18 January 2010
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# DDN
## Drink and Drugs News

**CRUNCH TIME**
Making the case for recovery-oriented treatment

**GET MOTIVATED**
Promoting behaviour change with motivational interviewing

**'There has been much talk about growing use in clubs, with people turning to it because of the poor quality of available ecstasy and cocaine.'**

# LEGALLY HIGH?
## THE DRAMATIC RISE OF MEPHEDRONE AND INTERNET DEALING

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DDN
Drink and Drugs News
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www.drinkanddrugsnews.com
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

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**Cover:** Sam Chamberlain

**DDN is an independent publication, entirely funded by advertising.**

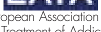
PUBLISHERS:

CJ Wellings

PARTNER ORGANISATIONS:

fdap
Federation of Drug and Alcohol Professionals

SUPPORTING ORGANISATIONS:



**Editorial – Claire Brown**

# Staying grounded

## Can legislation be meaningful to tackle highs?

The dangers of 'legal highs' have been hitting the headlines over the past few months, and the issue has inevitably brought with it its share of myth and conjecture. You only have to think about the storm in the ACMD's teacup at the end of last year to see why the experts are circling the issue warily on all sides. Mephedrone, known as miaow (or meow), is prolifically available online in such innocent guises as plant food – little wonder then that it's prone to experimentation, with the drug and alcohol workers featured in our cover story reporting users as young as 12.

Can an attempt to ban these drugs have any effect? Release has already voiced scepticism, accusing the government of chasing its tail in announcing that such drugs will become illegal. It will be interesting to see how the newly chaired ACMD's work on mephedrone is received – as well as that of Prof Nutt's new Independent Council on Drug Harms (page 4). In the meantime, as trainer Renato Masetti says in our article, it's important that drug teams know the specifics about these drugs so they are confident in treating clients and know how to dispense essential harm reduction advice.

As we begin a new year in which 'recovery' is the only flavour for many, the anthrax cases among heroin users in Scotland are a stark reminder that whatever culture changes are taking place or being proposed, basic safety in public health policy can never be neglected. Alongside Peter Martin's optimistic case for recovery-orientated treatment on page 10, Sara McGrail reminds us that political point-scoring must never threaten to unpick the vital progress in drug treatment over the past ten years. As she says, choice in treatment is vital, and we must resist every echo of the old abstinence v harm reduction divide. Whatever vote-courting drug policies are being drafted, it's vital that such complex issues are not distilled to public-pleasing soundbites.

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# Drug users face anthrax risk

**Drug users in Scotland are running the risk of taking heroin contaminated with anthrax**, according to Health Protection Scotland. As *DDN* went to press there had been 14 confirmed anthrax cases in heroin users, including seven deaths. Half of the confirmed cases were in the Greater Glasgow and Clyde NHS area, with others in Fife, Lanarkshire, Tayside and Forth Valley. The outbreak began in December.

'One avenue which continues to be investigated is that contaminated heroin or a contaminated cutting agent mixed with the heroin may be responsible for the infections,' says a statement from Health Protection Scotland. Anthrax is a bacterial infection caused by the organism Bacillus anthracis, and heroin or cutting agents can become infected with anthrax spores from the environment. Successful treatment depends on early recognition of the disease but, once infected, it is rare for anthrax to be spread from one person to another.

'Cases of anthrax infection have now been confirmed in five health board areas across Scotland, indicating that heroin users all across the country need to be aware of the risks of a potentially contaminated supply,' said consultant epidemiologist at the agency, Dr Colin Ramsay. 'I would urge all users to stop using heroin immediately and contact local drug services for help in stopping. If any heroin users do notice signs of infection, for example marked redness and swelling around an injection site or other signs of serious infection such as a high fever, they should seek urgent medical advice.'

Contaminated heroin is potentially dangerous to take via smoking or inhalation, not just injection, stresses Health Protection Scotland, and there is no way of telling if a supply is contaminated. Drug users who continue to inject should always use a clean needle and syringe and avoid sharing any equipment – including cookers or spoons – with other drug users, stresses the agency.

# Home Office replaces sacked Nutt at ACMD

**Professor Les Iversen has been appointed as the interim chair of the Advisory Council on the Misuse of Drugs (ACMD)**, following the controversial sacking of Professor David Nutt last year. Prof Nutt was removed from his post after declaring that alcohol and tobacco would come above cannabis, LSD and ecstasy in a drug harm ranking that included both legal and illegal drugs (*DDN*, 2 November 2009, page 4).

Prof Iversen has been an ACMD member since 2004 and was previously chair of its technical committee. His role is for 12 months, with immediate effect. As his appointment was announced, some newspapers leaped on the fact that he had described cannabis as 'one of the safer recreational drugs' in an article dating back to 2003.

Prof Iversen said he was 'honoured' to take up the position, and that the ACMD was 'committed to continuing the work on the harms of 'legal highs', particularly mephedrone – the last few months have seen an exponential rise in the use of the drug (see feature, page 6).

Home Secretary Alan Johnson has announced a forthcoming assessment of mephedrone, following the control of GBL, BZP, synthetic cannabinoids and other substances banned under the Misuse of Drugs Act last month. A new briefing on the substance, *Mephedrone – an update on current knowledge* has been issued by Liverpool John Moores University and the North West Public Health Observatory, while a poll of readers of clubbing magazine *Mixmag* by researchers at the National Addiction Centre found that one in three had used the drug in the last month.

Meanwhile, five former members of the ACMD have announced they are joining a new body, the Independent Council on Drug Harms, established by Prof Nutt. The council, he said, will aim to build a 'much stronger group of scientists working on drug harms than it's been possible to assemble under the ACMD with its complex regimentation of advisors from other areas of society such as the police and magistrates'. Among its first aims will be to produce a new harm assessment tool, a set of guidelines for the public on comparative drug harms and 'definitive guidance' on legal highs.

*For more information on the new drugs body visit www.crimeandjustice.org.uk*

*Mephedrone briefing available at www.cph.org.uk*

# NTA places recovery in the mainstream

**This week sees the publication of the NTA's *Commissioning for recovery***, a guide to help drug action teams deliver a recovery-orientated treatment system in their area. The NTA wants to see a renewed focus on care planning that incorporates reintegration – housing, employment and peer support – as an integral part of all individual plans.

In order to deliver against the 2008 drug strategy, recovery needs to be the 'bedrock' of all commissioning decisions, states the document. The agency wants to see partnerships 'articulate a vision for drug treatment in their area that meets the needs of the drug-using population' – whether in treatment or not. (See the next issue of *DDN* for an in-depth look at the guide.)

The NTA has also launched a micro-site in partnership with *Society Guardian* to promote the benefits of recovery and reintegration. The site features positive accounts of treatment encompassing healthcare, criminal justice and wider social support, and includes contributions from a GP, a chief superintendent, former service users and NTA chief executive Paul Hayes, among many others.

*www.guardian.co.uk/drug-treatment*

*Commissioning for recovery – drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships will be available from www.nta.org*

## News in Brief

**Disheartening figures**

A study published in the *European Heart Journal* shows that more than three per cent of sudden deaths in south-west Spain are cocaine related. 'This study shows again why we need to dispel the myth that cocaine is a "safe party drug"' said the British Heart Foundation's senior cardiac nurse, Fotini Rozakeas. 'The reality is that there are risks every time you use it. The potential deadly consequences from cocaine use can happen to anyone who takes it, even in previously healthy young people with no history of heart disease.'

**CHAMPing at the bit**

Nominations are open for this year's Mentor UK CHAMP (Promoting Children's Health through Alcohol Misuse Prevention) awards. Three £20,000 prizes are on offer for schemes that help prevent people of 14 or under from misusing alcohol, with winners selected by panels of under-14s themselves. Anyone can nominate – the deadline for applications is 21 April. 'With twenty million units per week drunk by 11 to 17-year-olds and with 500,000 young people drunk in the last month, we at Mentor UK believe promoting healthy attitudes and behaviours with young people as early as possible is vital and can prevent many lives being wrecked,' said Mentor UK chief executive Paul Tuohy. *www.champawards.org.uk*

**Targeting stigma**

The UK Drug Policy Commission (UKDPC) has been awarded a grant of more than £60,000 from the Paul Hamlyn Foundation to identify the scale of stigma and prejudice towards recovering drug users. The research will look at public attitudes and media reporting, as well as the experiences of drug users and their families, with the aim of providing a benchmark to measure the success of attempts to reintegrate recovering drug users into society. 'We hope our research will be the important first step in getting the evidence in place, to empower others later on to challenge stigma and prejudice towards recovering drug users,' said UKDPC chief executive Roger Howard. 'In the mental health, disability and other fields, solid evidence of stigma has provided the bedrock for subsequent campaigns for equality and inclusion.'

# Health select committee demands alcohol promotion overhaul

**The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries,** according to a damning report from the health select committee.

The government, it says, has given 'greatest emphasis to the least effective policies' – such as education and information – and too little to the most effective policies of pricing, availability and marketing controls. The report backs the call for a minimum price per unit of alcohol and also wants to see an alcohol strategy 'with robust needs assessment, and accurate data collection' for every primary care trust, along with mandatory targets for reducing alcohol related hospital admissions.

'Faced by a mounting problem, the response of successive governments has ranged from the non-existent to the ineffectual,' states the report. 'It is time the government listened more to the chief medical officer and the president of the Royal College of Physicians and less to the drinks and retail industry. If everyone drank responsibly the alcohol industry might lose about 40 per cent of its sales and some estimates are higher. In formulating its alcohol strategy, the government must be more sceptical about the industry's claims that it is in favour of responsible drinking.'

The country's level of alcohol misuse had reached a level that the government 'should be ashamed of' said Alcohol Concern chief executive Don Shenker, adding that it 'beggared belief' that the government was 'still dithering'.

Alcohol industry body The Portman Group, however, agreed that alcohol harm was increasing but said that a fall in total consumption over the past five years meant measures should be targeted at the 'minority of drinkers who abuse alcohol rather than the responsible drinking majority'. A minimum price would 'take money from poorer people and transfer it to the supermarkets – a curious piece of social justice,' said group chair Seymour Fortescue. A 'fairer and more effective approach' would be to use education and law enforcement to focus on dependent and binge drinkers, he said.

Elsewhere in a new year slew of alcohol documents, a report from the NHS Confederation states that more than a quarter of the population is drinking at hazardous levels and the burden on the NHS is unsustainable, while a new report from the Scottish Government estimates the societal costs of alcohol to Scotland at between £2,476m and £4,635m. The Department for Children, Schools and Families, meanwhile, has launched a national advertising campaign to raise awareness of how alcohol can make young people vulnerable to things like traffic accidents, unwanted pregnancies and poor school performance. *Why let drink decide?* includes videos featuring comedians such as Bill Bailey and Jo Brand.

*Health select committee first report of session 2009-10 – alcohol* is available to download at www.parliament.uk

*Too much of the hard stuff: what alcohol costs the NHS* available at www.nhsconfed.org

*The societal cost of alcohol misuse in Scotland for 2007 – research findings* available at www.scotland.gov.uk/publications

# Tories would scrap alcohol unit labelling

**A Conservative government would 'work with the drinks industry' to improve alcohol labelling**, according to its new public health green paper *A healthier nation*. Calling the units system 'misunderstood', it states that 'we will seek to agree the standardisation of labelling, where necessary at European level, and will ensure that alcoholic products provide an indication of calorie content.' The agreement would be voluntary, rather than mandatory as alcohol and health charities have repeatedly called for.

The green paper says the party would change the labelling system to 'take account of social norms' and help consumers understand the amount of alcohol they drink – for example, by including information about the amount of a particular drink consumed by an average person each week and the volume of alcohol contained. 'Study after study has shown that social norms are much more important than policymakers have traditionally assumed,' says the document. 'People are deeply influenced by the behaviour of those around them.' A tougher licensing regime, targeting problem venues, would also be introduced, along with a ban on selling alcohol below cost price.

Alcohol Concern chief executive Don Shenker said that public awareness of alcohol units was improving, however. 'Achieving uniformity to measure how much we're drinking across Europe is a good idea, but changing the system to improve awareness without subsequent mandatory action will not reduce alcohol harm,' he said. 'The Conservatives should pledge to make alcohol labelling mandatory if they're serious about prioritising public health over big business.'

