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DDN
Drink and Drugs News

'It's all very well putting "codeine" on a product but most people think it's just a painkiller – they don't realise it's an opiate.'

THE INNER LIGHT
The quiet process of recovery – a journey to Quakerism via AA

INNOVATION WALES
Think global, celebrate local – services look further afield

HIGH STREET ADDICTION

OVER-THE-COUNTER CODEINE: A GROWING AND UNDER-REPORTED PROBLEM

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Editorial – Claire Brown

Beyond the squeeze

Don't let recession kill the drive to innovate

Innovating in times of uncertainty can be a pretty tall order, particularly if management is already hinting that belt-tightening is imminent. We're already hearing of organisations terrorising their staff with the threat of budget cuts, and the mere process of managers acknowledging that they need to prove cost savings to their board can translate to debilitating fear of job losses in the ranks.

Staff at Swanswell in Birmingham are no more immune to the economic climate than anyone else, but they seem determined to turn the current situation into a positive challenge (page 14). 'If you have a good idea, have a go – even if you risk failing,' their chief executive urges. And the ideas that come forth might only seem small, but they can have a big impact on clients as well as staff morale.

What's important is that they're not being told 'no investment in new projects right now'. Without getting all 'Pollyanna' about it, optimism and motivation are paramount when your clients need more than ever to find hope at the door of their services. A culture of despondency cascading down the organisation is unlikely to make staff work smarter. Glyn Davies echoes the sentiment on page 16, calling for a celebration of progress every now and again, alongside facing challenges that can be tougher than ever.

Our cover story looks at an issue that's as tricky to tackle as alcohol regulation and as difficult to measure as dangerous drinking. Addiction to codeine can take hold before people realise that they're popping pills every day for more than just a headache – and there's not much around to help them when they realise they're hooked. Some doctors are dismissive of codeine dependency at best and can contribute to it at worst, and support groups are struggling to get any attention and funding for a legal addiction. I hope our article will at least help to improve awareness of the over-the-counter problem that's woefully under acknowledged.

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News in Brief

Driving research

A new policy briefing on drug driving has been issued by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Alcohol is estimated to be responsible for a quarter of all annual EU road deaths but no comparable figures exist for drugs – the centre wants to see evidence gathered as a basis for prevention, with surveys on drug driving carried out in all EU member states. 'Reducing the loss of life caused by driving under the influence of psychoactive substances requires measures that are based on a scientific understanding of this complex phenomenon,' said EMCDDA director Wolfgang Götz. 'The challenge to legislators is to design sound and effective laws that can be enforced and that give a clear message to the public.' A £2.3m drug driving campaign was recently launched by the Department of Transport (*DDN*, 7 September, page 4). Available at www.emcdda.europa.eu/publications/drugs-in-focus/driving

Leicestershire links up

Councils across Leicestershire have commissioned Addaction to train police, fire service staff, pharmacists, nurses and others to identify people with alcohol problems and offer advice, following one of the biggest increases in alcohol-related hospital admissions in the country. 'Addressing a problem this complex requires everyone working in the public sector to play their part,' said Addaction's assistant director of operations, Gerv McGrath. 'We are delighted to be pioneering this project with Leicester City, Leicestershire and Rutland councils and NHS, which will help to make treatment more effective.'

Costa counters

UNODC executive director Antonio Maria Costa has responded to calls from the former presidents of Brazil, Colombia and Mexico for a drug policy based on a greater degree of decriminalisation (*DDN*, 21 September, page 4) by saying it would 'unleash an epidemic of addiction' in the developing world, as well as increase demand and endanger public health. 'Let's be open-minded about how to improve drug control,' he wrote in *The Observer*. 'But let's do it in a way that will improve the health and safety of our communities and not just make it easier for city bankers and high-street models to snort cocaine.'

Minimum price could save Scots £950m over 10 years

The introduction of a minimum price per unit of alcohol will save the Scottish government £60m in year one and £950m over ten years, according to a new report commissioned by the Scottish government.

Scotland is committed to introducing a minimum price per unit as part of its strategy *Changing Scotland's relationship with alcohol – a framework for action*, stating in March that 'strong drinks will no longer be sold for pocket money prices in Scotland' (*DDN*, 9 March, page 4). The government commissioned the University of Sheffield to adopt its Department of Health-funded research into pricing and promotion policy options (*DDN*, 18 May, page 8) for a Scottish population-based model, using prices ranging from 25p to 70p.

Using an example of 40p per unit with a promotions ban, the research concluded that harmful drinkers would pay an extra £137 per year while moderate drinkers would pay just £11. However there would be a saving across the health, crime and employment sectors of £60m in the first year and £950m over ten years.

Total alcohol consumption would fall by 5.4 per cent, concentrated among hazardous and harmful drinkers, and there would be a 10 per cent fall in hospital admissions by year ten. Alcohol-related illnesses would fall by 1,200 in the first year, with alcohol-related deaths falling by almost 19 per cent by year 10. Harmful drinkers' consumption would fall by nearly 9 per cent – or 294 units – per year, the equivalent of 11 bottles of vodka per drinker. Recent research showed that alcohol is thought to be responsible for more than a quarter of deaths in Scottish men aged between 35 and 44 and for up to one in 20 Scots deaths as a whole (*DDN*, 13 July, page 4).

'These findings confirm that minimum pricing can be a key weapon in the battle against alcohol misuse,' said health secretary Nicola Sturgeon. 'Minimum pricing will not raise the price of all drinks. It will target products sold at rock-bottom prices which are harming our health and our communities.

'Those who are damaging themselves and others by bingeing on dirt-cheap alcohol will be hit hardest, while moderate drinkers will be almost completely untouched,' she said. While minimum pricing is not the whole answer, sensible drinking starts with sensible pricing. We have to listen to the evidence if we want to start cutting the cost of alcohol misuse to families, communities and our economy.'

BMA Scotland welcomed the findings and said the evidence was now clear in favour of minimum pricing. 'This is an ambition of which we in Scotland should be proud,' said chairman Dr Brian Keighley.

A minimum price per unit south of the border was recommended earlier this year by chief medical officer Sir Liam Donaldson but the government decided not to include it in its mandatory code on alcohol (*DDN*, 23 March, page 5). In a recent letter to members of a cabinet sub-committee seen by UK newspapers, business secretary Lord Mandelson appears to commit delaying imposition of the entire mandatory code until after 2011.

Available at www.scotland.gov.uk

'Crazy Chemist' warns of legal highs

A new FRANK campaign featuring a character called the Crazy Chemist has been launched to warn of the risks associated with 'legal highs'. Aimed at 18 to 24-year-olds, the campaign will include posters, flyers and wristbands in clubs, as well as flyers in bars and record shops. There will also be targeted advertising when people attempt to buy the drugs online.

The campaign targets substances including GBL (gamma-Butyrolactone), BZP (benzylpiperazine), MCAT (mephedrone) and herbal smoking products like 'Spice'. Last month the government announced that, subject to parliamentary approval, GBL – and related chemical 1,4-Butanediol – and BZP would be banned and controlled as class C drugs by the end of the year, while synthetic cannabinoids used to make cannabis-type smoking products would be controlled as class B (*DDN*, 7 September, page 4). The move, following the advice of the Advisory Council on the Misuse of Drugs (ACMD), was branded 'disappointing' and unlikely to be effective by Release.

'The Crazy Chemist needs human lab rats to test the latest batch of paint strippers and cattle de-wormers he's selling as "legal highs"' says the campaign. 'But just because they're (currently) legal, doesn't mean they're safe.' The campaign focuses particularly on the consequences of mixing the drugs with alcohol.

The campaign is a partnership with the National Union of Students (NUS) and clubbing magazine *Mixmag*, with distribution of materials at university events and print advertising. 'There is sometimes a misconception that because a substance is legal it is safe to consume,' said home secretary Alan Johnson. 'That is not the case – they are dangerous chemicals. Through this campaign we want to educate young people who might be tempted to experiment with legal highs that they don't know what they are taking and these substances can have devastating effects, particularly when mixed with alcohol.'

Alcohol fuelling STIs and teenage pregnancies

The extent to which the UK's high rates of teenage pregnancy and sexually transmitted infections (STIs) are drink-related is revealed in a new poll commissioned by sexual health charity fpa (Family Planning Association), with 40 per cent of young people who had had sex with a new partner without using a condom saying alcohol was a factor. One in eight of these cases had resulted in unplanned pregnancy, while 7 per cent had contracted an STI.

More than a quarter of the 18-30 year old respondents to the Ipsos MORI poll said they had had sex with someone they wouldn't normally find attractive, 73 per cent of whom gave alcohol as a factor, while 70 per cent of those who said 'I have taken part in sexual activity with someone and then regretted it later' also said alcohol was a factor. More than 80 per cent thought people were less likely to use a condom if they'd been drinking, but only half that percentage thought it applied to themselves. Nine per cent reported being unable to remember if they'd had sex, or what kind of sexual activity took place, 90 per cent of whom said alcohol was a factor.

The charity is distributing posters and leaflets as part of its campaign to 'encourage greater public recognition that alcohol can and does influence sexual decision making' and encourage people to enjoy sex responsibly.

'People don't go out to take risks, they go out to have a good time,' said fpa chief executive Julia Bentley. 'People may start with the best intentions but drinking alcohol reduces the chances of using a condom with someone new and impairs sexual decision making. fpa isn't here to tell people how much they should or shouldn't drink. The point is that you're more likely to take chances with your sexual health if you've drunk alcohol. The fact that some people in our research experienced an unplanned pregnancy or an STI as a result of sex under the influence of alcohol is extremely worrying. People frequently ring our helpline the morning after drunken sex, bitterly regretting what's happened and extremely worried about the consequences.'

The Family Planning Association's website is at www.fpa.org.uk

IHRA: harm reduction redefinition

A new position statement setting out exactly what 'harm reduction' means has been issued by the International Harm Reduction Association (IHRA) – a move designed in part to counter what the association sees as the hijacking of the term in recent years.

While specific harm reduction initiatives will clearly vary for different drugs, genuine harm reduction approaches are those that are defined by a strong set of underlying principles, says the association. These include dignity and compassion, transparency, accountability and participation, and universality of rights. Policies must be evidence-based, practical and cost effective as well as incremental – 'designed to meet people's needs where they currently are in their lives'. Finally they should also challenge 'policies and practices that maximise harm'.

Harm reduction practices are those that 'accept people as they are and avoid being judgemental' says the statement, as well as uphold the principle that human rights apply to everyone. 'People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health.'

'Although the term "harm reduction" has been widely used since the 1980s, there has always been some debate regarding the exact definition,' states IHRA. 'More recently this has led to concerns that some organisations may hijack the term to justify interventions and policies which would not normally be classed as harm reduction.'

Available at www.ihra.net

Trying to look the part: alcohol industry body The Portman Group has launched a new advertising campaign to raise awareness of its code of practice and complaints procedure, emphasising that drinks companies can only use people who are – and look – 25 or over, in their advertising and marketing. The group reacted angrily to the BMA's recent call to ban all alcohol advertising, claiming that 'advertising causes brand switching, not harmful drinking' (*DDN*, 21 September, page 5). 'We have chosen to promote the 25 year-old rule because it is one of the lesser known restrictions,' said chief executive David Poley. 'It applies to any marketing activity carried out in the UK by a drinks company. The industry has set itself extremely high standards across all its marketing. Now we want to ensure consumers know the rules and how to complain.'

