From FDAP in association with WIRED

DDN
Drink and Drugs News

3 July 2006
www.drinkanddrugs.net

COLOUR-CODED CARE
Anchor Project – moving people through services

TREATMENT EQUALITY
Tuning in to learning disabilities

COMMENT
Is excessive mangement squandering resources?

HOW DOES IT STACK UP?
DDN interviews Paul Hayes from the National Treatment Agency

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2006/07

Our university accredited, modular programmes incorporate the "Models of Care" framework, DANOS competencies and QuADS benchmarks. Being taught in five-day blocks, they are accessible to students living in or outside Kent, are ideal for those new to or returning to study. All programmes aim at a wide range of professionals in healthcare, counselling, criminal justice, the community and social care etc. who access clients with substance use related problems.

Certificate in Substance Misuse Management (Stage 1)

This access level Certificate provides a broad introduction for people currently working with problem substance users, or expect to be in the near future. The programme is delivered in Canterbury & across the UK where there is a cohort of 10 or more students. It is a recognised benchmark for those who seek an accredited qualification. The programme also benefits social, health and education professionals in all sectors whose work includes significant contact with problem substance users

18 month programme from September 2006 or by negotiation

Certificate in the Management of Substance Misusing Offenders (Stage 1)

This Certificate is an access programme for prison and probation officers, drug and alcohol workers, health and social care professionals working with problem substance users in the criminal justice system. It includes NTA and Home Office strategies, eg. DRRs, CJIP, CARAT and DIP issues, ethics, cultural factors, managing challenging behaviour and working in multi agency, criminal justice settings. Available across the UK for cohorts of 10 or more students.

18 month programme from September 2006 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the nature of substance misuse and addiction processes from biological, psychological and social perspectives, and focuses on the settings and approaches within which treatment is provided. The Diploma is appropriate for practitioners working in Tiers 2, 3 and 4a services for drug users or people with alcohol problems.

2 year programme from October 2006

BSc in Substance Misuse Management (Stage 3)

The BSc programme provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours, this includes training in ethics, research methods and the development of a research proposal. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. **POST-GRADUATE OPPORTUNITIES** are also available in this area of study.

2 year (top-up of Diploma) or 4 year programme from November 2006

For further information and an application form, please contact:
Teresa Shiel, Programme Co-ordinator, KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent CT2 7PD
Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk www.kent.ac.uk

Published by

CJ Wellings

On behalf of

fdap
Federation of Drug and Alcohol Professionals

WIRED
Empowering People

Drink and Drugs News in partnership with:

Adfam
The Alliance
ANSA
drugsandalcohol today
EATA
European Association for the Treatment of Addiction
The Federation
LDAN
Mentor
RELEASE
SMMGP

Drink and Drugs News

3 July 2006

Editor's letter

To a question about why different budget figures were quoted – 28 per cent here, 30 per cent there – at the NTA's treatment conference this week, NTA chief exec Paul Hayes responded, 'it's any number between 25 and 40 per cent, depending on what you choose to add in.'

That sums up a week when everyone's been scrutinising the wording of announcements and straining to hear government comment – working out whether they can still do what they had planned to do when the pooled treatment budget was going to be that much higher.

But whatever DATs were expecting – or dreading – at least the wait is over, and the drugs field has emerged with substantially more money than last year. Paul Hayes explains the workings behind the budget on page 8, and where to prioritise if you're feeling the pinch. Surely a chief concern has to be that money reaches past the target-governed priority areas, and out to service users who most need it. Let us know whether the budget works for you.

More good news this week in that the long-awaited Models of Care for Alcohol Misusers has just been published. Alcohol Concern have given it a cautious 'something is better than nothing' welcome as we go to press, approving the guidance for commissioners, but flagging up a lack of standards for working with families, children and in cases of domestic violence – with yet more implications for resources.

So announcements left, right and centre. Maybe it's been a good week to release news – we're still in the World Cup as we go to press. If you're needing cheering along after the match, have a look at Jane Benanti's article on page 10. She explains how the Anchor Project remodelled their system to get service users through the system better – with positive feedback from all involved.

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

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

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
Website maintained by wiredupwales.com

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Rebel Design Project

In this issue

UN chief calls for Europe to step up action on drugs

Drug control is working and the world drug problem is being contained, according to the executive director of the United Nations Office on Drugs and Crime (UNODC).

Speaking on the 'international day against drug abuse and illicit trafficking' on 26 June, Antonio Maria Costa said where this was not happening, it was because countries were not following a coherent, long term strategy – and as a consequence, had 'the drug problem they deserve'.

In remarks that were greeted with 'surprise and concern' by DrugScope, Mr Costa equated the harmful characteristics of cannabis with cocaine and heroin, warning that it was a mistake to dismiss the potent modern forms of 'the world's most abused illicit drug' as 'soft and relatively harmless'. The 'cannabis pandemic' required consistent commitment, and should not be prone to policy changes from changes in government, he said. Martin Barnes, DrugScope's chief executive, said it was 'misleading and irresponsible' to suggest other than that cocaine and heroin cause much greater health and social harms than cannabis.

Mr Costa's other main message for Europe was to step up efforts against rising cocaine use. 'I urge European Union governments not to ignore this peril,' he said. 'Too many professional, educated Europeans use cocaine, often denying their addiction, and drug abuse by celebrities is often presented uncritically by the media, leaving young people confused and vulnerable.'

Despite global opium production falling by five per cent last year, Mr Costa warned that production in Afghanistan could rise this year, unless governments stepped up their efforts to reduce both supply and demand.

World Drug Report 2006 is online at www.unodc.org/unodc/index.html

Complete change of focus needed on Scottish drugs policy, says SDF director

Massive efforts must be made to tackle deeply entrenched poverty, if Scotland's drug problems are to be tackled effectively, David Liddell, director of the Scottish Drugs Forum has told a Glasgow conference.

The country with 51,000 people with drugs problems – one of the highest levels in Europe – needs an overhaul of root problems that are currently seen as medical or criminal justice issues, Mr Liddell told the 'Drug problems and poverty' conference held by the SDF in association with the Scottish Poverty Information Unit of Glasgow Caledonian University.

Almost half of drug-related deaths occurred in the most socially deprived areas of Scotland in 2003, according to research by the Scottish Executive.

Mr Liddell called for a revert to 'the thinking of 20 years ago, when we looked upon problem drug use as primarily a social issue', asking questions about wider society's responsibilities for creating structures to allow drug use to flourish, instead of seeing problem drug use as an individual's personal failing.

Challenging the status quo was essential and would 'pose huge challenges for public policy in terms of its focus and spending choices', he said. By continuing to hold drug users culpable for society's wrongs, we were 'let[ting] those who have the power to influence the way we live completely off the hook.'

Edinburgh trials more efficient records system

Substance misusers in Edinburgh will get an easier journey through treatment services, if a pilot project trialling single shared assessment is a success.

Action on Alcohol and Drugs in Edinburgh have reacted to results of last year's review of the city's alcohol and drug agencies, which highlighted that there was no common system through which agencies could record information. Clients were accessing services from different agencies without them being aware of the duplication and waste of resources.

If the paper-based system being introduced across north Edinburgh is a success, an electronic rollout will take place across the city.

Tom Wood, chair of the Action Team called the initiative another positive step in making a crucial difference to clients and staff, and acknowledged that it was 'long overdue'.

Fiona Watson, clinical lead in substance misuse at NHS Lothian and chair of the project's steering group, said it was 'a much needed development, both in improving quality of care for clients and in demonstrating outcome measures'.

Birmingham drug centre inspired by shared care pioneer

Birmingham's 12,000 drug users will be offered the support they need through a new state of the art centre.

Result of a partnership between Birmingham and Solihull Mental Health Trust and Birmingham DAT, Orsborn House was opened by Clare Short, MP for Ladywood, who said it was 'fantastic that a medical service of such high quality has opened in this community. It is a much needed resource which will play a large part in helping local people with mental health and drug problems to get the support they need.'

The centre's name was inspired by Dr Ray Orsborn, a pioneer of shared care in Birmingham in the 1980s. He began treating drug users referred from the community drug teams and Birmingham Drugline, and one of his protégés, Dr Andy Thompson will provide regular prescribing sessions in the new centre.

Dr Orsborn said he was highly honoured to have the building named after him. He added: 'I would like to pay tribute to all those who were involved in shared care in the early days and who continue to practice now. Providing effective drug treatment is a team effort which brings with it the greatest of rewards.'

NTA conferences on treatment effectiveness

Make the best of the money we've got, says Hayes

Let's focus on our achievements to get future direction right, NTA chief executive Paul Hayes told an audience from all areas of the treatment field, at the NTA's treatment effectiveness conference.

Mr Hayes spoke in detail about the newly announced pooled treatment budget, which he said had been confirmed against a backdrop of improved quality and effectiveness, and better access to more people.

The four aims of the NTA – more, longer, faster, better, had been achieved this year, he said. The announcement of £750m for treatment included £385m through the pooled treatment budget, and meant there was 33 per cent more money available – 'a splendid result', according to Mr Hayes.

He dismissed worries about the £40m shortfall from the initial forecast, because 'we still have an awful lot more money than last year'.

'We are confident that we can deliver, because of the way money's being used at the moment,' he added.

Despite an overall picture of good health, Mr Hayes identified 'dramatic differences in spend across the country' that amounted to services in some areas costing eight times more than in another.

'This is not acceptable... and very difficult to justify,' he said. 'We need to get a better handle on what things should cost.'

Priorities for areas looking to make up the gap between money promised and money announced, were retention targets, local stretch targets, and contributing to Home Office targets of 750 offenders a week in treatment. Areas' ability to deliver their whole agenda depended on providers' and commissioners' ability to spend wisely, he said.

Things were getting better for service users – 'the real litmus test over figures'. But the continuing challenge for the NTA was in increasing expectations: 'it's no longer good enough to get into treatment via criminal justice and DIP,' Mr Hayes acknowledged. 'Every time we improve things the bar goes up – so we have to improve what we offer.'

Future strategy was consolidation – to 'keep on keeping on' without backsliding, to grow the treatment system. Mr Hayes warned that current levels of funding were unlikely to continue beyond 2008, and that there was a 'belt-tightening exercise coming'.

