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22 May 2006

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# DDN

Drink and Drugs News

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with acupuncture

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networks in Bristol

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# Drink and Drugs News

22 May 2006



## Editor's letter

How easy is it to hold regular meetings when they're the last thing that anyone has time for? When was the last time you cancelled the final fixture in your day because there just aren't enough hours? It's too familiar, and all too often the reason we don't liaise enough.

I was treated to a refreshingly different perspective in Bristol last week (page 10), when Nigel from CAAAD and Dina from the drug strategy team filled me in on some of the partnership working behind a strategy to give proactive support to those with Hep C in the city.

As well as doors being opened to as many professional participants as possible, the feedback mechanism seems to be in place for getting response from service users through the user group network. I'm sure the service doesn't get it right for everyone all the time, but there are concerted efforts to make sure services communicate to make

a clearer pathway through treatment.

It's an interesting case study of drug services working well with housing – which doesn't always seem to be happening elsewhere. Our report on Addaction's aftercare consultation (page 6) hears views from experts with different backgrounds, on improving partnership working to give stability and direction to those coming out of residential treatment or prison.

I was led to reflect just this week that while the will is there in so many parts of the field, the joined-up thinking doesn't always come naturally. A copy of DDN came winging its way back to us from the information officer of a main mental health charity with an explanatory note: 'please take us off your mailing list – it's too directed at drink and drugs for our needs. There are other dedicated services in the borough who handle this problem. We are more mental health.'

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## What's on?

### DDN partner events

#### 6 June – Scotland

*Drugs and Alcohol Today, Scotland Pavilion's* one-day event builds on its annual London equivalent, and will bring together representatives from all tiers of the drugs and alcohol sector. The event will feature 30 exhibitors and a programme of seminars running throughout the day. The exhibition will also feature the arts, training, awareness, online services and complementary therapy zones.  
t: 0870 890 1080  
e: info@pavpub.com

#### 13-15 June – Portsmouth

*National Convention for Safer Communities*  
Organised by National Community Safety Network, in association with FDAP and others. The event brings together strategic partners with 'safer, stronger communities' at the heart of their agenda. The programme will be developed and delivered by a multi-agency group of key stakeholders (including FDAP) and will offer delegates a choice of mini conferences, seminars and workshops, debates and local study tours.  
w: www.yarrington.co.uk/ncsn\_portsmouth/

#### 19 July – Derby

*Update on Methadone Prescribing*  
An RCGP update for primary care professionals on methadone and its uses in treatment. Looking at the evidence for methadone treatment in different people and groups, correct dosage and best practice. Speakers include: Dr Jenny Keen, GPSI clinical lead, Derby; Dr Jenny Scott, lecturer in pharmacy practice, University of Bath; Dr Chris Ford, GP and SMMGP adviser; Dr Kim Wolff, senior lecturer in the addictions institute of psychiatry; and John Howard from Reading User Forum.  
T: 020 7173 6091  
E: drugmisuse-enquiries@rcgp.org.uk

### Other events

#### 7 June – Blackpool

*Delivering the Treatment Effectiveness Strategy*  
Organised by NTA. One of three regional events focusing on informing practitioners about how to take forward the treatment effectiveness strategy, from inception to implementation.  
w: www.nta.nhs.uk

#### 15-16 June – Manchester

*Through Treatment... and Beyond*  
Organised by T3E, this year's two-day event, 'How to improve the client's journey; a European perspective', focuses on how interventions within treatment and beyond can help construct therapeutic alternatives to, or routes out of, substitute prescribing for opiate dependence. Participants will share their experiences of the degree to which these can promote sustainable opiate-free lives, or the degree to which safety and stability can only be guaranteed by continuing opiate maintenance.  
t: 020 8411 2460  
e: k.khan@mdx.ac.uk  
w: www.t3e-eu.org

# Regional alcohol indicators show problems worsening in the North West

New indicators showing alcohol-related problems in the North West will help local areas to understand how alcohol is affecting residents and services, and plan their development of interventions.

The Regional Alcohol Indicators, published by the Centre for Public Health at Liverpool John Moores University on behalf of the Regional Alcohol Harm Reduction Strategic Group, identify the extent of problems and the areas worst affected.

Urbanised areas such as Blackpool, Liverpool and Manchester were found to suffer highest levels of alcohol-related harms, with negative effects on life expectancy rising by nearly a quarter among both sexes between 2004 and 2005. The burden of ill health from alcohol translated to 38,500 hospital admissions for men during this period, and 25,300 for women.

Professor Mark Bellis, director of the Centre for Public Health, said the statistics uncovered just part of the

devastation caused by badly managed drinking venues, underage alcohol sales, and an attitude among some individuals that drinking to near unconsciousness and alcohol-related violence were acceptable.

The regional indicators would be 'another key development that improves our understanding of what else needs to be done to tackle alcohol misuse', he added.

Professor John Ashton, regional director of public health, said the report 'confirms what many of us have suspected for some time – namely that alcohol abuse is blighting the lives of many people in the North West and the problem is getting worse'.

There was now no excuse for local authorities, the Health Service, employers and others not to 'tackle this problem with vigour', he said.

*The report, Regional Alcohol Indicators for the North West of England, is online at [www.nwph.net/alcohol](http://www.nwph.net/alcohol)*

## Roving support for pregnant drug users in Edinburgh

A new pregnancy support team has been set up by Action on Alcohol and Drugs in Edinburgh, to be up and running by July.

A team of midwife, community psychiatric nurse, two nursery officers and a senior nursery officer/project co-ordinator, will operate a mobile service throughout Edinburgh to make sure all women have an effective care plan before arriving at hospital.

Becky Cropper, senior nursery worker

and project co-ordinator, said the holistic package of care on offer would enable a mother to address her drug issues before and after the birth, as well as delivering a healthy baby.

'I believe the approach and flexibility of our service will make a big difference to those we are targeting,' she said. The team will aim to reduce commonly reported problems associated with maternal drug use, such as low birth weight, pre-term

delivery, neonatal abstinence syndrome and sudden infant death syndrome.

The service plans to see 66 women over the next year and double the number the year after, with two-year funding of £104,000 from the Scottish Executive, and hopes to extend if it is successful. Around 150 pregnant women with substance misuse problems are estimated to give birth in the city each year, according to submitted midwifery forms.



**Vernon Coaker has been appointed Drugs Minister – the third in DDN's 18-month lifespan. A former deputy headmaster of Bigwood School who became MP for Gedling in Nottinghamshire in 1997, Mr Coaker was a government whip before joining the Home Office. He was previously Parliamentary Private Secretary to Culture Secretary Tessa Jowell, and to Estelle Morris when she was Secretary of State for Education.**

## Scots drug and alcohol associations merge for unified front

The Scottish association representing drug teams has merged with the association for alcohol teams to drive forward a unified agenda on substance misuse issues.