News in Brief

Family affairs

A series of regional consultations on working with families is being launched by Adfam. The events, to be held across the country between now and December, bring together commissioners, providers, government representatives and others to discuss the barriers to effective work. 'Families are now more widely accepted on the policy agenda than they used to be, but confusion remains about what form "improved support for families" will take,' said chief executive Vivienne Evans. 'Local partnerships and agencies are aware they're supposed to be helping families, but they don't really have the structures in place to do this yet. We can't rest on our laurels just because the word "families" is in the title of the drug strategy.' For more information call 020 7553 7640.

Disturbing trends

Use of prescription drug Zopiclone is a growing problem in the north east of England, according to research by Lifeline. The charity wants to see more support for its RADAR (routine assessment of drug-related activities and risks) research as the problem was uncovered by a pilot project questioning professionals, dealers and users. It found people were taking up to 40 tablets of the hypnosedative, often along with crack and alcohol. 'RADAR is one of the most effective ways of researching and building understanding of drugs, changes in their usage, and the social impact they have,' said director of communications Michael Linnell. 'The findings it produced on Zopiclone probably reflect the growing issue of prescription type drugs nationally – but we need more research to be sure. This type of research, which involves researchers who are in contact with, and have an understanding of, drug users – rather than those who just tick boxes – is vital.'

Capital idea

Phoenix Futures staff have raised more than £2,000 for the organisation's family services in Brighton and Sheffield by taking part in London's Great Capital Run. 'Fourteen members of staff signed up, some more begrudgingly than others,' said Julie Coombes. The money will go towards producing materials to help children of service users understand what is happening to their parents and why they have had to move house.

'I started taking a popular type of cough mixture that contained codeine and ephedrine. The two drugs combined gave me terrific high, but tolerance set in very quickly. I ended up taking more than nine litres a week.'

The medicine David Grieve is talking about, Phensedyl, is no longer available, but his addiction to it lasted 17 years and almost cost his life. An ex-police officer and prison hospital nurse, since 1993 he has run the support service Over-Count for others who've become dependent on over-the-counter (OTC) drugs.

Worries about the addictive potential of OTC medicines containing codeine prompted the Medicines and Healthcare products Regulatory Agency (MHRA) to issue new guidelines last month (*DDN*, 21 September, page 5). Warnings about the risk of addiction and not taking the medicines for more than three days will now feature on the label and patient information leaflet of all products containing either codeine or dihydrocodeine (DHC) – or, as the latter is more commonly known, diamorphine. There will be new controls on advertising – removing references to strength – and pack size, as well as information on the warning signs of addiction.

A report earlier this year by the all-party parliamentary drugs misuse group (APPDMG), *An inquiry into physical dependence and addiction to prescription and over-the-counter medication*, concluded that while there were 'no reliable figures' on the scale of addiction to OTC medication, the problem was significant enough to require action. 'The majority of the evidence the inquiry received in this area relates to over-the-counter products containing codeine', it states. These include household names like Nurofen Plus, Solpadeine, Propain Plus and Feminax, while DHC is found in Paramol. A survey by Over-Count of 1,600 of its clients quoted in the report found that the most frequently misused products were Solpadeine and Nurofen Plus, backed up by 2008 statistics from Ireland showing that the number of patients dependent on the two products – and requiring treatment – had more than doubled in two years.

Most of the clients surveyed by Over-Count said they had received little support when first approaching their GPs for help. Does that reflect David Grieve's own experience? 'I remember one GP saying – and these are almost the exact words – "I've got enough to deal with in my surgery with the alcoholics and heroin addicts without you bothering me with a trivial complaint. Stop taking the stuff and don't waste my time".

'I tried private doctors, the NHS, clinics,' he says. 'Most of the clinics were sympathetic and friendly but told me they had no knowledge of over-the-counter

Last month saw new guidelines on over-the-counter medicines containing codeine. **David Gilliver** reports on a growing – and still under-reported – problem

COUNTING THE COST

products and there was no treatment plan they could offer. I was offered Valium, methadone, Ativan – none of the stuff worked because there was no follow-up or support. I kept being told if I was a heroin addict or alcoholic then the unit would have specific funding for my treatment. The best I got was a ten-minute appointment once a month.'

Does anyone have any idea just how widespread addiction to OTC medicines is? 'We've got a database, but that's not our prime purpose,' he says. 'The MHRA runs its 'yellow card' system for pharmacies, GPs and professionals to report adverse side effects with either prescription or over-the-counter medicine. I'm a registered nurse and I filled in yellow cards to report addiction to over-the-counter medicines from when we started Over-Count in 1993 until 2000, but got fed up because every time it was "thank you for your report but unfortunately we have no entry point in our database for dependency" – if I'd put down "nausea and vomiting", no problem. So there's no national data.' The MHRA states that it is now possible to report dependency via the yellow card scheme and that the information will be collated into a database, but lack of reliable information remains a problem.

The Over-Count survey found that the majority of problems had started with people buying products to treat a minor complaint. 'Through lack of information they ended up addicted to the product itself,' says Grieve. 'There's a very small percentage who deliberately bought the product to misuse, but we found that was exclusively those who were already addicted to an illegal substance and had bought codeine-based products as a short-term alternative when they couldn't get hold of something else.'

There has been more talk in the media recently about OTC and prescription medicine dependence but the problem is still under-reported, with the all-party group's report stating that 'due to the covert nature of this type of addiction it is very hard to devise a profile for over-the-counter drug misuse'.

'I call it a "high street addiction"', says Grieve. 'The people affected haven't gone out and bought the product knowing that they were going to misuse it. The public aren't pharmacists, they don't know what these ingredients are. It's all very well putting "codeine" on a product but most people think it's just a painkiller – they don't realise it's an opiate. The adverts extol the benefits of the products but don't give you any indication of the risks. There are the new warnings, but you still have to buy the product to find out – we've been lobbying for years for more comprehensive information to be given to the consumer.'

His organisation even gets calls from people who've failed drug tests because of OTC medicines. 'We get police officers, firemen, train drivers who've been caught in drug tests,' he says. 'They take a couple of tablets for a headache and the test comes back positive for opiates – it's a job trying to prove that what they took was an over-the-counter product.'

The APPDMG report stresses the importance of online support groups like Over-Count, especially given the stigma associated with any kind of drug dependency. However, the experiences Grieve had when contacting services about his own problems are now being echoed in his attempts to secure funding for the service, in that it just doesn't fit. 'We've tried the Department of Health, the lottery, Comic Relief, common good funds, you name it,' he says. 'I've had letters saying it's too narrow to treat only legal drug misuse – that they can't discriminate against other drug users.'

As a result, so far this year the organisation has survived on less than £500 in total funding. 'We're dealing with more than 20,000 clients, including partners, and we're getting new clients all the time – in no way is it levelling off,' he says. He estimates that about 14 per cent of his clients have a 'transferred addiction', starting on a prescribed drug and moving on to OTC medicines when the prescription stopped. However, some have been given repeat prescriptions for years. 'It's worrying,' he says. 'Technically dihydrocodeine should only be prescribed for a short period. I had someone contact me recently who'd been on it for 14 years.'

The report raises the issue of busy doctors not taking the time to talk through patients' problems and prescribing, in effect, to get rid of them. Is that reflected in the experience of his clients? 'That can be a problem, but the public also need to take responsibility for themselves,' he says. 'If you go to your doctor you expect to be given a painkiller prescription, and for an overworked doctor it's easier to prescribe than to say no – they may think at least they're giving some supervision. Education of the public is a key issue.'

In the course of his dependency he would travel further and further, sometimes hundreds of miles in a day, visiting countless pharmacists. Did any warn him of the risks? 'I wasn't warned that the stuff caused dependency – I was just told it was out of stock,' he says. 'I sensed there was a reluctance to say "I think you're a drug addict" – I don't know why, because I was. Maybe they were being kind or they didn't want other people to hear that something they sold could be addictive. I just kept going to different places.'

The APPDMG report states that 'pharmacists need to be bold enough to challenge sales,' but acknowledges that making access difficult risks moving the problem to the internet. The Royal Pharmaceutical Society of Great Britain (RPSGB) estimates that 2m people in the UK now buy drugs from online pharmacies. How much of an effect is this having on dependency rates? 'That's a difficult one,' says Grieve. 'I used to do "trawling trips" because a lot of the gratification comes from the rituals of getting hold of the drugs – the anticipation, the travelling, the reward. At the moment only about 6 per cent of our clients are getting products online, but that is increasing.'

Last year the RPSGB launched an internet pharmacy logo to reassure people they were buying from a bona fide registered pharmacy, with the same criteria as the high street. 'The guidelines for UK online pharmacies are not being met,' says Grieve. 'It's supposed to be the same level of supervision as a pharmacy but, with drugs I'd get quizzed in a pharmacy about if I asked for three packets, online a little 'quantity' box drops down, going up to six. In a community pharmacy there'd be raised eyebrows if you asked for two.'

The RPSGB insists there are checks in place to stop people ordering bulk amounts online. 'The legitimate pharmacies that we regulate are basically governed by the same rules as a bricks and mortar pharmacy,' says an RPSGB spokesperson. 'If there's a restriction on a medicine and you sold them online you'd be regulated the same as in a physical setting. How online pharmacies sell their products may differ, but if there are rules governing a product it will be stipulated in the online form, and the pharmacist attached to that online pharmacy has to review all the forms – but I realise we can't make sure that people don't lie on the forms.'

The APPDMG report concludes there is a 'growing body of evidence' on addiction to OTC products, and states more research 'must be undertaken' on the scale and implications of the problem. 'It's the policy of both this government and the previous one to encourage responsible self-medication among the general public and, as part of that, deregulate products that were previously prescription-only to over-the-counter,' says Grieve. 'The policy isn't necessarily wrong but there isn't the back-up to provide support for people who've developed a problem. We urgently need research into the extent of the problem on a national basis and to plan for the provision of services for the people affected. And that is not happening.'

www.over-count.org.uk

'I've got enough to deal with in my surgery with the alcoholics and heroin addicts without you bothering me... Stop taking the stuff and don't waste my time.'

Launching Hope

Trinny Woodall had a personal reason to join guests at Hope House's relaunch

'If I hadn't had that breathing space to form strong bonds with other women, I don't know whether I would be clean or sober today.'

Television makeover star Trinny Woodall was talking at the official launch of Hope House, Action on Addiction's second-stage addiction treatment centre for women, which has relocated to south west London.

She recalled her struggle with drug and alcohol addiction and her experiences in rehab – particularly the difference that having time at a women-only facility made at a particularly chaotic time in her life.

'It's proven in school that children often do better in single sex environments and the same can apply to this,' she said. 'I made some incredibly nurturing relationships. A lot can be achieved with peer groups.

'Half-way care is so important,' she added. 'This unit should be bursting at the seams – but the reason it isn't is because there is still an issue with funding.'

Bess, a resident at the unit until six weeks ago, then took the stage to play the guitar and sing her own composition about the hope she now felt for the future. Next Vanessa recalled how she came to Hope House four years ago, 'pretty wrecked' as she 'hadn't let go of using drugs'.

'I wasn't ready, I wasn't prepared,' she explained. 'I left and relapsed, but they took me back. I was about seven stone and exhausted. I wasn't thinking anymore. I'd lost everything – I was homeless and my son was... wherever he was.