'Our challenge is to use resources as efficiently as possible,' he said. 'There only likely to be a 3, 5, or even 0 per cent uplift in future.'

NTA responds to user input

Adding the newly updated *Models of Care for treatment of adult drug misusers* to the 'tremendous amount of data collected over the past year' gave a clear picture of what helps clients, Annette Dale-Perera, the NTA's director of quality told conference.

'More than we realise want to be drug free,' she said.

The NTA's survey of service users had shown most respondents felt respected by their key workers and satisfied with the competency of staff and the way services were managed.

There were exceptions from service users who had experienced longer waiting times and from those without care plans.

'A little over half said they had an up-to-date care plan, so there were some "could do better" headlines,' she said. Other problem areas were identified by those who had not received help with housing, or support for their families.

Next year the NTA planned to add results to a database, 'so areas will be able to see their results'.

Feedback from the recent needle exchange audit had 'caused us most concern, for its massive variation in practice', said Ms Dale-Perera. The 80 per cent of needle exchanges that were pharmacy based had been about distribution, not exchange, had limited out-of-hours access and one-to-one interaction, and were not adequate to stem the rise in blood borne viruses. Many 'did not even provide the basics', like checking injection sites. Deficiencies would be a focus of the NTA's improvement review.

A prescribing audit had given more room for optimism. 'We can track a major increase in methadone and buprenorphine prescribing,' she said. Three quarters of methadone was used for maintenance, and a quarter for reduction.

It was important to take treatment delivery and exist routes at the client's pace, said Ms Dale-Perera.

'We can do more to encourage clients to be drug free, with more psychosocial inputs,' she said. 'Housing and employment have to underpin delivery,' she added, as well as 'working with service users to find out their aspirations'.

Ms Dale-Perera urged delegates to be aware of a changing treatment population, and to recognise that some people were not as drug dependent:

'We have people who haven't been using for so long, and there's better potential to divert them.'

MoCAM is online at www.nta.nhs.uk

Alcohol funding imminent, commissioners are told

The government is due to announce funding for alcohol services next month but it will not be ring fenced, an NTA conference was told this week, *writes Rebecca Norris*.

Public health minister Caroline Flint said a funding announcement was due out early next month. She also announced the launch of the Models of care for alcohol misusers (MoCAM).

Ms Flint was addressing the NTA treatment effectiveness conference for commissioners, in London. She left the conference without taking questions from delegates but Nick Lawrence, head of drugs and alcohol policy at the Department of Health, later confirmed that the funding would not be ring fenced. Responding to a question from a delegate, he said 'there is a very special situation for drugs. Before, there were 370 different budgets to PCTs including the PTB. This year there are two – the general allocation and the PTB. There is no ring fenced money for alcohol, as there wouldn't be for any other health priority.'

He added that the challenge at a local level was to make the argument for funding, and his team would also be making these arguments and supporting alcohol treatment. He said an additional 15 million from April 2007 would be made available under the Choosing Health Initiative and overall, the allocations for PCTs were currently £217m.

Ms Flint said she hoped commissioners would agree that the 30 per cent increase for the drugs budget was 'extraordinary compared to other NHS areas'. She was not yet in a position to announce money for 2007/2008 but said it would remain a key priority in the DH.

The minister added that the DH was working with the NTA and the National Audit Office to establish appropriate unit costs for treatment of similar drugs services, which she hoped would be enabling for commissioners. But the DH did not intend that this exercise would 'discriminate against the most complex cases and therefore the most expensive'. She added 'there are extremely large variations in the way commissioning is carried out. One concern we have is residential and rehab services.'

NTA chief executive Paul Hayes told commissioners: 'We need to make sure all the resources we have been given are used to better effect'. Alluding to the year on year 10 per cent under spend of this budget he added: 'The Treasury will be keen to take away resources if they are not being used.'

MoCAM is online at www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4136806&chk=iA9Ogu

'I recently announced an increase in drugs funding for 2006/7 which means that all DAATs will receive an increase of 30 per cent in their funding. In comparison to increases in levels of funding within other NHS areas in 2006/7, this increase is unprecedented.'

Unprecedented funding

I am writing in response to the article on 'DATs demand answers on budget' (*DDN*, 5 June, page 6).

Andy Fox from Calderdale claims that 'the DAAT/NTA honeymoon period is now over and we are being welcomed into the real world of Treasury sleight of hand...'

The Department of Health has already invested record amounts of funding in drug treatment, up from £129 million in 2001/2 to £300 million in 2005/6. On top of this, £200 million of local funds are spent on drug treatment every year.

This investment has led to substantial improvements in drug treatment services with:

- numbers in treatment at a record level, with us almost certain to reach our 2008 target of doubling the numbers in treatment two years early;
- more people year on year either being retained or successfully completing treatment; and
- waiting times for drug treatment at historically low levels.

However, I am determined that we should build on these improvements and to support this I recently announced an increase in drugs funding for 2006/7 which means that all DAATs will receive an increase of 30 per cent in their funding. In comparison to increases in levels of funding within other NHS areas in 2006/7, this increase is unprecedented.

I also announced capital funding of £54.9m at the same time. Details on how local partnerships can bid for some of this funding will be issued shortly. This funding will not only create additional capacity within the residential rehabilitation and inpatient detox sectors, but also will tackle the issue of long term certainty in terms of sustained revenue funding for providers of these types of services.

In conclusion, while not diminishing the challenges that lie ahead, I do not believe the article as published gave an accurate reflection of the reality in terms of both government commitment to drug treatment and the effectiveness of current service provision.

Caroline Flint MP,
Minister for Public Health

Out of control

Nick Barton's article on residential drug rehabilitation services (DDN, 5 June, page 8) and the many letters published in response, aptly describe the revenue and other problems faced by residential treatment; problems that the NTA is well aware of and working hard to address. However, as long as residential rehabilitation funding relies solely on community care funding and assessment mechanisms, these problems are unlikely to be resolved. Realistically, it is beyond the control of local commissioners, the NTA or other substance misuse policy units to effect any significant change in community care mechanisms.

So what should we do? There are examples of good practice where local areas use a mixed economy of funding to meet the needs of local users who need residential rehabilitation. Similarly, there are examples of good relationships between local commissioners and providers underpinned by contractual arrangements other than simple spot purchasing.

We are working to identify and share these examples of good practice and to build better relationships between providers and commissioners. The substance misuse field is renowned for being inventive, creative and solution-focused and we need this approach to residential rehabilitation as we all recognise that community care is not working adequately for our growing client group.

At a national level, *DDN* readers

Getting there early

Following the UN's International Day Against Drug Abuse and Illicit Trafficking on 26 June, the morning papers were full of the usual contradictory headlines – 'world is beating drug addiction, says UN' in one'; 'alarm at Europe cocaine use rise', in the next. Mentor UK's chief executive Eric Carling tells DDN why the charity's mission that prevention is better than cure is more timely than ever.

WHILE MENTOR UK's been pleased to be involved with the Home Office and the Department of Health, we still don't think that anything like enough money is being spent on prevention work. There's far far too much emphasis placed on the criminal justice system. Although we believe treatment's really important, you're never going to stop this whole problem unless you intervene early to get people not wanting to use drugs in the first place.

We want to encourage policymakers and practitioners to do more work that's actually evaluated, and that we can actually see the outcomes of. The kind of projects we do are trying to develop the evidence base for drug prevention work. For example, we know from the Hidden Harm report that young people who have a problematic drug user in the family, themselves end up being more at risk of having drug problems further down the line, for a range of reasons. It might be from being slightly neglected, it might be from being stigmatised in schools, it could be from not having a relationship with an adult – which is one of the strongest protective factors that young people can have.

With this project the DH has funded us to work with grandparent groups throughout the country, for us to find out how we can support the communications between children who are being cared for by their grandparents. It follows the idea that by strengthening that whole family situation and supporting that, you're actually doing drug prevention.

What grandparents needed more was information, better access to welfare benefits and for social workers to understand the situation they're in. Part of the project is a video of grandparents, where they tell their story to the camera. It's very emotional; they say 'we just want you to understand how it feels'.

One of the grandparents we've been working with is caring for three children aged between three and 17, because her daughter overdosed three years ago. They're living in a one-bedroomed flat, and their experience of the social work department is that they're frightened to say they have any problems in case you think they're saying they want the kids taken into care. That's not what they're saying: all they want to say is 'understand that this is not easy'. Although this project will benefit grandparents directly, our intention in doing it is drug prevention.

Through projects, we get end users to tell us what their needs are. We then help them to address those needs, and support them in establishing projects that are actually going to achieve something, and which are evaluated.

One project consists of 12 local projects in coastal and ex-mining areas. They're parent or mentoring projects, or arts and diversionary projects. We worked with local agencies and held their hands to help them get set up, and helped them put in monitoring and evaluation tools, so at the end of the project the government will know more about how to work in these isolated local communities.

Another is a young people's

will be aware that the NTA is already working with government partners and other stakeholders on a wide-ranging cross-government Tier 4 work programme that aims to improve the quantity, quality and effective use of residential treatment. Residential providers also have a part to play in improving purchasers'/commissioners' understanding of their services and in clearly demonstrating their quality, cost and effectiveness. With the recent announcement of an uplift of 30 per cent in the pooled treatment budget, we have to work together to maximise resources and current opportunities.
Annette Dale-Perera,
director of quality, NTA

Caged dismissal

I read with interest the article Caged Recovery (*DDN*, 19 June, page 8). I myself spent many years in the criminal justice system in and out of prison and mental hospital because of my illness of addiction, and would like to say that I would not be alive today if it wasn't for the 12 step recovery programme I and many more recovering addicts and alcoholics belong to.

To have someone say that they were dogmatic and religious makes me feel quite sad for Mr Pryor. If he had done any research at all into the 12 steps, he would find that we are not religious but a spiritual programme. I myself would have run a mile if it had been religious and many more recovering people I know would have done the same.

Doesn't Mr Pryor believe in giving his clients choice? I thought that was what getting people into recovery was all about, so please do not dismiss the 12 steps as a way to recover. It has helped millions of people worldwide to stay clean and sober for many years – including myself, now 14 years clean and sober, one day at a time working a 12-step spiritual programme.