The resulting body, the Scottish Association of Alcohol and Drug Action Teams (SAADAT), will be chaired by Tom Wood, currently chair of Action on Alcohol and Drugs in Edinburgh and formerly deputy chief constable of Lothian and Borders Police. It will represent more than 20 alcohol and drug action teams throughout Scotland, with the remit of bringing about improvements for those with drug and alcohol problems, and will advise on policy development both nationally and locally.

Tom Wood said he was delighted

to accept the role at a time when changes in society were desperately needed to stem binge drinking and prevalent drug use.

'Many of our current strategies have had mixed success and what we need is clear thinking and the courage to introduce policies and solutions that will make a genuine difference to the very complex problem of substance abuse,' he commented.

Mr Wood said his priority would be to ensure the views and experience of Scotland's Action teams were fed into the national review of drug action teams, and used to effect when new regulations for the Licensing Act come out in the autumn. Alcohol-related deaths have risen by 21 per cent in Scotland over the last five years, and now stand at one in 40 people.

## Competence awards go live

The Open University and the Federation of Drug and Alcohol Professionals have come together to develop a range of 'OU/FDAP competence awards' to help practitioners demonstrate their competence against the DANOS national occupational standards, in line with national targets on workforce competence and qualifications.

These awards are Open University-accredited qualifications based on an independent assessment of written evidence of competence supplied by the applicant in conjunction with their line manager.

Practitioners can apply for awards based around individual units or particular clusters of units – the ten-unit 'competence for drug and alcohol professionals'; three-unit 'assessment and care planning for substance users' and two-unit 'assessment of substance users' awards.

The ten-unit 'competences for drug and alcohol professionals' award provides all the

evidence required for accreditation under FDAP's 'Drug and Alcohol Professional Certification' scheme, and may be accepted as evidence of DANOS competence in its own right.

The individual unit awards, and the smaller cluster awards, provide externally validated evidence of competence and can be used as 'top-ups' towards FDAP Accreditation, as well as for demonstrating on-going professional development.

These awards are open to anyone in the field – but are available at reduced rates to FDAP members and the employees of corporate affiliate agencies.

For more information about the OU/FDAP awards, and how these link with FDAP Accreditation as a Drug and Alcohol Professional, as well as with national targets on competence and qualifications see the 'training and development' section at [www.drinkanddrugs.net](http://www.drinkanddrugs.net) and the 'professional qualifications' section at [www.fdap.org.uk](http://www.fdap.org.uk).

## Euromed launches training and accreditation bursary

For the second year in succession Euromed has agreed to set up a training and accreditation bursary to help support practitioners wishing to gain evidence towards FDAP Accreditation as a Drug and Alcohol Professional.

This year's bursary will give financial support to a total of eight practitioners, as follows:

- One grant of £1,000 towards the costs of the Bath University/Clouds Foundation Degree in Addictions Counselling.
- One grant of £1,000 towards the costs of the Open College Network/Addaction Drug and Alcohol Workers Core Competencies Certificate.
- Six grants to cover the full costs of the ten-unit OU/FDAP Competences for the Drug and Alcohol Professionals Award.

Each of these awards provides the evidence of competence required for accreditation by FDAP.

FDAP chief executive, Simon Shepherd, commented: 'We welcome Euromed's ongoing commitment to supporting training and development in our sector, including our OU/FDAP competence awards and Drug and Alcohol Professionals Accreditation scheme.'

DDN will be setting up a special panel to judge bursary applicants.

For more information on the scheme, including how to register, visit [www.euromed.ltd.uk](http://www.euromed.ltd.uk).

## Join the Skills for Health consultation

Consultation on draft competences for advanced practitioners is taking place on the Skills for Health website.

Five new DANOS units for advanced practitioners have been drafted and Skills for Health are inviting comments on these units.

Completed consultation questionnaires should be sent to Trevor Boutall by email at [Trevor.boutall@themsc.org](mailto:Trevor.boutall@themsc.org) or faxed to 0870 1671979 by 23 June.

View the consultation material at [www.skillsforhealth.org.uk/development\\_documents.php?id=25](http://www.skillsforhealth.org.uk/development_documents.php?id=25)

## Sandwell takes active approach to recruitment

An active approach to workforce development has been taken by Sandwell DAAT, which ran a three-day course for people interested in pursuing a career in the drugs field.

With additional funding support from the Home Office Drug Strategy Directorate, the DAAT ran a DANOS-mapped course facilitated by Dudley Craig of the Federation, which found participants by advertising at the local job centre.

As well as learning about drugs and their effects and the government's drug strategy, participants found out about career pathways and treatment modalities, and the core competences they would need to work in the sector with adults, children and young people. They were given the offer of a day's placement in a drug agency, and will be kept on the DAAT's database to be informed of future vacancies.



# Where to next?

Results of a three-year consultation on aftercare show areas of improvement – but also many missed opportunities to give back those emerging from prison or rehab their place in the community. DDN reports.



➤ 'When I left prison, they said "there's the bus stop. Adios".  
'I go to the drop-in, fill in forms, and wait. They say "there's nothing we can do today – but if you'd like to fill these forms in".'

These comments from service users interviewed by the charity Addaction, sum up too many people's experience of aftercare – or lack of it. Coming out of prison or rehab, their routine of a highly structured day ends abruptly, and they are faced with a stark choice: muddle along hoping to strike it lucky with finding somewhere to live and a way of earning a living – or go back to the routine they know best. It's hardly surprising then, that many who have struggled hard to leave their drug or alcohol use behind, succumb to the first phone call from a friend offering a little substance-based stress relief from the outside world, and start to see the revolving door back to prison as their lot in life.

Speakers at Addaction's 'Towards Independence' conference are determined it shouldn't be this way. But they will need a lot more than their own commitment to the cause to make real progress.

Adam Sampson has been in post for three and a half years as director of Shelter. Before that he worked in the drugs field as chief executive of RAPt. This is the first time he has been asked back to talk to the drugs field wearing his housing hat, he says. If we're serious about joining up services to provide meaningful aftercare, shouldn't professionals working in all areas be talking to each other?

Three years' work on Addaction's aftercare consultation, a piece of work commissioned by the Department of Health, has underlined the need for better links and closer relationships – between prison departments and other agencies; community-based drug teams and local housing providers; substance misuse services and self-help groups; and of course the client with all of the above.

Discussions with service users emphasised how much they needed a responsive caring worker to co-ordinate their path through aftercare support, from meeting them at the gates of prison or rehab, to paving their way back to everyday life. This is where partnership working must play an effective part, so that they have access to help from health services, benefits and employment agencies, training and education providers, the citizen's advice bureau, and housing associations. Backing up the one-to-one care with a client phone line, open 24 hours every day, has been shown to be one effective way of demonstrating flexible and responsive care.

The report acknowledges that progress has been made between services in certain areas of the country. But lack of housing slices through the aftercare project at every stage – and what hope is there for drug or alcohol using clients when there are a million people waiting for council housing, many of them with young children?

Drug Action Team commissioning groups must see housing as part of a holistic package of support, says the report. Treatment plans have to link with strategies on homelessness and the Supporting People programme (from the Department for Communities and Local Government).