'Hope House held me when I couldn't hold myself – they loved me when I couldn't see anything in me.'

She added: 'It was important to me that it was all women. It was scary as well, as everyone came with issues of mothers and sisters. But what I got from other women I couldn't describe.

'It enabled me to go out and do what I want to do. I grabbed a couple of diplomas and am heading for work in the substance misuse field.'

Nick Barton, chief executive of Action on Addiction, told visitors to the ceremony on a sunny day in late September: 'For all the tragedy in addiction, we know change is possible against all the odds.'

'The recovery agenda is a dishonest political agenda, by which some treatment agencies are positioning themselves for a seamless transition to a Conservative government. It ignores evidence and relies on faith... It is dishonest because it is completely undeliverable financially and it raises false hopes...'

From science to faith

Reading Peter Martin's article The economics of recovery (*DDN*, 21 September, page 10) made me cast my mind back to 1993 when I co-edited a book with the title *Psychoactive drugs and harm reduction: from faith to science*. Peter's article describes one of the biggest leaps of faith I have heard for a long time.

I am completely in favour of helping people who use drugs to stop, if that is what they want. I assume that is what is meant by 'recovery'. Working with anyone who has problems with drugs must start where the individual is and could involve a range of strategies. Harm reduction should permeate the services available to drug users, which should be used on the basis of evidence of effectiveness, including cost-effectiveness, and on the basis of allocating scarce resources in the most effective way on a population base.

The recovery agenda is a dishonest political agenda, by which some treatment agencies are positioning themselves for a seamless transition to a Conservative government. It ignores evidence and relies on faith. It is becoming evangelistic. It is dishonest because it is completely undeliverable financially and it raises false hopes. It is not a public health approach.

I am quite dismayed at Peter's dismissal of 'outdated psychiatric services for drug and alcohol misuse, including methadone maintenance'. What on earth is outdated about one of the most successful interventions, as well as being one of the most researched and evaluated? Opiate substitution therapy has been shown to reduce the frequency of injecting, to reduce sharing, to reduce HIV and to reduce the crime associated with the use of illegal drugs. On top of that, by stabilising people's lives, it gets them back as functioning members of society who are able to work and able to support their families. What is outdated about that? Is that not recovery?

Mark Gilman said recently, 'I came into drugs work to keep people alive and keep them out of prison' and these are still worthy, necessary and achievable goals. The basis of drugs work should always be harm reduction. It should always be public health-based and if it helps with public order that is fine with me.

I can do no better than quote Paul Hayes from the NTA. 'We need to keep maintenance prescribing as an integral part of the drug treatment system because it stabilises people, reduces crime and reduces deaths,' he said in an interview in *The Guardian* last year. He added, 'The National Institute for Clinical Excellence says it's the right approach, the World Health Organisation says it is the right approach – but always with the proviso that those people who could leave their treatment free of drug dependency should be encouraged to do so'.

What will happen to people who fail to recover or those who choose not to, if the money for harm reduction disappears? Will there be any harm reduction left to help them?

I was accused 20 years ago of 'hurtling headlong into the past' by an eminent member of the psychiatry establishment, in reaction to my preface in the book of the first harm reduction conference in 1991. I would

preface that with 'blindly' and say it about what is happening with the 'recovery agenda' today.

Professor Pat O'Hare,
honorary president, International Harm Reduction Association; executive director, HIT

Happy talk

In response to Peter Martin's article, at the next election we will see all the parties debating how we get economic recovery and, in the drugs debate, how we force the recovery of the drug user. The problem for me is whether this is the right priority.

The world economies often look to recovery in terms of gross domestic product (GDP), while with drugs we still too often look to abstinence. We want to look at tangible benefits without actually having a clue as to why we see either as progress.

In France the president commissioned a new way of understanding success for governments and economies. It is simple, how happy are people? In the UK we work longer, possibly harder, have fewer holidays and, yes, we are a miserable bunch. So maybe we need to think afresh – that for many of us it is not about economic recovery, it is about quality of life.

In the drugs debate it cannot be simply about abstinence or about taking drugs in a safer way. The question is surely why do people take drugs and keep doing so when they no longer really enjoy them? The answer to the drugs debate cannot be reduced to a reduction in crime or abstinence from drugs. The solution is much more complex, and ultimately the success of intervention is someone feels better about themselves, physically, emotionally and spiritually.

I am a touch overweight but I am not going to diet because abstinence from food would cause me misery. What I want to do is review what I eat and then decide – more exercise, less food or just accept the middle-age spread. The reason is, my goal is to live a life where I can be happier.

As the CEO of Kaleidoscope I do not want my workers, or the government, telling people what they want from life. Instead give me, and those I work for, the skills to make informed choices.

The UK economy is still in recession and France is not. Maybe being more concerned about happiness rather than GDP benefits the very area of life we are trying to see improvements in.

Martin Blakebrough,
chief executive, Kaleidoscope

Rocky road

It is clear that Mr Shenker feels strongly about the need to provide public health messages to consumers (*DDN*, 21 September, page 11). I wholeheartedly agree. All too often consumers are in the dark about how alcohol misuse can affect their individual health and wellbeing, let alone the wider impact it can have on family relationships, work and society. Without being aware of the impact it can have, accepting personal responsibility and changing individual drinking patterns will prove even more difficult.

Mr Shenker points out that although many people know there are unit guidelines, there is still a lack of knowledge about what those guidelines are. He's right, there is. And it shows what a long, often windy and rocky road is ahead of all of us in our mission to change the drinking culture and ultimately behaviour. But rather than casting aspersions on Drinkaware's effectiveness in achieving this, in only three years of operation, it might make more sense to unite behind credible efforts to tackle the problem.

Drinkaware is an independent charity committed to ensuring consumers have the facts and resources they need to make their own decisions about how to enjoy alcohol responsibly, as part of a healthy lifestyle. Our work is underpinned by medical evidence and we have reached more than 1m consumers in the last nine months through our website alone. Millions more have seen our campaigns and use our drinks calculators, fact sheets and guides.

We are very aware that changing the UK drinking culture will not happen overnight and that education is only part of the solution. But if we all – charities, government, health professionals and the drinks industry – work together and play our part, we may see the light at the end of the tunnel sooner rather than later.

Chris Sorek,
chief executive officer, Drinkaware

The next level

I see that UKDPC has been criticised for suggesting that law enforcement might be improved if more thought were given to harm reduction (*DDN*, 21 September, page 8). Professor McKeganey says that tolerating some level of drug dealing is a reason for criticism. This indicates very sloppy thinking, in my opinion.

Given that our drug classification laws provide that the most harmful drugs attract a higher criminal penalty than lower classifications, and that our criminal justice agencies follow the principle that responses are graduated according to risk levels, it follows that the criminal justice response regarding drugs is already based on some harm reduction conception. The insistence that 'drugs are against the law, the law must be enforced at all costs, infringement will result in punishment …' does not ultimately solve the problem. The idiosyncrasies of the laws, their inconsistency in the face of scientific evidence and a lack of attention to what works to reduce the problem, are all products of this flawed thinking.

If we took Professor McKeganey's approach literally, we would have to criminalise the dealers and users of one of our most pernicious drugs. Alcohol was ranked fifth among drugs in terms of its harms by a learned study by David Nutt, Leslie A King, William Saulsbury and Colin Blakemore in *The Lancet*. After heroin, cocaine, methadone and barbiturates, alcohol would earn a class A category, and by now it might have gone up to fourth or third. But making it illegal has already been tried and found to be a disastrous mistake.

Anyone who has any experience of this field will have realised that focus on a narrow target where resources are inadequate can have undesired effects. This is not just true of drugs but of many areas of public policy. The clearest example I can provide is the response of Michael Howard as home secretary in the mid nineties to information that suggested that there was a big drug problem in our prisons. He stridently denied it, but quickly introduced drug testing.

Unfortunately, punishments were given in response to positive tests regardless of which drug was used. Because the test could detect regular cannabis use up to a few weeks after, but regular heroin use was not detected after one day or even less, many prisoners switched use from cannabis to heroin. The result was a significant increase in heroin use that carried over upon release. This is an outrageous situation to inflict on our community, for want of some careful thought about consequences and some well-considered client consultation, directed towards reducing harm. A reduced response to a lower level of harm is not the same as blind tolerance.

The professor implies that there must be no tolerance of any drug dealing, falling into a similar error to the drug-testing fiasco, but does not suggest how that might be achieved. He cannot really have thought this through. Even if we could all agree on a set of drugs whose illicit dealing would attract a rational set of criminal penalties, there would still be implicit tolerance because of constraints regarding resources needed to convict in each instance. The present system increases rather than decreases the problem, because it targets 'drugs' rather than 'problems'.

This empty rhetoric is the basis for the 'war on drugs'. Who is the enemy? Ultimately it is the people. In my experience many of these people have been damaged by abusive or other traumatic experiences, their education and social development impaired by exclusions based on learning difficulties or minority identities, or untreated anxiety, depression and other mental ills. Generations of those leaving care have been subjected to institutional neglect. Not everyone with this background uses or deals drugs, but the prevalence of these problems among offenders is very high compared to the background level, and increases in proportion to levels of multiple needs.

I notice that my newspaper today has lots of ideas for tackling problems: with costs per adult offender at £40,000 and young offenders at £100,000, and 85,000 prisoners of whom 60-70 per cent have a drug problem, I reckon we are spending £250-300m 'imprisoning drugs' and making things worse, let alone the social costs. Why not try tackling and preventing the most problematic drug use more effectively? if we have energy left, we can then get to the next level.

Eleanor Levy, head of drug and alcohol services, St Mungo's

Fantasy island

The letters page seems to have been almost entirely given over to fantasists (I exclude Neil McKeganey from this although I often don't agree with him).

Elisabeth Reichert's letter (*DDN*, 21 September, page 8) refers to allowing people to 'recover their natural abstinence' – this seems to be judge-mental in suggesting this is some sort of ideal state and does not appear to recognise the fact that essentially every human society has used mind-altering substances. Indeed it can be seen as a basic human drive. Many people use many substances without problems, many people who develop problems change without help. We are also born abstinent from food and air – should we attempt to recover our natural abstinence there?

Letters continued →

Intriguing as it was I did not contact the number for Kenneth Eckersley's miracle (*DDN*, 21 September, page 8) although I believe it is important to point out that economists have not noted what he claimed – indeed the BMA's recommendation for a minimum price per unit of alcohol is based on precisely this principle. However, things are complicated and not everything can be reduced to black and white, as heroin demand is relatively unaffected by price (*ie* is inelastic). When people come from fundamentalist positions (which I am suggesting these two individuals do) they end up twisting facts, and the world, to fit them.

Niall Scott, mental health and substance use worker, Staffordshire.

Dying for a chance

In my native Scotland in the 1970s there was a small group of people addicted to various opiates. In those days addicts had to go to the GP who would arrange treatment in the local mental hospital and four weeks later we were 'magically' cured of all of our problems. I was 18 and bemused by the treatment of my fellow sufferers.

Clinics would treat addiction as a 'quick in and out' process and the cure was in sight. This course of action led to many close friends moving out of their native Scotland to major cities around the UK where they might find a sympathetic GP. This was like roulette.

In my case I went London and found a doctor who, for £100 a week, would let me have whatever would keep me happy. Fourteen years later I was still with that same GP and by then a wreck hooked on cocaine, Physeptone and diamorphine, and as long as I paid I was scripted.