Yours in recovery
Tam Jordan, Penzance Cornwall

Email your letters to claire@cjwellings.com or write to: Claire Brown, Editor, DDN, Southbank House, Black Prince Road, London SE1 7SJ. ***Letters may be edited for reasons of clarity or space.***

involvement project – a three-year venture working with different groups. We're training them to find their voices, so they can talk about their lives and drugs and alcohol and the impact on them. It's never just about drugs and alcohol – it's always much more holistic than that.

We work with them on group techniques and how to work as part of a team. In one exercise we asked them what they think that people think of young people – and it was all stabbing and teenage pregnancy, and drugs. Then we said, how about the good things you think that people think about young people? They find that really difficult. We had to move them back into being positive about themselves.

One of the things we want to do at Mentor is build the idea that all young people are not crap! Every time you turn on the news or read the newspaper it's all about the respect agenda – about 'young people need to have more respect for older people'. What about having some respect for the young people too?

We were doing a warm up exercise and I said to one young guy 'tell us something good about you and something about your town'. And all he could think of was 'where I come from there's lots of graffiti'. I gave him a few more minutes, and he said 'well I really like little kids and I wouldn't mind being a crèche worker'. These tough kids are often embarrassed about being sensitive and saying anything aspirational.

We're hoping to get this group to meet with the All Party Group on Drugs, to present their ideas. When Education Secretary Alan Johnson announced about the random drug testing in schools, we said let's look at what we actually think about this. Let's write to the Secretary of State and ask for a meeting. These young people's views and ideas are really considered – they don't jump to ridiculous conclusions. And they don't actually believe they should be free to do anything they like.

Another project is doing rap music workshops. When David Cameron came out with his idea that rap music's really evil, they sent him a copy of their CD. We'll see if he responds! **DDN**

Comment

Sane in an insane place

Funding is just not getting to ground level services where it's so desperately needed. Why can't we address failing policy logically, asks Danie Strydom.

With reference to the article 'save our rehabs' (*DDN*, 19 June, page 6) it was no surprise to read that registered service providers struggle to find service users to occupy the available bed spaces in residential treatment facilities. Further, it was no great shock to learn that a variety of problems and subsequent bed-space voids arise from a lack of available funding.

Touchstones12 is an abstinence based project that has an objective to serve homeless individuals who present with a substance misuse issues. Sadly our client group often fail to source funding for residential treatment from statutory circles. To add insult to injury, application forms and referrals are abundantly filed in our system today. With specific facts on the table, we believe that our governing powers have lost their way.

Without doubt, substantial amounts of money are pumped into fat-cat middle ground services where excessive management vigorously draws on funding resources. Let's not mince our words – the belief here is that our higher powers have got it wrong! Funding is not going where it is so obviously needed – ground level services such as detoxification units. It's a disgrace because direct access services are thin on the ground, which in turn fouls up the referral line.

To exemplify this, consider a recent enquiry from an alcohol service. Client 'X' wanted to access our service, but the hammer blow shatters his motivation to change when he is told that he will have to wait three months before he can access detoxification. (He might be dead by now!) In all honesty a majority of referrals often follow the same sorrowful pattern. In a nutshell, many referrals fall victim to a lack accessible services.

Get real, service seekers need help with immediate effect. Contrary to belief, waiting lists for detoxification would be longer in reality, but sadly a majority of service seekers are given unrealistic detox access dates. Demoralised, dazed and confused service seekers return to a dangerous life of drinking and/or using drugs – with significant risk of untimely death. (In some cases a quick death would actually be more humane!)

Touchstones12 is the only abstinence-based project in North Wales. Curiously we are rewarded for our efforts by receiving no revenue funding from any statutory source to specifically address substance misuse. Astonishingly, the funding that we receive from the Welsh Assembly is purely to provide supported residential services and 'signposting' services.

Steve Spiegel hit the nail on the head; is a policy created to stop the spread of HIV/AIDS the best solution we can come up with to deal with addiction? Well, is providing needles, methadone and Subutex in effect treatment? To further confuse, controlled alcohol consumption is encouraged under the name of harm reduction. (Where's the alcoholic who will only drink half of his bottle for that day?)

To aid our financial dilemma, we wrote to the minister in the Welsh Assembly addressing the lack of funding specifically for abstinence based treatment in North Wales. To our advantage we were told to access the local 'partnership process' who quite generously contributed £6,000 towards our £120,000 day centre costs for the previous financial year! Safeguarding our communities is important – yet worryingly, limited funding is available to address abstinence-based approaches. We need to stop putting plasters on people, stop massaging the figures and realise we have a failing policy that needs addressing.

Home Office figures in 2003 indicate that alcoholism cost the British economy £20 billion and lead to 22,000 deaths. This figure has increased in the last three years by almost 100 per cent. In any commercial enterprise this 'business' would face closure. In Britain we continue to gamble with the lives of the chemically dependent; it defies logic. Sometimes it really is a case of being sane in an insane place.

We would like to add our voice to the numerous registered service providers in Britain and ask Mr Blair to act now to ensure that alcoholism does not became a bigger killer than cancer in Britain. Please start now sir, by funding the least glamorous end of the field, ensuring that detoxification facilities and subsequent non-profit making services are adequately provided and funded.

Danie Strydom is project director at Touchstones12, a non-registered residential unit in North Wales that accepts referrals from homeless people with a substance misuse history.

How do the budget figures stack up?

Following weeks of speculation, drug action teams finally received the letter they had been waiting for from the NTA, confirming their pooled treatment budget. Chief executive Paul Hayes answers DDN's questions about how the budget should work.

DDN: *What was the reason for allocating less money than originally promised for the PTB? Is the message that DATs don't need the money because they didn't spend it last year, or because they've already met targets two years early – or is the reduction directly related to funding restrictions on the NHS?*

PH: It's a combination of things. It would be naïve to believe we can operate in a system that's divorced from what's happening elsewhere in the NHS. We're part of the NHS and they're experiencing financial difficulties. So it's incumbent on everyone to demonstrate that they're making best use of the money that's available.

The position we're in is that we've met most of the top line targets. The money was planned to be delivered to us between now and 2008 to meet those targets, so the fact that we've met them two years early suggests, on the surface, that we didn't need the money. And given that the rest of the NHS did need the money, we obviously then had to make out a case for why we should have it.

Other factors that certainly the Department of Health take into account, is the fact the not only have we delivered the targets two years early, but we've delivered them in a context in which a lot of DATs have under spent year on year. That again would suggest we'd need to make a strong case for why we needed as much money this year.

The third thing that comes into play, is that some people seem able to deliver good quality services for less money per head than others. So if you're a minister or DH official, you put all of those things in the mix. And you come to people like me and say 'how can you justify a 40 per cent uplift in these circumstances?'

DDN: *How did you come to a decision on the figure allocated?*

PH: I felt I could justify an uplift. Because although we've got 200,000 people in treatment this year, there are anything between 250,000 and 350,000 who need to be in treatment, so we still need to grow towards that. Everyone agrees we still need to improve the quality of treatment. And although we've met most of the targets, the crucial one we haven't yet met is to deliver 750 offenders a week into treatment. It's a Home Office target rather than a DH target, but obviously HO wouldn't be able to meet it unless DH continued to expand the treatment system.

Putting all those arguments together and doing our sums again, we came up with a figure of a PTB of £385m – a 30 per cent uplift – an amount that would give us the ability to continue to expand the treatment system, continue to improve retention, continue to improve quality overall, and give the HO their 750 a week into treatment.

DDN: *Is there any scope for negotiation, if an area had a complete crisis – around young people for example – but were only allowed to direct money towards it if they'd got a surplus?*

PH: There are two sides to fall off the tightrope in answering that question. I would never want to say that somebody couldn't come and say 'this has happened and we therefore need to revisit our plans'.

But on the other hand, I wouldn't want people to think that we will be sympathetic to wholesale revisiting of treatment plans. We won't. People have got 93 or 94 per cent of the money they thought they were going to get. Many of them historically have under spent, very many of them are not getting the best value for money out of what they've got at the moment. We're aware of two or three places in the country where there may be particular circumstances. But it would need to be a very powerful case, argued very cogently.

DDN: *How do DATs make up for the fact that a quarter of the year's gone? Are you saying there's enough slack in the budget to compensate?*

PH: Ah, that's a rather different issue! People complaining about this process are on much stronger ground if they complain about the timing of the announcement rather than the amount of money. I think it's unfortunate that it's taken this long. The early delays were about the agreement on the amount. And if we'd announced it on time, people would not have been happy because they'd have got much less money than they're getting now.

But obviously the further into the financial year it goes, the more difficult it becomes. It will be particularly difficult for people to guarantee that they can spend all the money. People inevitably will have been hedging their bets over the last two or three months. Some of them will have been taking worst case scenarios of what the uplift would have been. I think there are very few people who were expecting to get the 40 per cent, and acting as though they were going to. There are probably more who have been unduly cautious over the last three months.

I think that people will be surprised that it's rather more than they might have thought. But there will be some people who will have to get their skates on in order to make best use of the money they've got. And we appreciate that, and we'll be working with them to help them do that. I certainly wish that the announcement had been made about a month ago.

DDN: *Were you concerned that some areas weren't spending their budget because they weren't very good at it, rather than because they'd got too much cash?*

PH: Absolutely. There are very few places that aren't spending the money because they've got too much money. There are probably one or two places where they're probably over-resourced for what they need. Most places are either not spending enough per head, or are sitting on unplanned under spend – planned under spends are fine. If someone's actually got a capital project and they've effectively saved up money from one year to spend in the next, then I've got no difficulty with that.

There are some people who can't get their act together to spend the money well, and that's a problem. And there are people who've got too much money largely because they can't get people into their treatment system. Obviously what we need to do is get them organised so they can do that.

DDN: *You said in your letter to DATs that areas need to prioritise what they do, and that the emphasis should be very much on getting people into treatment, and keeping them in treatment. Are you concerned that some of the poorer performing areas will see it as a case of meeting targets and be let off the hook on some of the detail?*

PH: There's always that risk. One of the dilemmas is, if you don't set targets people tend to do very little. And if you

do set targets, it can result in only the targets being achieved and nothing else. That very rarely delivers the outcomes that you actually want from the targets. We're very aware that you can hit the target and miss the point – and we're not in that business at all.

