alongside its drugs work, and which has also set up its own specialist counselling service for survivors of abuse, Touchstone 165.

Both will be presented by Southmead Project chief executive Mike Peirce alongside Pat Johnson, an abuse and trauma specialist who has been training social workers on the issue for many years. The two organisations have been trying to get some training on the issue off the ground for some time. 'Mike Peirce realised that just about everyone he came across in his work had experienced some form of abuse, and thought there has to be some causal link there,' says director of the Training Exchange, Jools Hesketh. 'But he struggled for years to get the evidence together because he could never get funding to get the research done.'

The Southmead Project had an evaluation of its work carried out by the University of Bristol, during which researchers would time and again meet clients who disclosed abuse and trauma issues in their background. Funded by the European Social Fund, the research was eventually published in a 2007 book by Kim Etherington, *Trauma, drug misuse and transforming identities: a life story approach*, which uses extensive first person narratives to challenge pervasive notions of fixed identities in drug misusers. 'I knew we had to try and get an evidence base because people aren't going to change policies without it,' says Mike Peirce.

So is this something that's often overlooked in mainstream treatment? 'Massively,' says Jools Hesketh. 'That's what's inspired me to put the energy into it. It's a classic sticking plaster thing – we might be getting people through treatment but if we're not giving them the opportunity to address the underlying causes then we're just going to keep seeing them again and again. We're not helping them, we're just delaying things.'

The Southmead Project has been working with clients on deprived estates in north Bristol for many years, but also has drug user clients from across the city approaching them for help. 'They were coming into the charity and disclosing a background of often extreme trauma,' says Mike Peirce. 'And they were continually going round and round – they'd get so far with their methadone script and then relapse, time and again. And that's a national thing, because the root causes are not being addressed. It's not rocket science.'

But surely the link between childhood trauma and adult substance misuse is such a clear one in so many cases that it hardly needs stating? 'I don't have a drug treatment background myself and when I first heard Mike talking about this I just thought 'well yeah, that's obvious – why don't they do anything about it?' says Jools Hesketh. 'I suppose it's because services have so many other things on their plates that staff might think 'now we've got to become experts in this as well'. But what this is saying is that you don't need to become an expert – all you need to know is how to deal with it when it comes up.'

The one-day course for managers and directors does not set out to prescribe a

'... they were continually going round and round – they'd get so far with their methadone script and then relapse, time and again. And that's a national thing, because the root causes are not being addressed. It's not rocket science.'

set approach, but rather to raise awareness and equip people with the ability to choose what's best for their own service. Individual services can then decide whether they want to develop and expand their work in this area or re-allocate resources to specialist practitioners.

'It's to get them to think about what impact either ignoring the issue or taking it on would have on their services, because both will have a huge impact,' says Jools Hesketh. 'They can find out what we now know about the links between abuse and addiction, and think about whether they either develop a specific service within their service to support people who are disclosing abuse, or develop better referral links with a separate service that could deal with those aspects while they continue dealing with the addictions. It's a question of "do we want to train up every one of our staff so that they manage that, or acknowledge it, make sure everyone who works for us is aware of how to handle disclosure, and make appropriate referrals on to a service that has the skills to deal with it?".'

One option for managers is to send staff on the two-day practitioners course, *Abuse, addiction and disclosure – anchoring trauma*. This aims to provide the skills to respond to disclosure and 'hold' the person in the present while acknowledging the experience of abuse. It means the practitioner can continue with the addiction treatment work until the client is ready to start talking about their experience of abuse, whether that's managed by the drug service or by links to an external provider.

'The aim is not to train people to become competent at counselling people around sexual abuse and trauma,' says Jools Hesketh. 'It's more that if you're a drug worker and in the process of your assessment or engagement with a client that person discloses experience of abuse. You can address that without closing it down or ignoring it, but also without opening up a massive can of worms.'

Would it be fair to say that most drug treatment staff are unequipped to deal with these issues? 'There might well be those who aren't equipped with the skills to handle disclosure, because it's often horrific,' says Mike Peirce. 'They might well be good drug workers, but a big problem is that their agencies work with the presented problem but are often not to paid to work with what they sometimes call the 'can of worms' stuff. It's very difficult if you don't have those skills to be able to give the client the support they might need during that very painful process.'