When I read the recent studies by Prof John Strang (DDN, 21 September, page 4) I jumped for joy knowing he was a man of great knowledge and understanding in the drug field. But as I read on about the trials I saw they were only applicable to the so-called 'hardened addict' – the addict that was beyond help.

There are thousands of addicts in this country who are a crying out to be given the chance of injectable diamorphine. With this script they could start to rebuild their lives again instead of being put through hoops, having their scripts terminated and going back to using street smack.

Surely we cannot let these people down, many of whom have injected all types of brick dust and are in such poor mental and physical health, simply because the treatment is done one way – the clinician's way.

We have a chance to really help many people with this treatment pioneered by Prof Strang. Let us not overlook people all over the UK who need this valuable treatment and are dying to be given the chance to rebuild their broken lives. These people not only need this treatment, but also have a right to it, so for their sake get it rolled out throughout the UK and stop allowing them to fall through the net.

Bri Edwards, Cumbria

Living proof

What does gear mean to me?
Well it stopped the voices
Delayed ennui
Sometimes in a Daedalus way
When there's a drought
Nothing about
Anywhere.

I'd hunt the hit
From meet to meet
Pounding the street
Mobile as a phone
I'd seek the mother lode.

Hot when cold
Standing on corners
Waiting
Anticipating
Even praying at times
Sweating and sore
With a score in my fist:
'Christ,
Is this
What it means
to live?'

Rob Tracey

Apology to Victoria

Our apologies to Dr Vic Manning for referring to her as 'he' in our last issue (DDN, 21 September, page 12).

We welcome your letters...

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

Notes from the Alliance

Have your say

Don't miss this chance to make sure your voice is heard, urges Daren Garratt

THE HOME OFFICE DRUG STRATEGY UNIT is hosting a number of consultation events over the coming months, to which a wide range of stakeholders are invited to give presentations on how various aspects of the government's current drug strategy are affecting the families and communities it is designed to protect.

I've been asked to attend on Friday 9 October and provide a user perspective on how much progress the government has made against the targets set out in their 2008-11 action plan and, perhaps more importantly, what they still need to do.

Now I have a number of issues with this. Firstly, I'm not convinced that my individual opinion, or that of any specific, nominal person, can effectively reflect the views, needs, aspirations and experiences of such a diverse, unique and exceptional group of individuals that make up drug-using communities. What we can do, however, is consult, collect and present these real-life stories to government in as credible way as possible.

And this brings me onto my second issue – what are we actually meant to be measuring this progress against?

In conjunction with the government's ten-year drug strategy, the Home Office also published a three-year action plan, highlighting a series of key tasks and objectives to be achieved by 2011. They want to gather users' views on any relevant progress (or not) and I would be extremely grateful if *DDN* readers could contact me before 9 October with your views on issues such as:

- Have partnerships increased the number of crack users entering effective treatment providing additional support?
- Are services better adapted to the needs of groups who currently have poor access, including those with childcare needs and some BME groups, or who have complex needs such as serious mental health problems?
- Has treatment become more personalised and focused on outcomes, with more successfully completing treatment, having overcome dependency?
- Are services making full use of up-to-date evidence in the provision of treatment including:
  - injectable heroin and methadone
  - contingency management
  - the use of mutual support networks
- Do users have access to wider services to help them to complete treatment and to re-establish their lives, including:
  - referral of drug users in receipt of benefits into treatment
  - provision of an appropriate 'safety net' of support, to which other claimants would be entitled, for drug users in treatment
  - the use of the housing, employment and other indicators within the Treatment Outcome Profile to monitor the effectiveness of provision
  - guidance for ATOS healthcare professionals in carrying out medical assessments of fitness for work
  - joint planning by primary care trusts, JobcentrePlus and local authorities to coordinate the management of drug misusers through treatment and into work

To discuss these and many more issues and ensure your voice and experiences are shared with central government, please contact me at daren@m-alliance.org.uk and let's see if we can shape the policies of future governments.

Daren Garratt is executive director of the Alliance.

Enough is enough

Budget cuts are looming and the sector's identity is changing before our eyes. Someone needs to say stop, says **Andy Stonard**

IN THE LAST YEAR, I am told, around 40 per cent of the drug and alcohol treatment contracts in England have gone out to tender. From the conversations I've had with directors and chief executives, organisations estimate they spend around 10 per cent of their management time – and therefore budget – on tenders.

One year on, one of these organisations could have 20 services. A year later they could have 30, or 10, or still have 20, but with at least half of them different from the year before. I have been told that this is change, and that evolution is a good thing. The view from the NTA is that treatment is much better now and, anyway, they have very little influence over tendering.

Treatment should be driven by user involvement and local stakeholders – that is the mantra and I could not argue with that, though I think it is seldom practised. So is this what they want – a workforce that is unclear who their employers are going to be for at least six months during the tendering process and where contract change usually involves staff turnovers of between 25-50 per cent? Do they want valuable management time diverted from their own service? Do they need the animosity that this constant tendering competition generates?

These organisations are called charities. They used to operate as charities but they now exist on between 90-100 per cent statutory contracts. They have little or no time to drive innovative developments and they no longer represent the individual as they are a contracted service provider.

Their charitable aims also become lost in their advertising and PR drive – describing themselves as 'one of the largest', 'the best', 'reducing crime', 'changing lives', with bold new logos and a new website. What would be described on TV as a makeover.

In the contract world everyone plays the instant makeover game, agreeing that they can turn this person's life around, stop them offending and improve nearly every aspect of their life in under 13 weeks. And prove it statistically – honest guv – we haven't fiddled with the stats.

As a consequence, services that have been run for 30 years by one organisation are swept away by the new, with budget promises of £100,000 less or 'we can do double that for the same price' – the supermarket politics of stack 'em high and sell 'em cheap.

Tell me this is not the madness of the market. The simple economics are that this type of competitiveness drives down costs which inevitably drives down quality – despite what anyone says in their tender presentation. But the competition drives up costs for quality staff, for management, for human resources to manage the constant change, for researchers to demonstrate that targets are being met, for IT to keep up with the constant 'evolution' of the data set required, and of course for a painter and decorator to cover up the cracks!

The senior managers and chief executives I meet are a mixture of passionate, committed, exhausted and cynical. Some are deeply concerned, many are angry but they all share one thing – an apparent inability to stop the treadmill they're on and ask what's happening. I doubt whether those I don't meet are any different.

There are brilliant and talented people in the world of alcohol and drug treatment – caring, skilled and committed. We are losing those people, especially the older and experienced ones, the role models and natural leaders. I considered it a privilege to work in the treatment field – being around people who managed to transform their lives. I'm not alone in feeling this but, no matter what anyone says, I fear that belief is ebbing away from the top.

'In the contract world everyone plays the instant makeover game, agreeing that they can turn this person's life around, stop them offending and improve nearly every aspect of their life in under 13 weeks. And prove it statistically - honest guv - we haven't fiddled with the stats.'

When are chief executives and chairs going to sit down together and say enough is enough? I used to ask for this to happen, but the argument was that not everyone will sit down and agree a position, so what's the point? We now have a situation where about 12 organisations dominate 80 per of the market outside of the trusts – and probably two or three manage 50 per cent. I am not sure of the figures. However, the small local drug and alcohol charity is a rare breed. What I do know is that they all now behave in distinctly non-charitable ways at management level – most will say they have no choice if they are to survive.

Next year the hammer will fall in terms of funding, and everyone will be scrabbling for the crumbs. I pity the clients and staff of the 'charities' who have continuously undercut their rivals, claiming absolute quality and near 100 per cent outcomes for treatment. The clock is ticking and some key individuals need to be brave for everyone.

Andy Stonard is writing in a personal capacity

I haven't yet been a client in a rehab or 12-step treatment centre, but I've met many Alcoholics Anonymous members who have. Often their first exposure to the fellowship was by being taxied to an outside meeting, and they tell me that while in treatment they were encouraged – or even required – to take the first five steps, while aftercare often includes attendance at AA. I wonder how many are introduced to the remaining seven steps while in treatment, particularly the eleventh ('We sought through prayer and meditation to improve our conscious contact with God – as we understood Him').

AA's basic text – the so-called *Big book* – says, 'We think it no concern of ours what religious bodies our members identify themselves with as individuals… Not all of us join religious bodies, but most of us favour such memberships'. That was published in 1939 and might not apply today in secular Britain. But my spiritual awakening did involve such membership.

My wife thought I would get up and walk out from my first AA meeting. A meeting usually starts with a recitation of the 12 steps, and six of them mention God or derivatives. I was a surly, cynical agnostic and my wife, sitting beside me, thought, 'This won't work'. But I was a week on from a suicide attempt that I'd survived by the skin of my teeth and in no state to engage in theological wrangling. I listened with laser-like attention to anything that would keep me alive.

My last binge had not been that spectacular; in fact I thought I deserved a pat on the back for arriving home before the pubs closed. But my wife took one look at me as I reeled through the front door and fled out of the back door with our daughter. As they drove off into the night I cursed them for being so unkind, and then turned the place upside down, wreaking my frustration and resentment on the furniture.

The next morning, as I surveyed the wreckage, I knew this could not go on. I'd never smashed the place up before and was appalled and horrified. It finally dawned on me that while I kept on drinking my life had just got more chaotic, but despite all my efforts I could not stop. I couldn't face another ten, 20 or 30 years of that living hell so I decided to end it all. As an alcoholic, loneliness was a way of life. I felt despised and rejected, shunned like a leper, and I despised and rejected myself. But that morning I felt as though the cosmos itself had rejected me. I no longer belonged here. The pain of being alive was impossible to bear.

As I left the house, my wife and daughter arrived home. I muttered, 'They shoot mad dogs, don't they?' and pushed past them. I went to a chemist and tried to work out how many aspirins would do the job – 25, 50, 100? I bought 100 just to be sure, and a bottle of orange juice. I walked into nearby woods, left the path so I wouldn't be found, sat under a tree and gulped down the aspirins in handfuls. I then lay down and waited to die. I was saved by luck and ignorance. I thought I would swiftly lapse into unconsciousness and the oblivion I craved – I didn't know how long the tablets would take to work. I was aware of an insect scratching away next to my ear. I felt woozy but that passed, as did the ringing in my ears. I watched the sun passing through the branches. At one point I began to panic and struggled to get up. But I forced myself to stay there and told myself I had to go through with it.

Baffled that nothing seemed to be happening, I thought, 'You haven't killed yourself but you haven't done yourself any good, so you'd better get help.' A cynic might say, 'Well, why didn't you put your head on a railway line?' I don't know the answer to that – all I know is that I was confused, bewildered, and I wasn't thinking straight. Maybe the instinct for self-preservation had kicked in – I walked back into the town and gave myself up to the police. Two young PCs rushed me to A&E with the siren blaring and lights flashing. One of them said, 'Don't you be sick in our car' and, 'You're not going to like what they're going to do to you'. I found out what he meant when I was pumped out. I really did think then that I was going to die.

My wife refused to visit me, yet another disaster caused by my drunkenness. The kids persuaded her to come but she just sat at the end of the bed, quivering with rage, refusing to speak to me. Before I was discharged a psychiatrist told me, 'If you'd left it any longer before getting help, all they could have done was watch you die.'