The overarching message is that most people should be able to deliver their treatment plan in full. Even though they're not getting as much money as they thought they were going to get, we believe that most of them can identify savings so that they can deliver all the things that they were planning to do this year.

Those that genuinely can't deliver everything need to prioritise, we'll work with them to identify which of the other things they still can do. We believe there will only be a few places that can only do the priorities.

DDN: *Will it be down to your regional managers to make sure service users aren't penalised in areas of bad treatment?*

PH: Absolutely, that's the last thing we want. It will show in the retention indicator in the NHS performance management system – people who are receiving a lousy service will vote with their feet.

DDN: *You're introducing new money to increase capacity in inpatient and residential rehab. Will some of it be used to address the current problems with bed spaces and the criticism that the space isn't being used at the moment?*

PH: Yes absolutely. What will happen is that consortia of DATs will be asked to bid for the capital money. Very often this will be to refurbish and expand existing premises – and some of it will be new build. But they won't be given that money unless they commit to taking up a certain number of slots each year, and to fund those slots from their revenue.

In that way we not only expand the capacity, but also make sure there's enough revenue funding for the current and new capacity. What looks like an apparent nonsense, that we're not making the most of what we've got at the moment and we're building some more, is actually a sensible response.

DDN: *Are you still as committed to the workforce targets since restructuring the workforce development team?*

PH: Well it's a bit like the other things we've been talking about – the original workforce agenda's been achieved. That was the first of our level targets that we met, three or four years early. What we're doing is refocusing on our work around workforce with the regional teams. I've been in Nottingham today, and it's very clear that our regional team in the East Midlands has got a real grip on the workforce agenda locally, and that we're able to drive it forward better regionally than we were nationally. Essentially we've passed the baton to HO and DH nationally, and relocated the emphasis of our work regionally.

The NTA central role will be about policy, best practice, being a champion for drug treatment within government. The SHAs will be responsible to the DH for the delivery of drug treatment, along with all the other healthcare for their communities, and we will be the means through which DH will have the expertise to hold them to account.

We're championing from within, and will also be the eyes and ears of DH, to see whether things are good on the ground. And if they're not, we'll go in, find out why not, and do something about it.

DDN: *What about the NTA beyond 2008? If management of the NTA regional structure is going to SHAs, will NTA regional managers lose their independent status? Will there be any breakdown of that structure that keeps them informed at the moment, and keeps them motivated?*

PH: In all honesty, we don't know. The original plan was for the NTA to have disappeared by 2008. That now is not going to happen. The NTA as a national entity will continue beyond 2008.

There are no guarantees. We're already one of the longest established NHS bodies. We've been going since 2001, and most other bits of the NHS have been reformed twice. So there are no guarantees of anything in the NHS world. But the expectation is the NTA will continue past 2008, because the government recognises this is a very important agenda – but one that the NHS, left to its own devices, would never give the sort of priority to that the government would wish it to.

That's not a criticism of the NHS. If I was running a PCT, or an SHA, or the DH, I wouldn't give drug treatment very high priority, because it isn't that important a health matter, compared to many other aspects of health care. The amount of people involved, the amount of early deaths, pales into insignificance compared to, for example, tobacco and alcohol.

The NHS was probably giving drug treatment a legitimate amount of resource and attention before the NTA came on the scene; what produced the additional funding is the concern about drugs and crime. The government's acknowledged that if it wants the NHS to continue to devote the attention and resources that we've been doing over the past five years, it needs to keep the NTA in existence in order to champion the drug misuse agenda, within the DH, within government offices, and within the NHS. So the NTA will continue to perform that function.

It's also acknowledged that the SHAs and the government offices will need some resource working with them to deliver that, post 2008. What hasn't been resolved, is what the bureaucratic relationship will be between the central NTA, the NTA regional teams, the government offices, and the SHA.

There will continue to be an NTA, there will continue to be a regional team charged with delivering the drugs agenda, but what we don't yet know is how that will be badged up.

DDN: *What will happen next time around with the PTB? Will it be mainstreamed?*

PH: I honestly don't know. There's been no discussion about what happens in 2007/8. The current situation is that all the money that DH used to hold centrally has now gone to SHAs. There are currently only two budgets in the DH – one that goes out to SHAs, and the PTB that stands entirely on its own.

The rationale for that is because of the nature of this agenda, it makes sense to keep it separate – we couldn't guarantee that the funding would have been spent on drug treatment, if it hadn't gone down as a separate budget line. We need to have this same discussion next year.

DDN: *And you'll still personally be at the NTA to have this discussion, will you?*

PH: Oh I'm not sure that's a fair question! I have no other plans.

DDN: *Are you still as happy with your job after the last few weeks?*

PH: I love all this stuff – that's what I'm here for! Most people recognise that given the context in which we're operating, the drug treatment field hasn't done at all badly out of it. We did our best to tell people as much as we could, but we didn't want to give false reassurance till everything was nailed down. Also, if you start leaking all over the place, you're not trusted to have the discussions again next year. **DDN**

Main points from the letter to DATs announcing their PTB allocation

The national PTB allocation for 2006/7 is £384.6m – a 28 per cent increase over 2005/6. This includes £10m from the DH for capital spend.

Additional capital resource will be available from DH for expanding tier 4 provision.

The uplift is intended to increase treatment numbers by 25,000 and improve retention by 5 per cent.

The rationale behind reducing uplift from an expected 41.5 per cent is: targets on treatment access have been achieved two years ahead of schedule; many partnerships have failed to spend their allocation in previous years; and cost of treatment varies dramatically between partnership areas.

Areas that struggle to deliver should prioritise as follows: by delivering Local Delivery Plan targets for retention and local stretch targets for increasing numbers in treatment; by meeting the criminal justice system target of 750 referral into treatment through the Drug Intervention Programme and Drug Rehabilitation Requirement; by expanding services for class A drug users referred via non criminal justice routes.

Where areas need more money for young people, on top of the Young People Substance Misuse Partnership Grant, they can redirect more resources from the PTB – as long as the priorities above are covered first.

Government is working out a different cost structure for next year, based on establishing a level playing field between different areas. The current formula will change, and funding will be based on the unit costs for each type of treatment.

Traffic lights for treatment

Creaking under the strain of an ever-growing workload, the Anchor Project decided to introduce a colour-coded 'traffic light' system to get people moving through the system at the right pace for them. Results have been positive, as Jane Benanti explains.

Drug treatment services are creaking under the stress of the demands placed upon them by the criminal justice system and ever changing court orders. Agreed, there is additional government funding for drug services but the influx of new clients and the overwhelming volume of work created, puts pressure on the service as a whole. As a consequence of the new influx of criminal justice referrals, the generic service required a more structured way of working in order to avoid long waiting lists and meet government targets.

The Anchor Project is a multi-disciplinary adult substance misuse service, based in West Bromwich. It is part of Sandwell Mental Health NHS and Social Care Trust and provides community care, detox and harm reduction prescribing for drug and alcohol users. The Tier 3 team is made up of community psychiatric nurses, drug workers, psychiatrists, applied psychologists and social workers. One of the first changes introduced was the transfer of self-referrals (unless medically chronic) from Tier 3 to Tier 2 which reduced the Anchor Project DNA (did not attend) rate by over 70 per cent. The Tier 2 service is provided by Addaction and its role is to screen clients and provide sexual and physical health advice and counselling, but it is not a prescribing service.

New clients at Anchor Project were divided into three colour coded categories (called 'zones') according to level of need. These are the red, amber and green zones. Staff were assigned to each zone and were rotated every six months. After initial referral to the red zone for the more severely dependent drug users, clients could pass between the three zones, depending upon their level of need and ability to comply with treatment regimens.

The red zone is the point of entry for severely dependent drug users, referred to the service by Addaction. This zone is designed primarily to offer a medically oriented intervention with twice weekly contact with a drug worker and twice weekly drug screening for the first six weeks of treatment. During this period, service users are put on supervised consumption of buprenorphine (Subutex) or methadone. Compliant clients then progress to one day a week contact with their red zone worker and one day a week screening for drug use. If they achieve stability by not using heroin, they can then

collect their methadone or Subutex prescriptions from the pharmacy and supervised consumption is gradually phased out. The criteria for moving on from the red zone were consistent attendance of appointments, and providing objective evidence of being drug free via urine screens or mouth swabs.

If a client fails to meet these targets within three months, they are referred back to Addaction for advice and counselling but they lose their methadone or Subutex prescription. On the other hand, if all conditions are met, clients are referred on to the amber zone.

The amber zone is tailored to clients who are stable in treatment. In this zone, interventions become more focused on personal issues and sexual health as well as mental health difficulties. Clients are offered a range of interventions such as diet and lifestyle advice, anxiety management, relaxation groups and acupuncture. In the amber zone, the interventions offered are holistic, and many clients take advantage of individual therapeutic interventions offered both to themselves and to their relatives by the psychology team based at Anchor Project.

The green zone clients are those who have continued to perform well in treatment and maintain abstinence from street drugs. In these cases, service users' lifestyles show personal and social gains such as breaking with old drug-using networks, training and education, employment and new social activities. Should relapse occur in this zone (but always depending on the length and severity of the relapse), the client is re-referred back to amber zone, or in certain cases to Addaction for counselling and further preparation for treatment. In the green zone, prescribing is often carried out by the client's GP.

Exceptions within the zoning system are pregnant women or those with young children who can access all services at all times across zones. This group has additional support from the three social workers within the team.

The aim of the new 'traffic light' approach is to encourage a more consistent way of working and reinforce a sense of progression for the client. In addition, it weakens 'enmeshment' or collusion between client and worker. This tended to occur in the old system when clients become dependent on an individual worker during the treatment episode, and client progress was questionable. Workers themselves can be the bane of drug services if 'co-dependency' issues sabotage treatment.

All drug workers were asked to complete a questionnaire about the advantages and disadvantages of zoning, around ten months after zoning was first introduced. The questionnaire was followed by a structured interview carried out by two assistant psychologists on placement at Anchor Project. Three broad themes were identified and categorised as contradictions about the client's progression; contradictions surrounding the zoning guidelines; and disagreement over models of care. Although not all participants mentioned all of the three above, it was felt that the majority of responses fitted into at least one or more of these categories.