These are also often the crucial times when clients are much more vulnerable to relapse, he says. 'That's because all the emotions start firing out all over the place – they've kept a lid on their original abuse as well as all the things they might have done as an addict. There are a lot of emotions going on, and with the 'pat on the head and cup tea' stuff that many clients experience there isn't the opportunity to disclose – and they might not be encouraged to do so, frankly.'

The Southmead Project's trauma and abuse counselling arm, Touchstone 165, is able to carry out its work by means of lottery money, but obviously most services have no specific funding for this sort of work. 'We work with clients who disclose abuse because we get funding to do that, but there's a combination of reasons that mean a person could invest in their drug worker, finally decide to disclose and then be told 'sorry we can't deal with that'. That's because the object is often to get them off the drugs first and then work with the emotional stuff after – but without having anything in place at all.'

Is there a risk that untrained staff, even if they choose not to overlook disclosure and offer more support, could unwittingly end up doing more harm than good? 'If, for example, a person was sexually abused as a child then often they can blame themselves for that, so all that guilt, shame and stigma comes rolling out – that is a specialist area of work,' stresses Mike Peirce. 'What we're looking at in the training is at least equipping drug workers with more skills to support the client through that early disclosure process – to get them skilled up to do that, but essentially be able to refer them on to other places like ourselves.'

He is convinced, however, that the treatment system as it stands is fundamentally failing trauma victims. 'I believe the primary motivation behind the current harm minimisation strategy is basically to keep a lid on the crime figures,' he says. 'Why don't we stop to say why it's not working? We work with clients for over a year – the quick fix idea that's around at the moment is not conducive to working with abuse. It's shouldn't just be about people on scripts, managing to cope but staying on the dole and not doing any of the things that they'd probably like to do. That's not to say everyone would give up drugs, but certainly you can enhance the opportunities for people to get a life. '

And if there's one key thing that practitioners should be doing at these crucial early stages, what would it be? 'The most important thing is for the client to be believed – that's a massive thing,' says Mike Peirce. 'And for it to be fully acknowledged by whoever's listening that there is an impact, that it does play a massive part, and that it did have a shaping of their identity as a child. Ordinarily, a healthy child not in that environment would develop coping skills and an identity far different from someone who's abused. It's about transforming those identities.'

First available courses: Managing trauma and contributing to recovery, 31 March. To book email southmead_project@yahoo.co.uk, or call 0117 950 6022 for more details.

Abuse, addiction and disclosure – anchoring trauma, 7-8 May. To book email admin@trainingexchange.org.uk or email jools@trainingexchange.org.uk for more details.

International Treatment Effectiveness Project (ITEP) Training

Psychosocial Interventions for Practitioners

What is ITEP?

ITEP builds on an internationally evaluated model of service improvement. Following its successful implementation across London within Blenheim CDP services this model of psychosocial interventions provides evidence based and easily evaluated tools for use by keyworkers across the health and social care sector.

Course Outline

Blenheim CDP's unique 2 day training course (mapped to DANOS) focuses on the two approaches that are designed to be delivered by keyworkers as part of their client work sessions:

- Node-link mapping
- Brief interventions aimed at changing thinking patterns

Cost

The price for the 2 days training is **£180** per person (including lunch and workbook). Consultancy packages available on request.

Dates

The course will run on the following dates at Blenheim CDP's Head Office, 66 Bolton Crescent, London, SE5 0SE:

19th/20th February 2009
26th/27th March 2009
16th/17th April 2009
21st/22nd May 2009
25th/26th June 2009
30th/31st July 2009
24th/25th September 2009
29th/30th October 2009
26th/27th November 2009

Contact Details

For further information concerning ITEP training please contact:
Sharon Burke T:020 7582 2200: s.burke@blenheimcdp.org.uk

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Web: www.pcpluton.com

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Email: info@openminds-ac.com
www.openminds-ac.com

REALITY THERAPY WORKSHOP

4 DAY WORKSHOP (Certificated)

This is a practical skill-building workshop in its own right that will also serve as the first step in the Reality Therapy Certification process for those who wish to progress with this qualification.

5th to 8th May 2009 (hosted by Open Minds)
Workshop Leader: John Brickell, D.C., RTC

For brochure and further information contact:
Centre for Reality Therapy UK, PO Box 193, Romsey, Hampshire, SO51 6YE
Tel: 01794 885 898 Fax: 01794 885 899 Email: john@realchoiceuk.com
Website: www.realitytherapyuk.com

Drugs Alcohol & Criminal Justice

Drugs, Alcohol and Criminal Justice

Interventions – how do we make a difference?