The Drug Interventions Programme (DIP) has helped to draw investment to throughcare and aftercare, but the report finds that lack of housing and accommodation for recovering drug and alcohol users is a key barrier to delivering effective aftercare, and concludes that 'it is absolutely essential that further resources and creative solutions be put in place to address this issue'. **DDN**

**Deborah Cameron is chief executive of Addaction, which carried out the three-year aftercare study, funded by the Department of Health.**

'If service users are to succeed, they need to live in a reasonable environment, with the means to sustain themselves. They need physical health, family relationships, and skills for the job market. It's wrong to suggest that wraparound services create a culture of dependence. We've learnt that 'one size fits all' doesn't work.

DIP and associated interventions have undoubtedly improved things. But at Addaction, only 12,000 of 30,000 service users came to us from DIP

Seventy per cent of services are not funded to provide aftercare. It can't be right that those who are motivated to provide help in communities are so under-funded.

We have known housing was an essential aspect of community care. But up to a third of prisoners lose their home while in custody. Housing benefit rules allow prisoners to retain their housing for a very limited time.

Prejudice against substance misuse remains. More than six out of ten employers deliberately exclude people with a criminal record, or a record of substance misuse.

No one sector or specialism can provide all the solutions. We need to reduce barriers and stigma.'

**Paul Goodman is chief executive of the Ley Community, one of the original residential rehabs, which now supports its 64 residents through a programme of integration to the community.**

We're very ambitious about residents who come for treatment. 'Tough love' and 'self help' are our defining principles – and we believe everyone should have a second chance.

It's not a drug programme, it's a programme about life. Central to the process are residents' relationships between each other and staff.

People become institutionalised after nine months. So we enable them to socialise with the local community to reintegrate.

Employment is crucial to people's recovery. We've employed two resettlement officers, and they work half in, half out of the Ley community. All residents get employment when they come out. They go down to the job centre like everyone else, but by then their sense of self is so strong,

## **'If service users are to succeed, they need to live in a reasonable environment, with the means to sustain themselves. They need physical health, family relationships, and skills for the job market. It's wrong to suggest that wraparound services create a culture of dependence. We've learnt that "one size fits all" doesn't work.'**

they all get employment.

They budget, pay rent and save, then move on to a shared house, supporting each other. Resettlement staff that they've built a relationship with, have regular contact – through texts, phone calls, or a weekly group. Central to everything is continuity of care.

Some people need more help than others but relationships are maintained. The longer people are in treatment, the less likely they are to reoffend. Many settle around us, in the Oxford area – many local treatment services are staffed by our residents, who have become workers in their own right. Many choose to put back into community what they've gained. If you aim high, you can take addicts out of benefits.

Different approaches are needed for different clients. But it's what happens after they leave that matters – treatment is not an end in itself.

**Adam Sampson is director of Shelter, the charity that campaigns for decent homes for all.**

We need to understand the scale of the housing crisis in this country. If you're a single person, you have a real problem in getting housed. Local authority and courts have chosen to interpret legislation in a very narrow way.

You are categorised as intentionally homeless if you commit a crime. This is a way of getting around the spirit of the legislation – for a simple reason. There is a massive waiting list of one million people for council housing.

Our clients don't come top of the list. It's difficult to get people out of prison and into social housing. There are built up demands – it's like pushing water uphill.

Some housing authorities operate a blanket ban against people who have

had debt. They like to make sure tenants are good bets, and are likely to pay rent. So people with drug and alcohol problems have an increasing struggle to get access to the housing there is. People with previous history find themselves locked out.

We should be really clear about the importance of housing for drug users. If you can provide them with good housing, it's the best you can do for them. Everything else follows from that. Without housing, recovery from drug use is impossible.

We have a very strong case that improving housing saves on crime. We need to join up the housing, drugs and criminal justice field to move forward.

**Mark Stephenson is Addaction's national aftercare research co-ordinator, and part of the team that conducted the three-year study.**

Aftercare should be a package of interventions after prison and residential rehab, integrating clients into the community. It needs effective, relevant links and has to be extensive enough to meet diverse needs.

There have been positive developments in some areas, such as joint release planning and out-of-hours phone contact, quick and easy access to treatment and investment in throughcare. DIP has had a positive impact on aftercare.

But there are barriers. Housing and accommodation are the single biggest issues.

Adoption of a non judgmental approach is important for the worker/client relationship – and for retention. As well as interpersonal skills, it's important to have professional skills – assessment, care planning and care management skills. The care planning

needs to start early, so there is more time to link clients to services that are relevant to their needs. Workers also need to have networking skills, related to services in their area.

Aftercare shouldn't be a bolt-on extra, it should be planned. Services need to work together and be flexible, responsible, and relevant.

**Shereen Sadiq is aftercare team lead for the Home Office's Drug Intervention Programme. She has been closely involved with the aftercare consultation project.**

DIP is a crime reduction programme, and it's also about addressing some chasms in services. It's not a magic wand, but it's a commitment to address issues that aren't working.

If we don't use resources in the right way, we're in deep trouble. DIP came about because there were a lot of interventions – but we still didn't talk. Clients don't care which agency you come from, they just want quality of care. We need commitment to better joining up. Flexibility is about trying to get people into treatment, but supporting them when they come out. The penny's starting to drop; we can't put people in treatment and leave them there – and we do need to address housing. It's a package, a process of continuity, and we have to facilitate that process.

Research on aftercare shows there's no single model that works. We need to be responsive, with a single point of contact and co-ordination in the community, done at the pace of the client. It has to be a holistic approach.

It's good to talk. We need communication, job swaps, secondments, presentations. If we don't know where we stand with individuals, what'll we do when things get tough?

Most important is the rent deposit work [where the council provides a deposit for the first 12 months of tenancy]. Thirteen DATs have been part of this, and we're learning a lot. Housing's not been at the top of everyone's agenda.

Education, training and employment can't be done in isolation. It's about empowerment and identity – about learning and going at a person's pace.

*For more information on the National Aftercare Research Project, visit Addaction's website at [www.addaction.org.uk](http://www.addaction.org.uk)*



Cordelia Molloy / SCIENCE PHOTO LIBRARY

**'As for the research evidence for methadone prescribing as a tool for eventual drug-free recovery, well, I'm afraid that's pretty thin on the ground. The authors cite Dole and Nyswander as having "established its efficacy" in a paper 40 years ago. That is presumably the same paper from which the authors distanced themselves in subsequent writings, the one that described a small study which others were subsequently unable to replicate when they tried it with a more typical population than Dole and Nyswander's highly selective sample? Sorry, is that it?'**

### Unpleasant and petulant

What an unpleasant and, indeed rather petulant article you featured in your Comments section (*DDN*, 8 May, page 9). Carnwath and Ford are apparently much exercised by the idea that methadone is evidence-based (presumably the implication being that other treatments are not?) and that it is under threat.

For the record, the evidence-base for substitute prescribing is indeed strong in terms of its impact on criminal activity and health-related risk activity, but not so strong in other areas. For example, recent European research suggests that retention in treatment (one of the major planks upon which substitute prescribing methodology has been built) is only marginally better than that for residential rehabilitation.