Contradictions about the client's progression

Concern was expressed about referrals between the zones, with worries over some clients being kept too long in a red zone or moved on too soon.

'Workers pass clients on when they feel they are getting nowhere, regardless of whether they are ready.'

'Some workers do not pass on clients quickly enough.'

Contradictions surrounding the zoning guidelines

There appeared to be lack of clarity over how to handle relapse in each of the zones.

'What if a client relapses in amber? Should they go back to red or to Addaction? We need a clearer definition of what to do in a relapse situation.'

Disagreement over models of care

There appeared to be a split in the team about the best clinical approach in the red zone. Some drug workers agreed that the red zone should be structured with its main focus on medical intervention. Some held the view that they should be working closer with Addaction and referring clients back to Tier 2 if they were not compliant or ready for treatment at Tier 3 level. Other workers perceived Addaction as 'a punishment':

'If you misbehave you get sent to Addaction.'

There were issues with morale and worker satisfaction in the red zone. This was due to high caseloads, a complex and chaotic client group and lack of variety in the work:

'Red zone workers never get to see the best bit, the success stories.'

There were some negative comments. Staff reported that in practice there were problems with clients being 'bottlenecked' in zones waiting to be transferred.

'Clients don't move through zones – they're clogged up in red.'

'The model is purely medical.'

'There is disruption to the therapeutic relationship.'

On the positive side, all staff reported that they felt the zoning system provided a progression for clients (and staff) because the system offered goal attainment and reduced the risk of clients and staff becoming enmeshed in 'learned helplessness' and 'striving caregiver' roles.

'Clients can see their progression.'

'Zones are tailored to the client's level of need.'

Following service evaluation recommendations to the Anchor Project management, innovative changes were introduced for the longer term. The report suggested a more flexible approach in the red zone via a point system, whereby prescriptions are not stopped automatically but only after failure to attend a specific number of appointments. The red zone is now divided into Phase 1 and Phase 2. Phase 1 is a total of six weeks and clients need to score a minimum of 42 points to stay on their prescription.

Points are allocated for attending the pharmacy for supervised consumption of methadone or Subutex (maximum five points per week); attending appointments on time; and clean drug screens.

Clients with 42 points or more then continue onto Phase 2 of red zone where they are required to give clean drug screens for three consecutive weeks. When this goal is achieved, clients pass onto amber zone where more flexibility is built into the model to support individual ways of working. Both the amber and green zones focus on social care and constructive use of time. In addition to medical treatment, the amber and green zones offer group work, links to further education and training, acupuncture and psychotherapy. All staff rotate zones every six months so that they have experience of working in each area, thus preventing burn out in the red zone and allowing clients to be seen by a different worker each time they move zones.

Feedback was sought from service users. Those who were informally interviewed said they preferred the zoning system to the previous way of working at the Anchor Project. Some stated that zoning was fairer because they felt that treatment decisions were not aimed at them personally. It was not a tussle between 'a nasty worker who doesn't like me' or 'a nice worker who does like me'. It was about the protocols of a progressive system that allows for short-term goals and rewards positive behaviour change. The overall consensus of both staff and service users was, that in spite of earlier difficulties, zoning had brought about a more comprehensive and consistent approach to treatment.

'Those who were informally interviewed said they preferred the zoning system... Some stated that zoning was fairer because they felt that treatment decisions were not aimed at them personally.'

Jane Benanti is chartered counselling psychologist and lead psychologist in substance misuse at the Anchor Project (Sandwell Mental Health NHS & Social Care Trust) and consultant psychologist in addictive behaviour at Tranquil House, Worcs. The author can be contacted at jane.benanti@smhsct.nhs.co.uk

Tuning in to learning disabilities

For individuals with a learning disability or cognitive impairment, entry to treatment services can be fraught with obstacles. Dr Adam Huxley and Dr Alex Copello consider how we can be more responsive to their needs.

The Q&A feature in March (*DDN*, 13 March, page 14) had some interesting correspondence in relation to a request concerning information giving for people with learning difficulties and cognitive impairments. In Birmingham, we have considered the experiences of clients with such difficulties and found that drug services are not well equipped to meet the needs of this group.

This issue has not had appropriate coverage at a national level and people with learning disabilities are not represented well in drug treatment services, in common with several other marginalised groups.

Some individuals may experience impairments in their cognitive functioning due to chronic substance misuse, and may already be in treatment services. Others have a clinically significant learning disability (a global impairment that affects their ability to live adaptively) and are excluded from drug treatment services. We are focusing our discussion on the second group, as these individuals face barriers into drug treatment services and even when they attend learning disabilities services, their substance misuse is not accurately detected.

The stated aims and objectives of the National Treatment Agency are to 'ensure equality in drug treatment for the diverse population needs of England'. The NTA outlines its commitment to action to ensure 'equal access to relevant and appropriate drug treatment services for the whole population regardless of mental ability, mental health, geographical location, offending background, physical ability, political beliefs, religion, health or status or any other specific factors that result in discrimination'.

Groups currently under-served by the drug treatment sector include women, young people, people from black and minority ethnic backgrounds, stimulant misusers (including crack and cocaine), people with mental health problems, and homeless people.

There is evidence to suggest that people with learning disabilities do use substances problematically, with suggested prevalence rates varying from 0.5 per cent to 2 per cent of the general learning disabilities population. Studies of alcohol and illicit substance use within this population suggest that people with learning disabilities appear to use/abuse alcohol at about the same rate as their non-cognitively impaired counterparts, and illicit drugs at moderately low rates, but this research is likely to be an underestimate of true prevalence rates.

Problematic substance use contributes to poor outcomes in community living, can be a predictive factor to admission to secure hospital facilities for people with mild intellectual disabilities, has been linked to offending behaviour, and can exacerbate existing impairments. There is evidence to suggest that mild learning disability in itself is a risk factor among adolescents for engaging in binge drinking and drug related harms. An American study suggested that those with learning disabilities who misused substances experienced negative psychological consequences, family problems, social difficulties and psychiatric hospital admission.

Risk factors that increase the likelihood that somebody will misuse substances – unemployment, lack of housing, lack of social and support networks, and the presence of psychiatric illness – are all difficulties that people with learning disabilities face. Coupled with this, they may not have the responses, skills or support (protective factors) to avoid substance misuse.

Little is invested in educating people with learning disabilities about

the problems associated with substance misuse. The consequences of using substances for people with learning disabilities are perhaps more costly than those for the general population. They can experience further cognitive impairment, physical and psychiatric difficulties, and can be excluded from services as a result of behavioural problems. Problematic use can exacerbate existing impairments and lead to additional marginalisation and exclusion. There can seem to be greater barriers when trying to access services, and they have a greater risk of experiencing unemployment, poverty and crime. The lack of appropriate education, support, assessment and treatment services for this population can leave them 'untreated' and at risk.

Statistics from the National Drug Treatment Monitoring System in England, 2001/02 show that of problem drug users accessing drug treatment services, 73 per cent of them were heroin users. A study six years ago suggested that people with learning disabilities tend to use substances such as alcohol and cannabis rather than drugs such as heroin. The fact that people with learning disabilities tend to develop problems with substances that are not the core focus of current drug treatment practice in the UK, may explain why there are low levels of access to substance misuse services from this group.

Detecting individuals who have 'dual needs' (substance misuse and learning disabilities) is problematic. Staff typically do not have the training to screen for such difficulties and may consider the individual's 'difficulties' to be a result of cognitive impairment due to substance misuse itself, rather than premorbid deficits. Understanding that some individuals may have real problems with their ability to take in and retain information, comply with substitute medications and adhere to treatment regimes, might increase their chance of engaging in treatment.

The learning disabilities population living in the community is at risk of developing substance misuse problems. Limited education related to the harmful effects of substances is a risk factor contributing to substance use, yet little is invested in developing learning disabilities services that can provide people with enough information to make an informed choice about substance use. On the other hand, specialist substance misuse services are not geared to identify clients that have the types of additional needs highlighted in this article.

A way forward for drug treatment services would be to consider which individuals it currently provides a service for might meet the criteria for a learning disability. Establishing the needs of the individual will help provide the most appropriate treatment plan, aid retention and promote better treatment outcomes.

The lack of effective interventions for this population could be addressed through staff training, patient information, health promotion and therapeutic approaches. Research 25 years ago suggested that treatment for people with learning disabilities tends to be more behavioural, less confrontational, more directive and more likely to involve the client's family.

Perhaps the start of this process is acknowledging that this is an issue worthy of consideration among drug treatment services. When we have identified this hidden population, we can then begin to plan services for them. Until then they may continue to face many barriers to receiving a service and continue to be one of the under-served groups.

Dr Adam Huxley and Dr Alex Copello are at Birmingham and Solihull Mental Health NHS Trust. Contact the authors by email at adam.huxley@bsmht.nhs.uk

'Studies of alcohol and illicit substance use... suggest that people with learning disabilities appear to use/abuse alcohol at about the same rate as their non-cognitively impaired counterparts...'

Post-its from Practice

Treat the person, not the drug

Each patient always teaches you something new about treatment from their own journey, says Dr Chris Ford.

ONE AFTERNOON a couple of weeks ago, I noticed Jack had made an appointment to see me. I was pleased as I hadn't seen him for a couple of months since he had gone into rehab. He had started using crack over two years ago, aged 19 years and quickly realised he enjoyed it and couldn't do without it. He soon discovered heroin as a useful 'help' to deal with the 'comedown' after a period of heavy crack use. In a short period of time he stopped further education, got thrown out of his parent's home and began crime to pay for his drugs. He knew after a few months of pleasure that he wanted to stop but had no idea how to, or what help was available.

Jack had been registered with the surgery since birth and it seemed to him to be a good place to start. The receptionists are amazing and well trained in recognising someone who 'needs' an urgent appointment. When Jack first entered my room, I was confronted with an angry, agitated but obviously vulnerable young man.

We worked together for many weeks before he decided what he wanted to do, which was a detoxification and then rehabilitation. Each time he came, he left angry saying I was no use, but I was able to offer harm reduction advice and information about his possible choices. He stopped losing weight, was allowed back home and kept coming back!

