

# DDDN

## Drink and Drugs News

2 November 2009  
[www.drinkanddrugsnews.com](http://www.drinkanddrugsnews.com)

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### TALKING THERAPIES

Improving communication skills  
for both clients and professionals

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### REACHING FOR HELP

Overcoming cultural issues and  
building trust in the community

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**‘The care package, when it finally came, was six years too late... His distorted perception and inappropriate coping strategies were now deeply ingrained, he had lost trust.’**



# CAST ADRIFT

**WHAT HAPPENS WHEN SOMEONE'S PROBLEMS DON'T FIT THE SYSTEM?**

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# Bridge House

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Website maintained by  
wiredupwales.com

Printed on environmentally  
friendly paper by the Manson  
Group Ltd

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**Cover montage:** JellyPics



Editorial - Claire Brown

## Closing the gaps

Services must link to provide a stronger net

'We asked for help and ended up blamed.' Sue Foreman's story gives harrowing insight into the desperate isolation experienced by a family struggling to help their son with multiple problems (page 6). Knocking on the doors of drug and alcohol services, doctors, mental health, social services, the local authority, and learning disability services brought the family nothing but false hope for a short while, until they were packed off to chase the next possible lead. Meanwhile their son was becoming unreachable. The help did not come and time literally ran out for him. Why is it in such a situation that the more services that could help, the bigger the gaps between them? Why did the frequent brushes with the law and the episodes in A&E not flag up that this was a young man with severe problems for whom prison remands were the least appropriate solution? Not only was he being set up to fail, as his mother points out, but the whole family was let down repeatedly in so many contexts. Sue hopes her story will raise awareness of the plight of young people who slip between services and we thank her for going back over such painful memories to do exactly that.

Addaction's Breaking the cycle project (page page 14) aims to sidestep the mountain of bureaucracy that stood in front of Sue at every turn and keeps track of each family's progress, showing project workers what's working and what's not – a route to holistic family interventions that would have given her family a much better chance of getting help. From his perspective as a social worker, Tony Wright offers thoughts on improving communication skills and avoiding the risk of subjective assessments (page 13). And on page 10, Vic Motune looks at how Oldham's Reaching Out project is making sure cultural issues do not cloud the issue for families seeking help. In our fifth anniversary issue, we hope sharing experiences and the ideas for better practice will help to steer services away from the tragedies that should never happen.

DDN is an independent publication,  
entirely funded by advertising.

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## News in Brief

### Tried to make a claim about rehab

The NTA has refuted a claim by Amy Winehouse's father, Mitch Winehouse, that there is a one-year waiting list to access NHS drug treatment. Average waiting times for treatment are now one week, said the NTA. 'Drug treatment in England has never been more available to members of the public who need it,' said chief executive Paul Hayes. Mr Winehouse made the claim while giving evidence to the Home Affairs Select Committee's enquiry into the cocaine trade. The committee also heard from ACMD chair Prof David Nutt, who warned that ketamine may need to be re-classified from its class C status because of fears that it can cause irreversible bladder damage.

### Eastern promise

The Priory Group has opened its first clinic in Norfolk. It will 'give the people of Norwich and the surrounding area more choice when seeking treatment for mental health or addiction issues,' said hospital director Paul Pritchard.

### Abstinent century

LEAP (Lothians & Edinburgh Abstinence Programme) has celebrated the graduation of its 100th client. Launched in 2007, the community-based rehabilitation programme was the first of its kind in Scotland (DDN, 14 January 2008, page 6). 'We congratulate every one of our 100 graduates for their achievements and share their celebrations,' said clinical lead of LEAP, NHS Lothian, David McCartney.

### Young funds

Funding for drug and alcohol treatment for under-18s in England will be reallocated from next year to more accurately reflect levels of need, the NTA has announced. The move is designed to make sure that areas providing treatment for more people receive a larger share of funds. 'All young people in England should have ready access to specialist drug and alcohol treatment services where needed, and while service improvements will be expected from those areas receiving a greater share of funds, we would not expect to see disinvestment in services by those areas receiving a reduced share of funds in future,' said NTA director of delivery Rosanna O'Connor.

# Drug treatment will not be a condition of benefits

**The Welfare Reform Bill is to be amended to make it clear that benefit claimants cannot be required to submit to drug treatment, and there will also be limits placed on when people can be required to undergo drug tests. The announcement was made in response to amendments moved by Baroness Meacher.**

The Department of Work and Pensions' (DWP) plans to withhold benefits from drug users who fail to seek treatment were dismissed by the drugs sector last year as unworkable and discriminatory (DDN, 3 November 2008, page 4). Claimants will still be required to comply with a rehabilitation plan, but participation in treatment will only be included with the claimant's consent. However, refusal to 'engage' with 'educational sessions, or self-esteem, counselling or confidence building' could still result in a benefit sanction.

DrugScope welcomed the announcement that claimants would no longer be required to undergo treatment, and said it would be meeting with DWP

officials to 'seek clarification of the intended scope and content of rehabilitation plans', the activities claimants could be required to engage with and the circumstances under which they would not be sanctioned for failure to carry out parts of the plan.

'We are disappointed that a power to require claimants to undergo drug testing remains in the bill,' said chief executive Martin Barnes. 'While further limits on the use of drug testing have been announced, requiring a claimant to undergo testing if already in drug treatment or self identified as a problem drug user would arguably not have been a proportionate or reasonable use of the power. We hope the government will give further consideration to whether the drug testing provision is consistent with the aim of providing encouragement and support to problem drug users to take steps to overcome barriers to work.'

The bill receives its third reading in the House of Lords later this week.

## Illegality is distorting drug harm debate

**Alcohol constitutes one of the biggest 'drugs harm' challenges, according to a new briefing paper from the Centre for Crime and Justice studies. A 'drug harm ranking' that included both legal and illegal drugs would see alcohol in fifth place, after heroin, cocaine, barbiturates and methadone, says *Estimating drug harms: a risky business*.**

Tobacco would be ranked ninth, according to Prof David Nutt of Imperial College London, who was also chair of the Advisory Council on the Misuse of Drugs (ACMD) when the report was launched.\* Cannabis, LSD and ecstasy would be ranked at 11, 14 and 18 respectively. The report wants to see an end to the 'artificial separation of alcohol and tobacco as non-drugs' along with measures to improve public understanding of relative harms.

The paper calls for an evidence-based approach and says that focusing on the harms of illegal drugs creates an 'isolated and arbitrary' debate. The 'precautionary principle' used to justify the reclassification of cannabis to class B led to a situation where 'people really don't know what the evidence is,' said Prof Nutt, while basing drug classification on a desire to 'give messages other than those relating to relative harms' undermined any educational intention.

The report questions whether society's attitude to drugs is based on harm or is part of a moral debate. 'One thing this government has done extremely well in the last ten years is to cut away much of the moral argument about drug treatments,' it says. 'For reasons that are not clear, the same evidence-based change has not happened in relation to the classification of drugs of misuse.'

'We need a full and open discussion of the evidence and a mature debate about what the drug laws are for – and whether they are doing their job,' said Prof Nutt.

\*As DDN went to press, it was announced that Prof Nutt had been sacked by the home secretary from his ACMD post.

Report available at [www.crimeandjustice.org.uk](http://www.crimeandjustice.org.uk)

## Two fifths of IDUs infected with hep C

**Around two fifths of injecting drug users are infected with hepatitis C and one in 73 with HIV, according to a new report from the Health Protection Agency (HPA).**

Rates of HIV transmission among IDUs have increased, with around one in 77 becoming infected within three years of starting to inject, compared with one in 400 in 2002, according to *Shooting up – infections among injecting drug users in the United Kingdom*.

Levels of hepatitis C transmission are higher than a decade ago, it says, with a fifth of IDUs becoming infected within three years. Infection rates vary regionally, however, with around two thirds infected in London and Glasgow compared to a quarter in the north east and Wales.

Injecting into the groin and injection of crack cocaine, both associated with higher levels of infection, have become more common, while sharing of needles and syringes has declined, the report states. There has also been a 'marked increase' in the number of IDUs receiving the hepatitis B vaccine, with more than two thirds now reporting being vaccinated. However injecting site infections remain common, with around a third of IDUs reporting 'an abscess, sore or open wound' at an injecting site in the last year. One third of IDUs with HIV remain unaware of the infection, it says.

The report calls for the continuing development of 'high quality needle exchange services for those unable to stop injecting'. Practitioners also need to provide information and practical advice on safer injecting practices, as well as health checks and treatment for injection site infections.

Report available at [www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb\\_C/1195733837406?p=1191942172215](http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1195733837406?p=1191942172215)

# Alcohol death toll to top 90,000 over next decade says university research

**More than 90,000 people will die over the next ten years as a direct result of their alcohol consumption, according to figures from the Alcohol and Health Research Unit at the University of the West of England.**

The research, which maps the population's drinking levels against mortality, states that 90,800 people will die of alcohol-related causes by 2019 if drinking rates remain unchanged. The figures relate to avoidable deaths directly caused by alcohol and alcohol poisoning, and do not include deaths caused indirectly by alcohol, such as drink-related cancers or drink driving. The figures reveal that deaths tripled – from 3,054 to 8,999 – between 1984 and 2008.

'The UK has been experiencing an epidemic of alcohol-related health and social problems that is remarkable by international standards,' said lead author of the research, Prof Martin Plant. 'It is strongly recommended that reducing mortality should be the top priority for alcohol control policy.'