The green paper states that responsibility for improving public health – and its budget – 'must be decentralised as far as possible, away form central government and out to local communities', with councils, communities and independent providers 'rewarded' for reducing problems like alcohol misuse.

Personal choice is referred to repeatedly in the document. 'We can't escape the fact that today many of our most severe health problems are caused, in part, by the wrong personal choices' writes David Cameron in the introduction. Binge drinking and drug misuse would require 'an altogether different approach to the one we've seen before' he states, including the creation of a new Department of Public Health.

An incentive system would 'reward communities and providers which make progress improving public health against a set of outcomes', potentially including 'reduction in incidence of alcohol-related diseases' and 'reduction in prevalence of illegal drug use', says the document.

*Available at www.conservatives.com*

## News in Brief

### Cocaine rise continues

The number of teenagers entering treatment for heroin or crack has fallen by a third in four years – to 657 – according to figures from the NTA released last month. However, those being helped for cocaine problems increased by more than half, to 806, says *Substance misuse among young people – the data for 2008/09*. The number of cocaine-dependent women under 35 entering treatment also increased by 60 per cent in the last four years – the figures were 'consistent with national data charting the increased use of cocaine in recent years,' said NTA director of delivery Rosanna O'Connor.

### Opium export value falls

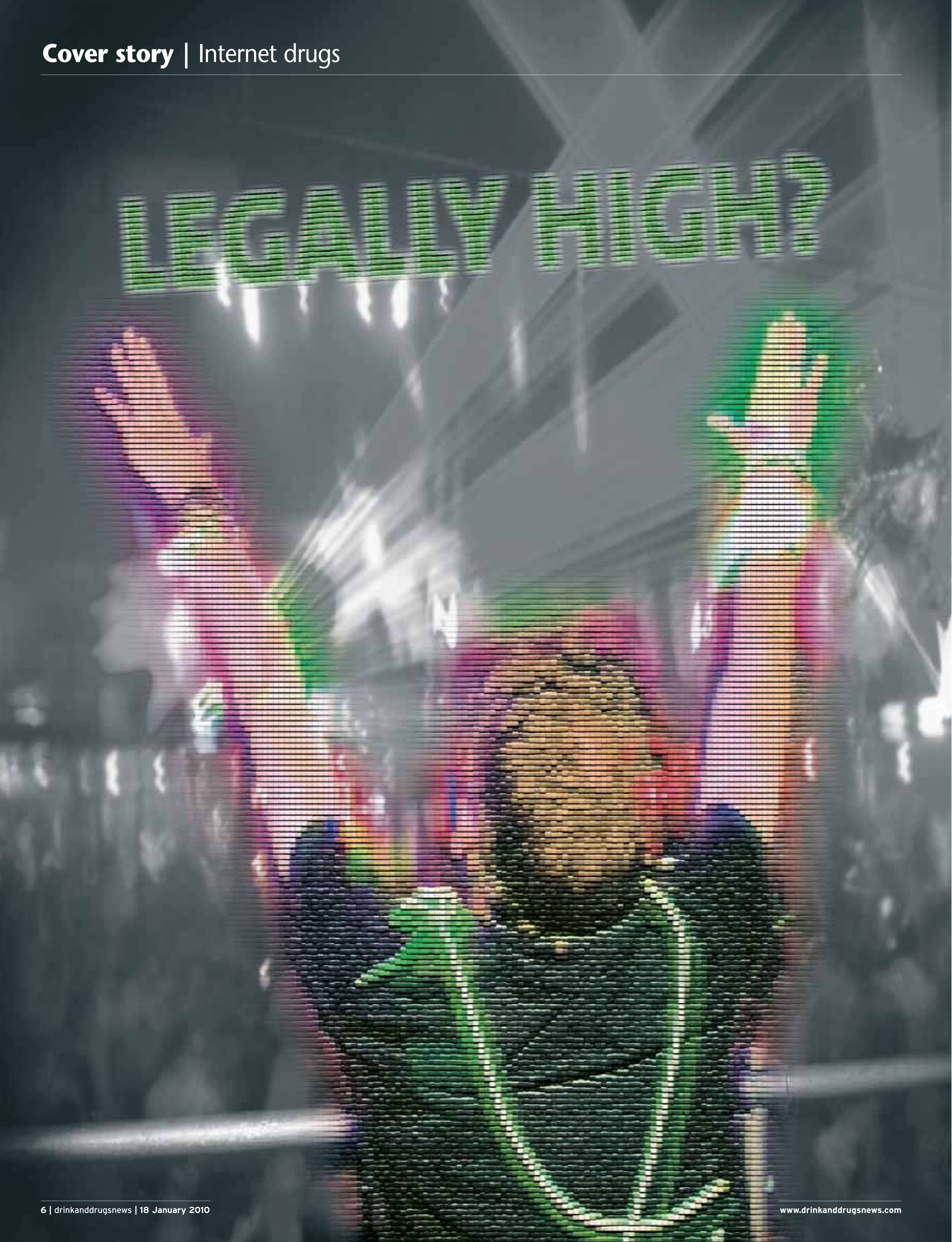
The potential gross export value of Afghan opium fell 18 per cent between 2008 and 2009 – from $3.4bn to $2.8bn – according to UNODC's *Afghanistan Opium Survey 2009*. The report attributes the fall to lower production, less cultivation and lower prices. However, annual fluctuations did not 'tell the whole story' said UNODC executive director Antonio Maria Costa, who called on the Afghan authorities to act to ensure that farmers had 'sustainable, licit livelihoods'. Available at www.unodc.org

### MACS gets max results

An outreach programme to help rehabilitate people who steal to fund their drug use has been singled out for praise by the Home Office. Merton adult crack service (MACS) targets newly-released prisoners and service users who have dropped out of other programmes by visiting their homes or meeting them in the community. 'Helping addicts to get the treatment they need removes the driving force behind crimes like robbery and burglary,' said Home Office minister Alan Campbell. Merton now had the best reduction rate for re-offending in London, said Merton police's acting chief inspector for partnerships, Helen Harper.

### Make the connection

The CONNECTIONS Project is compiling examples of good practice in prevention of drug use and infectious diseases in prisons and other criminal justice settings like police custody and probation. If you'd like your project to be be included in the research contact Karen.milne-skillman@kent.ac.uk


LEGALLY HIGH?

## The last few months have seen a dramatic increase in use of – and media interest in – 'legal highs', especially mephedrone or 'miaow/meow'. David Gilliver takes a look at a legislative minefield

When the government announced its intention last year to ban a range of 'legal highs' and make them class C drugs, Release accused it of 'chasing its tail' in an attempt to 'stay ahead of the demand for drugs and those who supply them' (*DDN*, 7 September 2009, page 4).

The chemicals were BZP and related piperazines, GBL and a related chemical and the synthetic cannabinoids used to make smoking products like Spice. Release's accusation seemed to be vindicated very quickly, however. Anecdotal evidence soon started to filter through about a sharp increase in use of the stimulant mephedrone (4-methylmethcathinone), known as 'miaow'. After the drug was implicated in the death of a young woman in Brighton late last year, there was a rash of mephedrone stories in the press, followed – a couple of weeks later – by stories about how that coverage had led to a huge boost in sales, with many online suppliers selling out altogether.

Luci Hammond is a young person's alcohol worker at Brighton-based service ru-ok? She started to notice a very sharp increase in miaow use in the second half of last year. 'It just hit very quickly,' she says. 'We started getting reports of it being used by young people and we had parents and professionals asking questions about it, but since then we've had a lot of young people coming to us themselves.'

There has been much talk about the drug's growing use in clubs, with people turning to it because of the poor quality of available ecstasy and cocaine – as little as 2 per cent purity in the latter case (*DDN*, 21 September 2009, page 5). However, what Hammond has found – and what the press has been quick to pick up on – is the worrying popularity of the drug among children.

So far, her youngest client to have used miaow is 12. The majority are 14 and up, but '14 is common' she says. Where are they taking it – presumably they can't get into nightclubs? 'The majority of them can't, but there are under-18 nights where they use it, as well as at parties and out on the streets. They'll sit in parks and cemeteries, so they're putting themselves at risk just through the location.' And what about other legal highs? 'This is the big one. We're hearing bits about BZP and Spice but nothing compared to this.'

John Ramsey runs the TICTAC drug-testing database at St. George's, University of London, and has seen a dramatic increase in the use of legal highs. 'We analyse the contents of club amnesty bins and we test purchase stuff from websites – that's how we come to be pretty up-to-date on new and emerging compounds,' he says. 'We've been doing this for ten or 15 years and at one time it was really unusual to find anything new. Now we find something new virtually weekly. We go to Glastonbury each year and there were huge amounts of mephedrone there last time – there was one seizure of 120g. Two or three years ago there wasn't any.'

Legal highs are available in 'head' shops but anecdotal evidence – and the scale of use being reported – would suggest that most people are buying them quickly and easily online. Indeed, many of the press mephedrone stories have practically been guides to getting hold of the drug, couched in obligatory disapproving language.

'If you go online and put in 'legal highs' you get hundreds of results,' says Renato Masetti, training coordinator at Suffolk DAAT, who puts on conference workshops to alert drug workers to issues around legal highs. 'They are available in shops but essentially it's an online phenomenon – you've got comments, forums, you can write in and say which one was good and which wasn't, just like on Amazon. There's a whole community out there – the online forums have gone mad.'

But presumably most 13 and 14-year-olds aren't buying the drugs online, unless they're using their parents' credit cards? 'A lot of our young people are getting it from friends, but we're hearing of dealers specialising in miaow and selling it to school-age children,' says Hammond. 'They're buying it in bulk online, possibly cutting it, and selling it on. We've also heard reports of young people dealing because they think it's risk-free, a legal substance. At the start the reports were "you get no comedown, it's all legal". It was seen as pure – everything sounded lovely. Now it's being used more frequently we've discovered it's not so lovely.' She's started to see behaviour change in her clients, like paranoia, aggression and anxiety, and even signs of dependency. 'We've heard about shakes and poor co-ordination with withdrawal,' she says.

How widespread is the problem in Brighton? 'I would say in terms of speaking to young people, it's probably about five a day,' she says. 'One young person will tell us that their friends are doing it, or a teacher will ring up and say that the whole class is talking about it. I'm a young person's alcohol worker but almost all my clients have tried miaow, even the ones who've always said "I'd never do drugs", because it isn't considered a dangerous drug. This is the message we're trying to get across – that it does seem to be a dangerous drug.'

How are they taking it? 'Most are snorting, which is what we're trying to advise against – if you are going to use it we'd rather it was bombed [swallowed]. We've had people smoking it as well, in a bong or cone. But it's really painful to snort, and we're hearing of nosebleeds that recur for days afterwards, as well as spinal and joint ache. And miaow isn't enough now – they want to do it with ketamine or acid or nitrous oxide. There seems to be a cocktail culture out there.'

Clubbers of the '80s and '90s were sometimes described as the 'guinea pig generation', as no one really knew what effects long-term ecstasy use might have. But with mephedrone and other legal highs – anecdotal chat room accounts aside – there really is no information, because there's been no research. 'How can there be – who's going to pay for it?' says John Ramsey. 'For example the cannabinoids in things like Spice are completely untested and yet they clearly work – the legislation has got to control about 240 of the things. Who can research 240 new chemical compounds?'

Indeed even the names seem something of a moveable feast, with a variety of drugs passed off as miaow depending on who's selling it and in

*Continued over* →

**'We analyse the contents of club amnesty bins and we test purchase stuff from websites – that's how we come to be pretty up-to-date on new and emerging compounds... We've been doing this for ten or 15 years and at one time it was really unusual to find anything new. Now we find something new virtually weekly.'**

what part of the country. 'There are fewer dealers in the chain and there does seem to be some evidence of people selling allegedly illegal drugs which when they're tested are found to be legal, so you have this fascinating phenomenon of the illegal market pinching from the legal market and pretending it's illegal – because people think illegal stuff is better,' says Masetti. 'We've been told that miaow can be made up of different compounds, and it's also being mixed with stuff now,' says Hammond. 'It started off a few months ago at £15 per gram and now it's £3.50. You can get pure mephedrone but you don't really know from mix to mix what you're getting.'