Jack undertook a rather unconventional community detoxification using buprenorphine, lofexidine and diazepam, which seemed to work for him. He then went into the 12-step rehab of his choice. This took some doing and needed Jack, with support, to continue to strive for what he wanted; and have a care manager who was also able to work with Jack as an individual.

But he did get in and was drug-free on entry and soon enough came skipping into my room having completed the first part of his rehab. He began by thanking me for sticking in there with him, especially as he had been so unpleasant much of the time. He wanted to make amends for his behaviour and seemed shocked when I showed interest in his step four, and asked how many meetings he planned to go to now he had returned to London.

Patients teach us new things every day, if only we allow them to. Jack, like most people coming into treatment know much of what they want. They will often need some help and facilitation finding their way but we need to trust them and their journey. Their choice may or may not be what we think best for them. One size (or drug) does not fit all and people must be allowed to make choices. To allow people to be able to make choices for themselves, those of us working in the field need to know what is available, including the 12 steps. If you have never attended a meeting, go to an open meeting of AA, NA or CA. Best not to judge others' choices without first having experienced it ourselves. The range of treatment options is small enough, so let's not make it smaller through our own prejudice. Let's remember to always treat the person – not one of the drugs they may be using.

Dr Chris Ford is a GP and Clinical Lead for SMMGP

I've been having a relationship with one of my clients and now we're really serious about each other. I was trying to keep it secret, but the rumour mill's started up. How can I handle this without losing my job?

'Phil'

External guidance

Dear Phil
I am an assessment and referral case manager for a Liverpool substance misuse unit, within an inner city area of Liverpool.

I would suggest that you read the protocols and ethics of your employer and seek guidance from an external councillor or supervisor. You will need to check your motives.

I work with individuals who emotionally can be very vulnerable; I also work with service users who are very emotionally mature, and capable of healthy relationships.

I suggest you check out your motives morally, ethically and lawfully. If this is checked and found to be sound, then why would you worry about gossip? If you clean your side of the street then you have nothing to fear or hide. The more transparent and honest with yourself and others you are, the better.

I have known of cases where a worker has ended up marrying an ex service user. I would stress the ex.

If your check your motives and the service user checks theirs, and you decide you are soul mates, then maybe you either move jobs, refer the client to a new service or worker that provides better or similar services, and close the episode or file with regards to your involvement in the case.

I would stress that I do not agree with staff taking advantage of their positions of trust, or their vulnerable needy clients.

Professional boundaries are very important, and I would think that it would be looked down on, even if you were not sacked.

If you care for this individual, maybe you should wait until her treatment is complete and her episode is closed.

George, Liverpool

Abuse of power

Phil,
You should hand in your notice immediately and think long and hard before working with any vulnerable group of people again. While you may feel 'serious' about your client, that's just what he/she is – a client, which means the relationship can't be an equal one. There are good reasons for rules banning relationships between workers and clients – to keep people safe – and you are abusing a position of power by breaking them.

Jenny Nicholson
Oxford

Breach of trust

Dear Phil
I think this is a very complicated situation. At my organisation this would be seen as a breach of trust and we have policies around these issues where you would end up losing your job.

We as workers have to shut off from our feelings and remain professional. Our primary focus is what's best for our clients. One of our roles is not to make our clients dependent on us. The only advice I can give is take it to a manager or someone you have supervision with. Harsh as it may seem, looking for a new job might be an answer.

John of Lifeline

Do the right thing

Dear Phil
You are asking the wrong question. It is not a matter of whether you can keep it secret but whether you should have been doing it in the first place.

Should a teacher have a relationship with one of their pupils? Should a doctor go out with one of their patients? The answer is of course 'no' and I don't see why drug workers should be any different. There are huge moral issues behind this and I'm not convinced you've given it enough thought. Your prime concern seems to be keeping out of trouble rather than doing the right thing professionally.

If this person is really the one for you, then you need to terminate your working relationship immediately. Your client needs to get another drug worker, preferably at another establishment. You cannot have things all ways.

Ian, Harrogate

Only human

Dear Phil
The answer is so simple that you will probably find it easy to ignore it, but here goes...

You can't handle this without losing your job and you shouldn't handle this without losing your job.

You are a professional, working with vulnerable clients and that means that you are required not to become personally involved with clients. There is no justification for this and it is clearly unacceptable, so that needs to be your starting point in your thinking.

The fact is, we are human beings, we make mistakes, we fool ourselves into thinking that there is clear justification for what we are doing or have done and sometimes these things just happen. The key to dealing with it, lies in being really honest with yourself and being prepared to face up to the consequences of your actions. You are not asking yourself to do any more than you would ask of any client who came to you asking for your advice and guidance about a problem in their lives, so what makes you so different? We often tell our clients that life is a game of consequences and often forget how real that it is for ourselves...

The 'we're really serious about each other' bit of your letter worries me, as I suspect that no-one could convince you otherwise at the moment. Please ask yourself why, with 60 million other people in the country, you end up in a relationship with your client? In all our interactions with our clients we are always asked to reflect on whose needs are being met in the process. Now is the time to ask yourself that question.

Martin Brown, director of services, Community Drug Project

Reader's question

Our organisation currently provides a staff smoking room, but the new legislation coming into force next year will outlaw this. While I could just kick the smokers out into the cold I would like to offer them some help to quit. Has anybody offered any smoking cessation schemes to their employees, and if so how successful was it?

Mick, London

Email your suggested answers to the editor by Tuesday 11 July for inclusion in the 17 July issue of DDN.

New questions are welcome from readers.

The drug experience: heroin, part 9

In his latest Background Briefing, Professor David Clark continues to describe Patrick Biernacki's research with 101 people who had recovered from heroin addiction without treatment.

People who have been addicted to heroin report experiencing cravings for the drug long after they have given up using. Many people who have gone back to using the drug after a period of abstinence attribute their relapse to their cravings for the drug.

A craving for heroin is used to describe a strong desire or need to take the drug. Craving is often brought about by the appearance of a cue that has repeatedly been associated with past heroin use. These cues may be associated either with the withdrawal from heroin (conditioned withdrawal), or with the pleasurable effects of the drug (conditioned reward).

Wikler first claimed that the relapse of abstaining heroin addicts can be attributed to conditioned withdrawal. Thus, people who have stopped using heroin can crave the drug if they are exposed to certain stimuli that they have learned, as result of their past withdrawal experiences, to associate with the withdrawal syndrome.

People returning to an area where they have previously withdrawn may experience withdrawal symptoms, and as a result of the discomfort, begin to think about the drug again, obtain it, and relapse.

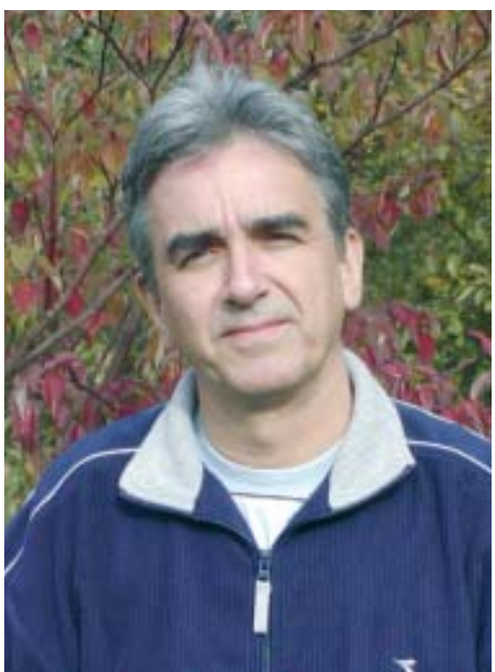
Lindesmith has postulated that in people who have repeatedly used heroin to prevent the onset of withdrawal symptoms, withdrawal distress can become generalised to all forms of stress. When they become abstinent, former users may experience a craving for heroin in non-drug related stressful situations.

Contrary to these ideas, Biernacki reported that only a small number of people in his sample described their cravings as being linked to withdrawal distress. Though they sometimes reported that problematic life situations during abstinence led to thoughts about the drug, they did not report any specific symptoms of withdrawal.

In this study, cravings were commonly described as emanating from associations made in past experiences of using heroin, and the associated drug effects. The cravings were 'experienced and interpreted as akin to a low-grade "high". The person feels a "rush" through the body and by feelings of nausea located in the stomach or throat, and he thinks about enhancing the feeling by using the addictive drug.'

This second type of craving was to be of short duration, generally 15-20 minutes, and rarely lasted longer than an hour. The frequency with which these cravings occurred diminished over time, generally appearing rarely, if at all, after a year.

Biernacki pointed out that these cravings can be managed in two basic ways, employed individually or together: drug substitution, and a rethinking of a person's experiences.



Craving is often brought about by the appearance of a cue that has repeatedly been associated with past heroin use. These cues may be associated either with the withdrawal from heroin (conditioned withdrawal), or with the pleasurable effects of the drug (conditioned reward).

As described in our last Briefing, the initial step in breaking away from heroin use – to minimise temptations to use – commonly entails a literal or symbolic move away from the drug scene. However, this move away does not necessarily negate the influence of drug cues, since many cues are present in a variety of environments. Moreover, a move away from the drug scene does not necessarily help the person manage the cravings once they do occur.

The first strategy that participants in the Biernacki study used to overcome heroin cravings was simply to substitute some other non-opiate drug. The most popular substitutes were marijuana, alcohol and tranquillisers such as valium. While some of the sample subsequently developed serious problems with alcohol, most who adopted this strategy used other non-opiate drugs only on an occasional basis.

A second strategy that was used to manage cravings involved a subjective and behavioural process of negative contexting and supplanting. 'When people experienced heroin cravings, they reinterpreted their thoughts about using drugs by placing them in a negative context and supplanted them by thinking and doing other things.' The foundation enabling the negative contexting and supplanting is provided by new relationships, identities and perspectives of the abstaining individual.

To illustrate the above, some people who overcome their dependence to heroin become very health conscious and concerned about their physical well-being. When they experience heroin cravings, they may place the thoughts about using the drug in a negative context by thinking about a physical illness that can arise from injecting the drug, *eg* hepatitis.

Furthermore, they may replace the thoughts of using the drug by thinking of the personal benefits that can be gained from some physical activity, such as cycling. The basis for these alternative thoughts comes from the social world of participatory sports. The person may then go cycling and the psychological and physical aspects of the craving can be masked by the physical exertion, or can be reinterpreted as an indication of exertion.