Alcohol Concern chief executive Don Shenker said that while there had been a small reduction in consumption and mortality over the last two years, overall consumption trends were still rising which ran 'in parallel with the growing affordability of alcohol.' 'This is an unacceptably high death toll and the worst part is that all of these deaths are avoidable,' he said.

The report states that price is the 'most effective, efficient and evidence-based lever' to achieve a reduction in heavy drinking, and backs the call for the introduction of a minimum price per unit of alcohol. A minimum price of 50p would cut 'alcohol-related hospital admissions, crimes and absence days from work,' said Prof Plant.

A minimum price was recommended by chief medical officer Sir Liam Donaldson but does not form part of the government's proposed mandatory code on alcohol (*DDN*, 23 March, page 5). The Scottish government has been pushing ahead with plans to introduce a minimum price (*DDN*, 5 October, page 4); however the recent appointment of Jackie Baillie, who opposes the move, as shadow health secretary has led to press speculation that the proposal will not be approved by the Scottish Parliament.

Meanwhile a YouGov poll commissioned by Alcohol Concern reveals that 88 per cent of people think that rates of drinking at home will increase as a result of the recession, and 42 per cent do not keep track of their consumption while drinking at home. 'Sticking to the sensible drinking guidelines when drinking at home can be difficult without the help of proper measures and standard servings,' said Mr Shenker. 'Improved labelling on bottles and cans is long overdue and would give consumers much more choice and control.'

Concerns over rising rates of liver disease have also led the Department of Health to appoint a national clinical director to lead the development of a national strategy for the disease. Without firm action it could overtake coronary heart disease and stroke as a cause of death within ten to 20 years, said the department. 'Liver disease is the only one of the top five causes of death which is continuing to affect more people every year at an increasingly young age,' said health minister Ann Keen. 'We know that by identifying people earlier, encouraging people to change their behaviour and making sure the right services are in place, we can improve the quality of care and stop the rise in this disease.'

## Afghan heroin killing 'more than the war'

**The number of people dying from drug-related deaths in NATO countries each year is, at 10,000, more than five times the number of NATO troops killed in Afghanistan in the last eight years, claims a new report from the United Nations Office on Drugs and Crime (UNODC).**

Afghanistan has a global monopoly on opium poppy cultivation, at 92 per cent, with 900 tons of opium and 375 tons of heroin trafficked from the country each year, says *Addiction, crime and insurgency – the transnational threat of Afghan opium*. The market is now worth \$65bn and is 'spreading HIV at an unprecedented rate' and fuelling insurgency, it says. The Taliban now make up to \$160m a year by taxing the opium trade, far more than it made when it was in power in the 1990s.

Around 40 per cent of Afghan heroin is trafficked into Pakistan each year, says the document, while 30 per cent enters Iran and 25 per cent goes to central Asia. However, 'corruption, lawlessness and uncontrolled borders' mean that only 2 per cent of the drug is intercepted, compared to 36 per cent of the cocaine leaving Columbia, leading to huge profits for criminal gangs. There is also an unaccounted-for 12,000 ton stockpile of Afghan opium, enough to satisfy world demand for two years.

'Newly-born narco cartels in and around Afghanistan are blurring the difference between greed and ideology,' said UNODC executive director Antonio Maria Costa. 'The perfect storm of drugs and terrorism that has struck the Afghan/Pakistan border for years may be heading towards Central Asia. A big part of the region could be engulfed in large-scale terrorism, endangering its massive energy resources.'

'The numbers are scary,' he continued. 'Even more frightening is the fact that governments have not recognised that they can only tackle this threat by addressing all links in the chain – assistance to farmers to reduce supply, drug prevention and treatment to curb demand and law enforcement against intermediaries.'

Responding to the report, Release stated that 'many of the statements contained in the report are highly speculative, though there is an obvious opportunity for both organised crime and terrorist or insurgent groups with the vast cash flows at stake in the unregulated illicit market. Mr Costa seems to believe that law enforcement measures, if vigorously applied, can resolve this set of problems; a hundred years of history, however, suggests otherwise.'

Available at [www.unodc.org](http://www.unodc.org)

## News in Brief

### Tailored service

West Glamorgan Council on Alcohol and Drug Abuse (WGCADA) has celebrated its 30th anniversary. From its beginnings above a tailor's shop in Swansea, the organisation now has seven centres and treats 4,000 people a year. 'We offer treatment, rehabilitation and support not just for people with addictions but for their families too,' said chief executive Norman Preddy.

### Binge bags

'Binge packs' containing alcohol advice and information along with condoms have been launched by Turning Point as part of its A&E brief intervention work. The scheme was piloted in Hertfordshire during Alcohol Awareness Week last month. 'If we can get to people when they are at hospital they can be very receptive,' said manager of Turning Point's Hertsreach Dacorum service, Glenda Lee. 'We think that this scheme holds great promise and is something that could easily be rolled out across the country.'

### Mr Pharmacist

Action on Addiction has joined forces with pharmacist welfare charity Pharmacist Support to expand health support for its members who experience problems with drugs or alcohol. 'This specialist service is critical to our clients who have issues with dependency,' said Pharmacist Support charity manager Diane Lester. 'It is only sensible to provide support to those who play such an important part in the nation's healthcare,' said Action on Addiction chief executive Nick Barton. 'Professionals are not immune to the problems that affect society as a whole.'

### Price plea

Directors of public health from the north west of England have written to *The Times* to add their voices to the call for a 50p minimum price per unit of alcohol. 'None of us comes to this policy solution easily,' says the letter, which urges the government to act 'quickly and decisively'. 'The politicians that take a lead in combating alcohol harm may find that they command the public's respect and support as a result' it says.

What happens when someone's problems don't conveniently fit the categories of a rigid, unyielding system? **Sue Foreman** tells the harrowing story of her attempts to get help for her son

**O**ur son was a shy, sensitive, introverted boy who struggled socially throughout his school life. His unusual body language and 'matter of fact' way of communicating, coupled with a flat monotone to his voice, meant that he was a target for the school bullies.

Academically, however, he excelled, winning shields and commendations, particularly in maths and science. But his shy, quiet demeanour gave way to sudden, unpredictable explosive outbursts that eventually caused him to be expelled. We asked for home tutoring or funding for a placement in a specialised school more suited to his needs, but instead he was placed in a pupil referral unit which he attended just two days a week. He was unable to settle or engage with other pupils and left after two terms with no qualifications and an abject sense of failure.

Bored and lonely at home, and with no job prospects, his outbursts escalated and his mental and physical health deteriorated. We sought help from mental health services but they failed to assess our son properly – after just two short appointments they discharged him from their services saying there was no evidence of mental illness and, worse, implied that we were a dysfunctional family who were probably the cause of our son's distressing behaviour.

Desperate to make friends, he lurched from crisis to crisis and would frequently come home in a distressed state because someone had made fun of him or taken his money. As his outbursts increased, I would frequently come home from work to find he had run amok in the house, smashing mirrors and ornaments. His response, once he had calmed down, would always be 'I got a bit upset. It all keeps going wrong for me'.

Eventually I had to give up work because our daughter was becoming unwell with the stress of it all. I went back to the mental health services to push for an assessment and to be recognised as a carer, but we were excluded from meetings even though it was abundantly clear to us that our son's lack of insight meant he was unable to give a true picture of his needs. Again we were informed that, as there was no apparent mental illness, they were not able to help. We requested a social worker to support him and a possible work placement but we were told that he was not eligible.

Our son's explosive outbursts started to take place outside of the family home, eventually bringing him to the attention of the police and judicial system. The courts ordered an assessment that led to an Asperger's syndrome diagnosis but, unbelievably, this did not win him the funding we so desperately needed. We were

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told that Asperger's did not come under the umbrella of mental health and that he was too 'high functioning' for the learning disability services. Meanwhile the local autistic society told us he was certainly eligible for help from them but that the funding had to come from the local authority – we were just going around in circles.

Tired, exhausted and unable to cope with our son living at home with us anymore, we set about trying to find him some suitable accommodation. With no support or funding in place we were unable to find him specialised or supported housing, so any housing we found would last about three or four weeks. He would get upset about something or someone, lose his temper, and get thrown out. Without our daily support he failed to eat properly and would constantly turn up at our door in a distressed state.

At times he was homeless and we took the painful decision to leave him in this predicament in the mistaken belief that he might then come to the attention of the 'caring' professional services. This was not to be. Left to flay around, he began to drink and was eventually befriended by people in the drug culture. He frequently came to the attention of the courts, who ordered another assessment. The judicial system paid over a thousand pounds for an in-depth assessment that confirmed his Asperger's diagnosis but once again we came unstuck with funding, in spite of supportive letters from our GP and the probation services.

Our son began to drink excessively to relieve the boredom and loneliness of long, empty days. He returned to live with us but when it all became too much we had to ask him to leave and he would go to the night shelter in a nearby town. Once again we pleaded for help and support for him to no avail. We steered him towards the alcohol and drug advisory services, who said they were unable to help unless the mental health services worked alongside them.