The inner light

One man's problem drinking led him to Quakerism via AA. Both, he believes, are practical, non-hierarchical and can help in a quiet process of recovery

I didn't plan to cut it that fine; I just wanted off the planet. The psychiatrist told me I would need to arrange psychiatric aftercare with my GP, and suggested I attend AA. I'd turned my nose up at AA years before but now I was terrified that if I drank again I would die, and I just I knew I would drink again because that's what I always did. In AA I often hear members say they lacked the courage to commit suicide. It seems a perverse sort of courage that enables someone to die but not to live. I didn't want to die but lacked the courage to live. I've seen suicide described as a supremely selfish act. In my case morality didn't come into it; I just couldn't take any more. Depending which statistic you believe, around a third of male suicides are drink related.

When I got home I phoned AA and the surgery. My GP encouraged me to go to AA and arranged an appointment with the consultant psychiatrist at an NHS addiction treatment centre. That evening two AA members visited me and told me their stories. They invited me to an AA meeting, which I went to with my wife. She had put me on probation. She thought going to AA was just another one of my 'tricks', as I was always making solemn promises not to drink again.

At that first meeting I felt hope that this was no longer my unique problem, and that there was help if I was prepared to use it. A few days later I met David Marjot, the psychiatrist at St Bernard's hospital in west London. He listened to my story and said, 'Well, I confirm the diagnosis – you're a chronic alcoholic and from now on things can only get worse'. I thought, 'I've just tried to kill myself – how much worse can it get?' He went on, 'I've seen hundreds of men like you. You're in your mid-40s, still employed and married – it will all go if you carry on drinking, and with your pattern of binge drinking you're in danger of having an oesophageal haemorrhage and bleeding to death'. He offered me an inpatient bed but said there was a seven-week waiting list. He added, 'I'll keep a place for you but in the meantime keep going to AA'. That was in September 1984. I still have his letter of appointment. I hope I never have to use it.

In AA there's a saying I found immensely consoling: 'I'm not a bad person trying to get good – I'm a sick person trying to get well'. I always blamed myself for not being able to control my drinking – I didn't realise I was very sick. The illness theory is controversial but I find it a useful metaphor – if not scientifically exact it works for me as experiential verification. And it doesn't let me off the hook. I had to try to put right the damage and hurt that I'd caused others in my alcoholic descent. As soon as I felt well enough I went to the police station and thanked the two PCs who had rushed me to hospital. I wrote to the hospital and thanked them too. Those people saved my life. I've tried to be the husband to my wife that I'd denied her while in my alcoholic wilderness. I've made amends to our lovely kids.

The AA group that I began attending met at a Quaker meeting house. There was a poster on the notice board that said: 'A silent Quaker meeting for worship can be a quiet process of healing and a journey of discovery'. That spoke to my condition so I plucked up courage one Sunday and went to my first meeting for worship. I was not told what to believe but welcomed for who I was.

'In AA I often hear members say they lacked the courage to commit suicide. It seems a perverse sort of courage that enables someone to die but not to live. I didn't want to die but lacked the courage to live.'

I was attracted by the similarities between Quakerism and AA. Both are practical, non-hierarchical, egalitarian and non-creedal – the AA programme makes useful suggestions about recovery while Quakers have our Advices and Queries. Both say the spiritual life is not a theory – we have to live it. I'm still an agnostic, though more open-minded than before. I thought the worst thing that happened to me was being an alcoholic – it turned out to be the best thing. If I hadn't found AA and the Quakers, I wouldn't have found myself. I drank for limitless expansion, but that thirst was never satisfied. Today it is, one day at a time.

The writer is a Quaker elder, a member of Quaker Action on Alcohol and Drugs and a former Quaker prison chaplain. He now helps run AA meetings in prison.
With acknowledgements to Quaker magazine The Friend.
National Quaker Week runs from October 3-11 www.quaker.org.uk
Quaker Action on Alcohol and Drugs www.qaad.org.uk

Culture of innovation

Enabling staff to see their ideas come to fruition can bring passion and drive to everything they do, according to Swanswell's chief executive, Debbie Bannigan. **DDN** reports

Pride in ideas: Debbie Bannigan urges Swanswell staff to take the first step towards world-changing practice at the annual staff conference last month

'I landed in a culture of innovation,' says Debbie Bannigan, who this week celebrates her second year as chief executive of Swanswell. Recruited to the charity to bring her business development background to running its community-based services, she found herself planted in an environment of 'continuous endeavour and continuous improvement', which started with Swanswell's first trustees, including president Dr John Bland.

Forty-one years later Dr Bland is still on the board and has developed his vision of an organisation that will develop and do well, says Bannigan. 'It's grown, it's fulfilled all of its ambitions year on year, it has a strong balance sheet and good business relationships, and it's grown a remarkable team.'

'Arriving at Swanswell was like falling into Debbie heaven for me,' she says. 'I'd got an incredibly talented team around me that achieves awesome results. And what I've found over and over again is that they are problem-solving people. My whole team has this drive to make things different and make things better.'

While she had 'an amazing team doing amazing stuff', her early observation was that no one was really shouting about it. Swanswell workers were going to conferences and hearing presentations from bigger, higher profile organisations about issues they were struggling to resolve, knowing that they had been carrying out similar work successfully for years.

'If we were one of the seven dwarves we'd be Bashful!' she says. 'We don't tell people how good we are. But it's essential that when we know how to do something we share it with other organisations.'

So Bannigan encouraged her team to develop a model to drive ideas forward and help Swanswell take pride in innovating.

'The model is very simple,' she explains. 'We start with the idea, the stimulus. The next stage is to find out if the solution we have for it can work – whether it is practical, whether it is possible, and whether we can answer the "how to" question.'

Next comes the pilot stage, 'which usually gives us a bit of evidence about whether what we've suggested will work and have a benefit', and a research partner might then be brought in to assess the impact of the proposed new practice. Out of this thorough process will come initiatives that make it through to the marketplace, in the form of a new or enhanced service.

Having the money to underpin such ventures is of course vital, and Bannigan stresses that the trustees have carefully tended the balance sheet over the years. But they are also resourceful in investigating all opportunities for grants and funding, and have recently decided to dedicate their small but precious pot of donations from former clients and their families to an innovation fund, rather than letting them get lost in general turnover.

Announcing this to staff has already had a motivating effect. As well as making it easier to grant the magical 'yes' to staff members' new ideas, it has inspired some to start raising money themselves for the innovation fund, including seven staff entering the Coventry half marathon later this month.

According to Bannigan, they've 'got the model, got the resources and got the general buzz'. So how did they connect these things for the desired effect?

'Talking to people around Swanswell I hear those ideas and that initial stimulus, and I can offer them the space, the time and the money – courtesy of our board – to explore those ideas. And I can offer them the skills, particularly around project management and partnerships to develop those ideas. When people have the space, the skill, the right partnerships and the right resourcing, they generally get on with it.'

And letting them get on with it is vital to the equation, she stresses. 'You've got to support people, but you've also got to be able to step back and let them have a go – because if I start directing things, what I lose is the special stuff, the gold dust. They know more about the problems and the issues than I could ever hope to.'

Swanswell's culture encourages ideas of every size and significance. An idea that's relatively small to resource can still make a difference in the world says Bannigan, recalling the instance of two workers, Lisa and Jade, who came to her recently to say they'd noticed that some of their female clients had an issue with self-esteem. They wanted to do a pilot with the FE college that ran courses in beauty therapy, hair care and grooming.

'They wanted a few hundred quid so I said yes, go do,' says Bannigan. 'The first group will be going through the programme about now, so we'll see whether it works and makes a difference.'

Another opportunity came up while she was talking to Swanswell's hospital liaison officer, Caroline Hammond, in the Coventry office.

'I asked her what sort of things really wound her up and she talked about a client with alcohol-related brain injury who was having problems with appropriate diagnosis and referral,' says Bannigan. A conversation with a commissioner shortly after revealed the lack of appropriate placements for people presenting with this condition, so she instigated a bid for money to research the problem further. Swanswell are now working on the problem in partnership with Warwick University.

'It was a direct response to that situation with that service user at that time – and the worker's ability to articulate that,' she says. 'We will get results from that piece of work.'

Projects at the larger end of the spectrum can be ambitious but could transform the way Swanswell reaches out to some of its clients.

'We know there are groups of people who would never walk through our doors and the concept of coming in to a "talking therapy" is so alien to them that they are never going to engage with it,' says Bannigan. 'Coming into a room and talking with a worker is never going to float their boat.

'So how do you get through to those people? What can you offer them? Well we're aware there's a significant amount of people who now access the world through the internet and who participate regularly in activities in a virtual environment. So why not use virtual reality to produce an alternative therapeutic environment?'

With funding from the Knowledge Transfer Partnership Scheme and a partnership with Reading University, Swanswell have begun to develop the prototype for a highly ambitious 'virtual reality' programme that will allow users to experience therapy through a computer-simulated environment.

'I don't know whether it's going to work as it's in development, but there's enough evidence to suggest it should,' says Bannigan. And whether it's a roaring success or not, the process of driving forward such initiatives adds to the determined culture of innovation.

'It's about making people realise that having a go is sometimes clunky and difficult and doesn't always work, but it doesn't matter – just have a go!' she says, emphasising that 'the start and end point is always the Swanswell team'.

'The service users are our reason for being, and that's never far from our thoughts,' she adds. 'But the strength of the team and every individual in it is what makes this organisation so very special. The end product of that is world-changing ideas – and we turn them into practice.'

Revolutionising the client experience

'We tend to believe that face-to-face is gold standard and that nothing but being in a room with someone else will work,' says Debbie Bannigan, 'But one of the important things to come out of research is the disinhibition effect of working in text. People put things in text that they wouldn't ever say to you.'

This is one of the advantages that Carly Smith and Tim Gunner found when they got involved in a project with Netmums, the UK's fastest growing online parenting organisation.

With funding from the Parent Know-How Programme, Netmums approached Swanswell for drug and alcohol-related expertise for their forum. Swanswell seized the chance to explore the possibilities of providing support services online.

Among hundreds of online topics ranging from finding shopping bargains to general health and wellbeing, the drug and alcohol threads are among the most visited. As part of a pilot project, Smith and Gunner spent time on the forum over a two-month period, providing information, reassurance and encouragement to visitors.

'One of the first things that struck me was that the drug threads were viewed more than the alcohol ones, perhaps indicating that people found it easier to ask questions about their issues from behind the cloak of anonymity that the site offers,' said Gunner.

In the eight week period their posts were looked at more than 16,000 times, Smith pointed out – 'more people than you could see in several lifetimes'.

In a context of lively debate, they see the opportunity to provide 'helpful balance' through the Swanswell posts. 'For example, in one alcohol thread all the talk was based on experience of 12-step treatment, stating that abstinence was the only real option,' explains Gunner. 'So I thought it was useful to point out that while this might be a good option, it was not the only one, and I provided some harm reduction advice.'

To fully engage with the other posters on the site, they had to learn the forum's own particular language and jargon – not just abbreviations such as IMHO (in my humble opinion) and LOL (laughing out loud) but Netmums' specialised abbreviations, where BF could mean 'breastfeeding' instead of 'boyfriend', as on other sites. 'I admit my first reaction was more WTF!' admitted Gunner 'but I soon started to get the hang of it.'