However the miaow John Ramsey has tested has been consistent. 'Every time we've analysed it it's been 4-methylmethcathinone, and there appear to be vast amounts of it about. I get a lot of calls from police officers who are being asked what they're going to do about it. Of course the answer is "nothing", because it's not illegal.'

The legal status does really appear to mean that many people think the drugs are safe and harmless. 'We've had parents saying "we're telling our kids not to do illegal things" and they're saying "but it's not illegal" says Hammond. 'I don't think many teenagers would think that they could buy something from a high street head shop that's going to cause them to end up in an A&E department,' says Ramsey. 'They wouldn't think people would be allowed to sell things that would do that.'

And A&E, it seems, is not an exaggeration. Luci Hammond visits regularly and whereas before her clients were there through drink or illegal drugs, now it's often miaow. 'We're starting to see people coming in with miaow overdoses – anxiety, excessive aggression, disturbed sleep, being sick. One parent brought her child in because he was screaming and shaking in his sleep and they put that down to a miaow overdose. One client did it at a party and kept collapsing – his knees would just buckle underneath him.'

'I've seen a couple of forums where there was talk about it causing blue knees and blue elbows,' adds John Ramsey. 'That means it could be an inhibitor of muscle metabolism – that's not beyond the realms of possibility.'

Does he think the government is really chasing its tail when it comes to legislating on legal highs? Won't the chemists just come up with a slightly different compound? 'To some extent, but the new legislation includes piperazines – BZP and that whole family – and it is proper generic classification, not a list of compounds, so it should cut off the piperazines as a family. While there's always scope for somebody to innovate something that hasn't been foreseen, it makes it much more difficult to do that. But obviously the legislation completely ignores the cathinones, like mephedrone, which haven't even been risk-assessed yet. The alternative is to do nothing, but you've got teenagers buying chemicals which are completely untested for safety and using them as drugs – you've got to try and prevent that.'

'It's an interesting challenge,' says Renato Masetti. 'I think we need to be creative about other responses, rather than just straight legislation. You've got the example of GHB and GBL – GHB was made class C a while back and yet you found the same amount of seizures of GHB as GBL. The fact that you've classified doesn't seem to have made much difference. Legislation is a very heavy hammer, and it's too clumsy with chemicals that can be altered quickly. Legislation becomes really difficult because if it's too broad it captures useful products in industry.'

He's also unconvinced that people are switching to these drugs on a large scale because of the declining quality of cocaine and ecstasy. 'That upshares/downshares has been going on for ages – purity rates go up and down. I think to some extent this is probably a separate thing – experimental people who don't wish to break the law and are looking for legal alternatives. This happened years ago when there was a big 'herbal highs' thing, but they were awful, caffeine-based things. I think people have been quite surprised this time – they've found that actually they're effective.'

In the myriad of online forums, the effects of mephedrone are often described as a kind of mix of amphetamine and MDMA, but with a shorter-lasting effect than the latter. 'The chemical structures are based on the khat plant, but the compounds have nothing to do with the plant – they're modifications of a molecule derived from the plant – so from a chemical point of view you'd predict that it's going to be a stimulant,' says Ramsey. 'I can't see how it's likely to be empathogenic like MDMA, it's more likely to be like amphetamine or even methylamphetamine. But it's never been used as a drug before so there's no data on its half-life, its potency or anything.'

The similarity with methylamphetamine/methamphetamine is borne out by the behaviour of Hammond's clients. 'We're hearing of people aged 14 or 15 who are doing three-day binges, seven-day binges. They're not able to go to school and we've had people saying "I feel like I'm dying, I can't stop." We've had people who've used illegal drugs saying this is the most addictive thing they've ever had.'

So what's the answer – is it better education? 'Absolutely, but it's a fine line between educating and promoting,' says Ramsey. 'We're used to that in the drug field, but we do need some sort of generic education.' What about the FRANK 'crazy chemist' campaign launched last year? (*DDN*, 5 October 2009, page 4). 'That's not based on any sound knowledge,' he says. 'Just anecdotal observations.'

'I'm a trainer so I'm biased but I think training is really important,' says Masetti. 'It's important for drug teams to know the specifics about these drugs, but not because treatment is going to be any different from what they're doing already – it's more around confidence-building. I'd like to see awareness-raising in services so they can engage with these clients who don't see themselves as traditional illegal drug users. We know very little about these drugs but because they're synthetic mimickers that work similarly to the illegal drugs they're mimicking, the treatments will be very similar – you don't need to learn any special techniques. But we do need to get some research going on these drugs asap, along with general harm reduction advice.'

Late last year two members of the Advisory Council on the Misuse of Drugs (ACMD) told *The Times* that the council had serious concerns about drugs like mephedrone and was proposing a more rapid system of appraisal, and the ACMD had in fact constituted a working group on cathinone compounds of which John Ramsey was a member. 'But all of that's collapsed now because everybody's resigned,' he says.

Sacked ACMD chair Prof David Nutt has said his new organisation, the Independent Council on Drug Harms, plans to produce guidance on legal highs, but they will be operating outside of government (see page 4).

'It's definitely getting to the "something must be done" stage,' says Ramsey. 'It's not going to go away, and it's not likely to be controlled by the Misuse of Drugs Act in the foreseeable future as they can't legislate under that without ACMD. ACMD would normally conduct a risk assessment and then recommend control or non-control but, given the disarray ACMD seems to be in, the alternative is the same process through the EMCDDA in Lisbon. They've collected information about these compounds, and it may well be that they'll do a risk assessment and recommend control throughout Europe, with all member states expected to follow.'

In fact the EMCDDA has called Britain the online capital of Europe for legal highs, with 37 per cent of all retailers operating from the UK compared to just 14 per cent in the Netherlands. 'True, but we bought some from a website that had a UK address – the credit card was debited in France and the material was shipped from New Zealand,' says Ramsey. 'But one thing is certain – there's very big money in it.'

*Renato Masetti will be running a DDN workshop on legal highs on 3 March. Call Ian Ralph for details on 020 7463 2081 or email ian@cjwellings.com*

## Prison prescribing works

There have been a number of articles in the media recently about the use of methadone prescribing within our prison systems. In October 2008 CRI were commissioned to deliver the integrated drug treatment system (IDTS) within the HMP Sheppey cluster. We now also deliver the service within two further prisons in England and so would value an opportunity to clarify some of the points around prescribing in prisons.

The IDTS programme has been introduced to ensure that treatment meets the same standards as in the community. This marks a change from the previous situation within the prison estate where drug treatment was inconsistent and often inaccessible.

Investment into IDTS has expanded the provision of detoxification, ensured that remand and short-term prisoners can benefit from continuity of treatment and significantly enhanced the provision of evidence-based treatments and therapies. IDTS has also improved the links between community-based treatment services and prison provision, which leads to higher compliance with treatment upon release and lower rates of overdose, drug-related crime and drug related death among prison leavers.

Some of the concerns around IDTS seem to rest on the spurious suggestion that the establishments 'start' people on methadone as a means of controlling the prison population. Whilst it is true that more prisoners are now in receipt of methadone and other substitute medication, this follows a comprehensive clinical assessment and in the main is a result – particularly for remands and short-term prisoners – of their existing prescribing regime being continued. Our teams continually assess offenders who enter the system on doses between 150-160mls of methadone, but reduction plans mean the majority of our case load now receive less than 50mls, a considerable step towards progressing recovery.

Longer-term prisoners are always encouraged to undergo a detoxification. Within CRI's IDTS provision in the Isle of Sheppey, 357 have completed a detoxification since April 2009 with a further 23 per cent participating in a reduction programme. The majority of prisoners prescribed by CRI within HMP Sheppey undertake treatment programmes of no more than three months, when they are either released and linked with community substance misuse services or transferred into psychosocial programmes within the prison. Another positive outcome of the programme is the significant reduction of the amount of prisoners on self-harm watch.

Of course we support the expansion of recovery oriented treatment systems and the availability of abstinence-based programmes, and in our view IDTS is a key component of this. It is useful when discussing these complex matters to place them in a context supported by fact and evidence.

**Mike Pattinson, director of operations, CRI**

## 'Pit stop' not a solution

As with Walsingham House in Bristol (*DDN***,** 30 November 2009, page 16), Kairos Community Trust has a 12-week community detox hostel in south-east London run in partnership with the local GP surgery. The service offers support within the hostel and provides a structured therapeutic programme at the Kairos healthy living centre, a five-minute walk away, facilitated by a team of trained counsellors.

The main objective of both is to help residents achieve and maintain total abstinence, improve general health, link with vital services and make decisions for continued abstinence and wellbeing. When a resident feels ready, he/she is helped to establish connections with a care manager, the ultimate aim of which is to secure a community care assessment (CCA). We feel this is the outstanding benefit of a 12-week programme – a person stabilised, confident and able enough to make decisions and establish links for a progressive onward recovery.

A cohesive continuum of care and support is provided by a post-detox 12-week programme of structured therapy followed by move-on supported accommodation and post - rehab aftercare. This offers an opportunity for people to address their substance misuse issues through to independent living. Aftercare and supported housing contribute immensely to this process, avoiding the dangerous post-rehab limbo. Successful recovery is a process, not a short pit stop. The pit stop agenda is a financial agenda and at the end of the day a waste of money.

Aftercare broadens the scope by looking at unresolved issues and referral to specialised services. A person in recovery can be supported to explore options regarding education, housing, work, family reconnection, volunteering and self-help groups and the outcomes are there for all to see.

Time and process are proven to be the essential elements for an addict to reconstruct a stable, healthy physical and bio/psychosocial lifestyle. Sound outcomes are much better than pressurised statistical outputs.

**Mossie Lyons, director of the Kairos Community Trust**

**Please email letters for publication (up to 350 words) to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Our discussion forum is now open at DDN's new website – visit www.drinkanddrugsnews.com**

# Notes from the Alliance

## Pushing carbs

**From his hot seat as the Alliance's new patron, comedian** Stewart Lee **pens a column for** ***DDN***

**My father wasn't the sort of person you'd think of as an addict. He left school at sixteen to work for an insurance company in Birmingham, and then as a sales rep for a sock manufacturer in Rugby. But my father was addicted. Addicted to crisps. Did this make him a bad person, a person who should be punished?**

He never really had a problem with crisps as a child, or even as a young man in the fifties, immersed in the after-work crisp eating culture of the pubs around the Cathedral square. His problem began in the sixties, during endless motorway journeys, laden with sock samples, with nothing to eat but forecourt food – pasties, wine gums and yes, eventually, crisps, any crisps. Crisps, crisps and more crisps.

Throughout the first few decades of his dependency, Dad maintained that he needed that carbohydrate push to propel him home from Sheffield, Leeds, wherever. Anyway, he always bought chicken crisps. He liked the taste of chicken crisps. Surely an addict would eat any crisps, irrespective of the flavour? But he was not a bad man. He was a man trying to stay awake on a motorway, sometime in the early Seventies, in a brown Morris Marina full of socks.

Then, in September 1984, long after his crisp-induced divorce, my Dad took a long dreamed of road trip around Arizona and New Mexico. But American crisp packets were so much bigger than ours, enough for a British family, that upon his return he needed many more bags to maintain his usual level. And thus began my Dad's lost decade, his face always smeared with crisp dust, his fingers perpetually yellow and salty.

But my father's decision to eat larger bags of crisps was not an ethical one. It was circumstantial. When he reached for that first big bag of crisps, just outside Wilmslow Arizona, he was not trying to invoke the ire of our moral guardians. It was 3am. He was hungry and it was all they had. Good and evil didn't really come into it.

Eventually my dad accepted he had a problem, and I hold a memory of him, finally healthy, travelling west on the M5 with a Tupperware box of newly boiled Jersey mids on the dashboard, for him to nibble at as he drove. A counsellor had suggested them, something to stem the cravings he could now control but never fully escape.