Biernacki provided examples, of other ex-users who became religious converts, or who engaged in political activity. He emphasised that, 'an effort such as this must be made each time the cravings appear, until the power of various cues to evoke the cravings diminishes and the cravings are redefined as the ex-addict becomes more thoroughly involved in social worlds that are not related to the use of addictive drugs'.

[to be continued]

Recommended Reading: Patrick Biernacki (1986) Pathways from heroin addiction: Recovery without treatment. Temple University Press, US.

DipHE/BSc (Hons) Substance Use and Misuse Studies

Starting October 2006, February and June 2007, at our Ealing Campus

Programme Structure

The programme provides an essential insight into substance use and misuse issues from the perspectives of health and social care, mental health and public health, criminal justice, child protection, young people and community care. It explores various types of substances commonly used and introduces a variety of evidence based interventions.

Modules can be taken alone or combined leading to a Diploma or Degree.

This multi-disciplinary programme has been mapped against the Drug and Alcohol National Occupational Standards (www.danos.info).

Modules

- Substance use and misuse in context
- Substance use and misuse treatment intervention
- Enhancing practice
- Enhancing cultural competence in dealing with people with drug and alcohol problems
- Dual diagnosis: exploring interventions for people with mental health and substance misuse problems
- The Criminal Justice System and Substance Misuse

Who can apply

The programme is suitable for a wide range of professionals working with alcohol and drug users including nurses, social workers, drug and alcohol treatment workers, those who work in homeless and youth services and in the criminal justice systems, in both the statutory and voluntary sector.

Tel 0800 036 4036
healthenqs@tvu.ac.uk
www.health.tvu.ac.uk/sums

Apply on-line at **www.tvu.ac.uk/apply**

TVU Thames Valley University
London Reading Slough

The Training Exchange

Evidence Based Approaches to Counselling Substance Users (EBA)

Accredited Drug & Alcohol Training Programme

the TRAINING exchange

Who is it for?

- Workers and volunteers who are new to the field of substance misuse work
- Experienced practitioners seeking recognition of professional practice
- Those working with substance users in related fields

What is involved?

The course is divided into 4 units; students attend 13 days of formal training that take place over 8 months. Additional time commitments vary according to the level at which students submit evidence of learning.
Maximum group size is 16 with ongoing tutorial and resource support provided.

What do I get?

An Open College Network (OCN) accredited qualification at level 2 or 3. Mapped to DANOS units: AA1, AA2, AB2, AH3, AH10, AI1 (optional units AJ1 & AJ2).

Programme Dates

(All days are held in Bristol)

Unit One: Critical Issues in Dependency and Treatment

Orientation	*12th September*
Drugs and Society	*19th September*
Models of Change	*26th September*
Attribution and Self-Efficacy	*3rd October*

Unit Two: Counselling Pre-Decisional Change Drug Users

Therapeutic Alliance	*14th November*
Motivational Interviewing Part 1	*21st November*
Motivational Interviewing Part 2	*28th November*

Unit Three: Counselling Post-Decisional Change Drug Users

Behavioural Change	*9th January 2007*
Solution Focused Therapy	*16th January 2007*
Relapse Prevention	*23rd January 2007*

Unit Four: Dependency Counselling in Context

Working with young drug users	*6th March 2007*
Dual Diagnosis	*13th March 2007*
Ethics and Practice	*20th March 2007*
Debriefing (morning)	*27th March 2007*

Phil Harris from Freespace leads course delivery.
Course Fees £1600 + VAT

For more information contact
The Training Exchange
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
Further details and feedback from previous programmes can be found on our website

www.trainingexchange.org.uk

The Training Exchange is an independent training and consultancy service.

SOUTHAMPTON CITY COUNCIL

Safe City Partnership
making Southampton safer

TENDER FOR PROVISION OF A STRUCTURED PSYCHOSOCIAL INTERVENTIONS SERVICE FOR DRUG USERS

SOUTHAMPTON CITY COUNCIL invites applications from suitably experienced organisations that wish to be considered for selection to tender for the provision of a Structured Psychosocial Interventions Service for Drug Users in Southampton.

Structured psychosocial interventions are clearly defined psychosocial interventions, delivered as part of a client's care plan, which assist the client to make changes in their drug using behaviour. These interventions are normally time limited. These services were provided by a number of agencies in the City and Southampton Safe City Partnership now wishes to commission a single agency to provide this service, at Tier 2 and Tier 3 levels.

This contract has a proposed commencement date of January 2007.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) may apply to this Service. Some capital funds will be available to the successful applicant: this would be subject to a charge.

Organisations interested in being considered for invitation to tender should apply in writing to Miss S O'Neill, Corporate Procurement, 1st Floor, Southbrook Rise, Millbrook Road East, Southampton SO15 1YG (email: sharon.o'neill@southampton.gov.uk) by no later than 24th July 2006. Applicants will be required to complete a pre-qualification questionnaire which must be returned by no later than 31st July 2006.

Further information on the service requirements can be obtained by contacting Joan Ward on Southampton 023 8083 4257 or email: joan.ward@southampton.gov.uk

The contracting authority undertake to use reasonable endeavours to hold confidential any information provided in the proposal submitted, subject to the contracting authority's obligations under law, including the Freedom of Information Act 2000. If the applicant considers that any of the information submitted in the proposal should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The contracting authority will then consider the sensitivity statement before replying to any request received under the Freedom of Information Act 2000.

Tender documents or notice of non-acceptance, as appropriate, will be sent to all applicants.

London Borough of Redbridge

Contract for:
RESETTLEMENT AND AFTERCARE SERVICE IN THE LONDON BOROUGH OF REDBRIDGE
OPEN TENDER PROCEDURE

Notice is hereby given by the London Borough of Redbridge ("the Council") that:
Redbridge Drug and Alcohol Action Team, as part of the Council, invites tenders from suitably qualified contractors for the above Contract.
The contract will run from 1st September 2006 up to and including 31st August 2007.
The Contract comprises the development of a 12-month pilot resettlement and aftercare day centre within the London Borough of Redbridge for clients who have become abstinent from drugs and/or alcohol or those who have completed a programme of drug and/or alcohol treatment. This must be made up of diverse multi-agency input, and offer a broad range of interventions/activities to support abstinence and longer-term stability. In order to deliver the Service the successful Service Provider will need to acquire premises within Redbridge that comply with the specified requirements of the Council.
Statement of Intent:

- Tenders will be evaluated based on the following, in percentage terms and in descending order of priority: Technical ability (35%); Quality (25%); Price (15%); Equal Opportunities (10%); Ability to find premises (10%); and Health and Safety (5%).
- The Council requires high quality services and only organisations capable of providing this should apply. Potential Tenderers should recognise that the Council will be rigorous in examining their ability to meet the Council's expectations within the legal framework.
- Organisations shall be experienced in providing similar services and will be required to complete a questionnaire relating to information about their economic and financial standing, their ability, technical competence and other general information.

Application and Tender Documents are available from:– Mr John Harrington, London Borough of Redbridge, Strategic Services, Town Hall (Room 19) 128-142 High Road, Ilford, Essex IG1 1DD (Tel 020 8708 2374, Fax 020 8708 2976).
E-Mail: john.harrington@redbridge.gov.uk
Further information may be obtained from Jenny Beasley, DAAT Joint Commissioning Manager, Station Road Centre, Station Road, Barkingside, Essex IG6 1NB (Tel 020 8708 7837, Fax 020 8708 7802).
E-mail: jenny.beasley@redbridge.gov.uk
Deadline for receipt of tenders is 16.00 on 21 July 2006.

fdap

DANOS qualifications workshop

FDAP is running a series of three half day workshops on the national workforce development targets and the four main routes to demonstrating DANOS competence – the NVQ in Health & Social Care, national Development Awards, Open University Competence Awards and FDAP Accreditation.

Birmingham – 10 July

London – 11 July

The workshops will begin at 12:30 with a sandwich lunch, and conclude by 15:30. They are free of charge. To reserve a place, and for venue details, please contact us:

e: office@fdap.org.uk **t: 0870 763 6139**

brighton housing trust

BHT ADDICTION SERVICES

BHT's Addiction Services provide a comprehensive programme of support to men and women, many of whom are former rough sleepers in the City, who are committed to abstinence and recovery from their addiction to drugs and alcohol.

PROJECT WORKER (Recovery Project)

Salary £20,235 – £22,293 pa, plus 6% (reviewed annually) pension contribution
NJC scale point 25, rising by annual increments to NJC scale point 28
Working 35 hours per week
Annual leave entitlement starts at 25 working days

We are looking to recruit a Project Worker to assist on a daily basis, as part of a team responsible for 30 clients, in the efficient running of the Recovery Project and move-on accommodation. The job requires the post holder to undertake a range of housing management, support, and therapeutic interventions both on an individual and group basis. Areas of specific responsibility are allocated from time to time by the Project Manager.

The successful applicant will possess a relevant professional qualification, such as a diploma in counseling or addictions, or be actively working towards this, and have significant experience of working in the addiction field. They should have experience of group work, an ability to demonstrate a thorough knowledge of substance misuse and its related problems and possess excellent interpersonal and communications skills. An ability to work within the 12 step model of recovery is essential.

Closing Date: 12 noon Monday 17th July 2006
Interview Date: Monday 24th July 2006

This post is exempt from the provisions of the Rehabilitation of Offenders Act of 1974.

INTERESTED? For further details and an application form please e-mail jobs@bht.org.uk or write to the HR Officer, Brighton Housing Trust, 144 London Road, Brighton, BN1 4PH, specifying the post you are interested in and enclosing an A4 self addressed stamped envelope (.48p). Please note CV's will not be accepted

BHT operates an Equal Opportunities Policy. Please note that a CRB Enhanced Disclosure will be required as a condition of employment.

Setting new standards for Social Care Professionals.

Specialising in the provision of Substance Misuse Personnel

Substance Misuse Workers
DIP Workers
Arrest Referral Officers
Project Workers
After Care and
Thru Care Workers

rig

Telephone **020 8249 6416**
Email **info@rigsocialcare.co.uk**
Internet **www.rigsocialcare.co.uk**

REC Recruitment & Employment Confederation

LOOKING FOR HIGH QUALITY,SKILLED, SUBSTANCE MISUSE STAFF?