He was frequently taken to A&E to be resuscitated because he failed to understand the cut-off point when using drugs. Instead, he would get upset, take huge amounts in one go and then go for weeks on end without using any at all. The substance misuse services told us that he was not an addict in the true sense as there was no pattern to his using, and we were advised that as a vulnerable young adult he desperately needed help to address his lack of self awareness and his emotional distress. They called a meeting with the mental health team but they were still adamant that our son's difficulties did not fit their remit. To make matters worse they implied the diagnosis was wrong and that he probably had an untreatable personality disorder.

After seven years of fighting for funding we finally accepted we were on our own and our son returned to living with us full time. Then, one evening at the end of March 2007, he came home in a distressed state. Unable to manage his feelings, the following morning he travelled to a nearby town and bought some drugs from one of his homeless friends. He also drank a bottle of alcohol. The combination proved to be fatal. Slipping into unconsciousness, he suffered a cardiac arrest. For six days he remained unconscious on a life-support machine. He was severely brain damaged and we took the painful decision to have the machine switched off. He died at just 23 years of age, his entire life coloured and driven by the need for acceptance.

The questions I have for services are too numerous to list. Why was the mental

health team so dismissive from the outset? After just two short appointments my son was deemed not to have a mental illness and denied crucial early intervention, which meant no preventive measures were put in place. As he was clearly a troubled young man, why was a 'wait and see' policy adopted, rather than keeping him engaged in treatment with helpful and encouraging dialogue – a person-centred approach and open-door policy to allow him to dip in and out of the service as his needs dictated? Does someone need a clear diagnosis before they can be treated? Surely you need to work with what you have. Early sessions should always be 'led' by the client.

It was recorded that we are a dysfunctional family – based on what? Since no one was interested in coming out to assess our needs, and consequently I was not recognised as a carer, how was this conclusion arrived at? We were a caring, loving family desperately asking for help to enable us to support our son through his difficulties and protect our daughter's wellbeing. We asked for help and ended up blamed.

Why did it take a barrage of letters to reinstate my son in services? And why was he not maintained in the system? Someone would wade in, put my son on some course or other and then discharge him from their caseload, rather than giving him ongoing long-term practical and emotional support. Concerns voiced by his family were ignored.

The care package, when it finally came, was six years too late. My son was relying on drugs and alcohol to help him through and manage his feelings. His distorted perception and inappropriate coping strategies were now deeply ingrained, he had lost trust and doubted anyone's ability to carry out what they promised.

My son should not have had to face the ordeal of prison remands while awaiting assessments. The judicial system deals with the offence, not the distress that caused it. The fact that my son would frequently say 'it keeps going wrong' shows what little understanding he had of his own contribution to the problem. He should have been given the opportunity to address this in a safe and caring environment, instead of being set up to fail over and over again.

I am astounded that, given the amount of times my son ended up in A&E, no concerns were expressed, even though each time a discharge letter was sent to the GP and mental health services. It was perfectly clear that my son would probably die without urgent intervention.

My son wanted his voice to be heard and to be shown some respect. Accepting him as he was would have brought about a change in his mindset. Substance misuse and alcohol, not intervention from the mental health sector, helped to make his life more bearable. My son was very much aware of his powerlessness and loss of control, but what choices did he have?

In his short life he had 25 convictions for affray and yet was not considered a criminal. He had five admissions to A&E for drug and alcohol overdoses and yet was not considered an addict. He was too bright and intelligent to be diagnosed with a learning disability and not 'mad' enough to be diagnosed as mentally ill. In short, he fitted nowhere in the system. Instead our intelligent, deeply troubled son was condemned to a life on benefits, frequent homelessness and certain death.

**'My son wanted his voice to be heard and to be shown some respect. Accepting him as he was would have brought about a change in his mindset. Substance misuse and alcohol, *not* intervention from the mental health sector, helped to make his life more bearable.'**



People management

# Transfer talk

## DDN hears how a new guide aims to help managers navigate the intricacies of transferring services

**WITH CONTRACTS FOR DRUG AND ALCOHOL SERVICES** usually awarded on a three-year basis, at any one time it's likely that employers will be bidding for new services – or to maintain existing ones – or involved in the transfer of staff to a new employer. Now a guide has been produced by members of the national HR group for substance misuse services and published by the Chartered Institute of Personnel and Development (CIPD) to help steer managers through any upheaval.

*Preparing and transferring services in the public and non-profit sectors* covers commissioning, incoming and outgoing service providers, pensions and harmonisation of terms and conditions. There's also an extensive section of tools and appendices, including case studies and sample letters.

'We identified a need to try and work through the muddle and confusion that transfer can bring and get some practical guidance out there,' says the report's co-author, workforce development manager at Sussex DAAT, Elizabeth Flegg. 'Certain things are stipulated by the law, certain things are unpredictable, but certain things you can predict and there are tools that can be in place to help that.'

'It is often expected that there is a core expertise regarding the people management aspects of preparing and transferring services, but this is often not the case due to the complex legal and practical requirements,' she says. 'These guidelines can be applied directly for anyone involved in writing tenders for services, assessing bids received for services, and guiding incoming and outgoing service providers on the transfer of staff.'

**'These guidelines can be applied directly for anyone involved in writing tenders for services, assessing bids received for services, and guiding incoming and outgoing service providers on the transfer of staff.'**

Why produce a guide like this now? 'Well it's taken a year to evolve, so we identified the need over a year ago,' she says. 'There were multi-agencies involved in producing it, so we had to meet as and when to pull it together. What's made it happen is that the national HR group meet quarterly and there were lots of moans and groans about transfers and that kind of thing, so someone said why don't we do some practical guidance to help others.'

She co-authored the report with representatives from Addaction, Kent DAAT and Blenheim Community Drug Project among others. 'It's been fantastic how all the different agencies have worked together and produced something that we're really proud of,' she says. 'I think it's brilliant that we've got statutory workers and independent workers and we've come up with this product. At the last HR meeting at the end of September we presented the guide to group members, and they thought it was great.'

Are a lot of people in the sector are in the dark on these areas? 'Yes, that can be the case,' she says. 'It's such an unpredictable area to manage – sometimes someone who's new in their post might not appreciate all the legal complexities of TUPE (The Transfer of Undertakings [Protection of Employment] Regulations) and transfers, and there's a section in there to try and outline what's involved. There are also the appendices and people tools that organisations bidding for services can use as part of making the transfer happen.'

The guide, however, is not exclusive to the drugs field – other public sector and voluntary employers can use it. 'Version one was very exclusive to drug and alcohol services but with CIPD publishing the guide we've had to streamline it and make sure it was relevant to more people,' she says.

'We hope to offer people managers involved in business transfers and service provision changes much-needed guidance,' said senior public policy adviser at CIPD, Ben Willmott. 'In too many instances managers have to rely on trial and error which creates real risks that service delivery will be compromised. This guide sets out some step by step advice on how to manage this process effectively.'

Addaction's director of HR, Guy Pink, said 'there is very little practical advice out there to help new managers in particular. If people follow this step-by-step guide, it will take a great deal of the grief and anxiety out of the process.'

The aim now is that the sector adopts the guidelines in terms of best practice and minimum standards. 'We all developed our own skills during the process, by sharing experiences and discussing good practice,' says Elizabeth Flegg. 'I'm really proud of the guide and I'd like managers across the service delivery sector to benefit from it.'

Available at [www.cipd.co.uk/subjects/emplaw/tupe/\\_transferring\\_services\\_tupe.htm?lSrchRes=1](http://www.cipd.co.uk/subjects/emplaw/tupe/_transferring_services_tupe.htm?lSrchRes=1)





## 'Clients are trapped in a climate of negativity, with mental health counselling services that only treat those who are drug free, and drug services that either do not have staff qualified to offer appropriate treatment, or that stop staff from carrying out this vital service.'

### Climate of negativity

I was so pleased to read your article relating to the huge difficulty that substance users have finding appropriate help for their underlying issues (*DDN*, 19 October, page 6).

I have worked in drug and alcohol services for the past seven years and until relatively recently, practised as a psychotherapist and counsellor with addicts. The process of helping people through their pain while slowly reducing their habit is both challenging and rewarding, but completely doable.

Once the clients are stable, I see using drugs to help traumatised individuals cope with memories as an integral part of treatment. This has resulted in many clients successfully working through their therapy, enabling them to move on with their lives.

Unfortunately the commissioners for my project in Leeds no longer regard this work as part of an overall drug strategy, so I no longer have an appropriate forum in which to work and can only offer this work privately.

Clients are trapped in a climate of negativity, with mental health counselling services that only treat

those who are drug free, and drug services that either do not have staff qualified to offer appropriate treatment, or that stop staff from carrying out this vital service.

I hope that your article will help to change the minds of those who hold the purse strings and bring more therapy into drug treatment services.

**Name and address supplied**

### United we stand

I came to writing this letter in a strange sort of way. For the last few months, I have been talking to myself as if I was narrating a story, and in many ways that is what this is. Service user involvement to me is totally crucial in any treatment – the option that we can go it alone is a non-starter. United we stand, divided we fall, and fall we surely do. For some of us, falling is not an option.

I am writing this as I am so concerned that there is no service user group in place in my area. After spending several years going through the difficult process of setting up a viable SU group, we had a group that was thriving – so much so that there

was a real excitement every time I went to one of the meetings to discuss strategy, getting alongside other groups and networking our ideas, and going from strength to strength. A vibrant group of service users who really had a vision for our group

Then in the month of April our meeting was cancelled for some reason. Well no problem, I thought – people may be busy. As the weeks passed I started to realise that our SU group was going down the tubes, meetings were cancelled, buildings could not be found. It slowly dawned on me that this group was fragmenting. I wrote emails, telephoned various people, all with similar replies – we are waiting. For what, I wondered, and I am still wondering what is going on. Why has our SU group gone to ground? I believe I know the reason.