There are, they say, downsides to working in an online environment, such as the time-consuming process of reading back over threads that might go back over months, before making a comment. But the upside of that is that very little is missed, as everything is documented. Both Smith and Gunner also acknowledged that some of the intensely personal stories can make it difficult to 'switch off' when you have 24-hour access to your clients and the possible temptation to view updates and developments from home.

Smith and Gunner's enthusiastic report on the trial strongly recommends continuing and building on the work with Netmums. They have ambitious plans for developing their work and improving the interactive experience between themselves and site members.

'The online world provides an opportunity to reach a vast amount of people who may never come in contact with drug and alcohol services,' said Gunner.

'With 65 per cent of homes having internet access and 80 per cent of people online accessing social networking sites, the opportunity to reach out to this amount of people is too good to miss.'

Netmums is at www.netmums.co.uk. Swanswell will be providing an online clinic during Alcohol Awareness week, 19-23 October, at www.netmums.com/support/Swanswell_expert_answers_your_questions.3606/

Learning in partnership: Carly Smith and Tim Gunner explain to Swanswell colleagues how they are reaching hidden clients through the Netmums project

Welsh services often compare themselves to their English counterparts. But, says *Glyn Davies*, it's time to look further afield for comparisons, as well as celebrate innovation at home

THINK GLOBAL, CELEBRATE LOCAL

HAVING BEEN FORTUNATE ENOUGH to attend the International Harm Reduction Association (IHRA) conference earlier this year (*DDN*, 4 May, pages 6-18), I came away feeling inspired that our services in Wales are among some of the most innovative around. However I also left feeling slightly puzzled as to why we don't do more to celebrate the great things being achieved.

It was fascinating to learn of the positive work being carried out in countries across the world and consider how these practices could influence and shape services back in Wales – not just the progressive countries but those people struggling in places with an adverse cultural standpoint on dealing with substance use. Many in these countries 'work around' barriers that we in the UK would consider the basics of treatment, such as access to substitute medications.

From a Welsh perspective it feels as though we focus on benchmarking our services against neighbouring countries, but we often don't reflect the distance we as a sector have travelled over a relatively short period under the devolved health responsibility of the Welsh Assembly Government and wider partnership working.

Looking internationally can offer creative inspiration and the opportunity to learn what works, particularly in relation to service development and alternative approaches to service improvement. From my perspective in a drug interventions programme (DIP), focusing on how different countries integrate drug treatment in a criminal justice setting, it's difficult to take in the diversity of approaches being implemented, from the extreme of capital punishment in some countries to the harm reduction approach of needle exchanges in prison.

This last example – from Moldova – of integrating harm reduction policy into the criminal justice agenda is difficult, at this time, to imagine in a UK context. But in Moldova this has resulted in prison needle exchanges being facilitated by peer inmates, to overcome suspicion by prison staff, while simultaneously addressing concerns about discarded injecting equipment.

In southern Australia, meanwhile, the use of positive policing regarding prostitution has resulted in two key benefits – relationships of trust being forged across two previously opposed groups and a reduction in blood-borne viruses and STD rates. A lower rate of HIV infection is emerging within the participating communities than with other neighbouring states posing the question of whether we should be taking a similar approach towards sex work in Wales.

In the US there are fresh attempts to shift sentencing policy, responsible for the incarceration of 52 per cent of the prison population for drugs offences and a disproportionate impact on African American communities – a minimum five-year mandatory sentence for possession of 5g of crack, which is more prevalent among African Americans, compared to 500g of cocaine hydrochloride, more prevalent among white Americans. This raises the question of whether we should we be monitoring the impact of the *Tough choices* intervention programme on sentencing, especially in relation to the increased number of crack and cocaine users being identified.

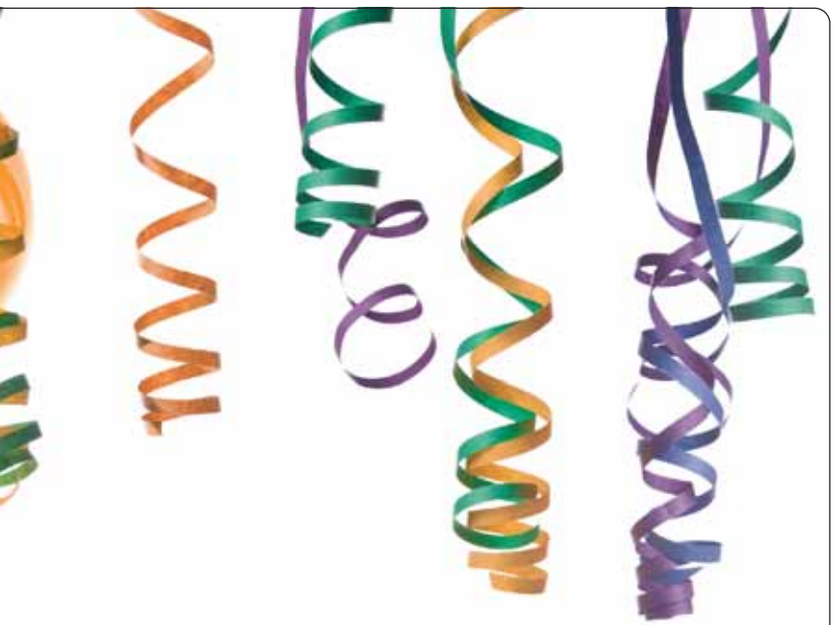
So what can Wales and DIP learn from these disparate approaches? To varying degrees the world over, countries integrate their criminal justice and harm reduction agendas – some more punitive and some more progressive. But what about here in Wales? It is apparent that over the past decade we have seen a significant investment in the substance misuse sector through the Welsh Assembly Government – health and criminal justice services have both benefitted from additional resources, enabling service users to engage with a tiered system of treatment. This is not to say we've got it perfect, but compare it to where we were not so long ago with no integrated treatment systems, long waits to access services, restricted access to substitute medications and inhumane prison treatment for service users.

The difficulty is in the comparisons we draw upon in Wales, particularly when benchmarking ourselves. We look to England and ruminate over 'how good they have it' with two week waiting times and yet we don't reflect on what we are delivering for the level of investment being made. Within this context, services in Wales are offering unquestionable value, and having heard from countries where there is minimal access to substitute medications, needle exchanges and vaccination programmes, we should recognise how lucky we are and what else we can achieve with the resources we have.

With the new ten-year drug and alcohol strategy in Wales, *Working together to reduce harm*, a fresh emphasis has been placed on moving the agenda forward. For many people it can be difficult to distinguish and understand how policy translates into everyday frontline practice, and yet we are witnessing a number of strategic strands being enacted in earnest. The role of drug-related death panels, for example, clearly demonstrates how strategy influences practice, with lessons learnt being disseminated and implemented across the country.

The move by Welsh Assembly Government to consider a national approach to naloxone, through its demonstration sites, is another example, making the strategy a meaningful framework for delivering harm reduction objectives. Despite the potential controversy such a life-saving initiative may bring with it, political will has prevailed. A fringe benefit of the naloxone initiative has been the positive joint working between health and criminal justice partners across the country, demonstrating a shared belief in harm minimisation.

When applying a harm reduction approach to the criminal justice setting, it could be questioned how these two often opposing stances can synergise in



everyday practice, so the concept of needle exchanges proposed for police custody suites should be warmly welcomed. The initiative, making new injecting equipment available for service users on release, must be applauded for putting public health before public conjecture.

Another example is Barnardo's and partner agencies implementing recommendations from the *Hidden harm* agenda, including training all DIP staff to a consistent skills and knowledge level regarding children of drug using parents, an approach that has also meant an opportunity to learn from every corner of Wales and discover services delivering quality – if not in some places world class – services.

When looking for inspiration we tend to look towards Switzerland with its injecting rooms – rarely do we look closer to home. But we too offer innovative services in Wales. A number of examples immediately spring to mind – in South Wales and Dyfed Powys we are hosting the first network of automated methadone dispensing machines in community and custody settings, using iris recognition technology. The dispensing machines have the capability of linking systems across participating sites, with eleven custody and community prescribers initially being identified as possibly leading the way. The project will enable a service user to move between the two settings, while ensuring a safe and seamless approach to their continuity of care. The use of this technology will also result in long-term financial savings, freeing up resources for other aspects of service delivery.

Other examples include the creation of a new service in Dyfed Powys to help service users experiencing substance use-related mild mental health difficulties. The organisation Helping Groups 2 Grow (HG2G) aims to treat those individuals whose needs are not met by mainstream services, while the Lamplighter project is a creation of a national peer mentoring service that will help service users aiming to access education, training and employment. Supported through European funding, the scale of the scheme will galvanise peer support initiatives across the country. In Gwent and North Wales there too are many examples of good practice ranging from partnership working to one of the leading service user groups, Word On The Street (WOTS).

The substance misuse sector in Wales and the rest of the UK has grown at an exponential rate over recent years and, whether a practitioner works within a health or a criminal justice setting, we need to recognise the positive impact we are having on service users and communities. We need to reflect more on the progress that has been achieved in recent years and the successes we continue to experience. We have a lot of good practice to share in Wales and we need to do more to recognise it.

Glyn Davies is deputy regional DIP manager, South Wales

Focus on race and drugs

Next month the 'drug professionals university' will host a summit for countries dismantling the 'war on drugs'. Race and drugs will be at the heart of debate, says Kazim Khan

Leading thinkers from European and Latin American countries let the forefront of moves to dismantle the 'war on drugs' will meet this November at a 'winter university' for drug professionals in Portugal, whose 2001 decriminalisation was recently judged 'a resounding success' in a report from the US Cato Institute (www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf).

Mounted with help from Portuguese partners led by Dr Luis Patricio and university organisers Erudictus, the event forms part of a programme of EU-funded research by T3E (UK), the UK arm of a pan-European network advancing training and education for staff in drug services. Via an Iberian-American network, news of the event reached Latin America, and the project was asked to include a special satellite session with speakers from Bolivia, Brazil, Peru and Venezuela.

It will be an important coming together of two European (Portugal and Spain) and several of the Latin American nations leading international decriminalisation moves. Last February a commission report from former presidents of Mexico, Brazil, and Colombia condemned prohibition as a failure. Brazilian ex-President Fernando Henrique Cardoso called for 'A paradigm shift... away from repression of drug users and towards treatment and prevention'.

T3E (UK) incorporates the Race and Drugs Project, and decriminalisation could be a key way to relieve the discriminatory repression of visible minority populations in several areas hardest hit and least well serviced by anti-drug policies. 'De-stigmatising drugs also begins to de-stigmatise those who use drugs,' he said. 'The ripple effects of this step-by-step shift to new socially-just policies could have important implications well beyond the countries concerned.'

The project points out that discourses on race and drugs are almost inextricably intertwined; both are concerned with constructions of the 'other', both invoke images of the crossing of national frontiers, and often combine in a volatile mix. This historical intertwining constitutes a major obstacle to tackling racially-based injustices, still a reality in public life – education, employment, housing, health, social welfare, policing and the law – of every EU country.

Using seminar formats and interactive presentations, the university in Lisbon on 2-4 November will be used to consult on emerging findings from the Race and Drugs Project's research in nine EU countries, evaluating how equitably the needs of drug using offenders from visible minorities are being met and what can be done to enhance equality of provision.