And were these potatoes, boiled and very lightly buttered, good potatoes? And were those other potatoes, sliced and fried in saturated fats, bad potatoes? And was the man eating the boiled potatoes somehow a better man than the man eating the fried potatoes five years previously? Or does morality not come into it? Were not the potatoes just potatoes, and was the man eating the potatoes not just a man? I don't know. But in the ever shifting shadows of the policy makers, potatoes remain potatoes, and people remain people. Politics, meanwhile, can suddenly change.

*Stewart Lee is a comedian, writer, director and fan of Daren Garratt's drumming.*

# Crunch time

## Concerns about public spending mean there's never been a better time to make the case for recovery-oriented treatment, says EATA chief executive **Peter Martin**

The season of the political manifesto is upon us. Politicians are waking up to the fact that the problems caused by drug and alcohol misuse run like multiple fault lines across the UK – eating away at community and family stability and costing billions in criminal justice and health responses. Are there are no votes in drugs and alcohol policy?

So what's the point of producing a manifesto for drug and alcohol treatment policy, as EATA is doing with its proposals in *Pathways to recovery*, and pushing it out for wider consideration beyond our membership? The reason is there's never been a better time to change the prevailing drug treatment system and use concerns about public service spending to argue that costs as well as lives can be saved with a new recovery direction.

Between 2001, when the NTA came into being, and 2005, the focus in policy and funding was on getting more people into harm reduction programmes and stopping people ending up in prison. Methadone, at around £3,000 per person per annum, was provided as a stabiliser. It worked up to a point in cutting crime, but produced a new dependency and in many cases a circular path in and out of treatment and prison. The sector needs to be helped out of its groove.

The idea that people could get off drugs completely and have a much greater chance of leading independent lives was not integral to policy or treatment at the outset. It is now, however, with the welcome guidance to commissioners – *Commissioning for recovery and reintegration*, published by the NTA.

We have a small but inspiring example of integrated recovery orientation in state-funded treatment in the north west pilots promoted by Mark Gilman of the NTA, involving a one-stop-shop for all substance misuse. For heroin users it includes methadone, but as a step change to drug-free independence. Choices are on offer from the start, although those for alcohol are shamefully limited.

We're hearing the voices for recovery becoming louder and there's nothing like noise to make politicians sit up. Some tremendous work is being done to open up debate on recovery and choice, and the debate is being nurtured by people who have personal experience of recovery – engaging with each other and agencies and commissioners as well as trying to persuade the local authorities and strategic partnerships that direct budgets at local level.

In a recent 'Inexcess' TV debate, Mark Gilman talked about the 'hot communities' in the UK where a core of families take up a hugely disproportionate amount of local resources – from policing disturbance on estates to the consequences of domestic violence. All tend to involve individuals and families where alcohol or drug misuse act as triggers to disruptive behaviour. Turning the life around of just one individual in these circumstances brings huge social and cost benefits.

Ordinary people who are now drug and alcohol free have for too long been below the waterline when it comes to publicity – unless they're a celebrity who can afford private rehabilitation. To refocus the investment in treatment to promote from the onset will be difficult for some but it will bring huge dividends in social, human and economic benefits.

The tensions between political parties centre on how much will be cut from public services, how much the machinery of the state will be dismantled and in whose interests those changes are likely to be. A policy that prioritises recovery orientation, offers real choices, eschews bureaucracy and simplifies access may not make it into the mainstream manifestos, but will bring enormous benefits to individuals, families, communities and ultimately to the public purse.

We must seize the day and inspire politicians with facts and projected figures on savings and effectiveness, and persuade them of the huge potential for social change that a new direction can bring. The onus is on all of us who recognise this to work together, make the case and publicise it so that our political representatives listen, understand the message and are prepared to act upon it.

Below is a summary of *Pathways to recovery*. (The full document can be found at www.eata.org.uk) The principles underpinning the manifesto include fostering independence and developing courageous leadership to change systems and objectives at all levels. The manifesto includes alcohol as an equal partner with drugs and promotes recovery-oriented treatment as the starting point from initial assessment onward. Harm reduction is a vital part of the process but not an end in itself.

An outcome-focused approach will benefit individuals by basing funding on health improvement, social wellbeing, abstinence, training for work and coming off benefits. The manifesto proposes the engagement of 'recovery mentors', as their experience and empathy are key to carrying an effective message of hope.

Self-help groups like AA, NA and

SMART are already well embedded in communities at no cost to the state and there are other effective abstinence models that are not 12-step. Self-help groups encourage lifestyle change, and users can become part of a support network with people who have made a commitment to leading lives free of drugs or alcohol – professionals need to better understand what these and other self-help groups have to offer.

A 'personalisation agenda' as part of the recovery approach gives power and resources to service users, and well-managed, flexible services with a single point of entry respond better to client needs. EATA has designed an outline of an evidence-based local treatment model, available on our website. We believe that rationalisation of complex bureaucracy will provide savings, and that mainstreaming recovery policy into welfare, child and family policy is crucial. Streamlining costly acute medical services will yield savings, and third sector organisations will be able to provide professional services, working with GPs to reduce numbers in long-term methadone treatment by helping people to abstain and move into recovery and independence.

Competitive community care funding for substance misuse treatment will need review if tier 4 rehabilitation is to be sustained, and commissioning needs reform – with PCTs joining with local authorities and strategic partnerships to plan and prioritise within the framework of a recovery approach. Methadone maintenance as the only option needs to be challenged if outcomes for service users are to improve, and workforce training and development needs to be prioritised as for some it is a barrier to success – it must be a priority for change.

*Peter Martin is chief executive of EATA*

# Policy notes

## BARGAIN BASEMENT?

### The scramble for political point-scoring must not sweep away effective interventions, warns **Sara McGrail**

**Politics and drugs have always been uneasy bedfellows.** Politicians like simple solutions to complex problems. They do not believe the voter has much in terms of intellect and understanding, so tend to go for lowest common denominator policies – ones they believe will be accepted as common sense by middle England. In 1998 the drugs field made a pact with New Labour. Give us the funding for treatment, we said, and we will cure your social ills – and save you money. We got the funding. And because we'd already offered them the solution, we were bound to spend the investment on deploying it. Treatment. Uber Alles.

But the problems we experience with drugs (and alcohol) are complex. And simple solutions will only ever address part of that complexity. We gained a lot in the past ten years – but nobody would pretend that the system is perfect.

Substance use weaves in and out of a whole range of issues in our lives – sometimes helping us cope and sometimes making matters worse. People often need to dig deep and look at pretty complex issues in their lives and because of this they may need many different kinds of support. This might change over time, with different services coming into play at different points. People also need other public services, and support with employment and housing. And we need to ensure these services are accessible to all, not something that 'wraps around' drug treatment.

That's why we've begun to recognise that enabling people to define their own recovery, and work towards a better life, is so important. We understand as workers and as commissioners that there are huge risks in putting all our eggs in one basket. There is no more point developing a treatment system entirely oriented towards abstinence than there is in having one where substitute prescribing is pushed onto everyone without any choice. People need to make choices to realise their potential and to do that they need to have things to choose between.

And it's the same in national policy. Britain experiences a range of problems in relation to substance use. Lost working days, family breakdown, health problems, crime – the list goes on. We need interventions that deal with these problems – and we need to avoid dogmatism. When we start to propose – as some in the field currently are – that what we have been doing is wrong and that we need to radically change direction, we have to be careful that we are not simply swapping one set of political conveniences for another.

Do we need abstinence-oriented services? Without a doubt. Do we need services that will stabilise and support people with substitute medication? Absolutely. We need to look at how we can balance our treatment systems so people can access the services they need. Clearly for some that will be abstinence based but there will always be others not ready to stop using – and for them we need to provide interventions that keep them as safe as possible for as long as possible.

National policy should not be based on protectionism of any one part of the drugs field. Nor should it seek to dictate individual outcomes. Recovery is not something that can – or should – be defined by the state. Effectiveness of any set of interventions can only really be validated by the person who experiences them. Both main political parties are now talking in terms of Patient Reported Outcome Measures (PROMS) as the most critical arbiters of investment in healthcare.

Substance use is a public health problem – and we need interventions that minimise harm and health inequalities. It is a crime problem and we need policies that protect communities from out of control drug markets. Problematic substance use is often a symptom of other deeper problems, which we need to ensure we tackle. But essentially it is a deeply personal problem – and we need a sophisticated range of options that enable people to get the very best out of public services to make their lives better, and so give us better value for money. And that doesn't mean turning the whole field into a politicians' bargain basement – or throwing away the gains we have all worked so hard for over the past ten years.

Recovery

# GET MOTIVATED

## Motivational interviewing can yield excellent results and the basic skills and techniques are easy to learn. **Dr Malcolm Thomas** sets out the basics of promoting behaviour change

Helping patients or clients to change their behaviour can be frustrating. As professionals, we can get into a cycle of giving advice and making suggestions, only to feel that everything we suggest is being rejected. Specialist workers often have some training in more effective techniques – this article is aimed at frontline staff, most of whom will not have had such training.

There is now rather compelling evidence that the approach known as motivational interviewing produces better results than standard care (also called 'business as usual' or 'finger wagging'). A full motivational interview takes between 45 and 60 minutes. The necessary training takes two, three or more days so it's not surprising that this has been the preserve of specialists.

However, the insights and techniques of motivational interviewing are available to 'ordinary' practitioners. I work for a training company and it's our contention that everyone whose job includes counselling patients or clients regarding behaviour change can enhance their professional effectiveness with some understanding, and judicious use, of relevant techniques.

Each of the following techniques takes no more than a few minutes to use and frontline practitioners can use them flexibly in relevant professional conversations. Regard the list as a toolkit from which the relevant tool can be unpacked as needed.

Many clients exhibit two or more behaviours that may profitably be changed, such as alcohol, drug use and diet. Usually it's the professional who chooses which one to talk about, but allowing the client to choose the focus may enhance motivation. This can be achieved by running verbally through the options as the professional sees them and inviting the client to choose, such as:

*'It looks there are three things we could talk about today. Firstly your drug use, secondly your drinking and thirdly your diet. Does that sound right?'* Then, if the client agrees: *'OK, so which would you like us to focus on today?'*

People can be a bit vague about their habits. A typical answer to *'how much alcohol do you drink'* is likely to be something like *'Well, that's a good question. It's hard to say. Depends on this and that.'*

It's usually profitable to clarify what is going on at an early stage in your professional relationship. A recommended technique is the 'typical day' question. For example, *'I wonder if I could spend a couple of minutes learning more about your drinking? Can I ask you to talk me through a typical day, starting when you wake up and finishing when you go to bed? Tell me where you go, what you do and where your drinking fits in.'* Variations on this include asking about a specific day (yesterday, last Saturday) or a typical week (which can be better for some behaviours).

It's normally very helpful to gauge the client's readiness to change or consider changing. This may be apparent from things they have said and it certainly can emerge naturally from the conversation, but this is not always the case. While it's rare for there to be no real clue, it can often be very unclear just how much readiness there is to change.

It's helpful to break readiness to change down into two components – importance and confidence. One strategy is to ask specifically about these in turn, using 'scaling questions'. For example, *'Can I just ask you a couple of questions? On a scale of one to ten, how important is it for you to cut down your drug use?'*

Say the client responds with *'Oh, I don't know. Maybe around a three,'* your response could be *'I see – thanks. Can I ask a similar question? On a scale of one to ten, if you decided to cut down, how confident would you be that you could make the change?'* Their response might be: *'That's a good question. Maybe six-ish. I cut down quite well for a while once. I think I could do that again.'*

One advantage of this approach is that you can use it as a launch pad for further exploration, such as:

*'You told me you were at three or four for importance. So can I ask you why three and not one or two?'*

*'Well, it does sometimes get me into trouble. I'd like to think I had a bit more control over it and that it didn't dominate my life quite so much.'*

*'Alright, so what would have to happen to move that score up to say five or six?'*
*'Well, if I got properly sick with it, I think that might do it.'*

People aren't daft. They indulge in unhealthy behaviours because there's a payoff. Being overweight is a side effect of eating, which is usually pleasurable. Substance users get some sort of 'high' from their substance, or a relief from withdrawal effects if dependent. Behaviours have a social context and many people enjoy doing things with friends, whether smoking, drinking or injecting.