Firstly, leadership was patchy because we never held the budget for the group and we had no say over when and where the meetings were to be held (something I was never happy with and considered unacceptable). Secondly all ideas by members of the group had to be reviewed by one person. Subsequently decisions were made by a body who had been given the job of coordinating the group for approximately one year – extended to another year – with their own agenda. I feel the Cumbrian DAAT has let a wonderful chance of having an established SU group fall apart. After six months there has been nothing – no meetings and no contact apart from a couple of emails.

I have to say to the DAAT that this group will rise again. We will be a force to be reckoned with – we demand to be involved in all DAAT

business, as the Orange guidelines make so clear. The message that drugs kill needs to be delivered in a powerful way. I have over 40 years of experience to share – surely you are not going to pass up on an offer like that. There are many others just like me who want to get alongside all kinds of people to help, so for God's sake use us.

**Bri Edwards**

### Conflict resolution

Harm reduction versus abstinence – O'Hare, Best, McCartney and Kingdon (*DDN*, 5 October, page 8 and 19 October, page 10). Surely it's not either/or but both.

In any case, abstinence is also about reducing harm. Science v faith – why the conflict? Dr Jacqueline Chang, one-time non-alcoholic trustee on Alcoholics Anonymous' general service board, wrote the introduction to AA's 60th anniversary book *Share and share alike*, published in 2007. In it she said, 'There are a number of scientific, evidence-based reasons why AA works. Behaviours such as association with others, laughter, altruistic helping, sharing with others, forgiving, prioritising, deferring gratification, making amends, acknowledging errors promptly, and many others have been scientifically proven in situations remote from AA to make people feel better. These new behaviours can be for a majority of recovering people far more effective and longer lasting than anti-depressants and other prescribed medicine.'

**Laurie Andrews, Essex**

**We welcome your letters... Please email them to the editor, [claire@cjwellings.com](mailto:claire@cjwellings.com) or post them to the address on page 3.**



## Happy birthday to us!

The DDN team lines up on press day to commemorate five years of publishing the magazine (left to right, Jez, Ian, Charlotte, Claire, Faye and David). Launching on 1 November 2004, DDN was the first freely-distributed magazine for the drug and alcohol field, reaching service users and their families and all corners of the workforce every fortnight. We'd like to thank our readers, contributors, advertisers, and the many organisations that feed us with information for supporting us so enthusiastically from the word go.

# Reaching for help

Cultural issues can stand in the way of families getting the help they need for drug and alcohol problems.

**Vic Motune** reports on the Reaching Out project's success in overcoming them through building trust in the community.

**I**t's not often you hear about a Muslim family in which a daughter is physically abusive towards her mother and steals money from her. But for 48-year-old Saira (not her real name), a mother of four from Oldham, this was a situation that had endured for five years after her 21-year-old daughter began using cannabis and cocaine.

Because of the respect given to parents and grandparents in the tightly knit Muslim community in which she lived, Saira kept quiet about the abuse. She knew that if she spoke about it her daughter would be shamed and ostracised by friends and neighbours. However her main concern was that her daughter got the help she needed to end her drug dependency and become part of the family unit again.

Not having a good command of English and knowing little about where to find drug treatment services, the violence continued. It was only when she heard about the Manchester-based Reaching Out project that the situation began to change for the better.

Reaching Out is a pioneering multi-faceted project aimed at raising awareness about, and treating, substance misuse in black and minority ethnic (BME) communities. It's long been claimed by BME service users and campaign groups that they face considerable barriers in getting the help they need to tackle substance misuse.

Often-cited issues include eurocentric treatment approaches which ignore the role that family and community play in the lives of those who need help, poor awareness of local drug and alcohol treatment services, and the reluctance of individuals who need help to ask for it, either for cultural and religious reasons or fear that their immigration status may be compromised. And since the publication of a 2007 report from the London Drug and Alcohol Network, which found that

people from minority ethnic communities across the country are not getting the help they need, critics of drug rehabilitation programmes say not much has changed.

The Reaching Out project aims to tackle many of these issues by using a community focused, multi ethnic partnership approach. Although a number of outreach programmes have been established around the country over the last five years aimed at specific ethnic groups, central to the concept of Reaching Out is that community organisations themselves are often better placed than service providers to gain access to their communities, build trust and create awareness about drug and alcohol use.

Also central to the Reaching Out model is that without community involvement, knowledge and practice cannot become embedded beyond the life of the project. Reaching Out targets seven key groups in the Greater Manchester region, which include the Chinese, Pakistani, Bangladeshi, African, Caribbean, Somali and Kurdish communities.

'We work with the key organisation in each community,' says Reaching Out's coordinator, Jawad Mahboob. 'Each organisation nominates someone to be trained up to deliver awareness and education sessions and also to screen and refer anyone who they think has a drug or alcohol problem, as well as providing culturally relevant moral support.'

'It's a really important approach because drug misuse problems are different for each community. For example, a big issue with the Somali community in Manchester is the use of khat. Other south Asian communities are having to face issues such as increasing cannabis use, so sessions are individually tailored, rather than a one size fits all approach. This approach is also important because people feel there isn't any kind of programme available for them.'

'They may be aware of outreach programmes around other areas of health such as diabetes or asthma, but are very often not aware of help that is available for drug and alcohol addiction. That maybe down to the fact that drug use is a touchy subject. Some BME communities feel they don't have a drug problem, that issues with drugs are going on elsewhere and as a result problems in their midst are often not talked about.'

Adds Mahboob: 'It's this approach that enabled us to help people like Saira. When she heard about Reaching Out she was desperate to get help for her herself and her daughter. However, she had struggled to find that help because her English was poor, making it difficult to access certain services. When she came to us, we did her assessment in Urdu which helped us to understand her cultural and religious issues so that we could support her as best we could. Because domestic violence was involved, we had to refer her to a number of other services to ensure both she and her other children got the support they needed.'

'At the same time, we're looking at securing the kind of treatment her daughter needs to help her kick her drug habit. If Saira hadn't contacted Reaching Out, which she'd heard about through our community networks, she would have continued to endure violence at the hands of her daughter.'

Reaching Out was inspired by research studies undertaken in 2006 by BME community organisations as part of the University of Central Lancashire (Uclan)'s Community Engagement Programme. The studies looked into the treatment needs of black and minority ethnic communities in Manchester and revealed a distinct



lack of knowledge about drugs and alcohol among these communities. There was also a lack of culturally-relevant services in the city to help people from these communities with substance misuse issues.

The Reaching Out project was launched later that year as part of the city's Black Health Agency, and funded by the Manchester Drug and Alcohol Action Team. The original idea was to use outreach workers to target these communities. However, with Mahboob's appointment in 2008, the project adopted a new community-led approach – and it is one that has seen remarkable results.

According to a recent evaluation of the project by Manchester Drug and Race Unit, 75 per cent of people from the local community organisations who received training said it was the first time they had received any information about drug and alcohol issues. More than a third of those trained said they had passed information on to friends and family members. Several people suggested they had altered their own substance-using behaviour as a result of the training.

'The idea to adopt a community-led approach was about us asking ourselves "how do we become more effective in getting across information and help about substance misuse?"' says Mahboob. 'Leading members of the organisations we worked with felt that it was impossible to get people from their own areas who had drug problems into treatment if they themselves were not aware of what treatment services actually do or what the issues were. It's especially important when we're delivering sessions to women or mothers because they become really keen to get that message across to their children, their husbands or other family members.'

'But another great benefit of the Reaching Out model is that we're able to gain lots of intelligence from the grassroots organisations we work with, which informs what we do at a strategic level and it enables us to better inform decision makers, service providers and funding bodies in the north west about real issues and problems they may be unaware of.'

The success of this approach has been complemented by a newly launched telephone helpline. Mahboob coordinates the helpline with a team of five staff members from the Manchester Drug and Race Unit who are trained to deal with helpline calls.

'Because there is still a taboo around drug use, people can be anxious and hesitant about approaching their community centres,' he says. 'In many cases they worry about confidentiality. The advantage of the helpline is that they don't know the person on the other side of the phone, which allows them to be open and honest about what is happening. When somebody rings, we have a spreadsheet on which we log the name of the caller, their ethnic background and a short description of exactly what the call is about, and from there we provide advice and information. What we often find is that there may be a related issue around domestic violence or parenting, so we have a national database of contacts that we can refer them to.'

While Reaching Out has won plaudits in Manchester and the north west, the question remains as to whether the national picture is as hopeful. Harry Shapiro, communications director of DrugScope, believes there is some way to go before projects like Reaching Out become the norm.

'It doesn't look at as though the situation regarding access to treatment services for black and minority ethnic communities has improved that much in recent years,' he says. 'There are some local projects like Reaching Out doing

**'Another great benefit of the Reaching Out model is that we're able to gain lots of intelligence from the grassroots organisations we work with, which informs what we do at a strategic level and it enables us to better inform decision makers, service providers and funding bodies...'**

some very good innovative work. However on a national level, it's very piecemeal. Drug rehabilitation services still need to work out a national strategy on how to engage communities where drugs are seen as taboo.