The research will benchmark as never before how Europe, including the UK, is performing at the politically-fraught intersection between race and drugs. Against this backdrop, university delegates will draw on their practical experiences to explore the journey through European justice systems of drug-using offenders from pre-arrest to reintegration. The focus will be on the young, on those from visible minorities and those whose sole offence has been possession or consumption. How a society treats these most marginalised of the marginalised amounts to a 'stress test' of its overall approach to drug-related offenders.

T3E (UK)'s research forms one of the strands of the EU-funded CONNECTIONS project (www.connectionsproject.eu) examining integrated responses to drugs and infections across European criminal justice systems. For more on the Race and Drugs Project visit www.raceanddrugsproject.org.uk; go direct to www.raceanddrugsproject.org.uk/may2009.html

Kazim Khan is project coordinator for the Lisbon conference, Drugs. Health. Justice: perspectives on race equality. *For information including links to the application process and programme, e-mail kazimkhan@mac.com*

CONFERENCE CONSORTIUM

Connections

Integrated responses to drugs and infections across European criminal justice systems

DIARY DATE AND CALL FOR PAPERS

'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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Substance misuse personnel

Samantha Morris
Solutions Action Management
Founder & Company Director

Sam established Solutions Action Management in 2001 in response to the ever-growing need for specialist, skilled and experienced personnel. Prior to setting up the company, Sam started as a student at WDP where she underwent her social work training in conjunction with Brunel University. She continued to study and work undertaking her MA in social work at The Tavistock Institute whilst working as a care manager for local authority substance misuse teams. Wanting to make an impact in the field, she took a strategic role and became a DAAT Co-ordinator. In 2001 she decided to work on a freelance basis and undertook needs assessments, CAD projects and interim DAAT roles for various DAAT partnerships. With a vast network and a growing demand for consultants and temporary staff, SAM (Solutions Action Management) was founded.

Solutions Action Managment continued to develop and registered with the Care Quality Commission (formerly CSCI). Sam now supplies substance misuse nurses alongside social workers, drug workers, counsellors, senior managers and strategic consultants.

Sam is now launching a new division, SAM Elite, for those in strategic or managerial positions and earning over £45,000. There has been a noticeable gap for good operational and strategic managers in the field and, with so many requests for interim cover and short-term consultancy, Sam is looking to expand on her already established high-calibre team. For temporary, permanent and consultancy positions call to register your interest, or if you are seeking that exceptional manager, don't hesitate to call for an informal discussion.

With many years of experience within the field Sam and her team feel they are best placed to assist all organisations involved with substance misuse remits and Solutions Action Management continue to provide excellent personnel for all service levels. Sam is always available to discuss your needs.

SAM

Tel: 020 8987 6061 **www.SamRecruitment.org.uk**

EATA European Association for the Treatment of Addiction (UK)
the independent voice of the sector

Bristol - 3rd November 2009
Derby - 16th November 2009
London - 18th January 2010

Regional Conferences 2009/10

You are invited to take part in the Regional Conference of your choice as organised by EATA, specifically targeted at representatives from substance misuse organisations (both members and non-members of EATA)

'The Future for Drug and Alcohol Services'

Speakers include:

Peter Martin CBE - Chief Executive, EATA and former Chief Executive of Addaction
David Finney - Former CSCI Inspector
Daren Garratt - Chief Executive, The Alliance
Pauline Bissett - Chair of EATA's Accreditation Panel
Steve Rossell - Chair of EATA Board
Viv Ahmun - Director of Core Plan UK and Equanomics UK
Maggie Telfer - Chief Executive, Bristol Drugs Project

*please note: speakers will vary according to venue. More speakers expected to be announced. £27 EATA full members (2nd FREE!), £89 non-members.

To confirm your place at what promises to be a valuable day, please visit www.eata.org.uk/events to download a booking form or email louise.walsh@eata.org.uk or call 020 7553 9580 and please remember there are limited places - allocation will be on a first come, first served basis.

Visit our website www.eata.org.uk for more information

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Society for the Study of Addiction

SSA

Annual Symposium, 2009
'Treatment Policy'

Thursday 12 and Friday 13 November at the Park Inn, York, UK

Christine Godfrey will give the Society Lecture:
'Addiction Treatment: Do economists contribute to the policy debate?'

Themes:
- Service-user involvement
- Young people & families
- AERC symposium: What does the AERC do?
- The Randomised Injectable Opioid Treatment Trial

The AERC panel will consist of:
Angela Attwood (University of Bristol), *Val Curran* (University College London), *Debby Allen* (Oxford Brookes University), *Alyson Smith* (University of Wales Institute Cardiff)

Prices:

SSA member	£220
Non-member	£250
Unwaged member	£140
Unwaged non-member	£170
Additional dinner guest	£35

Speakers:
- Gillian Tober, Leeds, UK
- Gerhard Bühringer, Dresden, Germany
- Anne Lingford-Hughes, Bristol, UK
- Jo Neale, Oxford, UK
- Ann McNeill, Nottingham, UK
- Connie Weisner, California, USA
- Rhoda Emlyn-Jones (OBE), Cardiff, Wales
- Eileen Kaner, Newcastle, UK
- John Kelly, Boston, USA
- John Cunningham, Toronto, Canada
- Antoni Gual i Solé, Barcelona, Spain
- Keith Humphreys, California, USA
- Isidore Obot, Geneva, Switzerland

There will also be 3 sessions of delegate speakers, as well as many delegate posters.

Contact
Email: graham.hunt@leedspft.nhs.uk
Phone/Fax: +44 (0)113 295 2787

Visit our website for more details & application forms:
www.addiction-ssa.org

DDN Drink and Drugs News

DDN workshops

Be ready when the inspector calls!

If you are involved in managing or running a residential service this one-day workshop is essential.

EXTRA DATE NOW AVAILABLE!

Central London, Wednesday 11 November

THE PURSUIT OF EXCELLENCE
in residential drug & alcohol services

Former substance misuse lead at the Commission for Social Care Inspection (CSCI) David Finney will show you how to achieve and maintain a "good" or "excellent" quality rating from the Care Quality Commission (www.cqc.org.uk) – essential for maintaining contracts with local authority purchasers. David, author of the national guidance for inspectors of residential services, will advise on what needs to be done now, while also looking ahead to the new compliance criteria to be introduced in 2010.

Places on this workshop are strictly limited.
Delegate rate £135 including lunch and refreshments

For more information and to book places on this course contact
Ian Ralph e: ian@cjwellings.com t: 020 7463 2081

Drugs • Health • Justice

Perspectives on Race-Equality

T3E – CONNECTIONS WINTER UNIVERSITY • PORTUGAL – LISBON

2 – 4 November 2009

As partners in the Connections Project, our university will examine the issue of "integrated responses to drugs and infections across European criminal justice systems", but with reference to issues of race-equality. The university will focus upon the imagined drug using offender's journey from arrest, through assessment and being referred for treatment.

Key speakers from the academic world as well as from EU-wide public agencies, such as the Council of Europe, the EU Fundamental Rights Agency and EMCDDA have been invited to provide a conceptual and theoretical context to the proceedings. These include: Professor Antoine Lazarus, University of Paris XIII; Professor Stephan Feuchtwang LSE, London; Professor Terry Williams, New School of Social Research, New York

In light of recent press coverage we have added a plenary on the Iberian Experience, and five years of decriminalisation in Portugal.

Full programme available at

www.eruditus.pt

Or Contact Kazim Khan
kazimkhan@mac.com
for more details.

Lifeline Project Ltd

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

Team Leader x 3 posts

(Salary: Pts 32-37 £26,784 – £30,546) 35 hrs per week

Team Leader – Lifeline Calderdale Young Person's Service

This is an exciting opportunity for an ambitious and highly motivated individual to set up and develop a new service for young people in Calderdale. This is a fully integrated tier 2 and tier 3 substance misuse service for young people working on a locality basis. The service will also deliver a centre based clinical treatment service for young people with GPwSI support. The service will offer advice and information, 1:1 support and therapeutic interventions, healthcare services including a regular clinic, harm reduction interventions, education, training and family support service as well as diversionary activities.

Team Leader – Lifeline Leeds Young Person's Service

We are looking for a dynamic and self motivated Team Leader to develop and enhance our established tier 2 Young Persons Service in Leeds. The service offers both targeted / early intervention work to young people involved with or at risk of substance misuse as well as Hidden Harm interventions with children of substance misusing parents. This is a varied post and an exciting opportunity for an ambitious individual to make positive changes and enhance service development.

Team Leader – Lifeline Rotherham Adult Alcohol Service

Following recent contractual changes, we are looking to recruit an experienced and committed Team Leader to support the development, implementation and re-launch of the Tier 2 Alcohol Service for Adults in Rotherham. The service provides 1:1 support, harm reduction, brief interventions, group work, targeted outreach to street drinkers and is establishing stronger links with partner delivery agencies such as ETE and criminal justice. You will be a quality focused and self-motivated individual with the ability to lead an established service through a new phase of delivery.

The successful candidate will be keen to achieve and deliver to a high standard. The Team Leader will focus on staff development, partnership working, service promotion and monitoring and reporting. They will work closely with the Service Manager and Commissioners, but will be able to demonstrate a high level of ability to use their own initiative and resources.

To be successful in the role of Team Leader, you will have

- A problem solving approach and initiative
- The ability to deliver high quality services to a diverse range of people
- Qualities to lead people in developing a flexible and exiting service model

For further information and an application pack download from www.lifeline.org.uk Alternatively email ann.fleming@lifeline.org.uk (Rotherham and Halifax posts), or admin.step2@lifelineleeds.org.uk (Leeds post) to request a pack.

Closing date: 9.30am Monday 12th October 2009
Interviews: w/c 19th October 2009

Lifeline Project is an Equal opportunities Employer and invites applications from all regardless of race, colour, nationality, ethnic or national origin, religion, marital status, sex, sexual orientation, age or disability.

Kent Drug and Alcohol Action Team (DAAT) and the Eastern and Coastal Kent NHS invite expressions of interest to tender for the Tier 3 structured Alcohol service

Kent DAAT and the Eastern and Coastal Kent NHS are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 3 structured alcohol service within the geographical boundaries of the Eastern and Coastal Kent NHS area. The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting https://www.businessportal.sece.gov.uk and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

Kent Drug and Alcohol Action Team (DAAT) and the Eastern and Coastal Kent NHS invite expressions of interest to tender for the Tier 2 Alcohol service

Kent DAAT and the Eastern and Coastal Kent NHS are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 2 alcohol service within the geographical boundaries of the Eastern and Coastal Kent NHS area. The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting https://www.businessportal.sece.gov.uk and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

Kent Drug and Alcohol Action Team (DAAT) invite expressions of interest to tender for the Tier 4 Inpatient detoxification service

Kent DAAT are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 4 Inpatient detoxification service for the people of Kent. We would welcome expressions of interest from organisations that can offer block and/or spot purchase services The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting https://www.businessportal.sece.gov.uk and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

Please note the above services will be within three separate contracts, provider organisations can apply for either one or all three.

Kent Drug & Alcohol Action Team

TORFAEN COUNTY BOROUGH
BWRDEISTREF SIROL TORFAEN

Tender for the provision of a Substance Misuse Open Access Service and a Substance Misuse Community Prescribing Service within Gwent.