As for the research evidence for methadone prescribing as a tool for eventual drug-free recovery, well, I'm afraid that's pretty thin on the ground. The authors cite Dole and Nyswander as having 'established its efficacy' in a paper 40 years ago. That is presumably the same paper from which the

authors distanced themselves in subsequent writings, the one that described a small study which others were subsequently unable to replicate when they tried it with a more typical population than Dole and Nyswander's highly selective sample? Sorry, is that it?

If we're going to talk about the evidence-base, then let's talk about all of it. The implication that those who question the dominance of substitute prescribing are in some way 'born-again... 12 stepper(s)' with no grasp of the scientific literature is both offensive and untrue. 'There are many, many approaches to treatment recovery, aside from 12 step and the evidence-base is exceptionally strong for some approaches and goes back an awfully long way.

Consider the evaluation of the work of Maxwell Jones and Dennie Briggs with drug addicted prisoners in the USA in the late 1950s and early 1960s – some of the earliest evaluative work undertaken by this client group. Substitute prescribing does not have a monopoly on research evaluated efficacy and it is misleading to imply that this is the case.

The truth is, that far from being under threat, substitute prescribing (mostly on the back of infection

control and crime prevention scares) has become the undoubted cuckoo in the treatment nest. In the past decade, methadone has made the notion of a broad range of treatment responses little more than a rather utopian dream about how things should/could be.

What is truly worrying about this development is not that there is anything wrong with substitute prescribing, but that the 'market share' of methadone in the treatment arena has now reached such a size that it threatens other treatment initiatives. Not least, this will happen simply because we are 'growing' a generation of treatment professionals who have never seen recovery and are sceptical that it exists. This is not speculation or anecdote; it's from my own research (that means it is evidence-based!).

What is perhaps more worrying still, is the near hysterical response that greets every attempt to point out these developments. No-one that I'm aware of is really saying that methadone should not exist as a treatment option. What some of us are saying is that when one treatment option becomes almost the only game in town, then it will threaten the continued existence of other options – if for no other reason than its sheer size.

Consider the impact of the big supermarket chains on small independent retailers – same thing. Simple market economics. Which is fine if we seriously want to marginalise groups like AA, NA and CA and if we don't really see the need for all these irritating non-medical interventions. But a rational, constructive debate on what kind of balance of interventions we really want will not be possible, if those who raise these concerns are simply castigated as turncoats or ridiculed for their lack of evidence base.

**Rowdy Yates, Senior Research Fellow, Scottish Addiction Studies, Sociology, Social Policy and Criminology Section, Department of Applied Social Science, University of Stirling**

### Polarisation problems

Unfortunately unnecessary polarisation of the abstinence/methadone debate has been further advanced by the comment article by Tom Carnwath and Chris Ford (*DDN*, 8 May, page 9).

While they quite rightly point to the substantial and convincing evidence base for methadone, they ignore the growing evidence base for 12-step interventions and groups. A glance at this month's *Addiction* journal shows how research has moved on and taken over from anecdote.

However, let's not dismiss the value of experience either. There are well over a thousand Narcotics Anonymous and Cocaine Anonymous meetings in the UK every week. They are full of clean and sober recovering addicts. Each individual's personal experience of recovery is a powerful reminder that it can be done, as the recent *DDN* article on the CA convention showed.

There is a major challenge here to entrenched thinking. As treatment providers we can no longer ignore what patients are telling us they want. 'Doctor knows best' just doesn't cut it anymore. A year or two back there was uproar when research on a large



cohort of Scottish service users showed that more than half actually wanted to become drug free. Most got methadone. This year the NTA has released data on 7,000 patients showing that 80 per cent of opiate dependent users wanted to become abstinent. Are we to drown out their voices with a tidal wave of methadone?

Methadone does save lives, it reduces crime and it can improve social functioning. I prescribe it and will continue to do so. However, I have yet to see the evidence that methadone is the best route to abstinence. The DORIS study in Scotland showed it to be the poorest. Services need to get as good at helping clients become drug free as we are at maintaining them on methadone. This is not an either or debate. It is about choice.

There are dozens of papers published now showing improved outcomes from 12-step involvement. There is also research showing that the attitude of the service providers is a major determinant of whether clients actually go to groups like NA. If this article is anything to go by, few of the authors' clients will get the opportunity to achieve what they actually want. Now isn't that sad?

**Dr David McCartney, GP with a special interest in addictions, Edinburgh**

## Answer the questions

In the comment section of *DDN* (8 May, page 9), Drs Carnwath and Ford suggest that there is a backlash within the UK against methadone and cite, amongst other things, my contribution to the debate on harm reduction at the recent Drug Treatment Conference in Glasgow.

If there is a backlash against methadone, it seems to me that this has been created not by commentators, such as myself, but by the reluctance on the part of those who are supporting and prescribing methadone to ensure that we have answers to some pretty basic questions. Such as: how many people do we have on methadone in the UK? How long have they been on it? What progress are these individuals making towards their recovery? And how many are actually coming off methadone?

If we fail to get answers to these basic questions many people will fear that what we face in the UK is the prospect of every greater numbers of drug users being prescribed ever greater amounts of methadone, for ever longer periods of time, at ever greater cost.

Drs Carnwath and Ford clearly take exception to anyone questioning the value of these prescribing practices; however drug users, their families and others are rightfully asking what the policy of widespread methadone maintenance prescribing is actually achieving in terms of drug users eventual rehabilitation.

The answers to these questions needs to be a good deal more revealing than the suggestion that those who are raising the questions should go to Russia to see the effects of alternative drug treatment policies.

**Neil McKeganey, Professor of Drug Misuse Research, University of Glasgow**

## Life without drugs comes first

I am dismayed to read that Dr Michelle Cave believes that service user networks should be campaigning against prohibition in order to facilitate 'the right of someone to use quality drugs safely' (*DDN*, 8 May 2006, page 12).

My experience of service users (and indeed, of being a service user myself) is that most are looking to control or eradicate their drug use. Their priorities are less about the quality, cost and availability of drugs, and more to do with how they can be assisted in dealing with life without drugs.

I encounter people who are looking for help and support around issues such as housing, relationship breakdown, anxiety, detoxification and stabilisation, emotional support needs, dealing with cravings and relapse prevention. Support in areas like these are what is needed. Where such support is lacking, or would benefit from improvement, service users are using their collective power to bring about change.

Dr Cave seems to be suggesting a charter for drug users, rather than service users, which I suggest is a distraction. I would urge service user networks to focus on ensuring that quality support services are being delivered before becoming involved in campaigns against prohibition. I also think it is worth considering the massive amount of damage that is caused to individuals and to society by a drug that is cheap, available and of quantifiable purity – alcohol.

Feel free to pursue your crusade for legalisation Dr Cave, but please don't co-opt the service user movement to that end.