'The issue has also become more complex in recent years because of the influx of communities from eastern Europe, for example, who bring a different set of substance misuse issues than those minority communities who have been here for a few generations such as the African Caribbean and south Asian communities. Having said that, we mustn't always assume that the way forward is that only people from a certain community can help other members of that community. I believe that as long as people are being treated humanely and in a way that is sensitive to their needs, the ethnic background of the person delivering the service shouldn't matter.'

However, Pete Burkinshaw, who leads the National Treatment Agency's (NTA) programme on standards and inspections is much more hopeful of progress. 'This was a priority area for a recent joint service review by the NTA and the Healthcare Commission, which highlighted the significant progress that has been made by drug services in England in recognising the needs of diverse client groups,' he says. 'It also identified areas for improvement, particularly to make sure that those needs are being fully incorporated into the development of local services by partnerships, and for broader consultation with groups who may not be currently accessing treatment.'

Looking to the future, he adds: 'The NTA also drives this agenda through needs assessment and treatment planning mechanisms with service commissioners, to ensure that local areas appropriately meet the needs of their communities.'

*Vic Motune is a freelance journalist*





**'What we say on our leaflet is "do your kids know more about drugs than you?" and a lot of the time that's the case.'**

## Learning curves

DDN hears how Wandsworth Drug Project is helping to raise community awareness of drugs issues at the same time as passing on essential practical advice

**FOR THE PAST FIVE YEARS WANDSWORTH DRUGS PROJECT (WDP) HAS BEEN RUNNING A DRUGS AWARENESS COURSE** for anyone resident in the borough, but specifically aimed at single parents, unemployed people and BME communities.

The free eight-week course is funded by WDP, with extra money from the widening participation fund, and has now been accredited by the Open College Network (OCN), which as well as validating the work means clients receive an OCN certificate at the end of the course.

The courses are always held in WDP's drop-in room. 'That means we can show the learners the service, because a lot of them have never been inside a project like this,' says community development outreach practitioner Terri Laing. 'A lot of them say they didn't even know that projects existed.'

WDP runs three courses a year with around 15 participants each time, which helps keep the atmosphere intimate. 'The feedback has been excellent,' she says. 'This time around we haven't even advertised it and we've already got 14 people on our waiting list through word of mouth. Many have gone on to become volunteers in the drugs field, while others have gone to college or started NVQs in social work.'

What kind of people did they find wanted to sign up? 'Some are mothers that wanted knowledge about drugs because of their children or their partners – in

the case of their children either because they're actively using or they're worried they might,' she says. 'What we say on our leaflet is "do your kids know more about drugs than you?" and a lot of the time that's the case. They just want to know what's going on – we cover street names and slang names for drugs, as well as things like peer pressure, prescribing, BBVs, stereotypes and stigma. We also have a day when we do law and people's rights – we're trying to cover everything in the time we've got. A lot of people are really surprised by the things they learn. The parents love it.'

Often participants come along with rigid and entrenched beliefs that the course helps to challenge. 'There have been times when we've really changed people's perceptions,' she says. 'We have an ex-service user giving a talk and people are blown away by that. Because of the stigma around drugs and alcohol, it's letting people know some of the reasons behind addiction, as well as looking at the effects on families and the community.'

Where it differs from some similar projects, however, is that it also covers employment topics like CV writing and interview tips. 'We get a job tutor in – he starts off with body language, the way people talk in interviews, eye contact, building confidence. We get a whole range of voluntary and training organisations and colleges from Wandsworth in on the day we give out certificates, and our learners are able to go and talk to all these different people and sign up with them. It was easy to get the organisations on board – they were all really willing.' There is also reunion held after every course. 'The atmosphere at those is great, really positive, with people going through all the things they've learned.'

Wandsworth is an inner city borough with all the problems you'd expect, and as well as its own needle exchange and a drop-in, WDP offers a cannabis group, men's group and women's group, and works closely with tier 2 and 3 and DRR clients. 'We do a lot of outreach work as well, working with BME communities,' she says. 'We're always busy.'

Other local drugs services have also come on board and now staff from job centres and pharmacies are also being approached to sign up for the courses, where they can see presentations from needle exchange staff. 'We've found that a lot of our clients don't like having to go into pharmacies – they find it awkward and uncomfortable,' she says. 'This is just to try and help raise some awareness.'

*For more information call 020 8875 4400*

# Talking therapies

Social worker and *Tackling drugs, changing lives* award nominee

**Tony Wright** describes a highly unusual – but very successful – way of improving communication skills for both clients and professionals

**HAVING BEEN A SOCIAL WORKER FOR MORE THAN 25 YEARS**, virtually all of it at the ‘sharp end’ with the most disadvantaged, socially isolated and marginalised people in our society, I have come to the conclusion that it doesn’t matter what the presenting problem is, or what negative labels someone has acquired on the way – the only way to positively influence behaviour is to ensure that the professional relationship is based on respect. It must be non-judgmental, with boundaries regarding expected behaviour and interactions both verbal and non-verbal, set and adhered to.

It’s essential that practitioners develop and improve their communication skills, paying particular attention to appropriate body language, active listening skills, empathetic responses and the building of rapport in a short time and often-artificial environments. Plain talking and the avoidance of ‘mixed messages’, along with honesty, truth and integrity – no matter how unpalatable and uncomfortable at the time – are the essential skills.

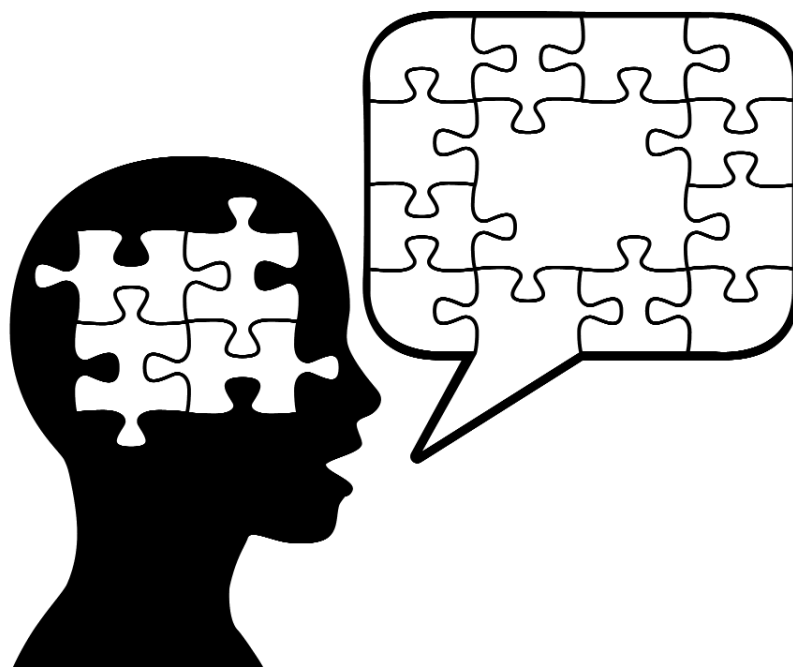
Yet how often do we see professionals avoiding dealing with difficult situations or decisions? Situations then spiral out of control, and ultimately the client is blamed – labelled difficult, manipulative, uncooperative or potentially dangerous. I can think of only one occasion in 25 years when a client was given a full and unreserved apology.

It’s usually in the heat of battle that such subjective assessments are made, invariably when the client feels let down or when they have been misled. It’s a fact that many people have a limited emotional vocabulary and struggle to deal objectively with disappointment or a sense of injustice, and emotive issues often manifest themselves in angry verbal interactions. It’s at this point when the power imbalance makes itself apparent, with negative representations of the client recorded in their file. I’ve often read a case file and expected to be confronted with an axe-carrying psychopath, not the diminutive, inarticulate, world-weary client before me. Sadly this can influence interaction for decades.

So how do we get back to good old-fashioned straight talking and open communication? The key may be the use of debate as a vehicle to teach and improve communication skills for both professionals and clients.

Last year I approached Dr Peter Warburton, director of sport at Durham University – someone with whom we’d collaborated to allow access to sporting facilities for problematic drug users – to ask if he would approach the Durham Union Society, one of the oldest student debating societies in the world, to see if they would consider teaching debating skills to me and my staff and, more importantly, clients with experience of alcohol or drug dependency, the criminal justice system, homelessness or at risk of sexual exploitation. The then-president agreed and during eight weekly sessions we were taught the basics of British Parliamentary Debate. It was immediately apparent that the staff team was on a steep learning curve and the real latent talent lay with the volunteer participants.