Torfaen County Borough Council, acting on behalf of the four Community Safety Partnerships of Blaenau-Gwent, Caerphilly, Monmouthshire and Torfaen and the Gwent Drug Interventions Programme, invites tenders for the provision of the following contracts:

Part 1 – Open Access Substance Misuse Service
This Service will deliver psychological, social and crisis support, care co-ordination and high intensity case management for clients with drug or drug and alcohol issues. The Service will also act as the gateway to other Tier 3 services as well as providing on-going care planning for those clients engaged with the Part 2 Community Prescribing Contract across the four localities.

Part 2 – Substance Misuse Community Prescribing Service
This Tier 3 Service will provide titration, stabilisation, maintenance and community detoxification prescribing across the four localities and Newport for DIP clients only.

The contracts are expected to be awarded for the period 1st April 2010 – 31st March 2013, subject to continued Welsh Assembly Government and Home Office funding and may be extended, subject to performance, for a period of up to two years. Parties will be expected to act and negotiate in good faith with any changes of service provision which may arise from the establishment of the Gwent Area Planning Board.

The indicative budget for the provision of both services is approximately £1.4 million (full year). The split between each Part is expected to be in the region of 45% for the Open Access and 55% for Community Prescribing, however, organisations bidding for both Parts may wish to propose an alternative configuration of resources. Individual, joint and consortium bids will be considered.

Organisations interested in wishing to tender for one or both of these services should apply in writing to Heidi Anderson, Contract Manager, Community Safety Team, Torfaen County Borough Council, Civic Centre, Pontypool, NP4 6YB. The closing date for the receipt of tenders is 12 noon on 13th November 2009.

D McGowan Training and Consultancy LTD
www.dmctrainingconsultancy.com

Providing training and consultancy in all areas and aspects of Substance Misuse, we offer a range of courses throughout the year as well as providing a range of in-house or bespoke courses to meet specific need.

We currently offer over 20 different courses including: Drug, Alcohol or Mental health awareness /advanced, 'A gram and a pint', Crystal meth, Complete Crack, Relapse prevention, Risk management, Motivational interviewing, Addiction, Treatment retention, Drug use in pregnancy, Brief interventions, Harm reduction, Dual diagnosis, Safeguarding adults and YP Cannabis /YP Alcohol.

All courses are practical and applicable to the workplace. Participants will learn skills for working with clients not just a load of facts and figures! All courses are DANOS mapped and come with comprehensive manuals and hand-outs. Our rates are also very competitive.

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CRI

CRI – Cumbria Harm Minimisation & Health Promotion Services

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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.

Project Worker

(Ref NM298)

CUMBRIA DRUG & ALCOHOL ACTION TEAM

Salary: £22,578 – £24,089 per annum
Hours: 37.5 per week

CRI is a national charity providing cutting edge services that support individuals, families and communities whose lives are adversely affected by crime, substance misuse, homelessness, anti-social behaviour, domestic violence, social deprivation and lack of opportunity. We work in close partnership with a range of organisations including police, probation services and judiciary, local authorities, health services and voluntary sector organisations.
In partnership with the Cumbria DAAT, CRI are seeking to recruit a permanent worker to deliver Tier 2 open access and needle exchange services in the North of the County. Working as part of a multi-disciplinary team, this post has been created to further enhance the range of harm minimisation and health promotion interventions delivered to service users not yet engaged with structured treatment. You will be joining a highly skilled team and will be afforded the opportunity to shape the future of services within the emerging treatment system across Cumbria. This role will cover the full scope of Tier Two activities and will include advice, information and harm reduction work. You will be flexible and enthusiastic in your approach to client engagement and have knowledge of assessment and care planning processes.

Closing date: 19th October 2009
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).

INVESTOR IN PEOPLE

Safer communities, healthier lives

Papa Stour Project

ASSISTANT MANAGER/ SUPPORT WORKER

Salary £15-16,000
plus accommodation and food

This is a residential post funded by SADAT, in partnership with Community Alcohol and Drugs Services Shetland.

We offer a unique opportunity for a self-motivated, enthusiastic couple or an individual to work in a three-bed, Christian-supported housing service for men aged 18-45 seeking to rebuild lives free from drug/ alcohol dependency.

For further particulars or to obtain an application pack:
Telephone – 01595 873238
Email – sabina@papastour.org
Online – papastour.org

Closing date: 19th Oct 2009

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

ROCHDALE METROPOLITAN BOROUGH COUNCIL

Tender for the provision of Rochdale Young People Substance Misuse Service

Rochdale MBC and NHS Heywood, Middleton, and Rochdale PCT invite tenders from suitably experienced organisations to provide a locally accessible, fully integrated Tier 2/3 substance misuse treatment service for young people age up to 19 (with clear transitional arrangements for those aged 18/19).

The provider will need to demonstrate their commitment to delivering services which contribute to achieving positive outcomes for children and young people including the five outcomes from Every Child Matters.

Those wishing to tender will need to register on our electronic tendering portal 'The Chest'.

To register, access "www.thechest.nwce.gov.uk" and click on the link to the "Suppliers' Area" and then "Register free".

The closing date for submissions is not later than 2pm on Tuesday 10 November 2009.
Interviews will take place on Tuesday the 8th December 2009.

The contracts will commence from April 2010 and will be for an initial period of 3 years subject to funding with the option to extend for a further 1 year.

The contact for this tender is Nick Batty 01706 925481.

CRI

Middlesbrough Care Coordination and Assertive Outreach

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.

INVESTOR IN PEOPLE

Care Coordinator x 2

(Ref NM289)

£21,197 – £24,089 • 37.5 hours per week

CRI deliver Care Coordination and Assertive Outreach services across Cleveland with bases in Middlesbrough and Redcar. The services provide tailored support for individuals by delivering effective, high quality interventions working with both Criminal Justice and voluntary clients. CRI are looking to recruit the following position for the delivery of the care Co-ordination service in Middlesbrough:
The post holder, under the direction of the Manager and team leader, will care coordinate a caseload of clients offering assessment, support and care planning to support clients through their treatment journey. This will involve joint work with a number of professionals and work with common triage and assessment tools. This role will also have additional responsibility in relation to the Drugs Intervention Programme and clients accessing treatment. You will have a good working knowledge of substance misuse, the criminal justice systems and case management to be successful in the role of Care Coordinator.

Closing Date: 14th Ocotber 2009
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.

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- Youth Offending
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- Ex-Offenders & Resettlement
- Commissioning
- DIP and DAAT

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dan.essery@synergygroup.co.uk

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Supplying experienced, trained staff:

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

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Merged programme based on progress2work and progress2workLinkUP and the 2010 Problem Drug Users' Employment and Support Pilots

ADVANCE NOTICE IS GIVEN of forthcoming Pre Qualification Briefing Events.

The Department for Work and Pensions (DWP) is tendering for a national merged programme based on progress2work and progress2workLinkUP, to provide support for customers who are disadvantaged in the labour market because of a history of drug misuse, an offending background, homelessness, alcohol misuse or a combination of these issues. Contracts awarded are likely to cover multiple districts.

In some Jobcentre Plus Districts and as part of this tender exercise, DWP will also procure a pilot programme of services to support those at greatest disadvantage and furthest from the labour market, because of their use of heroin and crack cocaine.

In those contract package areas where pilot districts are located, one contract will be awarded for delivery of both the merged programme and the pilot provision.

Supplier Briefing Events
DWP will be holding events for potential bidders at which information on the requirements of the contracts and on the procurement process will be provided.

The dates and locations are as follows:

Tuesday 20 October 2009 – London

Wednesday 21 October 2009 – Cardiff

Thursday 22 October 2009 – Glasgow

Full details of the event locations will be provided at a later date to suppliers who return a Delegate Request Form as described below. All events are accessible by public transport and at some locations car parking may be available.

The events are open to suppliers wishing to be considered as prime contractors and also to smaller organisations who may wish to work with the prime contractor on a sub-contract basis. Organisations are invited to attend one event only (maximum two representatives only). The information presented at all events will be identical, with all questions and answers published on the DWP website.

For further information please see the Advance Notice on the DWP website at the following address:

http://www.dwp.gov.uk/supplying-dwp/what-we-buy/welfare-to-work-services/opportunities-to-tender/

To request a place on an event, please return a completed Delegate Request Form (which can be found as a link to the Advance Notice) to the following e-mail address: leedswhitehallii.p2wdelegates@dwp.gsi.gov.uk

PLEASE NOTE THAT THE LAST DATE FOR BOOKINGS IS WEDNESDAY 14 OCTOBER 2009.

INVESTOR IN PEOPLE

European Union
European Social Fund
Investing in jobs and skills

DWP Department for Work and Pensions

NHS
Herefordshire

DRUG SERVICE HEREFORDSHIRE

Herefordshire is a beautiful semi-rural environment nestling between the Malvern Hills and the Black Mountains.

DASH is based in Hereford City and serves the whole of Herefordshire, which includes five market towns and extensive rural areas by providing a range of community based practical and therapeutic interventions including advice, information, assessment, support and psychosocial interventions to drug users with the aim of reducing drug related harm.

DASH is open to all people in Herefordshire, irrespective of gender, age, sexuality, disability, HIV status, or ethnic and cultural background.

We are looking to appoint Drug Workers to contribute to the continuation and expansion of the integrated multi-disciplinary and comprehensive provision to drug users in Herefordshire.

We are looking to appoint full time (37.5 hours per week) as follows:

Drug Worker

AFC Band 5

£20,710-£26,839 (Permanent Posts)

Drug Worker (CJDT)

AFC Band 5

£20,710-£26,839 (12 months, fixed term)

You will be expected to have experience of working with those using drugs and of providing psychosocial and practical support to those with varying and often complex needs.

For informal enquires please contact, Sally Jones, Team Leader on (01432) 263636 or Spencer Wiggett, Criminal Justice Team Leader on (01432) 272521.

For application pack please contact Human Resources Dept, Herefordshire PCT, Plough Lane, Hereford on (01432) 383803.

Closing date for both posts: 19th October 2009.

Only short-listed applicants will be contacted.

As this post involves working with vulnerable adults and where you may have access to children you will be required to consent to an enhanced disclosure (under the provisions of the Police Act 1997). Herefordshire Primary Care Trust will require you to give permission to carry out a disclosure. Having a criminal record may not necessarily debar you from working for the Trust.

dash

Herefordshire Public Health Team – Making every contact with our community count towards better health.

The Trust is an employer committed to Equal Opportunities.

HSJ NT 100 HEALTHCARE EMPLOYER

www.herefordshire.nhs.uk

See more vacancies on drinkanddrugsnews.com

RIGHT HERE, RIGHT NOW!

The third national service user conference

4 February 2009

Holiday Inn, Birmingham

DDN Drink and Drugs News

The Alliance
Taking treatment forward

Supported by:

Concateno
global drug testing services

NHS
National Treatment Agency for Substance Misuse

Be part of a day of inspirational presentations...

Service users from all different backgrounds will throw open new challenges for better policy and practice.

Programme includes...

Theo Van Dam – Dutch User Group LSD
Jacquie Johnston-Lynch – co-organiser of the UK Recovery March
Service user views from Scotland, N Ireland, Wales and England.
Practical workshops: naloxone training, advocacy services, nutrition, and user magazines.

Service user group exhibition...

The event will once again showcase the work of the country's most innovative service user groups.

Video booth...

Our video booth will be open for vox pops and feedback for the special issue of DDN.

Book online now at www.drinkanddrugsnews.com
Or email ian@cjwellings.com for more information