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

Thursday 25th June 2009 (10.30 to 4.30)
Venue: Friends House, Euston Road. London

The aim of the conference

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

Who should attend

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

The cost – £145 plus VAT

info@conferenceconsortium.org
www.conferenceconsortium.org

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Visit our website
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Open access programme

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Bristol venues

One day courses (£125 + VAT)

Addiction, dependency & change	*29 Jan or 22 Sept*
Difficult & aggressive behaviour	*23 March*
Lone working	*25 March*
Alcohol & poly drug use	*29 April*
Engagement & assessment	*13 May*
Effective communication	*9 June*

Two day courses (£210 + VAT)

Abuse, addiction & disclosure	*7 & 8 May*
Groupwork skills	*26 & 27 Feb*
Motivational interviewing	*10 & 11 Feb*
Training for trainers	*3 & 4 March*
Brief solution focused therapy	*10 & 11 March*
Relapse prevention	*31 March & 1 April*
Key working & support planning	*21 & 22 April*
Dual diagnosis	*18 & 19 May*
Supervision skills	*6 & 7 May*
Management & leadership	*2 & 3 June (*£250)*
Working with concerned others	*23,24 & 25 June (*£295)*

Making the connection

Having been established late in 2007 the CONNECTIONS Project is looking forward to holding its first European conference, in March, in Krakow, Poland.

The project managed by the European Institute of Social Services at the University of Kent and funded by the European Commission seeks to draw on experience and work of previous networks to exploit potential for multi-agency, multi-disciplinary partnerships within the criminal justice systems of the EU member states to develop effective responses to drugs and related-infections, particularly HIV/AIDS and hepatitis.

All evidence points to marginalised populations, in particular problematic drug users, being at risk of blood borne infections and diseases whilst in custody, with conditions in custodial settings increasing the chances of cross-infection to other prisoners, criminal justice staff and even the community at large. Custody also provides opportunities for intervention, acting as a gateway to services and help for those confined.

CONNECTIONS has engaged over 5,000 professionals and service users, co-ordinating activities through lead contacts in each EU member state, to identify and disseminate good practice and using evidence to influence policy development, both at national and EU levels. Improving public health and enhancing human rights are imperatives for the project.

As well as providing information via its website www.connectionsproject.eu and e-newsletters, CONNECTIONS organises training academies and offers the opportunities for staff exchanges and study visits between different countries. The conference is also a key part of the strategy to inform and influence all those concerned with work in this area.

Entitled 'Joining the Dots: criminal justice, treatment and harm reduction', and being held 25-27 March 2009, Krakow, Poland, key note address will be given by Lord David Ramsbotham, former HM Chief Inspector of Prisons and Chair of the UK Cross-Party Group on Drug and Alcohol Treatment and Harm Reduction. Other high profile speakers for other parts of Europe and beyond will present their views on the obstacles and opportunities for the provision of drug treatment and health services within the criminal justice system. Confirmed speakers include Dr Kate Dolan from the National Drug and Alcohol Research Centre, Australia, Professor Krzysztof Krajewski, President of the European Society of Criminology, Jagiellonian University, Poland and Professor Dwayne Simpson, Director of the Institute of Behavioural Research, Texas Christian University, USA. Professor Simpson will also be running a master class on quality and continuity in drug treatment in the criminal justice system.

DDN has been invited to attend and report on the conference which will comprise a variety of presentations, debates, round table discussions and

workshops with the emphasis on delegates' participation. All conclusions and recommendations generated from the event will be circulated widely to maximise their impact.

To get more information on the conference, or about the CONNECTIONS Project generally, please visit www.connectionsproject.eu/conference2009

Harbour Drug & Alcohol Service provides a range of interventions for people with problematic substance use in the City of Plymouth. Harbour combines the skills and experience of a diverse workforce and welcome applications from candidates who wish to contribute to this valuable service.

The following exciting opportunities have arisen within Community Access Services:

Substance Misuse Specialist

12 Month Fixed Term Contract

Part Time – 30 hours a week (Ref: SMS15)

Starting Salary: £22,187 per annum pro rata

The role of the Substance Misuse Specialist is to help reduce the harm caused by substance misuse to users themselves, affected others and to the wider community. This is achieved by providing services to clients that are tailored to suit their individual assessed needs. The successful candidate will have experience of working within a substance misuse environment, specifically around drug misuse, and working closely with other professional organisations to provide appropriate through and after care services. Applications are welcomed from individuals holding a minimum NVQ Level 3 with drug and alcohol modules or equivalent qualification or experience.