We learned how to project our voices so we could modulate them, not only in volume but emotional content, as well as how to present our views logically and in



**‘Plain talking and the avoidance of “mixed messages”, along with honesty, truth and integrity - no matter how unpalatable and uncomfortable at the time - are the essential skills.’**

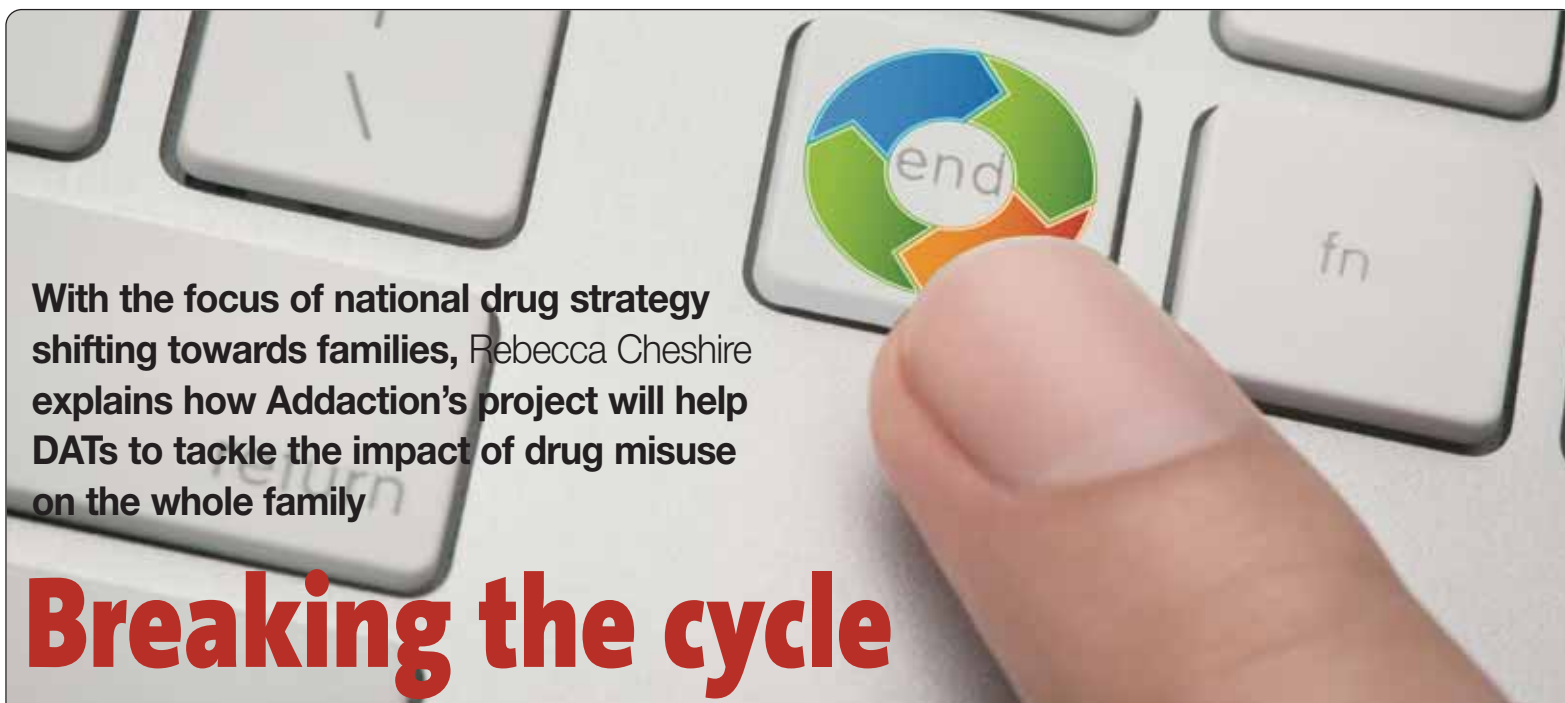
front of a group. We were also taught the importance of listening intently to what others had to say, practicing deconstructing the opposing team’s argument through logical, critical analysis and learning how to be verbally spontaneous but also how to structure an argument. The learning environment broke down barriers between staff and clients and it became a level playing field – I and several of my colleagues felt very self conscious, as if it was expected that we would automatically excel in this role. It soon became very clear we did not.

Boundaries and expectations were set and established – common courtesy became the norm and it was clear that the more the group understood the social protocols involved in debating, the more the environment felt psychologically safe, allowing people to operate outside their comfort zone, give freedom to self expression and trust in others while growing in confidence emotionally and spiritually.

The atmosphere at the final event was electric, probably more in anticipation that it would be an unmitigated disaster and we would be picking up the remains of shattered egos for months to come. However it exceeded all expectations and was triumph for all involved – it has since become an annual event in the Durham Union Society fixture list, enabling others from disadvantaged backgrounds to improve their life skills and ability to communicate.

The use of debate training to improve communication skills, and indeed citizenship, could be rolled out to a host of different communities – young people, families, marginalised groups and anyone involved in the criminal justice system, including serving prisoners. I would argue that it should be used as part of a bigger project to educate communities about the democratic process and their role within it – groups that finish the training could link up with an MP from their constituency and visit the Houses of Parliament to see debate in action. This inclusive approach could promote active citizenship and go a long way towards strengthening our communities, as well as addressing the current apathy towards politics in general.

*Tony Wright is a social worker.*



**With the focus of national drug strategy shifting towards families, Rebecca Cheshire explains how Addaction's project will help DATs to tackle the impact of drug misuse on the whole family**

# Breaking the cycle

**OVER THE PAST DECADE** there's been a rapid growth in parenting and family interventions, which aim to support problems ranging from anti-social behaviour through to youth offending.

The next few months will see a further flurry of policy statements. A Families Green Paper from the Department for Children, Schools and Families (DCSF), due towards the end of this year, will introduce the next stage of the family policy. The NTA and DCSF will produce a paper on working with families, and the Conservative Party is expected to publish a discussion paper on the family ahead of the next general election.

At government and opposition level there's a strong wish to move towards holistic, 'whole family' approaches to delivering support and treatment, yet this area remains fragmented both in terms of policy and delivery. Very often local authorities, voluntary and public sector organisations are developing different responses to the same challenge. And these differing agencies are monitoring and evaluating their work differently, too – service structure, referral criteria and intervention types can differ greatly from one to another.

So while excellent local initiatives exist, it's been an area neglected at a national level in England – until now. In May 2008, the government launched its 'Think Family' initiative to ensure differing services work together to respond to the needs of the whole family. Fifteen local areas have been acting as 'pathfinders', testing and developing the initiative.

Drug Action Teams around the country face many challenges as they align themselves with this new family focus, however. A key one is how best to link these differing agencies, and their sets of figures and outcomes, into one cohesive, manageable whole.

For the last three years, Addaction has been piloting a project called 'Breaking the Cycle', funded by the Zurich Community Trust and set up specifically to help children in drug or alcohol-abusing families. The project has worked in different areas of the UK, from the capital to remote parts of Cumbria, and families were referred from a variety of agencies, including treatment organisations, children and family services and probation.

Previously, the work of social services and the drug service would not have been sufficiently coordinated to take account of the impact of drug misuse on the whole family. Workers look at family dynamics and use a 'genogramme' – a sort of sophisticated family tree to chart drug misuse – to unearth patterns of behaviour and pinpoint the psychological factors that may have a negative influence on familial relationships. The workers are often advocates for the

families, helping them access and negotiate support while devising strategies to reduce substance use and become better parents.

The results of the pilot, verified by the Mental Health Research and Development Unit (MHRDU) at Bath University, have been impressive. Over 450 families have been helped – three quarters of which have children (half of which are between one and seven years old). Eighty per cent of the parents involved in the project are mothers.

Parents involved in Breaking the Cycle significantly reduced their use of drugs or alcohol, improved their skills as parents and started putting the needs of their children first. Proper routines were instigated at home, and mums and dads improved their financial situations by looking for work or education.

And Breaking the Cycle taught us a lot about the level of organisation needed for cross-agency family work to work properly. We believe it provides a ready-made model for DATs, who will need to meet the protocols set out in the new drug strategy.

It works for two simple reasons. Firstly, Breaking the Cycle is based on the skill of an individual worker, whose advocacy on behalf of a client and their family (and the management of a caseload between agencies) sidesteps a potential mountain of bureaucracy. It also has the advantage of focusing resources on where they can be most effective.

Secondly, it works because of the project's systematic approach to evaluating impact. Addaction has developed an outcome-monitoring tool to chart a family's progress, and to provide project workers with an early indication of what works (and what doesn't). The tool measures against 14 outcomes, covering issues such as education, parenting skills, family finances, harmful behaviour and social competence.

Each month, what has been achieved is looked at, as is what needs working on. The value of this work is enormous, as it provides hard evidence on the impact holistic family interventions have.

So, as the focus of the drug strategy has changed, the treatment sector's focus has to adapt and change, too. We believe that sharing the experiences of effective work is not only the way to do this, it's essential in the building of effective interventions and getting help to the families who need it.

*Rebecca Cheshire is family development manager for Addaction.*

*For more information, and a copy of the summary of the Breaking the Cycle report, contact [a.booth@addaction.org.uk](mailto:a.booth@addaction.org.uk) or ring 0207 017 2757*

**On Findings' tenth anniversary, editor Mike Ashton recalls how the largest working drug and alcohol library in Britain first started.**

## Finding the evidence base

**CAST YOUR MIND BACK TO THE LATE 1990s.** Then, as now, hats were doffed to the 'evidence base' and doing 'what works'. A government-ordered effectiveness review had spawned NTORS, the largest ever UK drug treatment study, and the emerging results from the sample recruited in 1995 were making a case for expanded funding. On the practice side, £1bn a year was being spent on tackling drug and alcohol problems, and more was on the way.

But there was a problem. Research's business was research, while practitioners were busy getting on with practice. It was the core business of neither side to link up with the other. Researchers talked to each other in academic journals which practitioners did not read – or if they did, they were in no position to interpret the findings. To do that would mean placing each new study in the context of the world literature, which would mean finding and analysing that literature in the first place – an impossible task.