**Paul Cavanagh, Bath and North East Somerset Service User Group**

## Ignored therapy

I would 'care to comment' on Peter O'Loughlin's sanctimonious letter (*DDN*, 24 April, page 9) regarding those of us who believe that cannabis is a relatively safe substance.

Nobody I know with these views believes that cannabis is not detrimental to the minority of users but the same could be said of any other drug. Does he really think that 'upgrading' the law on cannabis will allow us to impart the necessary health promotion message that cannabis can exacerbate mental health problems?

By the same token presumably, Peter O'Loughlin would like to ignore the millions of people who find cannabis useful for therapeutic purposes, but who continue to be criminalised because so called experts regard cannabis as harmful?

**Chris Brookes, by email**

**Email your letters to [claire@cjwellings.com](mailto: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.**

## Notes from the Alliance

### Tough on Choice, Tough on the Causes...

**Taking a turn in the Alliance's hot seat, Richard Maunders is worried about those already experiencing the sharp end of Tough Choices.**

Well, Daren's over in Canada addressing the International Harm Reduction Association conference, so I've taken it upon myself to nick his laptop and scribble a few notes on a subject close to my heart.

By the time you read this article the government's Tough Choices project (an expansion of the Drug Interventions Programme) will be making its presence felt across the country. (See *DDN* cover story, 24 April, page 6; and Daren's column in the same issue, page 7.)

From last month, under Tough Choices you could find yourself whisked into your local police station and tested for illicit drugs, irrespective of whether you have committed an offence or not. If you test positive and then fail to attend a mandatory assessment (for whatever reason) you will then find yourself charged for the offence of non-attendance, regardless of whether you are charged with the original 'offence' or not.

Some may say this is an over-simplified view and that it is cynical to assume that this system will lead to abuse (something we in the West Midlands are all too familiar with). I say it is extremely naïve to believe that it won't.

That the government has introduced this legislation does not surprise those of us who never fell for the New Labour line. What does concern and disappoint me is the number of self-proclaimed humanitarians within the sector who are content to support and even endorse this pernicious legislation.

Some have argued that the Tough Choices program is a worthwhile addition to the treatment realm, in that it provides people an opportunity to access treatment and receive the support they need. Those of us who value users' rights know that there are more ethical and efficacious ways to provide those opportunities.

Coerced treatment is not only immoral but also an extremely poor indicator of positive outcomes. There's a splendid irony in the fact that this ultimate coercion of users comes from a government that never tires of extolling the virtues of choice...

We are not yet in a position to measure the long-term efficacy of DIP with any certainty. What we do know from the government's own evaluation of its initial pilots is that we shouldn't be too optimistic. In Doncaster, for example, only 5 per cent of those tested positive stated that they were less likely to take drugs in the future if they thought they would be tested, and only 11 per cent stated they would be less likely to offend.

It is essential that those of us who remain concerned about users' rights challenge this legislation in any way possible. The Alliance would particularly like to hear from those who have had the misfortune to experience the sharp end of those Tough 'Choices'.

For me, I've just got my fingers crossed Daren doesn't want to press charges for that stolen laptop.

*Mallender J., Roberts, E. and Seddon, T. (2002). Evaluation of drug testing in the criminal justice system in three pilot areas, Home Office Findings No. 176. London: Home Office*

PS Oh, and congratulations to Cozart shareholders, whose investment almost doubled in value between December and March of this year.

*Richard Maunders is an Alliance Advocate for the West Midlands.*

# A positive pattern for Hep C services

➤ When Nigel O'Malley was diagnosed with Hepatitis C a decade ago, he found treatment options were limited, and support and information thin on the ground. He was told that he couldn't take Interferon – the only drug offered at the time, before the combined dose with Ribovirin became available – as it would be a 'pointless exercise', with only a 10 or 15 per cent chance of clearing the virus.

He was angry at the time, he says. After feeling helpless for a while, he decided to pick himself up, look at his diet, options for healthier living, and alternative therapies. His experience also gave him a particular mission when he began working as a volunteer at The CAAAD (Community Action Around Alcohol and Drugs) Project in Bristol.

'I wanted to set up some support for people with Hepatitis C, because a lot of the clients were still finding it difficult to get hold of good consistent information,' he explains. 'We began by looking for information and running a support group – but it didn't always meet their needs.' Eighteen months on, and still committed to the 'grass roots upwards development' of Hep C support, O'Malley needed to find paid work. He was in luck: the Drug Strategy Team (as Bristol call their DAT) offered CAAAD money to employ him part time as specialist hepatitis worker, and he was able to start galvanising a Hep C strategy for the whole of Bristol.

It was a big turning point, he says. Finally he had the go ahead to rally interest and get immersed in consultation – lots of it. Visiting other projects, being in their drop-in centres, distributing leaflets and meeting people to ask 'what do you want to see; how can things be improved?' produced the immediate feedback that there were gaps in knowledge and services that people were only too happy to put their heads together to address.

So as a first stage of the strategy, 'we began to offer training to other service providers,' says O'Malley. CAAAD already had good links with statutory services that provided testing, treatment and vaccinations, so he felt encouraged that testing could be made more accessible to the community.

Linking closely with Avon and Wiltshire Mental Health Partnership (AWP), 'who had the beginnings of a Hep project themselves', added momentum. In fact, he says, 'we met a lot of people who were

working quite disparately at the time, with very little knowledge of what anyone else was providing.'

Making these links with other services was invaluable for the client. 'One of the daunting things for clients, was not knowing what to expect on the journey from being tested, all the way to treatment,' O'Malley explains. 'So it was important to link in services and gain some knowledge and understanding of what they provided.'

The latest stage of the strategy has been to develop a documented care pathway, taking the client from the initial stage of where to get a test, all the way to the end of treatment. O'Malley waves a proof that's being prepared for a launch in June or July. At first glance the care pathway chart looks complicated, but on closer inspection it demonstrates very clearly your options at each stage of treatment. And if someone's not ready to access Hep C treatment, because they're still using: 'we'd look at what programmes we can get you into, what alternatives we can offer you, until you've stabilised or stopped injecting or drinking'. It can take up to 12 months to access treatment, while the patient undergoes tests – a liver scan and biopsy to establish which of six different types of the virus they have. This is not lost time, according to O'Malley, as it 'gives you time to go through a process in other areas of your life.'

This, really, is one of the main purposes that O'Malley has been driving towards: to engage a network of services that stop the fear and isolation of Hep C, as much as speeding up treatment.

He is quick to acknowledge that everyone reacts differently to the disease – both to the physical symptoms and to interacting with medical and support services. Some people find it difficult to get treatment, 'perhaps because it's difficult, perhaps because their circumstances aren't quite right'. But he has found that once they've engaged, even for a short while and been through part of the process, it makes it easier for them to return when the time is right.

To this end, Bristol's Harm Reduction Strategy Group aims to make contact with as many would-be clients as it can. Staff from CAAAD, who include a complex needs worker, drop-in support worker, outreach engagement worker, and volunteers – join partners including local drug projects, the mental health trust, PCT, drug strategy team, Health Protection

Being let down during his own Hepatitis C treatment a decade ago only made Nigel O'Malley more determined to make sure Bristol did more for clients in future. DDN reports on the creation of a dynamic and responsive network.