Safer Injecting Service Coordinator

Part Time – 20 hours a week Monday – Friday afternoons (Ref: HRED) *(Some evening availability required on request)*

Starting Salary: £22,187 per annum pro rata

The purpose of this role is to promote a harm reduction philosophy within the client group and provide support and education within the community. This role involves the coordination of the day to day activity of the Safer Injecting Service incorporating needle and syringe programmes. The successful candidate will have proven experience of working within a harm minimisation strategy. Applications are welcomed from individuals holding a minimum NVQ Level 3 with drug and alcohol modules or equivalent qualification or experience. Car user essential.

To download a role profile and an application form please visit our website

www.harbour.org.uk

If you require any additional information please telephone Harbour HR Services on (01752) 314254

Closing date for both posts: 5pm on Friday 6th February 2009

Benefits include:

- 25 days annual leave per annum (including incremental increases) plus recognised Bank Holidays
- Company Pension Scheme
- Life Assurance Scheme
- Free Occupational Health Services
- Implementation of policies to positively promote a work/life balance
- Commitment to Continued Professional Development

Harbour is an equal opportunity employer and invites applications from all sectors of the community. All post holders will be subject to an enhanced CRB check and satisfactory references.

TIER 4 SERVICES & DAY PROGRAMME FRAMEWORK

Lewisham Drug and Alcohol Strategy Team (DAST), on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust, is looking to appoint a range of providers under the following categories ('lots') for a 4-year period.

Lot 1: Structured Day Programmes (non abstinent & abstinent)
To undertake a range of interventions in relation to a structured day programme format for individuals with a primary drug problem or now abstinent. Day programmes should be within reasonable travelling distance from the borough of Lewisham by public transport.

Lot 2: Residential Rehabilitation Programmes (abstinent drug and/or alcohol)
To undertake a range of interventions and approaches e.g. 12-step; therapeutic communities, cognitive based, behavioural, social learning, eclectic/ integrated, faith-based, skills based, single gender establishments for abstinent clients requiring rehabilitation. Can be based locally (borough of Lewisham/London) or outside of London.

Lot 3: Residential rehabilitation day programmes or quasi residential rehabilitation day programmes (drug and/or alcohol)
Where treatment is provided at a different location to accommodation, to provide a range of interventions and approaches (as in Lot 2)for abstinent clients requiring rehabilitation. Can be based locally (borough of Lewisham/London) or outside of London.

Lot 4: Residential Programmes and/ or residential rehabilitation day programmes drug and/or alcohol
To provide a range of more specialist interventions in addition to rehabilitation e.g. for people on court orders such as DRRs and tags; mother and baby; family interventions; younger adults, people who may require medical support such as those with mental health problems, people with physical disabilities or health problems: people with learning difficulties; psychotherapeutic interventions for sexual/physical/ mental abuse survivors; detoxification. Can be locally based (borough of Lewisham/London) or outside of London.

Expressions of interest are sought from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to be included in a framework to deliver these services to meet the needs of a diverse population. Providers may apply for one or more lots.

The term of the framework will be from July 2009 for four years, during which time contracts will be 'called-off' from the framework.

To request a tender pack, either in writing or by e-mail, contact: Mike Hurst, Procurement Team, London Borough of Lewisham, 3rd Floor, Lewisham Town Hall, Catford, London SE6 4RU
Email: mike.hurst@lewisham.gov.uk Telephone: 020 8314 6556

Expressions of interest should be made by Monday 23rd February 2009, and completed tenders must be returned for receipt by no later than 12 noon, Monday 2nd March 2009.

For details of all **Phoenix Futures** vacancies see www.drinkanddrugsnews.com

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Register online www.SamRecruitment.org.uk

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

Assistant Manager/Support Worker

This is a residential post funded by SADAT.
37 hpw fixed term appointment 6/4/09 – 5/4/10.
£16-17k, depending on experience.
In partnership with Community Alcohol and Drugs Services Shetland

We are looking for a self-motivated and enthusiastic person, with experience of 12 Step programme. The Papa Stour Project is a 3 bed Christian supported housing service based on a small island in the Shetland Isles. We provide support and aftercare for men aged 18-45 seeking to break free from drug and alcohol dependency.