An axiom of motivational interviewing is that our client can see pros and cons to their behaviour. Rather than offering our professional opinion, we can help by allowing the client to bring these out into the open – and then feed it back to them:

*'Can I just try to understand a bit better? Can I ask you about the pros and cons of your marijuana use? First, what are the pros of smoking it from your point of view, the things you like about smoking marijuana?*

*'Well, it relaxes me a bit, you know. And when I light up a joint with my mates, we have a good laugh. And to be honest, I prefer a smoke to a drink because you don't*

*get the hangovers – you know what I mean?'*

*'Yes, I think I see that. Ok, what about the cons? The things you don't like so much?'*

*'Well, it sometimes costs me quite a bit you know. And if I get really stoned, then I miss half the day, which isn't right. And my girlfriend isn't keen – I think she might not stand for it forever.'*

*'Can I recap then? You're telling me that it relaxes you, that you do it with your mates and that you prefer it to alcohol. On the other hand, it can cost a lot, you sometimes miss half a day and your girlfriend doesn't like it?'*

*'That's about right, yeah.'*

*'Where does that leave you today?'*

**'An axiom of motivational interviewing is that our client can see pros and cons to their behaviour. Rather than offering our professional opinion, we can help by allowing the client to bring these out into the open – and then feed it back to them.'**

This can really help in our efficient use of interview time. The client response usually tells us if they are ready to go further and get involved in change talk – or alternatively it may be clear that it isn't profitable to take things any further today.

At any point in the discussion, resistance may emerge. It is tempting to meet resistance with reasoned argument – pointing out all the scientific reasons on the side of a behaviour change. Unfortunately, this usually has the effect of stiffening resistance. For example, *'You really need to lose weight you know.'*

*'I guess so.'*

*'I think you should go on a diet.'*

*'I can't because...'*

This is known as negative self-talk. It has been shown that an increase in the amount of negative self-talk in an interview is associated with a lower chance of behaviour change occurring. It seems prudent to avoid provoking such statements. For example, *'I get the impression I may be pushing you a bit too far here. Shall we stop talking about this today?'*

*'No... It's ok, go on. It's just that this is difficult for me to get my head around.'*

This is known as 'rolling with resistance'. It can be a very effective tactic to prevent the emergence of negative self-talk. It demands that professionals should be on the lookout for signs of resistance at pretty much any stage in a behaviour change discussion.

Most of us who work with clients develop a well-polished series of mini-lectures by way of explaining all the regular things that come up and need explaining. Unfortunately, these mini-lectures may not really be wanted. Or else, we may fail to address important questions on the mind of the client. A mini-seminar might be better. A useful way of looking at this is 'elicit – provide – elicit'. Elicit any questions or information needs and provide answers or information in response. When it comes to action talk, it is better to provide a range of options to be chosen from. Finally, elicit a response – find out how your information has been received.

An example: *'Can I explain anything to you, answer any questions?'*

*'Well, have you got any information about how many units are in my various drinks. And what do you think I should do to cut down?'*

*'Ok. Let's see. This leaflet is good for information about units. How does this look?'*

*'Very clear, actually. Can I have that?'*

*'Definitely – it's for you to take away. Anything catch your eye?'*

*'Yes. Look at this about glasses of wine. I had no idea there were so many units.'*

This approach can lead to more effective use of professional time, while again minimising the risk of negative self-talk developing. Motivational interviewing gives better results than 'business as usual' and many of the individual skills and techniques are easy enough to learn and can be used in routine conversations with patients or clients. I've outlined and demonstrated a range of the most useful micro-skills, with examples of how they might fit into your conversations but a very readable and immensely practical textbook I'd recommend to any *DDN* reader is *Health Behavior Change – a guide for practitioners* by Stephen Rollnick, Chris Butler and Pip Mason (Churchill Livingstone) – despite the spelling, it's a British book.

**Dr Malcolm Thomas is director of national training provider Effective Professional Interactions Ltd. www.effectivepi.co.uk**

Eva Harvey **describes how Phoenix Futures has piloted therapeutic communities training for its staff, and extends an open invitation to commissioners**

# Therapeutic futures

**At Phoenix Futures we take pride in our ability to support service users at every stage of their recovery.**

Our adult residential rehabilitation services run a therapeutic community (TC) programme, and following the evaluation of previous 'understanding therapeutic communities' training, we have gone on to pilot some groundbreaking training for staff working in TCs in both prisons and residential settings. A working group was established to discuss how best to develop training for all new staff working in TCs, and last July a very realistic, experiential TC training package was developed by senior operational managers, the head of operations for prisons and the service manager for Sheffield Adult Residential Service.

The five-day package was designed to be run in an actual residential service setting, with training split into two halves – mornings consisted of formal training looking at the theoretical aspect of TCs, while afternoons were reserved for putting the theory into practice, with participants becoming residents and living as part of the community. Although they did not stay in the residential service – as beds were needed for service users – they did experience all of the daytime routine and had to keep development logs and journals to demonstrate how they could put the theories and methods into practice.

So that new staff in all our residential services could take advantage, it was agreed that service managers would be best placed to deliver the training. Sheffield Adult Residential Service became the pilot, with the first course run during last September by service manager Claire Groves and treatment manager at HMP Garth TC, Lyndsey Hague. I attended the training along with eight other Phoenix Futures staff members, including four from the actual service.

The programme has four stages – induction, primary, senior and re-entry. The induction stage is the settling-in stage where residents can expect a high level of support from both other residents and staff while they familiarise themselves with the programme, structure, house routines and rules. The primary and senior stages are where the real work begins, as residents concentrate on personal development, self-awareness and identifying the underlying issues that play a role in dependency.

Using a comprehensive programme of groups, workshops, seminars, community meetings and key work, the re-entry stage focuses on supporting the individual to take the first steps toward integration into the wider community, with re-entry accommodation provided off-site.

As soon as we arrived on the Monday, participants were treated as 'new inductions' and assigned jobs with other members of the community – kitchens, maintenance, gardens and front desk. The first day was a bit nerve-wracking and confusing, as we had to learn the terminology and rules, including reporting to the front desk.

We all had a chance at facilitating the morning meetings, but each group opted to do different activities – they participated in groups, sat in on a 'life story' from one of the residents and even had a 'mock' encounter. An encounter group is a form of psychotherapy in which a small group engages in intensive interactions to increase self-awareness and improve interpersonal relations, with group members encouraged to be completely honest and open.

All nine participants learned about the TC principles in the most realistic way. By Thursday we had moved to the primary stage of the programme and were given more responsibility. Some even got 'pull ups' – written slips from other residents unhappy about aspects of their behaviour within the community. By Friday we were veterans of the community and became seniors, even participating in our own graduation ceremony.

The success of this pilot means we can now implement the programme as part of the induction of all our staff in prison and residential settings, allowing first hand experience of how the TC model works in practice. Nicola Owens from HMP Wymott described the training as 'an overwhelming, emotional but fantastic rollercoaster of personal discovery, as well as a far greater understanding of a TC than I ever could have anticipated'.

For myself, it was the most groundbreaking experience of training I have ever had. I learnt more in that week than I have in my ten years in the field – not only about TCs but also about how our service users feel about entering residential treatment on an emotional level. It's a very humbling experience and I think it would be great for commissioners to experience this for themselves – they would certainly get a better understanding of what we do, what our services offer and how sometimes six months' funding may not be enough.

Every person entering treatment is different, as are their needs – where one may be ready to go into resettlement, others may need longer. By understanding service user needs on a realistic level such as this, commissioners would be able to see that funding needs to be allocated on an individual basis.

It was an amazing experience and I know it will certainly improve the practice of our staff, including my own. We would certainly welcome any commissioners that would like to experience this training, and I'd also like to thank all at Sheffield Adult Residential Service for making us feel so welcome – the experience was all the greater for your support.

*Eva Harvey is head of learning and development at Phoenix Futures. For more information contact Eva Harvey on 020 7234 9753 or 07800 681 622. Email: eva.harvey@phoenix-futures.org.uk*

*Pictured above: Eva Harvey (front) with the other training participants.*

## Post-its from Practice

# Main course

### Care is in danger of becoming lost among the trimmings, says **Dr Chris Ford**

**Alex arrived at the surgery on Christmas Eve without his usual large smile.** He said that he had just been cautioned at a nearby supermarket. He explained that he had been shopping for his Christmas lunch, but when he reached the till he realised he didn't have enough money to buy the turkey so he decided to slip it into his bag without paying.

He was observed, challenged, and the turkey was removed, but he was pleased not to be arrested. He was allowed to pay for the rest but asked not to come back. 'Well, the roast parsnips are my favourite bit' he said.

Alex has mental health problems as well as a drug problem. He has settled well into treatment, has responded to counselling, 20mg citalopram and 80mg of methadone daily. This was his first Christmas in his own flat after years of being homeless and then living in a hostel. He had started a computer course and was using his subsidised gym membership. Alex had not self-harmed for over two years, which was the longest period in his adult life without doing so. He told me that he hoped 2010 was going to continue to be positive.

I asked him again about his finances. Presently he is getting the higher rate incapacity benefit at £89.80 per week, as his claim had started before October 2008 – if he was applying now, it would be Employment and Support Allowance. He has also been appealing his loss of DLA (Disability Living Allowance). He does get housing benefit on top of this but by the time he has paid all his bills, he has about £35 a week remaining to buy all his food and cigarettes.

He stopped all alcohol use in 2009 and hopes to do similar with his smoking in 2010. However, at the moment he smokes a packet a day at a daily cost of around £6, or £42 a week. It soon becomes easy to understand why Alex attempted to supplement his income with a free turkey!

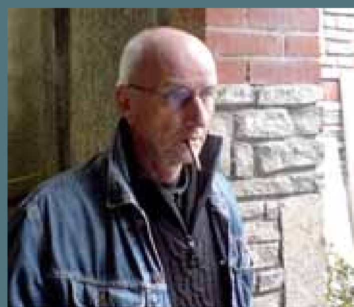
The recent changes in the government benefit system seem to me to work against patients like Alex. Many people with dual diagnosis, drug and/or alcohol problems and severe HIV and/or hepatitis C problems are being made to reapply or even have their benefits stopped. Care seems to have been lost in the system and it appears that everyone is assumed to be a malingerer, which Alex most certainly isn't.

Alex is not the quietest person and his story had spread, so while he was in with me, the staff and several of the other patients clubbed together to buy a turkey. Alex was presented with it as he was leaving. He (and I) were extraordinarily touched and he came back to thank everyone again following the holidays, adding that 2010 was definitely going to be a good year for him!

*Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP. To become a member of SMMGP and receive bi-monthly clinical and policy updates and be consulted on important topics in the field.visit www.smmgp.org.uk. Dr Ford will be part of our panel at the Right here, right now! conference in Birmingham next month*

# Dutch courage

### Our *Right here, right now!* conference in Birmingham next month sees a rare UK presentation from Theo van Dam, outspoken head of Dutch service user organisation LSD. He explains the genesis of his organisation and his often volatile dealings with the authorities



**I grew up in Utrecht in the centre of the Netherlands and started to take drugs when I was 15. Even then I wanted to show people that you can feel good taking drugs, but eventually lost control and felt unhappy with the situation.**

I tried to detox in several ways with several different programmes. After my last detox in the '80s I decided not to fight against drugs in the way I had before. Now I just wanted to focus all my energy on creating a better world for users. First, I started at an illegal drug consumption room – a total mess and very risky. After that I started to work in a crisis centre. During my interview I said 'I should be better than all of you, because I know the useless ways of detox'. I worked there for three years and liked it a lot. In that time I met a guy who had asked for money from the government for an experimental project on Aids prevention, but he didn't know how to start his project. After a night of discussion I realised that I had to do that job.

I wanted to start with two paid active drug users but the ministry didn't agree with me. I eventually made it clear that this was the way to do it. I was freewheeling all that time and initiated the first safe® use training session. I had many negative comments about that, but I believed in the ideas. When you take drugs, enjoy it – and do it safely. My office started to be a consumption room. After three years I stopped this project because it had to move to a better – and for the workers, safer – location, protected by cameras.