Agency, pharmacists, and researchers, in meeting regularly to discuss ways of reducing infections, as well as making sure people who are infected have all the support they need to get through treatment.

Service users are actively encouraged to play their part in consultation and feedback, and there are good links with service user groups, including UFO – Users for Organisation – the main body for service users in the area.

'We absolutely try our best to keep people engaged,' says O'Malley. 'And because there's such a range of services available, there's always the option of going to another.' Options are around workers as well: 'You can have a different worker in the same service. Anything that will help people engage with a service, we try and provide.'

Of course initial engagement isn't everything, and much of O'Malley's energy is directed at filling in the wider picture of essential needs. 'A lot of clients are homeless, and many have issues around trying to manage a tenancy,' he says. So the partnerships that work so well around treatment must extend to housing, social services, and all other aspects of life that underpin stability.

Housing shortages are as acute in Bristol as elsewhere, with many homeless people put up in bed and breakfasts. So information must go to B and B landlords, about directing people into services, while training is offered to hostel staff on Hepatitis and harm reduction. Where a client's stuck around others using drugs, and surrounded by temptation, O'Malley says Bristol's services pull together as best they can to get them into a support programme and re-housed if at all possible. He counts himself lucky that he has an agreement with Bristol City Council that he can nominate a dedicated number of clients each year as priority housing cases – as long as they are going to access treatment for their Hep C. 'Because of the lack of housing at the moment, that number is limited,' he says. 'It's an amazing start though.'

Proactive work extends to the local prison service. Bristol Prison are 'incredibly good' at providing information and advice to those infected. They vaccinate everybody who comes through the door, says O'Malley, and offer testing and treatment in prison. While it's difficult to get security clearance to take CAAAD's services into prison, a liaison nurse



**'One of the daunting things for clients, was not knowing what to expect on the journey from being tested, all the way to treatment... So it was important to link in services and gain some knowledge and understanding of what they provided.'**

better than the last'.

He knows what his clients are likely to go through – the exhaustion, headaches, and not wanting to be around people – but he is keen to point out that the treatment experience is different for each person, and that some clients 'come sailing through, hardly even knowing they're on it'.

When clients don't find things so easy, he likes to help them separate the side effects of treatment from the side effects of real life, he says. The Interferon can trigger depression and consuming bouts of self analysis 'that can be quite off track from what's really happening to you. So it's nice to be able to say all this retrospective and introspective stuff you're doing isn't quite the true story of what you're actually like as a person'.

He can also point them in the direction of feeling better in themselves along the way – a specialist acupuncturist is on hand at CAAAD, who does treatment in a quiet room at the top of the building, away from the drop-in. As well as helping to reduce the side effects of treatment and the symptoms of Hep C, 'it's time spent with a caring professional, it's not hurried'.

There's a lot to do before the care pathway document launches in the summer, but O'Malley is further motivated by the thought of the new pathways poster being pinned up in GPs' surgeries in the near future.

Although it's hard work, he is inspired by every sign that someone's journey through getting treatment has been made easier – particularly when he sees the commitment being made by clients.

'I've got a client at the moment who's suffering from such massive multiple health issues,' he reflects. 'To see him stay committed to get through and get treatment has just been humbling really.' **DDN**

Contact the Hep C service via CAAAD, by email at [caaad@bartonhillsettlement.org.uk](mailto:caaad@bartonhillsettlement.org.uk), or call 0117 9042200 between 10am and 4.30pm. The website is at [www.caaad.org.uk](http://www.caaad.org.uk).

from hepatology at Bristol Royal Infirmary visits regularly, and O'Malley and team are waiting to pick up people from prison and bring them to the service, as soon as they are released. 'We'll meet them and chat through what we offer,' he explains.

The team's caseload is getting busier, as more people discover where to find them, but O'Malley is confident that between them, they are well equipped to address complex needs. Everything is geared to working 'to the best advantage of the client'. So when someone accesses the service, they have a brief

assessment, their case is taken to the next team meeting where they look at the client's needs; then they work out who has the most appropriate experience and could offer the client the best service, and write to offer the client their first appointment.

O'Malley and colleagues have come a long way in developing care pathways over the last 18 months. His own journey through treatment is similarly making progress: he completed treatment just a month ago, and is just beginning to feel better, although slowly – 'each day's a little bit

# Breaking down barriers

Complementary therapy can work well as a way of drawing clients into treatment. Mike Blank explains how Surrey Alcohol and Drug Advisory Service is using acupuncture to break down barriers.



## How is it for you?

DDN asks members of a weekly auricular acupuncture class if the treatment seems to be working for them.

**George:**

**'I feel calmer, more able to cope.'**

I've had acupuncture for roughly nine months, for alcohol and drugs. It seems to be working so far.

It's relaxing. I feel less agitated, calmer, more able to

cope. I feel generally much better.

We do meditation with it, and I do Tai Chi myself. So it's the whole thing together that's making a difference.

It's one of those things I think that either works for you, or it doesn't. If you don't believe in it, then it's never going to

work in a million years. If you've got an open mind, then it can.

Ear acupuncture works well in a group setting. In fact it probably works better in a group. I have body acupuncture as well, because I've had a stroke. That was what started me off on acupuncture, because that worked excellently for me.

**Pete:**

**'You need to relieve yourself from the bombardment of stress.'**

I've had acupuncture and meditation for about a year, for alcohol.

I've found it very helpful. I'm treated with ear acupuncture in a small group – I find Qi Gong, meditation and acupuncture are better in a group setting.

We go in, do the Qi Gong, have acupuncture in our ears, then sit down and meditate for three quarters of an hour.

If you can get into meditation – and you can't always – you feel really peaceful and calm at the end of it.

The therapy's an ongoing thing. Every day you're bombarded, getting stressed or whatever, so each week you need to relieve yourself of all

Perception hangovers from the 1980s and 90s tend to classify drug treatment services 'as those traditionally accessed by white male heroin users' – which can often prevent users from setting foot within the very places that can provide them with treatment. Crack cocaine users are among groups that are often seen as 'hard to reach' when it comes to offering treatment or other interventions.

The work that staff at Surrey Alcohol and Drug Advisory Service (SADAS) has been undertaking in the field of auricular acupuncture has helped to break down these barriers.

It is widely reported that acupuncture helps lower stress levels and can reduce the desire to take drugs, and some of SADAS' clients have indeed found it successful as part of their treatment for addiction. Some that have joined our programme have commented on an improved sleep pattern; one client stopped drinking with the aid of acupuncture and another stopped smoking. However, the benefits that acupuncture seems to produce to help clients reduce anxiety levels, and cope with the stress of their addiction combined with everyday life, are not SADAS' main driver for providing this type of intervention.

Individuals in 'hard to reach' groups often reject conventional treatment options but they seem to respond well to trying this complementary therapy. In fact, this approach has been so successful that most clients self-refer or hear about the service through word of mouth. So much so, that there has been a continuous rise in demand.