Consultancy, Permanent, Temporary

We Talk Your Talk…
- *A comprehensive database of specialist substance misuse personnel*
- *Providing staff for Public, Private, Voluntary and Charitable organisations*

We Walk Your Walk….
- *Recruitment consultants with many years experience in the substance misuse field*
- *Meeting all your recruitment needs for the substance misuse field: Criminal Justice; Treatment; Young People; Communities; Availability*

Contact us today: Tel. 020 8987 6061
Email: SamRecruitment@btconnect.com or register online

www.SamRecruitment.org.uk

SAM Solutions Action Management Recruitment & Consultancy

DIRECTORATE OF
EDUCATION & CHILDREN'S SERVICES

Social Worker/ Consultant Practitioner – Parental Substance Misuse

Ref: EDC733

£23,952 - £31,653 pa for Social Worker

£30,843 - £35,772 pa for Consultant Practitioner

Both positions are full-time for 37 hours per week and salaries are subject to experience and career progression.

Are you an experienced and registered Social Worker with expertise in Parenting Assessments & Substance Misuse?

If so, you could be the person we need to lead our plans on early intervention in working with parental substance misuse and fast tracking into treatment services.

Local research has shown that parental substance misuse and associated chaotic lifestyles, especially during pregnancy, are significant factors in Child Protection Registrations and Care Proceedings. To tackle this the Reading Drug & Alcohol Action Team and Targeted Services for Children have created this new joint-funded post.

If you are enthusiastic and committed to driving and implementing change for children, in the context of productive joint working arrangements, we would like to hear from you.

We offer strong management and peer support, with a commitment to ongoing training and development.

For an informal discussion please contact **Estelle Kelleway** or **Matthew Randle**, Joint Team Managers of the Family Support Centre on **0118 901 5320** or Denise Cooke, Team Manager of Referral & Assessment on **0118 955 3600**.

Closing date: 12 July 2006, Shortlisting date: 14 July 2006, Interview date: 3 August 2006

To apply

Application forms can be downloaded or completed on-line at **www.reading.gov.uk**

Alternatively, email: **recruitment@reading.gov.uk** or call **0118 939 0039** (24 hour answerphone) quoting the relevant reference number and stating which position you are interested in.

Application forms should be returned to the Directorate of Education & Children's Services HR team, Recruitment & Employment Services, Reading Borough Council, Floor 4, Fountain House, Queens Walk, Reading, RG1 7TD. Please do not send a CV. For the purposes of equal opportunities, we can only accept Reading Borough Council application forms.

A Criminal Records Disclosure will be sought from the successful candidate.

Equal opportunities for all. Positive about disability.

What's in it for you?

- **flexible working**
- **24 days holiday rising to 32 days**
- **excellent training & career opportunities**
- **staff club – further discounts & activities**
- **season ticket/transport loans**
- **final salary pension scheme**
- **retail & leisure discounts**
- **staff support service**

Reading BOROUGH COUNCIL

MIDDLESBROUGH PRIMARY CARE TRUST
(on behalf of the Safer Middlesborough Partnership)

EXPRESSIONS OF INTEREST
user led throughcare and aftercare service

Middlesbrough PCT (on behalf of the Safer Middlesbrough Partnership) is inviting expressions of interest from suitably experienced organisations for the provision of a user led throughcare and aftercare service.

The successful organisation will be expected to develop a service that has as its central focus the recruitment of ex service users/service users into paid posts and the utilisation of these workers in supporting current clients in drug treatment services. The service will form part of the SMPs community based response to substance misuse in Middlesbrough and will include the following components:

- A service that is predominantly staffed by ex service users/carers at all levels of service
- Aftercare/throughcare support for clients by ex service users/carers
- Assertive outreach/follow up support by ex service users/carers
- Basic awareness training for tier one staff
- A peer advocacy service to users
- Lead agency support for the development of appropriate user representation
- Abstinence based interventions and support
- Research into the utilisation of service users/carers in drug treatment services

The PCT/SMP would welcome expressions of interest from organisations within the substance misuse related sector but also from those with a history of service user involvement/employment in other related sectors.

The indicative Budget for this service held by the Safer Middlesbrough Partnership is (full year) £118,000. Part of the evaluation of the tenders will be an assessment of the tendering organisations ability to attract additional resources to develop the project, e.g. by grant aid or charitable sources

The contract is expected to be awarded in the first instance for the period to 31 March 2008 and is expected then to be renewed for a further 12 months subject to satisfactory performance and commitment of finance by the Safer Middlesbrough Partnership.

Expressions of interest in tendering for this contract should be submitted in writing by Friday 28th July at 12 noon and should be sent to: David Jackson, Joint commissioning Manager, Safer Middlesbrough Partnership,2 River Court, Brighouse road, Middlesbrough,TS2 1RT, Email; d_jackson@middlesbrough.gov.uk

SOUTHAMPTON CITY COUNCIL

Safe City Partnership
making Southampton safer

TENDER FOR PROVISION OF AN INTEGRATED DRUG INTERVENTIONS PROGRAMME (DIP)

SOUTHAMPTON CITY COUNCIL invites applications from suitably experienced organisations that wish to be considered for selection to tender for the provision of an Integrated Drug Interventions Programme (DIP) in Southampton.

The DIP aims to help drug-using offenders out of crime and into drug treatment services. Southampton is a non-intensive DIP area and services are currently provided by a variety of different agencies in the City. Southampton Safe City Partnership now wishes to commission an Integrated DIP Service incorporating Throughcare and Aftercare, Arrest Referral, DTTO/DRR Provision, PPO Scheme, 24/7 Out of Hours/Single Point of Contact and Tough Choices. Substitute prescribing will not form part of the contract and the Integrated DIP Service will be expected to accommodate and work with the existing provider.

This contract has a proposed commencement date of January 2007.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) may apply to this Service.

Organisations interested in being considered for invitation to tender should apply in writing to Miss S O'Neill, Corporate Procurement, 1st Floor, Southbrook Rise, Millbrook Road East, Southampton SO15 1YG (email: sharon.o'neill@southampton.gov.uk) by no later than 24th July 2006. Applicants will be required to complete a pre-qualification questionnaire which must be returned by no later than 31st July 2006.

For further information contact Roma Andrews on Southampton 023 8083 2127 or email: roma.andrews@southampton.gov.uk

The contracting authority undertake to use reasonable endeavours to hold confidential any information provided in the proposal submitted, subject to the contracting authority's obligations under law, including the Freedom of Information Act 2000. If the applicant considers that any of the information submitted in the proposal should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The contracting authority will then consider the sensitivity statement before replying to any request received under the Freedom of Information Act 2000.

Tender documents or notice of non-acceptance, as appropriate, will be sent to all applicants.

drink, drugs and edp

Exeter, East & Mid Devon Adult Services
EDP is well recognised as THE leading non-statutory service provider for drugs work within Devon. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

Senior Practitioner EEMDA Services – Ref No: 23.06
- £25,437 rising to £28,220 (NJC Scale 32-36)
- Hours: 35
- Base: Exeter

The Successful applicant will become a key member of the Exeter, east & mid Devon Adult Services. You will assist in service development in line with evidence based best practice, National Standards and EDP drug & alcohol service policies and procedures. You will deputise for the Head of Service and contribute to the management, supervision, appraisal and support of staff, students, trainees and volunteers in the team.

You will be familiar with the delivery of tier 2 and tier 3 interventions to service users and you will carry a caseload of clients who may have complex needs. You will be expected to model good practice to the team. You will have the ability to undertake comprehensive needs assessments and implement and review packages of care. Your record keeping will be excellent and you will be committed to multi-agency working and practice. You will hold a driving licence and have access to a car.

You will ideally have a professional qualification (e.g. social work, psychiatric nursing, community work, counselling, teaching, addictions) or equivalent experience and/or training.

Criminal Justice Worker EEMDA Services – Ref No: 21.06
Fixed term until 31.03.07, with potential for extension
- £20,894 rising to £24,708 (NJC Scale: 26-31) *Pro-rata = £10,452-£12,354*
- Hours: 17.5 per week
- Base: Exeter

We are looking for an enthusiastic and flexible worker to deliver, as part of the multi-agency Criminal Justice Team and the Drug Intervention Programme (DIP), through-care/after-care in Exeter, east & mid Devon. You will be required to work in a variety of settings including Police and Court cells, visit Prisons to carry out assessments, and develop care plans to ensure through-care and after-care needs are met for individuals passing through the Criminal Justice System. You will be required to deliver tier 2 & tier 3 interventions, and you will need to have experience of case management, assessment, care planning and multi-agency partnership working. A professional qualification in a relevant field is desirable.

Community Drugs Worker EEMDA Services – Ref No: 22.06
Fixed term for 1 year
- £20,894 rising to £24,708 (NJC Scale 26-31) *Pro-rata = £10,452-£12,354*
- Hours: 17.5 per week
- Base: Exeter

The successful applicant will be an experienced practitioner and have extensive knowledge and experience of drug treatment. You will be required to provide tier 2 advice and information regarding harm reduction, including safer injecting, and support to individuals who approach the Service, be they users, friends and relatives or other professionals working with drug related problems. You will be required to deliver tier 3 interventions, manage a caseload and effectively implement care plans and structured interventions. You will also have experience of multi-agency partnership working. A professional qualification in a relevant field is desirable.

EDP employs individuals who possess:
A motivation to achieve, a commitment to evidencing professional responsibility and accountability in all that you do, a desire to learn, develop and reflect upon practice and an enthusiasm for working in this sector.

EDP will provide you with:
Training, support and supervision and opportunities for career development within the organisation. An excellent employee package, including 5% employer pension contribution and annual leave entitlement which rises to 30 days per year.

Enquiries to: Caroline Moore, Head of Exeter, East & Mid Devon Adult Services, **after receipt of the application pack** (01392 666719)

Application forms available from: Georgina Burford, Human Resources Officer, EDP Drug & Alcohol Services, Dean Clarke House, Southernhay East, Exeter, EX1 1PQ). Or E-mail **recruitment@edp.org.uk** quoting the *reference number*

Closing date for applications: 12th July 2006 12noon