After that I started the LSD foundation, the Dutch national interest group for drug users. I initiated and coordinated more than 24 local unions in Holland and supported 20 other user groups all over Europe. I felt free to work in my own way by thinking about goals, effects, support and, especially, respect for all my friends. I could prepare campaigns and actions in a creative way for and with users. In my latest illegal drug consumption room I only had one rule of the house – behave normally. It really worked, but because of the police I had to stop. However, the policy makers have worked harder creating drug consumption rooms since then.

In 2005 I was no longer able to get funding. I was seen as hard to control and many people were hoping I would stop my activities. I didn't. I started my private company doing the same as before. I still like to wake up people with extreme actions, as long as users are happy with that. And I love to be the spokesman for all those users who are not able to fight for our rights.

**Drug and Alcohol Teams, Social Services**

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# Change through People

**Bring out the best in your organisation.**
Work in partnership with us to manage and respond to your training and development needs.

The Training Exchange has over 12 years experience in drugs, alcohol, supported housing & criminal justice sectors.

We care passionately about our work.

We genuinely believe that we can make a difference, improving outcomes for service users by building a confident and competent workforce.

Our courses cover:
*People skills*
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*Specialist topics – Drugs, Alcohol and Mental health*

Book onto our open course programme (see listings opposite – online booking available), or bring us in to deliver training tailored to your organisational or area needs.

**For an informal discussion contact Steve or Jo on 0117 941 5859 or info@trainingexchange.org.uk**

*Visit our website*
www.trainingexchange.org.uk

## Open access programme

**All courses closely mapped to DANOS**
**Bristol venues**

**One day courses (£125 + VAT)**

| Course | Date |
|---|---|
| Addiction, dependency & change | *1 Feb* |
| Assessment skills | *2 Feb* |
| Alcohol - Brief interventions | *10 Feb* |
| Key working & support planning | *2 Mar* |
| Difficult & aggressive behaviour | *4 Mar* |
| ITEP and Node link mapping | *19 May* |
| Steroids & other body building drugs | *8 Jul* |

**Two day courses (£210 + VAT)**

| Course | Date |
|---|---|
| Motivational interviewing | *8 & 9 Feb* |
| Management & leadership *(*£250)* | *24 & 25 Feb* |
| Brief solution focused therapy | *11 & 12 Mar* |
| Controlled drinking programme | *25 & 26 Mar* |
| Training for trainers | *30 & 31 Mar* |
| Relapse prevention | *22 & 23 Apr* |
| Dual diagnosis | *11 & 12 May* |
| Project management *(*£295)* | *17, 18 May & 9 Jun* |
| Supervision skills | *25 & 26 May* |
| Groupwork skills | *17 & 18 Jun* |
| Community reinforcement approach | *22 & 23 Jun* |
| Working with concerned others *(*£295)* | *30 Jun, 1 & 2 Jul* |
| Abuse, addiction & disclosure | *12 & 13 Oct* |

# Families Plus

## Professional Development

***"Thinking Beyond the Individual:***
***Working with Families and Substance Misuse"***

**Course dates** Mon 17 – Fri 21 May 2010
Mon 6 – Fri 10 Sept 2010
Mon 10 – Fri 14 Jan 2011

Following publication of the NTA guidelines "Supporting and involving Carers", this professional development focuses on the importance of working with families and carers and offers training in:

- Evidence based practice
- Exploring theoretical models of working with families
- Involving families/carers in the treatment of the substance misuser
- Developing services to family members/carers in their own right

*With visiting lecturers, Professor Alex Copello (Birmingham and Solihull Substance Misuse Services & the University of Birmingham) and Lorna Templeton (MHRDU at Bath – Avon & Wiltshire Mental Health Partnership NHS Trust and the University of Bath) presenting current research*

This course is accredited by the University of Bath

For details and an application form: **Families Plus**
Jill Cunningham House, East Knoyle, Salisbury, Wiltshire SP3 6BE

**Tel: 01747 832015 Email: debby.williamson@actiononaddiction.org.uk**

Action on Addiction

INVESTOR IN PEOPLE

UNIVERSITY OF BATH

# Connections

Integrated responses to drugs and infections across European criminal justice systems

## DIARY DATE

*'Drugs, Alcohol and Criminal Justice: ethics, effectiveness and economics of interventions – the second European conference of the CONNECTIONS project'*

**Friends House, London, UK**
**24-26 June 2010**

For more information on submitting abstracts and papers visit

**www.connectionsproject.eu/conference2010**

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Liverpool

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Amber offers a safe residential environment for unemployed men and women aged 17– 30 who want the opportunity to make a new start.

Amber has a 15 year track record of getting people from socially excluded groups back into independent living, offering those who have lost their way the chance to put the past behind them and move forward.

A comprehensive package is available allowing the opportunity for a young person to progress from our rural centres in Devon and Surrey back into an urban environment.

What we offer:

- An alcohol and drug free environment with supervised testing, counseling services and relapse prevention
- Removal from negative peer groups and influences, allowing individuals to break from negative cycles
- The opportunity to learn skills and overcome barriers to progression, helping rebuild self-esteem and confidence
- In-depth needs assessment with an individually tailored action plan and regular progress reports
- Nationally accredited personal development courses, including basic skills and maintaining a tenancy
- Bed spaces available on a block contract or spot purchase basis
- Value for money

In addition to the above, for young people ready to move into further education or employment our Bythesea Lodge centre in Wiltshire also offers:

- An urban environment, close to amenities
- Projects with British Waterways on Amber's narrow boat
- Opportunities to return to further education and to enter employment, with on going support
- Accommodation whilst working towards self sufficiency

**If you would like further details of what Amber has to offer or would like to visit one of the Amber centres, please contact Olly Giddings, Recruitment Manager on: 01769 582022 or email olly.giddings@amberweb.org**

"Amber could be just the answer you are seeking. The benefits to the individual and society far outweigh the costs"

www.amberweb.org

# DDN/FDAP WORKSHOPS

## We are pleased to offer the following workshops in 2010

### 23 February
### Masterclass – registration with Care Quality Commission

All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

### 24 February
### Healthy eating for a better life

Helen Sandwell, nutritionist, DDN columnist and author of the DDN nutrition toolkit offers advice and guidance on healthy eating for clients with drug and alcohol problems. Attendees of this workshop will receive a free download of DDN's nutrition toolkit, *Healthy eating for a better life*. *Cost: £115 + vat*

### 3 March
### Legal highs and other new developments in drug use

This workshop will look at some of the latest developments in the use of pychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

### 18 March
### What is clinical supervision?

Good performance management and clinical supervision are key elements of providing safe, efficient and effective services to clients. Where staff are not supervised and their practice monitored there is a risk of danger to the client, the organisation and to themselves. This one-day workshop explores best practice in clinical supervision and how to achieve this in your organisation. Run by Fiona Hackland. *Cost: £135 + vat*

### 19 March
### What is management supervision?

Line managers are often expected to cope with everything and are not always given the support to provide staff with the resources they need. This course will help managers look at different elements of their role and identify how best they can ensure they offer appropriate, timely and effective supervision, so staff can develop their skills through reflective practice. Run by Tim Morrison. *Cost: £135 + vat*

***15% discount to FDAP members.***

**All courses run from 10.00 am – 4pm in central London, and include lunch and refreshments.**

**For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. Or visit www.drinkanddrugsnews.com**

*DDN training is run as a partnership between DDN magazine and independent training providers. DDN offers trainers promotion, advertising and marketing resources, a central London venue, and admin support. If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.*

# WOMEN AND CHILDREN FIRST ?

***Supporting Female Substance Misuser's and their Families***

**Brighton Oasis Project**

25th May 2010

**Audrey Emerton Building, Brighton**

Brighton Oasis Project has over 12 years experience delivering community based substance misuse interventions to women. Our unique portfolio encompasses services for: *Women offenders; Sex workers; Children and Young People affected by familial substance misuse; Services for young women; Psycho- social interventions for women whose children are "at risk" due to their substance misuse*

This conference will bring together speakers from a variety of disciplines to discuss issues affecting female substance misuser's and their children.

We are pleased to announce that the Conference Opening Address will be given by Baroness Doreen Massey, Chair of the National Treatment Agency.

Themes to be covered in both plenary sessions and workshops include: *Dual diagnosis; Building resilience in children affected by substance misuse; Domestic Violence and substance misuse; Parenting capacity; Working with diverse groups; Primary Care; Addressing Pathway 9 (working with sex workers); Implementing a community response to Corston; Supporting affected family members; Safeguarding Children.*

**Delegate rate: £120 per person including lunch and refreshments. For more information, please e-mail info@brightonoasisproject.co.uk or call 01273 696970 or look at our website:**

www.oasisproject.org.uk

# OPEN ROAD

Reducing the **harmful impact of drugs and alcohol** on users, their families, partners and society

Open Road is the largest charity in Essex providing drug and alcohol treatment services and has been established for over 19 years. We operate centres across Essex including a range of outreach services delivering support, advice and information and structured treatment.

**Project Worker** Brentwood, Essex

£17,000 - £20,000 per annum 37.5 hours per week

The role of Project Worker is to manage the our open access service including the drop-in area, meeting and greeting new service users, offering assessments, operating the needle exchange and recruiting and supporting a team of volunteers. You will work as part off a multidisciplinary team and will need to work with service users and partner organisations.

**Service Manager** South Essex

£26,000 - £32,000 per annum 37.5 hours per week

An exciting opportunity has arisen for a lively, enthusiastic individual to manage our Tier 2/3 Open Access service in South Essex. You must be able to demonstrate strong motivational, leadership and networking skills and have a vision for the development of services across the area. You will have responsibility for a number of teams, ensuring that a quality and effective service is delivered to service users. You will ensure the smooth running of our services across Brentwood, Basildon, Castle Point & Rochford.

**New Horizons Keyworker** Colchester & Tendring, Essex

£17,000 - £21,000 per annum 37.5 hours per week

The role involves working with service users to develop their aspirations, interests, skills and involvement in meaningful community activities including education, training and employment. You will work as part of a multidisciplinary team providing assessments, planning, delivering and co-ordination of care. You will deliver 1-1 work including keyworking, group work and referral to other service providers as part an integrated process of care.

**Application packs are available via our website or by contacting Caroline Warwick on 01206 766096 or email caroline.warwick@openroad.org.uk - Applications should arrive by Thursday 4 February.**

INVESTOR IN PEOPLE

*Open Road values and respects the diversity and individual differences of our service users, staff, including contracted consultants who work for us, and our volunteers*

**www.openroad.org.uk** Registered Charity No. 1019915 Registered in England No. 2806113

# RAPt THE REHABILITATION FOR ADDICTED PRISONERS TRUST

## stopping addiction. stopping crime.

**RAPt** is a voluntary sector provider of drug and alcohol services, that help people move away from substance misuse and addiction. We are the UK's leading provider of prison-based addiction treatment, and also manage a range of other services in prisons and in the community. At RAPt we offer a generous employment benefits package including work-related clinical supervision allowance, competitive annual leave entitlements, a contributory pension scheme, death in service benefit, healthcare scheme, childcare voucher scheme and comprehensive training opportunities.

### CARAT Manager

**HMP Wormwood Scrubs, London W12**

**Starting salary £29,657 + £1,099 London weighting, 40 hrs p/w**

We are looking for a CARAT Manager to oversee all aspects of the RAPt CARAT Service in our team at HMP Wormwood Scrubs. With substantial experience of providing line management to a minimum of 2 other staff, you will also have experience of supervision of the therapeutic work of others and comprehensive knowledge of different approaches to working with drug users. An understanding of prison culture and the criminal justice field and an ability to manage and achieve demanding targets are essential to be successful in this challenging and rewarding role.

### Treatment Manager

**HMP The Mount, Hertfordshire HP3**

**Starting salary £29,657, 40 hrs p/w**

We are looking for a Treatment Manager for our drug rehabilitation programme at HMP The Mount. For this position, you will need experience of working in a primary addiction programme and a thorough knowledge of, and commitment to 12-step drug treatment. A recognised counselling qualification, managerial experience and experience of clinical supervision of others is essential. You will need to be highly motivated, efficient and determined to work in the challenging environment of a prison.