For all the supposed commitment to evidence-based practice, there was no vehicle for promoting it. It was a glaring contradiction, which risked squandering the investment in both research and practice.

That contradiction gave birth to the Drug and Alcohol Findings project, itself a coming-together of Britain's leading addiction research base at the National Addiction Centre, and the two national representative bodies for alcohol and drug services respectively – Alcohol Concern, and what was then the Standing Conference on Drug Abuse (SCODA). Midwifing the partnership was Mike Ashton, recently emerged from two decades at the Institute for the Study of Drug Dependence (ISDD), who became the project's editor. ISDD later merged with SCODA to form DrugScope, but apart from that, the partnership has remained the same.

This tiny one-man project aimed to create the missing link between international research and practice in the UK. Then both ISDD and Alcohol Concern had thriving and internationally important libraries. Findings drew on those and later on the National Addiction Centre's access to the academic literature.

The project's focus was on the production of the world's first magazine for drug and alcohol practitioners, devoted to bringing them the fruits of international research in a form they could understand and make use of. Ten years ago in 1999, the first edition was published.

It was, and its successor remains, a unique hybrid, allying scientific rigour with practitioner-friendly and practice-informed analysis and commentary. In fact the partnership believes it is, and needs to be, more rigorous than academic journals, because the aim is not to discuss and debate findings, but to put them in to practice in ways which will affect the lives of communities, clients, patients and young people.

Favourite of many accolades from researchers and practitioners is one is from Dr A. Thomas McLellan, then director of the Treatment Research Institute in Philadelphia and editor of the *Journal of Substance Abuse Treatment*, now second in charge of President Obama's national drug policy unit: 'I don't think I have ever seen so much useful and well-integrated information in one place. I just started at the front and couldn't put [it] down... keep up the great work.'



**'The project's focus was on the production of the world's first magazine for drug and alcohol practitioners, devoted to bringing them the fruits of international research.'**

There was start-up funding from project partners and from Action on Addiction and the Department of Health's Substance Misuse Advisory Service, then headed by Don Lavoie, and some indirect help along the way from the National Treatment Agency. But apart from this, the magazine was self-sustaining on subscriptions, until in 2006 it hit the financial buffers and turned to the J. Paul Getty Jr. Charitable Trust and later the Pilgrim Trust for support.

Guided by them, the project transformed itself in to a web-based publisher and database, offering free of charge everything subscribers had previously paid for and much more. It was a wrench, but wise counsel. From a few hundred keen subscribers, now each month its analyses are downloaded more than 25,000 times. Past magazine content and current analyses can be searched using a newly upgraded custom-made system, and downloaded and stored as PDF files on your computer for future reference. A click of the mouse takes you to related content and sources for original research articles and reviews.

But what of that back room? Its library grew like topsy and now numbers about 13,000 documents, nearly all the newer material stored and retrievable electronically. It is not directly available to the public (a longer-term ambition), but it forms the evidence base used to interpret the significance and meaning of each new research finding analysed and disseminated by the project. When Alcohol Concern and DrugScope recently divested themselves of their own libraries, it became the largest 'live' drug and alcohol library in Britain, and almost certainly one of the largest in the world.

And what of the future? Falling by design between research and practice stools, funding remains a potential problem, but the commitment of the partners and the reason for the project's existence are as strong as ever. Above all, the project is fortified by the reactions of its practitioner users and the researchers whose work it subjects to its forensic analyses.

The project is small, but by most accounts, pretty well perfectly formed, and there is still nothing like it anywhere else in the world.

Visit the project's web site and sign up for free bulletins on new research findings at <http://findings.org.uk>

Contact Mike Ashton at [editor@findings.org.uk](mailto:editor@findings.org.uk), or on 0208 888 6277



# The poor relation

Do tier 4 services always lose out?

**Peter Walker** looks at how to arrest the decline in rehab and promote recovery



**T**ier four residential services have been in decline since the inception of the first national drug strategy in 1998. There are two main reasons for this. The first is the decision not to assign responsibility for the funding of tier 4 services nationally, to the NTA or similar body, or locally, to drug action teams, while the second is the decision to pursue primarily a harm reduction approach to drug misuse and so marginalise the abstinence-based approaches of most rehabs.

The combined impact is a national reduction in take up of tier 4 services and the closure of many rehabs. While the number of people engaged in treatment has increased dramatically, the number of drug-free outcomes has been negligible.

Only recently has the NTA given serious attention to the protection and promotion of residential services, with a number of reports and initiatives. These have been seen as an attempt to reverse the decline in the use of tier 4 and bolster opportunities for clients to achieve drug-free exits from treatment, in line with the new national drug strategy which states 'The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency.'

In Bristol, as in most other parts of the country, local tier 4 services until recently sat outside of the local drug strategy team (DST – equivalent to a DAT) commissioning framework, with most providers seeking referrals on a spot purchase basis from local, regional and national sources. Again, like most other areas, Bristol purchased tier 4 treatment from a wide range of rehabs, some local and some much further afield.

In 2007 the DST began to take a more strategic interest in tier 4, with the development of a 'preferred providers' list of rehabs. The aim was to make greater use of local provision, much of which was part-funded by Bristol City Council through the Supporting People budget, and to achieve better value for money.

In 2008 the DST and the Supporting People team recommissioned all Supporting People-funded drug and alcohol accommodation, including most local tier 4 provision, and commissioned a number of new accommodation and non accommodation based housing support services. For the first time – and

possibly uniquely in the UK – the DST had in place a specialist accommodation service directly linked to treatment services. In all, 52 tier 4 beds were commissioned from three local providers and the DST agreed a number of block purchase agreements to cover the cost of treatment in some, but not all, of the bedspaces. However, despite this recommissioning exercise, all three providers have seen a continued overall decline in the use of their tier 4 provision with no apparent link to performance, as outcomes remain good.

Access to tier 4 is different to other treatment services in that a specific assessment process has to be conducted and, in most cases, individual funding has to be secured or approved. This process is perceived by both clients and drug workers as an impediment to referrals and access.

An audit in Bristol found that the average time taken to complete a community care assessment for drug misusers was 16 days, with the shortest time one day and the longest 46 days. The common assessment form used to assess the needs of drug users for all other services – aimed at enabling the swift transfer of information and avoidance of multiple assessments – is not considered appropriate for tier 4 clients, adding to delays. It's also known that clients have often been required to 'prove' their motivation, while missed appointments and lapses are considered to mean they are not 'ready' for rehab. These conditions are not applied to clients accessing community-based treatment services.

In July this year a seminar was convened for all those with an interest in tier 4

**'The national drug policy has clearly shifted to state that the goal of all treatment is abstinence.'**



services in Bristol, to address the low level of referrals. Delegates endorsed the high quality and importance of local tier 4 services and identified a range of possible causes for low referral rates. These included the lack of strategic importance given to tier 4 compared to harm reduction services, lack of local accountability and responsibility for tier 4, and lack of awareness of the availability of tier 4 services among professional and clients.

Also identified were low levels of client expectation regarding rehab availability, lack of ambition on the part of harm reduction drugs workers in supporting clients to achieve abstinence, and a perception among drug workers of insurmountable obstacles to accessing tier 4. There was also a feeling that clients could get their needs met through community rather than residential-based services – an inability to differentiate between the needs of clients and to match services appropriately.

In Bristol there are an estimated 6,000 problematic drug misusers – 4,000 of whom are engaged in treatment, with approximately 1,500 prescribed methadone. However in 2007-08 just 100 (63 drugs and 37 alcohol) placements were made in tier 4. In 2008/09 this figure had fallen to 83 (40 drugs and 43 alcohol) – less than 1.8 per cent of those in treatment.

Given that most drug users engage with treatment because they want to get off drugs, this low figure suggests the treatment system is not necessarily helping clients achieve their aspirations. The need for treatment services to be more ambitious to enable clients to become drug free is a view now expressed by the NTA.

To date, the national drug strategy has been weighted in favour of harm reduction, with a particular emphasis on methadone. The system has also been heavily target-driven – getting people into, and retaining them in, treatment. There have been no incentives to move people out of treatment and no drug-free targets. As a consequence, referrals from tier 2/3 service providers to tier 4 in patient and rehabilitation services have been low.

The national drug policy has clearly shifted to state that the goal of all treatment is abstinence, and any change in policy should there be a change of government is, if anything, likely to emphasis even further the importance of drug-free outcomes as the objective of treatment. Recently shadow home secretary Chris Grayling said 'We need an abstinence-based approach to treatment... There is increasing evidence that the current approach of stabilisation is not working.'

A wide range of actions can be taken to improve the current situation and increase tier 4 take up. In Bristol the DST has established a tier 4 group to address the changes needed to improve referral rates. But there are specific actions that could be agreed at a strategic level which would make a difference, including reviewing local treatment systems in line with NTA priorities to focus on recovery, removing obstacles to achieve equality of access – replacing the requirement for a community care assessment – and widely publicising the availability of tier 4 provision to counter client perceptions that it is too difficult or too expensive to access.

Others include establishing a training programme for tier 2 and 3 drug workers to equip them with the skills to be 'more ambitious' for their clients in achieving a drug-free life, monitoring tier 2 and 3 services to ensure there are consistent levels of referrals to tier 4, setting local targets for getting people off drugs and financially securing existing tier 4 provision to guarantee future availability.