Once we have enrolled clients for acupuncture then we in a strong position to introduce them to the interventions we offer and if needed, give them the necessary support to help them move on to other

treatments provided by the NHS or residential services. As an industry, we know if we can introduce users into a treatment programme, we are better able to manage addiction, and risk of harm is reduced.

Evidence suggests that if we can enrol clients on a regular course of acupuncture that also includes access to our conventional services or those of partner agencies lasting a minimum of 12 weeks they are much more likely reduce or stop their use eventually than those who do not receive help from a recognised organisation like SADAS.

The acupuncture service is based, at the time of writing, in a street agency. Many of the acupuncture clinics are held during the evening and weekends to make it as easy as possible for people to come along and gain relief from this complementary therapy. At the same time it gives us the opportunity to introduce them to SADAS' full range of interventions including housing, help with benefits, counselling, harm-reduction and onward referral.

The agency first started offering acupuncture on a Monday morning during September 2003. Within three weeks we were averaging 19 clients per month. In the first full year of providing acupuncture, SADAS' qualified staff treated 26 clients per month. In 2005 this rose to an average of 35 clients per month.

Two and a half years ago, when the acupuncture clinic began with just one National Acupuncture Detoxification Association UK (NADA) worker, an auricular acupuncture procedure manual was put in place, as well as a record sheet that records the number of needles used and an information sheet which outlines the acupuncture treatment. This was signed by the client, giving consent to treatment. As

well as a necessary requirement, the data recorded has proved invaluable to help us analyse the relevant success of the venture of the time of the project.

Since original registration and certification, SADAS now has five staff and one user group member trained to deliver treatment. Training of these staff, undertaken by NADA, took place at the project and the necessary clinical assessments were also completed on site.

Re-assessment of therapists occurs regularly and identifies possible areas of staff shortages and travel costs etc. It also outlined the pressure on re-assessment providers and as a result, SADAS' senior therapist has now become an in-house qualified assessor, able to give re-assessment at the project during the Monday morning clinics.

SADAS intends to double the number of clients treated through acupuncture over the next year and is also looking at gaining access to funding for two full time alternative therapists – trained not only in acupuncture but also in other evidence-based complementary therapies.

Although it is challenging to come up with scientific evidence that proves the benefits of these complementary therapies, our statistics demonstrate that SADAS has been able to treat well over 300 people that were unlikely to access our services at all without the acupuncture programme. In this way we feel complementary therapy has a definite role to play in the future of treatment for drink and drug problems.

*Mike Blank is Executive Director of Surrey Alcohol and Drug Advisory Service (SADAS), which offers a range of tier 2 and 3 services to people with alcohol and drug related concerns. SADAS' website is at [www.sadas.org.uk](http://www.sadas.org.uk)*

that. I'd like to have it twice a week really, instead of once.

### **Suzannah:**

**'I felt so much more relaxed it was ridiculous.'**

I find the acupuncture very therapeutic. I've had a lot of conventional medicine and was in psychiatric hospital for a long time.

I had all sorts – electric shock treatment and all sorts of mood stabilisers, everything like that. But it was like taking a sledgehammer to a tiny nail.

I was diagnosed as having a borderline personality disorder,

which means that my emotional coping skills aren't good. You can take anti-psychotics, you can take valium, but they have side effects. I wanted to go for a more holistic approach.

The first time I ever had it done, I felt so much more relaxed it was ridiculous. I could even feel my face felt drained as well.

I have the ear acupuncture in a group session. I think the atmosphere with candles and music helps – people seem to relax to it. It sort of makes everybody on an even plateau and says 'this is the mood I

want you to be in'.

Our therapist does a particularly good job. One day I went in after my birthday when I'd been on a bender. I went in shaking, and she said right, OK, just sit there and let's brew a bit. It's all very non-judgmental.

I think people can be put off if they've just had people patronise them. That doesn't happen.

*DDN was talking to members of Cathy Dixon's class in West London. Names have been changed to protect privacy. Cathy's website is at [www.energyroots.co.uk](http://www.energyroots.co.uk)*

**'I find the acupuncture very therapeutic. I've had a lot of conventional medicine and was in psychiatric hospital for a long time. I had all sorts - electric shock treatment and all sorts of mood stabilisers, everything like that. But it was like taking a sledgehammer to a tiny nail.'**

# QA

**I've just had a bad experience with a service user. On our second meeting I was trying to explain her options for getting in contact with services, when she stormed out saying I didn't understand her, and what was the point. I feel devastated – I've not been in my job that long, and feel as though I've failed my client badly. Can anyone give me advice on handling things better in future?**  
*Shelley, Birmingham*

## Suspicious minds

Dear Shelley,  
My experiences with clients within the prison environment have been that they can be notoriously suspicious of my motives as a drug and alcohol worker. This can also make them mistrusting of any services offered.

I have found that spending time building up a rapport has led to a more satisfactory working relationship with my clients. Once this relationship has built up, I have my clients meeting me in a more relaxed mood and therefore more receptive to treatment offered.

I consider time spent building up an effective working relationship as an investment in developing a client's treatment needs.

**Ian Bowerman, York**

## Pain is good

Oh Shelley, you haven't failed anyone. The fact this has caused you so much heartache and soul-searching shows just how caring, conscientious and professional you are.

My suggestion is to drop this lady a line and tell her you're available to have a chat when she's ready to talk again. Don't push it – the desire to improve things has to come from her.

Handling things better in the future? Sounds to me like you'll do just fine. But remember – you can't win 'em all.

**Ian, Harrogate.**

## Experience comes with time

Shelley  
Familiar? Yes!

I think understanding plays a big part in managing such experiences – and experience comes with time.

What I would say, is that this rather common outcome would not necessarily be down to anything you did or did not do. So be gentle on yourself, but be open to exploring these factors with colleagues and within your supervision, to find this clarity.

Service users can, and will, continue to express forms of anger and upset inappropriately. This too can be fuelled by wanting to or feeling a need to sabotage all things good. Maybe if, or when, this or similar were to happen again, you could reflect on your resource of knowledge and separate yourself enough to be able to encourage them to stay with whatever it may be.

Feed back to them before they are able to leave, if you are aware that they have become angry and upset. Suggest that you acknowledge this, but you also would like to understand what these emotions are about. If equipped to do so, stay with it. Alternatively, if not, suggest that maybe you can put them in touch with one of your colleagues.

This may or may not work, but at least

you have tried to support them with their problems.

Good luck

**Jason D, HAWKS, Bristol**

## Get to the root

Dear Shelley  
I do not feel that you have let your client down. Sometimes in these situations feelings can become a little confusing, especially when your client is involved with substance misuse and has problems. I have had to deal with some similar cases.

What you have got to remember is that despite what was said, you have just got to keep working at the relationship and try and find out why she has said you don't understand her. I do know it is hard and I know I take my work home with me sometimes when I feel I could have done more for a client, but one thing you have got to learn is how to switch off from work and the feelings that sometimes affect our lives as treatment and support workers.