### Senior Counsellor

**HMP Everthorpe, Brough HU15**

**Starting salary £26,362, 40 hrs p/w**

### Senior Alcohol Counsellor

**Senior Alcohol Counsellor, HMP Bullingdon, Bicester OX25**

**Starting salary £26,362, 40 hrs p/w**

We are looking for a Senior Counsellor and an Alcohol Counsellor to join our teams at HMP Everthorpe and HMP Bullingdon respectively. You will need experience of providing 12 Step abstinence based treatment as well as experience of providing line management and clinical supervision, as well as experience of facilitating therapeutic groups.

### Counsellors

**HMP Bullingdon, Bicester OX25, 40 hrs p/w**
**HMP Coldingley, Surrey GU24, 40 hrs p/w**
**HMP Everthorpe, Brough HU15, 40 hrs p/w**
**HMP The Mount, Hertfordshire HP3, 40 hrs p/w**
**HMP Wayland, Norfolk IP25, 24 hrs p/w**

### Alcohol Counsellor

**HMP Bullingdon, Bicester OX25, 40 hrs p/w**

**Counsellors starting salary £23,066, (pro rata for part time)**

The successful applicants will have experience of providing counselling services to this or a similar client group, experience of facilitating therapeutic groups and will hold a recognised counselling qualification. A thorough knowledge of and commitment to the 12 step process of recovery from addiction is essential.

### CARAT Administrator

**HMP Pentonville, London N7, 40 hrs p/w**

**Starting salary £16,476 plus £1,099 London Weighting**

### Rehab Administrator (Alcohol Programme)

**HMP Bullingdon, Bicester OX25, 20 hrs p/w**

**Starting salary £16,476 (pro rata)**

To be successful for the above Administrator posts, experience of IT and databases is essential, as are good communication skills. You will also need to be efficient and enthusiastic to work within the challenging environment of a prison.

### SDP (Short Duration Programme) Group Facilitator

**HMP Norwich, Norfolk, NR1**

**Starting salary £23,066, 40 hrs p/w**

The purpose of this post is to deliver the SDP, a structured group work programme for prisoners with a history of problematic drug use. The role includes assessment of and reporting on group participants and ensuring delivery is to the required standard. We are looking for individuals with substantial experience in working within substance misuse services and have an ability to be flexible in your approach to work in order to meet the needs of clients and that of prison service commissioners. You must also have experience of facilitating group work and conducting a range of one to one interventions. A psychology qualification or background in psychology is desirable.

**To apply for any of the above positions or to apply for Sessional work, download an application pack at www.rapt.org.uk or email your request to recruitment@rapt.org.uk. Alternatively, please send a SAE to: Human Resources Dept, RAPt, Riverside House, 27-29 Vauxhall Grove, London, SW8 1SY. Please clearly state which location you would like to apply for/prefer.**

**Closing date for completed applications: 12 February 2010.**

**Registered Charity No: 1001701**

*RAPt strongly encourages applications from Black and Minority Ethnic individuals and from those in recovery from addiction.*

*Registered charity No.1028663*

### COMMUNITY DRUG SERVICE for SOUTH LONDON

## AFTERCARE SUPPORT WORKER for SUBSTANCE MISUSE

*Full Time – 36 hours weekly, Grade 27, NJC Scale, (6% Employer's Contributory Pension Scheme)*

The successful candidate will work with clients who have completed and/or dropped out of substance misuse treatment and will support them further through their recovery. This involves offering supportive services at Tier 2 level with the aim of meeting their needs further, E.g. relapse prevention, re-access Tier 3 services if needed, supporting them towards education, training, employment.

**For an Application Pack, please call: 020 8773 9393.** **Closing date for completed applications: 5th February 2010**

*Position Funded by Henry Smith Charity.*

*Lifeline has a national reputation for effective and innovative work with individuals, families and communities affected by drugs or alcohol.*

## WE ARE DELIGHTED TO OFFER THREE NEW OPPORTUNITIES IN TOWER HAMLETS, LONDON

### NURSE RNMH OR RGN – full time

**Salary: £33,328 – £35,079 pa** **Hours: 35 hours per week**
**Closing date 22-01-2010** **Interview date 27-01-2010**
**Annual Leave: 25 days plus four privilege days**

We are looking for an individual with outstanding knowledge and experience of working with adults who have a substance misuse issue. You must have an understanding of working within a shared care prescribing service.

Lifeline Project have made significant progress in the development of local community drugs services for the London Borough of Tower Hamlets. You will have to carry a caseload for adults with drug, alcohol and or poly use substance misuse problems. You will be assessing client needs and implementing the appropriate care plan, undertake full risk assessments and act as a key worker. Lifeline CDT operates a drop in service and you will play an active role in the drop in area.

You will be expected to have knowledge of the NDTMS and data reporting systems and ensure that TOPS are completed and reviewed regularly. You will work closely with GP's and play an important lead with the Satellite GP services within Tower Hamlets. You must have a current PIN Number NMC requirement.

*To discuss the post or obtain an application pack please contact Godfrey Emekekwue on 020 7790 1344 or email godfrey.emekekwue@lifeline.org.uk*

### SUBSTANCE MISUSE WORKER CDT – full time

**Salary: £25,220 - £26,784 pa** **Hours: 35 hrs per week**
**Closing Date: 22-01-2010** **Interview Date: 26-01-2010**
**Annual Leave: 25 days plus four privilege days**

An exciting opportunity has arisen for an experienced full time Substance Misuse Worker at Tower Hamlets Community Drug Team in an adult tier 2/3 shared care service.

Your main tasks will be to participate as a member of the community based multi disciplinary team in Tower Hamlets, delivering assessments, prescribing and intervention services to adults with drug, alcohol and/or poly substance misuse problems. To also act as a liaison worker between Lifeline and local GP's or other community settings as part of a shared care scheme.

This position requires one late night per week 12.00 – 7.30pm
NVQ Level 3 (health and social care) essential

*Potential applicants are encouraged to ring for an informal discussion about the role. Please contact Shelley Ratcliffe, Nurse Manager of Lifeline on Tel: 020 7790 1344 or Monsurat Alabede, Team Leader, on 020 7790 1344. To request an application pack please email tamantha.hearne@lifeline.org.uk*

### SUBSTANCE MISUSE WORKER CDT – part time

**Salary: £25,220 - £26,784 pro rata** **Hours: 15 hrs per week**
**Closing Date: 22-01-2010** **Interview Date: 26-01-2010**
**Annual Leave: 25 days plus four privilege days (pro rata)**

An exciting opportunity has arisen for an experienced part time Substance Misuse Worker at Tower Hamlets Community Drug Team in an adult tier 2/3 shared care service.

Your main tasks will be to participate as a member of the community-based, multi-disciplinary team in Tower Hamlets, delivering assessments, prescribing and intervention services to adults with drug, alcohol and/or poly substance misuse problems. To also act as a liaison worker between Lifeline and local GP's or other community settings as part of a shared care scheme.

This position requires one late night per week 12.00 - 7.30pm
NVQ Level 3 (health and social care) essential

Potential applicants are encouraged to ring for an informal discussion about the role. Please contact Shelley Ratcliffe, Nurse Manager of Lifeline on Tel: 0207 790 1344 or Monsurat Alabede Team Leader 0207 790 1344.

*To request an application pack please email tamantha.hearne@lifeline.org.uk*

*Lifeline welcomes applications regardless of race, colour, nationality, ethnic origin, gender, sexual orientation, marital status, disability, religion or age. All applicants are considered on the basis of their merits and ability to do the job.*

## Alcohol Worker

**£27,500 pa**

**Based HMP Bronzefield, Middlesex**

Kalyx is a business with a social purpose, providing custody with care for male and female prisoners and young offenders. HMP Bronzefield is the only privately managed purpose-built prison for women in the UK.

In this role you will be working with women both in groups and individually, who have misused alcohol. You will undertake alcohol assessments, and provide appropriate counselling and support. This is a sensitive subject area, and we would look to you to educate and train staff in relation to alcohol dependency. You will be working much of the time in a team or co-operative setting, which will include delivering the Alcohol Awareness Group with programme tutors, working with healthcare staff and the mental health team, as well as developing ongoing contact with relevant support agencies.

You will of course hold a relevant professional qualification or equivalent, which clearly demonstrates DANOS experience. You must have worked in a criminal justice setting, ideally a prison, and show the flexibility, sensitivity and communication skills to work in multidisciplinary and team environments.

Interested? For more information or to apply, please email your CV, with a covering note, to: **donna.oldman@kalyxservices.com**

Closing date: 29th January 2009.

**www.kalyxservices.com**

*Kalyx - a business with social purpose*

**REACH Rochdale Psychosocial Interventions Project**

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.

## Team Manager *(Ref NM334)*

**Salary: £28,863 – £30,303 • 37.5 hrs per week**

## Administration Worker *(Ref NM335)*

**Salary £16,302 – £17,038 pro rata • 22.5 hours per week**

CRI are seeking to appoint a full time Team Manager and part time Administration Worker for the Psychosocial Interventions Project in Rochdale.

REACH Rochdale is a structured day service for substance misusers, providing both group and 1:1 key-working sessions. The project also hosts the peer mentor and volunteer training scheme for the borough.

The Team Manager post holder will line manage and supervise a small team of project workers and an administrator. You will have excellent communication and developmental skills, experience of managing staff and knowledge and experience of working with substance misusers so that you may deliver high quality services in accordance with NTA & MOC guidelines.

The Administrative worker post is a new post designed to develop the service and ensure all administrative duties and data collection are managed effectively. You will therefore have experience of data collection and administrative duties and the ability to communicate effectively with a range of individuals.

There is an expectation that both post holders will take responsibility for their own professional development and will be a professional representative for CRI at all times; developing and maintaining effective working relationships with other service providers and stakeholders.

**For further information please contact: Clare Sinclair – CRI Services Manager – 07872841796**

**Closing date: 29th January 2010**
**Only electronic applications will be accepted via 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).

*safer communities, healthier lives*

## Part Time Employability Worker

**£15,494 (Pro Rata) plus benefits**
**18.5 hours per week**

*The post is funded initially for a three year period from the Lloyds TSB Foundation Grant.*

Welcome is an independent charity, working in partnership as part of Solihull Integrated Addiction Services (SIAS). We offer easy access to appropriate support and treatment for individuals whos drug use has become problematic.

We are currently looking to recruit a part time employability project worker to provide support and advocacy for individuals who have, or have had problematic drug use. The successful candidate will assist individuals in gaining access to existing provision in order to increase their employability.

Candidates should have some experience in working in the substance misuse field and previous experience in providing employment support.

**For further information, or for an application pack, please contact Lauren Lovatt on 0121 6784733**

## SUBSTANCE MISUSE USER AND CARER INVOLVEMENT WORKER

***SALARY: £21,000-£24,500***

The **Wiltshire Substance Misuse Community Safety Partnership** is looking for a dynamic and enthusiastic individual to support service user and carer involvement across Wiltshire (not Swindon). This includes supporting the Wiltshire Addiction Support Project to provide peer support and advocacy, as well as in influencing the development and provision of Substance Misuse Services in Wiltshire.

The successful applicant will have an understanding of how these services are commissioned and delivered, and will be confident operating in a multiagency environment, engaging with service users and carers, and be familiar with managing a budget.

The successful applicant must demonstrate a commitment to working for the benefit of current and potential service users and carers. This position offers the opportunity to work in an exciting and challenging environment and make a genuine contribution to improving the lives of substance misusers and their carers.

Some flexibility over working hours is preferred i.e. it is essential that the successful candidate is available for some evening and weekend work in order to meet the needs of Service Users and Carers. The candidate will have a clean driving licence and the use of a car.