Most people recognise the quality and importance of residential services to the treatment system. However, low referral rates threaten the very survival of that key part of the system, just at the time when government and NTA policy is seeking the kind of results that residential services have consistently delivered. The challenge for commissioners is to safeguard tier 4 provision as the basis of a recovery-orientated treated system and ensure that more people have the opportunity to lead a drug-free life by increasing referrals. This will involve a cultural shift among many commissioners and providers, as treatment moves away from focusing on getting more people into treatment and keeping them there, to helping them exit treatment drug free.

*Peter Walker is chief executive of Addiction Recovery Agency*

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## RCGP conference

Meet us at the RCGP conference in Glasgow on 5th, 6th and 7th November. This conference will showcase the latest clinical and policy developments across the UK and will bring together an impressive range of national and international speakers. Our team are supporting the exhibition and will be available on the Concateno stand to answer any questions.

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We are committed to the highest levels of Accreditation, Certification and Quality Assurance and work actively with the industry to improve upon existing best practice. This includes accreditation of our laboratory services to BS EN ISO 17025:2005 and certification of our management systems to BS EN ISO 9001:2008 and BS EN ISO 13485:2003. In addition, we are subject to a range of external and internal Quality Assurance programmes.

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*Mainliners is also pleased to announce that Dr Brian Iddon MP will give the keynote address at the opening of the conference.*

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Drink and Drugs News

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Presented by the following speakers: David Skidmore, National Treatment Agency; Elizabeth Flegg, Sussex Drug and Action Team; Carole Sharma, Federation of Drug and Alcohol Professionals; Phil Harris, Independent Consultant; Ryan Rowe, Safer Bristol; Raj Carr, Workforce Development Partnership; Nigel Hills, City of Bristol College.

*Conference registration fees: Statutory £95; Voluntary £60*

**For further information and/or registration form:**  
Shirine Borbor, Conference Manager, City of Bristol College  
Tel: 0117 312 5851 Email: [thebristolconferences@cityofbristol.ac.uk](mailto:thebristolconferences@cityofbristol.ac.uk)



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Camden Council values the diversity of its community and aims to have a workforce that reflects this. We therefore encourage applications from all sections of the community.

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For an informal discussion, please contact Karen Wood, Joint Commissioning Manager on 01202 458740.

For more information, closing dates or to apply online for ANY of our current vacancies visit <http://jobs.bournemouth.gov.uk>

Alternatively, an application pack may be obtained via:  
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This post is subject to a pay and grading review which may result in a change to the grade and salary.


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[www.blackburn.gov.uk](http://www.blackburn.gov.uk)

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You will be responsible for working in a multi agency/partnership way within the structure of the local Community Safety Partnership and will be a point of contact for all regional and national bodies such as the National Treatment Agency, Government Office North West and the Department of Health.

You will be required to co-ordinate various standing and time limited development groups within the remit of the Drug and Alcohol Action Team's day to day business as well as taking a lead on the development of a commissioning strategy and organisation of the Joint Commissioning Group responsibilities.


You will also be required to deputise for the DAAT Co-ordinator when required and you will work directly in partnership with the Drug and Alcohol Strategy Manager to ensure effective strategy development and implementation. **Ref No: BB4240.**

**Closing date: 20th November 2009.**



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In 2009 the Carol and Travis Jenkins Award was presented to Holly and Korsang – now internationally renowned as an example of best practice in the field.

The Conference Consortium, on behalf of IHRA and working with the sponsors, exhibitors, organisations and companies involved in the International Harm Reduction Annual Conference, are asking you to consider supporting Korsang financially. We are trying to raise US\$35,000 for them over three years.

Korsang coordinate activities in an extremely difficult political environment – protecting clients from police 'round-ups' and detention centres, and highlighting their plight to international policy makers, donors and the media. Korsang remains Cambodia's only harm reduction programme. Holly led a delegation of nearly 30 staff, peer educators and people who use drugs to the IHRA conference in Bangkok in April 2009, including 'Kormix', a hip-hop group of Khmer drug users which played at the conference party (pictured).

The people running Korsang are an inspiration and it was an honour to meet many of them at the conference. Their work and their struggle is documented in the following links:

[www.korsangkhmer.org](http://www.korsangkhmer.org)  
[www.youtube.com/user/korsangus](http://www.youtube.com/user/korsangus)  
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For details on how to donate please contact Andy Stonard.  
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See more vacancies on  
[drinkanddrugsnews.com](http://drinkanddrugsnews.com)

## Do you provide training?



On 30 November, **DDN** will be featuring our first **Training and Development Directory** as a pull-out and keep section. If you or your organisation provide training, in any part of the substance misuse field, make sure your free basic listing is included.

To submit your entry, or for information about advertising and sponsorship opportunities, contact Faye Liddle.  
t: 020 74632205 e: faye@cjwellings.com

## Training and Support Team – Identification and Brief Advice

Wigan MBC and NHS Ashton, Leigh and Wigan invite tenders for a time limited service to provide a training and support team who will specialise in developing capacity in relation to Identification and Brief Advice for alcohol.

The provider will be responsible for the promotion of IBA, the development of a standardised training programme and associated materials. It is also expected that a support network is established together with advice and guidance with practical support on setting up and running IBA sessions for a range of individuals across a range of settings. It is anticipated that the programme will be mainstreamed at the end of the funding period.

**The closing date for submissions is 23rd November 2009.**

**The contact for this tender is Paul Keeling: P.Keeling@wigan.gov.uk**



### Stoke-on-Trent Safer City Partnership

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

CRI in partnership with Stoke-on-Trent Safer City Partnership are delighted to be in the position to offer exciting opportunities working within the Adult Community Drug Service on a team dedicated to the treatment of Hepatitis C.

As part of this service CRI are now seeking to recruit highly motivated individuals to champion this new development.

In return CRI offer a very competitive salary, excellent training opportunities set against individual personal development plans with a strong emphasis on Continual Professional Development. Professional supervision which will be consultant led.

This new initiative will be delivered within a community setting offering specialised treatment for clients diagnosed with the Hepatitis C virus who are presently under the care of the Community Drug Service. It is anticipated as part of this treatment sphere there will be an expectation of offering significant treatment episodes per year. This will require the team to work effectively and collaboratively with all care providers to assist individuals in achieving optimum health.

### Clinical Nurse Specialist – Hepatitis C (Ref NM313)

£29,708 to £33,325 • Permanent – 37.5 hours per week

The successful candidate will ensure that nursing staff consistently deliver high quality interventions for service users, ensuring high professional standards that comply with best practice guidelines. You will provide a comprehensive, highly specialist service to screen, assess and treat individuals attending drug treatment for HCV infection.

The successful candidate will be equivalent to NHS Band 7.

### Hepatology Nurse – Hepatitis C (Ref NM312)

£26,696 to £29,099 • Permanent – 37.5 hours per week

The post-holder will consistently deliver high quality interventions for service users, ensuring high professional standards that comply with best practice guidelines. You will provide a comprehensive, highly specialist service to screen, assess and treat individuals attending drug treatment for HCV infection.

The successful candidate will be equivalent to NHS Band 6.

### Health Care Support Worker – Hepatitis C (Ref NM311)

£15,285 to £16,313 • Permanent – 37.5 hours per week

The post-holder will work as part of a team to consistently deliver high quality interventions for service users, ensuring high professional standards that comply with best practice guidelines. You will provide support to assist the delivery of a comprehensive, highly specialist service to screen, assess and treat individuals attending drug treatment for HCV infection.

The successful candidate will be equivalent to NHS Band 3.

If you would like to discuss any of these positions further please contact Stuart Fisher R.M.N

Tel: 07775 505192 between the hours of 9am – 5pm Monday - Friday

Closing date: 18th November 2009

Only electronic applications will be accepted via [www.cri.org.uk](http://www.cri.org.uk)

The successful candidates will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

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

Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861),

Company Registration Number: 3861209 (England and Wales).

## BUSINESS MANAGER

### Action on Addiction

Based in London with monthly travel to East Knoyle

**Full-time. Up to £40,000 pa**

(dependent on experience)

We're looking for an experienced business development manager to generate funded referrals into our treatment centres.

Action on Addiction is the only UK charity working across the addiction field in research, prevention, treatment, professional education and family support. Helping people tackle addiction, we strive to be market leaders and continually offer high quality services.

#### THE ROLE

You'll be joining a small but hard-working team where you will conduct market analysis, manage projects and build relationships with new and existing clients to generate and sustain funded referrals into our treatments centres in London and Wiltshire.

This is a new role with the opportunity to develop innovative marketing solutions and drive initiatives.

#### YOUR BACKGROUND

You will have a strong track record in business development, marketing and account management, ideally in a charity environment. You will have a proven ability to manage projects and budgets, develop client relationships and close deals. You will thrive on delivering on time and hitting targets.

#### IN RETURN

We offer a friendly working environment, 25 days holiday per annum increasing with length of service, 7.5% non-contributory pension scheme and the opportunity to make a real difference to the lives of addicts and their families.

If you're as serious about tackling addiction as we are and are ready for challenge, please visit the job section of our web site.

**Closing date: 13th November 2009**

**Interview dates: 26th and 27th November 2009**

[www.actiononaddiction.org.uk](http://www.actiononaddiction.org.uk)

Action on Addiction is the only UK charity working across the addiction field in research, prevention, treatment, professional education and family support. Charity No. 1117988.



safer communities, healthier lives