Closing deadline for enquiries 8/2/09. For further particulars or to obtain application pack telephone 01595 873238, email sabina@papastour.org or online at papastour.org

Phoenix House, White Lodge Business Estate, Hall Road, Norwich NR4 6DG

Tel: 01603 677577
Fax: 01603 677566

TENDER

Norfolk Drug & Alcohol Action Team

The Young People's Joint Commissioning Group of the Norfolk Drug and Alcohol Partnership wish to invite tenders for an integrated service offering universal, targeted and specialist substance misuse interventions to young people in Norfolk. These will include consultancy and support for universal services; substance misuse education (formal and informal) and prevention in universal and targeted settings; advice and information; outreach; psychosocial interventions; community prescribing: specialist harm reduction; family intervention services; and access to residential substance misuse treatment. The service will be comprised of geographically focussed teams.

The Young People's Joint Commissioning Group intend to commission this service for 3 years with a possible extension of 2 years, subject to government funding.

Tenders will be evaluated using 'most economically advantageous tender criteria'. Proposed costs should not exceed £745,000 per annum.

Requests for a formal tender pack should be sent to Carol Bowen, Contracts Officer, at the above address or by email to ***carol.bowen.dat@norfolk.gov.uk*** *and should be received no later than* **14.00 on Monday 9th February**. *Email addresses should be provided as tender packs will be sent electronically unless otherwise requested.*

Formal tenders are to be submitted no later than 14:00 on 19th March 2009.

Short listed applicants will be invited to present their tenders on 30th March 2009.

www.nordat.org.uk

Tameside MBC

TENDER FOR THE PROVISION OF A YOUNG PEOPLES SPECIALIST SUBSTANCE MISUSE SERVICE

Tameside MBC working with NHS Tameside and Glossop invite suitably experienced and qualified organisations to tender for the provision of a high quality Young Persons Specialist Substance Misuse Service across the Borough. Due to the NHS geographical boundaries, services will also be provided in the Glossop area.

The successful organisation will be able to demonstrate expertise in the delivery of a Young Person's Specialist Substance Misuse Service as well as an understanding of the priorities for Tameside's Children and Young Peoples Partnership and Crime and Disorder Partnership. They should be able to demonstrate how these priorities will be applied within the service, therefore contributing to improving outcomes for young people and their families through effective substance misuse treatment.

The successful tender will be able to show experience of working in partnership with other key stakeholders and with service users.

The provider will be able to evidence the existence and implementation of sound governance and performance management arrangements.

It is proposed that the Contract will commence on 1st April 2009 and will run for a period of 2 years (to 31 March 2011) with a possible 1 year extension.

The award of the contract will be in keeping with a Best Value approach, which will jointly evaluate quality factors and price.

Organisations should be aware that Transfer of Undertaking (Protection of Employment) Regulations 2006 may apply.

The closing date for tender submissions is 12pm noon, Friday 20th February 2009.

Organisations interested in applying should request a tender pack, in writing either electronically or by post, from:

Jane Forrest, Joint Commissioning Manager, Strategy and Commissioning, Services for Children and Young People, Room 2.101, Council Offices, Wellington Road, Ashton-under-Lyne OL6 6DL

E-mail: jane.forrest@tameside.gov.uk

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PRIORY

The Priory Hospital Woking is a 26-bedded independent Psychiatric Hospital. Situated in Knaphill, Woking. We currently have vacancies for the following positions:

Full-time Addictions Therapist

Woking, £18,791 - £30,066
Grade 6, 37.5 hours per week

Part-time Addictions Therapist

Woking, £18,791 - £30,066 pro rata
Grade 6, 22.5 hours per week

We are currently looking for a full-time Addictions Therapist and a part-time Addictions Therapist to join a team of highly skilled Addiction Therapists providing a 6 day treatment programme to in, day and out patients. Abstinence based 12 step programme is the core of the service.

Candidates will be qualified as an Addiction Therapist or equivalent and have a minimum of 2 years experience in facilitation of group and individual therapy within the addiction field. FDAP membership and accreditation or evidence of working towards this is required. Experience with eating disorders and family work is desirable but not essential.

Flexibility is required within these hours. Primary days would include Saturday working, subject to change responsive to service needs.