Salary range from £21,000-£24,000 Depending on Knowledge, Skills and Experience

*For an application form please contact Bill Carlton, Director.*
*Email: bcarlton@swads.org.uk Tel: 01793 695405*
*Swindon and Wiltshire Alcohol and Drug Service,*
*Bradford House, 13 Milton Road, Swindon SN1 5JE.*

*For any additional information contact: eleanor.stirling@wiltshire.nhs.uk*

**Closing date: 29th January 2010**
**Interview date: 16th February 2010**

## LEWISHAM DRUG & ALCOHOL ACTION TEAM (DAAT)

## TIER 2 AND TIER 3 DRUG & ALCOHOL SERVICES

## ADULT SERVICES

## TENDER

**Are you able to champion and drive forward high quality Drugs and Alcohol Services, providing skills in the field of Health and Community Services? Do you have a track record in Performance Improvement and sustaining high quality service delivery?**

The DAAT on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust invites expressions of interest from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver substance misuse services to meet the needs of a diverse population. Prospective providers are invited to tender for a multi-purpose service under each of these headings and consortium tenders will also be considered. Services will be expected to provide a range of treatment interventions that include:

**Tier 2 - Advice, information and support**

- Advice /information (including different community languages);
- Initial assessments and referral on to appropriate services;
- Full range of harm minimisation advice;
- Preparing service users for accessing structured care;
- Needle Exchange;
- Innovative and creative outreach (with other local partners);
- Active engagement of family support groups;
- Drop-in service provision;
- Complementary Therapies;
- Tier 2 interventions for service users within the criminal justice system including those on Drug Rehabilitation Requirements (DRRs).

**Tier 3 for drugs and alcohol interventions**

- Expert medical drug/alcohol assessments including physical or psychological;
- Dose Assessment/Titration;
- Methadone/Buprenorphine stabilisation or maintenance;
- Benzodiazepine prescribing;
- Community drug or alcohol detoxification;
- Controlled drinking support and a pre-tox group;
- Joint Assessments/care planning;
- BBV Vaccinations;
- Needle exchange including availability of condoms;
- Key working including Motivational Interviewing;
- Relapse Prevention;
- Preparation and referral for detoxification;
- After care and contingency management;
- Hospital Liaison referral route into treatment;
- A&E Alcohol service;
- Dual Diagnosis;
- Psychology;
- Ante/post natal service;
- Social need including Child protection referrals;
- Day Programme/ skills development/ETE referrals;
- Community Integration and Life skills;
- Integration with the Drug Interventions Programme;
- Carers/Parents and Significant others support;
- Outreach, including needle exchange;
- Carer's assessments.

**The expected term of each of the services will be from 1st October 2010 initially for three years, with six month no fault break clauses either side, with an option to extend for a further two years, subject to review. The contracts will be based in part on a performance payment in relation to achieving a set of Treatment Outcome Indicators.**

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

*Expressions of interest should be made by **12th March 2010**, and completed tenders must be returned for receipt by no later than **12 noon, Friday 19th March 2010**.*

**See more vacancies on drinkanddrugsnews.com**

## Stoke-on-Trent Safer City Partnership

**Procurement of Pharmacological Interventions and Associated Provision to Support Recovery Focused Community Drug and Alcohol Service Delivery in Stoke-on-Trent (Reference number ITT288825)**

Stoke-on-Trent Safer City Partnership recently redesigned substance misuse services in line with a recovery focused, community based model that considers all aspects of need, including drug and alcohol use, health, offending behaviour and social functioning.

In 2008/2009 the partnership commissioned service providers to deliver adult and young people's community and inpatient services. The next stage is to commission a suitably qualified and proficient organisation to deliver **Pharmacological Interventions and Associated Provision to Support Recovery Focused Community Drug and Alcohol Service Delivery.**

Please register with Bravo Solution www.wmcoe.bravosolution.com to express an interest and receive further details. Proposals should be completed and returned by 12 noon on Friday 12 February 2010.

A training event will be held in Stoke-on-Trent on Wednesday 20 January 2010 to provide interested parties with further information.

**ADULT & CONSUMER WELLBEING**

## 3 x Substance Misuse Worker

**£24,646 - £29,236 & essential care user allowance**
**Matthew Webb House / Portico House Ref: 002700**

Telford & Wrekin Community Substance Misuse Service is a community based multi-disciplinary agency working with people with drug and alcohol problems. The service which is jointly provided by Telford & Wrekin Council and Telford & Wrekin PCT NHS.

You will need to hold a relevant professional qualification in Social Work, Nursing, Occupational Therapy or Psychology and demonstrate a commitment to multi-agency working with post qualifying experience of working in a relevant care environment.

For further information please contact Lindsey Huxtable, Team Manager, Matthew Webb House on 01952 381730 or Barbara Jones, Team Manager, Portico House on 01952 381777.

**For further details and an application form visit www.telford.gov.uk/jobs Alternatively, email the Recruitment Team at jobs@telford.gov.uk or ring 01952 383535 quoting the reference number. You must be eligible to work in the UK and please note that CVs will not be considered. Full job information is available on our website.**

Closing date: 20 January 2010.

Positive about Diversity.

Committed to protecting children and young people. All posts working with children, young people and vulnerable adults will be subject to an enhanced CRB check.

**Portsmouth City Council** is working to tackle substance misuse amongst young people. We have a post available, within our Health Improvement & Development Service, aimed at reducing the impact that substance misuse has on the individual, their family and the wider community.

## Senior Officer

**(substance misuse & young people)**
*Ref No: 1536. Salary: £28,636 - £31,754 p.a.*

This post will develop and lead the local plans for young people focusing on the prevention and treatment strategies.

**Closing date: 29 January 2010**

*To learn more about this role please call 023 9268 8536, or visit*

**www.jobsatportsmouth.co.uk**

*Harbour Drug & Alcohol Service provides a range of interventions for people with problematic substance use in the Plymouth area.*

*Harbour combines the skills and experience of a diverse workforce and welcome applications from candidates who can demonstrate a genuine commitment to achieving positive outcomes for highly marginalised client groups.*

## Service Manager – Criminal Justice Team

37 Hrs Per Week, Full Time, Ref: T3TM1
***£30,041 per annum***

An exciting opportunity has arisen for a Service Manager who will be responsible for the day-to-day operational activity of the Criminal Justice Team. This role forms part of the larger integrated offender management programme for the City of Plymouth.

Applications are invited from candidates who have specialist knowledge in substance misuse and previous experience of working at a management level in a regulated health or social care profession or similar discipline. This must be underpinned with a minimum level 5+ qualification. Proven experience of working in a community based multi-disciplinary team is preferable. Candidates must be able to deliver high quality leadership and management to their team whilst developing effective relationships with their peers both internally and externally to the Agency.

This role requires the successful candidate to have access to a vehicle and be willing to travel.

**Closing date for applications 5th February 2010**

**For further information about this post contact Julie-Anne Sunderland on (01752) 434283.**

To download further information and an application form please visit:

**www.harbour.org.uk**

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

Lewisham NHS Primary Care Trust

Lewisham

## LEWISHAM DRUG & ALCOHOL ACTION TEAM (DAAT)

## TIER 2 AND TIER 3 DRUG & ALCOHOL SERVICES

## YOUNG PEOPLE'S SERVICES

## TENDER

**Are you able to champion and drive forward high quality Drugs and Alcohol Services, providing skills in the field of Health and Community Services? Do you have a track record in Performance Improvement and sustaining high quality service delivery?**

The DAAT on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust invites expressions of interest from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver specialist support services, substance misuse services and a full range of support and therapeutic interventions for young people that meet the needs of a diverse population.

Prospective providers are invited to tender for a multi-purpose service under each of these headings and consortium tenders will also be considered. This service will provide a range of treatment interventions that include:

**Tier 2 – Advice, information and support**

- Advice /information (including different community languages);
- Offering user friendly, confidential substance use/misuse interventions to young people/adults;
- Initial assessment and referral on to appropriate services;
- Full range of harm minimisation advice;
- Prepare young people for transition into treatment;
- Offer support and aftercare when a young person has exited treatment;
- Innovative and creative outreach (with other local partners); including specific Targeted groups such as Young women and BME groups;
- Active engagement of family support groups;
- Drop in service;
- Complementary Therapies;
- Sex & Relationship Education including Condom distribution and Chlamydia testing.

**Tier 3 – Care Planned Psycho-Social intervention**

- Range of psycho-social interventions utilising; Motivational Interviewing, Brief Solution Focus, Cognitive Behavioural, Person Centred counselling etc;
- Comprehensive holistic assessment;
- Multiple access points to service;
- Joint care-planned interventions with partner agencies including adult treatment agencies for the 18-21 year age group;
- Care planned referral pathways to other treatment agencies including inpatient detoxification and stabilisation services;
- Referral pathways for pharmacological interventions if required;
- Satellite provision in primary health-care clinics, Schools & Colleges, Youth Clubs, Voluntary Sector and statutory children and young people's agencies;
- Joint care planning with Connexions in order to engage young people into employment, education and training.

**The expected term of each of the services will be from 1st July 2010 initially for three years, with six month no fault break clauses either side, with an option to extend for a further two years, subject to review. The contracts will be based in part on a performance payment in relation to achieving a set of Treatment Outcome Indicators.**

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

*Expressions of interest should be made by **17th February 2010**, and completed tenders must be returned for receipt by no later than **12 noon, Wednesday 24th February 2010**.*

## TENDER FOR THE PROVISION OF TIER 3 PSYCHOSOCIAL INTERVENTIONS FOR SUBSTANCE MISUSE CLIENTS IN POOLE

Poole Drug and Alcohol Action Team is seeking expressions of interest from suitably skilled and experienced Providers who would be able to deliver:

i) structured psychosocial interventions (pre and post test counselling) for clients affected by blood borne viruses

and

ii) psychosocial interventions for clients with complex needs referred by the Substance Misuse Assessment & Referral Team. Current service provision is 400 sessions per annum although we would expect the provider to work with a flexible approach in accordance with any possible increase in referrals.

Poole DAAT intends to contract with an experienced provider who submits the most economically advantageous tender. Potential providers must have comprehensive knowledge of the needs of substance misuse clients and their families/carers and the wider community. Applicants proposing to submit a tender must have at least 3 years experience of providing services of this kind, hold a current counselling qualification with a recognised accrediting counselling or psychotherapy body such as FDAP (NNAC), UKRC, BCAP or CPCAB. The Provider will be expected to provide premises within the Borough of Poole for this service.

The contract is due to commence at the beginning of April 2010 for a period of three years with an option to extend by a further period of two years subject to annual review, satisfactory performance and recurrent funding.

Poole DAAT does not bind itself to accept the lowest or any tender.

**Expressions of interest should be made in writing by 29th January 2010 to: ros.chalker@poole.gov.uk or Ros Chalker, Contracts Officer, Poole Drug & Alcohol Action Team, Borough of Poole, Civic Centre, Poole, BH15 2RU.**

Tender packs will be sent out week commencing 1st February 2010 with a return deadline of Friday 19th February 2010 (2pm).

**A new alcohol service for East Sussex.**
**A new job for you.**

Action for Change has secured a new three year contract to deliver a significantly larger and more responsive alcohol service across East Sussex. As part of this service a new dedicated alcohol team will be based within the Lewes Prison Healthcare team. They will deliver alcohol detoxifications, structured interventions, and work closely with prisoners and prison service staff to ensure effective liaison with community organisations across Sussex for prisoners when released. The team will work to ensure that the continuity of care for alcohol misusing prisoners is of the highest quality.

To accomplish this task, Action for Change is recruiting the following staff to deliver the service:

## Alcohol Nurse

**£24,831 – £33,436 | 37 hours per week**

You should be able to demonstrate skills and experience of working with alcohol misusers, excellent liason and networking skills, and good organisational and ICT skills.

In return, we offer 27 days annual leave entitlement; a pension employer contribution of 5%; an excellent working environment; and first class training and development.

**For a job pack, please email reception.hh@action-for-change.org or visit www.action-for-change.org for more information.**

**Closing date: Monday, 1st February 2010.**

All posts are required to have the Prison Service Enhanced Security Clearance and an Enhanced CRB check. Action for Change seeks to be an Equal Opportunities Employer, and welcomes applications from all sections of the community.

Registered Charity No. 1043142. Company Registration No. 2920770.

**www.action-for-change.org**

# DON'T MISS..... The DDN Residential Treatment Directory

The next pull-out-and-keep directory from DDN will be the Winter edition of *The Residential Treatment Directory*. This definitive, comprehensive listing for both statutory referrers and those seeking treatment will feature in the next issue of DDN on Monday 1 February.

**To create or verify a listing for your treatment agency please contact Faye Liddle before Friday 22 January on 020 7463 2205 or email faye@cjwellings.com**