If you meet the above criteria, then call Joan Bendy for an application form and job description on 01483 489211 or email joanbendy@priorygroup.com

For informal visits/information contact Peter Davies, Team Leader on 01483 489211 or email peterdavies@priorygroup.com

Closing date: Friday 13th February 2009

The successful candidates will be required to apply for a Disclosure at the Enhanced level from the Criminal Records Bureau. Further information can be obtained from www.crb.gov.uk

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Tender for the Provision of the Supply of Needle Exchange Packs and Associated Services

SaferPeterborough Partnership invites expressions of interest from suitably experienced firms wishing to tender for the supply of needle exchange packs and provision of associated services to local pharmacy needle exchanges.

It is anticipated that any contract will be awarded from 01 April 2009 and is likely to be for a period of 2 years, subject to ongoing satisfactory performance.

The contract will cover the provision of:

- *Needle exchange packs and associated paraphernalia to pharmacy needle exchange services*
- *Delivery of the above supplies to the pharmacies*
- *Provision of appropriate clinical waste services to remove and dispose of returned needle exchange paraphernalia and bins*
- *Management of needle exchange payments to pharmacies*

For full details of the Partnership's requirements and the minimum standards expected of contractors, please refer to the Invitation to Tender (ITT) documents.

The information and documents for this tender will be accessible from Monday 2 February 2009 at the following website http://www.delta-ets.com. To be able to access these documents you will firstly need to register your company details and thereafter you will be issued with a USERNAME and PASSWORD. You must then log into Delta-ets and then click on the VAULT tab. You can then view the ITT title, click on this link and you will be taken to the ITT documents. Please check that you are able to access these online ITT documents.

If you are experiencing problems then please contact the Delta helpdesk at Helpdesk@delta-ets.com or call 0845 2707050 for further assistance.
Your tender bid must be completed and submitted electronically by using VAULT through BiPs Delta-ets by the due date of Monday 2 March 2009 by 12.00hrs.

Drug and Alcohol Manager and Commissioner

Spot salary range **£40,650 - £44,430** pa
Full-time, 37 hours per week **Ref: SSC520**

This is a key post, commissioning drug and alcohol services for the Royal Borough in conjunction with partner agencies. Working directly to the Head of Adult Services, you will be expected to commission a range of effective services and to meet performance targets as set not only by the Royal Borough but also by the National Treatment Agency. There are national targets set by the National Treatment Agency which the borough is required to meet including the number of problem drug mis-users in treatment and also the number of people retained in treatment.

In this role, you will manage a small group of staff who cover both drug and alcohol misuse services. Your main responsibilities will involve commissioning treatment services from a range of providers in both the statutory and the voluntary/independent sector. In addition, you will be part of the crime and disorder reduction partnership and will need to meet targets established by the local area agreement, given the significant link between criminal activity and some people who misuse drugs and/or alcohol. Other areas of work will include health promotion, given the importance there is in developing preventative strategies for this group of people and assisting in educational activity through a range of projects including peer related education.

For more information, please contact **Allan Brown,** Head of Adult Services on **01628 683701** or email **Allan.Brown@rbwm.gov.uk**.

Dual Diagnosis Professional Lead

£31,385 - £34,805 pa
Full-time, 37 hours per week • Fixed-term for 2 years **Ref: SSS109**

We need you to take the lead in developing a dual diagnosis service across the Borough, ensuring that adults who have substance misuse issues and mental health problems get the support they need to build more positive futures. It's all about maximising the potential of partnership working and creating care pathways that deliver high-quality case management and structured interventions.

You'll also take on a caseload of service users yourself, so you won't lose touch of the operational aspects of dual diagnosis practice.

You'll bring solid experience in a mental health/substance misuse setting, together with a good understanding of dual diagnosis.

Strong leadership and communication skills are also important, plus a commitment to multi-disciplinary team working and a real enthusiasm for taking dual diagnosis to another level.

For an informal discussion, please contact **Bridget Fairbairn** on **01628 626948**.

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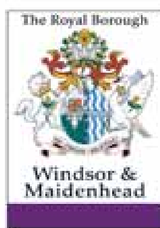
All posts are subject to an Enhanced CRB.

Closing date for both posts: 6 February 2009

We value diversity and welcome applications from all sections of the community.



To view all our current vacancies go to: www.rbwm.gov.uk