My coping mechanism is to go for a meal on my own when I have had a testing day. I find that works – you will be able to find one too. Just do not beat yourself up.

**John, Lifeline, Kirklees**

## The nature of things

Dear Shelley  
Firstly do not feel as though you have failed, you have merely experienced the unpredictable nature of service users. You have gained valuable information to help you deal with this service user in future, ie they may not be ready to face the fact that they have a problem, they may want to discover solutions for themselves, they may not want someone to point out their failings.

I would also advise that a second meeting may be too soon to be addressing potentially life-changing issues such as accessing services. Depending on your organisation, this early stage should be about focusing on the service user's perception of their situation and what their aspirations are.

You said that you were accused of not understanding her; this seems to indicate that she was looking to build trust with you and to gauge whether you understood her point of view without judging. She may not be looking for solutions at this point, just the chance to communicate with someone.

Do not be put off by isolated incidents such as this, particularly as you are just getting to grips with your job. I would recommend gaining some training in motivational interviewing, which can be an excellent approach for situations such as you described.

I wish you the best of luck with your continued career.

**Keith, Service Manager, Kidderminster**

## Too early intervention?

Dear Shelley,  
You're obviously very upset about the reaction of your client and feel that you have failed her. What you have failed to do is give your client exactly what she wanted, and she left telling you that you didn't understand.

It can take a while to build up trust and get a good client relationship going and some clients are unforgiving if you don't deliver exactly what they want – but it's not always easy to know what their expectations are.

It sounds like you tried to offer options, but she wasn't ready for them. Perhaps what your client wanted was just to know that you understood her – just some empathy. Your response to her talking was an intervention that was perhaps a little early.

Often when a client presents with their situation, they just want to talk about it first and offload. They will want someone to listen and they want you to understand what it's like for them. It's a very natural reaction to want to help, but the client may not want help quite as soon as we want to give it. It sounds as though this is what might have happened here.

Your client got angry because she didn't get exactly what she wanted, and she failed you; she didn't give you the chance to meet her needs, she judged you and left.

If this client has been failed by others, she could have perceived you as the same, and may have come with pre-conceived ideas that you wouldn't be much help – 'another person who doesn't understand her and is giving her advice she doesn't want', which may have led to anger or impatience. She may have arrived with a 'you have got one chance at this' attitude.

Sometimes we need to apply our helping breaks, and just listen carefully and give the client chance to say how it is for them. Give them time to explore what they want to do, and when they are ready for help they will let you know. What the client often doesn't voice is 'I don't want the answers, I just

want you to listen and understand how it is for me'. I guess this can be the difference between the client staying and leaving.

Your client will have taught you something, so it's not all bad.

You didn't fail at all – you just may have tried a little too hard. It may be useful to talk with an experienced worker; I find good supervision is essential in restoring your confidence when it's taken a knock.

Your letter shows your willingness to learn, reflect, and improve your practice. Well done for writing, and view this as a learning experience rather than a bad one. It's only through our clients and trial and error that we learn what's helpful.

Good luck with your casework and don't be too hard on yourself.

**Mel, Wolverhampton**

## It's not personal

Dear Shelley  
I can't tell you how many times this has happened to me in person and more recently to a member of staff I supervise. He took it very personally too, and felt he had no option but to close the case file as his client had stated he wouldn't see him again.

I encouraged him to contact him by phone and acknowledge his distress and anger, and offer to sit down and talk with him about what had fuelled this. The client really appreciated the call and even apologised for his behaviour, saying that he was having a really bad day and he wanted to meet again.

Our clients so often come with a lot of problems and their lives are often stressful and difficult. If we respond to their anger personally and don't give them the opportunity to re-engage with us, then we have let them down too – and often this just confirms their belief about themselves that no-one can, or will, be able to help them.

Give it 24 hours settling time and make contact – it worked in our case!

**Tina, by email**

## Reader's question

**I am being driven insane by my colleague. Not only is he unable to keep his own workload under control, but he is patronising beyond belief and treats me as if I am hormonal if I raise genuine concerns. His work is getting shoddier and I am worried that his incompetence is starting to affect service to our clients. How can I handle him tactfully?**

*Anne-Marie, Cardiff*

**Email your suggested answers to the editor by Tuesday 31 May for inclusion in the 5 June issue of DDN.**

**New questions are welcome from readers.**

## The drug experience: heroin, part 6

**In his latest Background Briefing, Professor David Clark continues to look at the process of recovery from dependent drug use, as described in seminal research by James McIntosh and Neil McKeganey.**

In the last Briefing, we started to look at the recovery process for people who become dependent on heroin. Analysis of the interviews with 70 recovering addicts in Scotland emphasised the importance of the person wishing to restore a 'spoiled identity' as being key to a successful recovery. The person must not only desire a new identity, but also want a different style of life. They must also believe that this is feasible.

Nearly all the interviewees described previous attempts at trying to stop taking drugs which ended in failure. These failed attempts are not simply a waste of time and they may play a significant role in the process of recovery.

A period of abstinence can clarify and highlight the extent their identities have been damaged. During abstinence, addicts can examine their drug-using lifestyle from the perspective of a non-user. Also, the addict's residual identity (non-using identity) can re-emerge and comparisons can be made between it and the drug-using identity.

Addicts not only acquire first-hand experience of an alternative lifestyle, but also potentially see its feasibility. If they can abstain from taking heroin for a time, why not for good?

Despite knowing that they need to stop taking heroin, a person may continue because they fear the pain and discomfort of withdrawal. Ambivalence is a striking feature of addiction, particularly when the person has made a rational decision to stop using and makes attempts to do so. There is a conflict between wanting to change on the one hand and a reluctance to give up the drug on the other.

In people who have become dependent on heroin, the vast majority of periods of abstinence are followed by relapse. It is much easier to stop taking drugs than it is to stay stopped.

Factors that are known to precipitate relapse include: craving or continued desire for the drug; negative emotional states such as depression, boredom and loneliness; the experience of stressful or conflicting situations; and pressure from others to resume the drug.

However, these risks, or predisposing factors, do not lead inevitably to relapse. Many addicts recover successfully despite these negative experiences. Why?

McIntosh and McKeganey emphasise that '...the key to successful recovery from addiction is the construction by the addict, of a new identity incorporating non-addict values and perspectives of a non-addict lifestyle'.

The construction of a new identity, or a renewed



**'The drug using lifestyle has provided much of the meaning, structure and content of the person's life, often for many years, then all of a sudden it is gone and something has to take its place.'**

sense of self, has to be built and constantly defended against a variety of often-powerful opposing forces.

'One of the reasons why the transition is so difficult is because the individual has to get used to an almost entirely different way of life. The drug using lifestyle has provided much of the meaning, structure and content of the person's life, often for many years, then all of a sudden it is gone and something has to take its place.'

It is generally very difficult for addicts to re-enter conventional life – they often feel strange, incompetent and lacking in important practical and social skills. They have been detached from mainstream activities and culture for a long time, and have often done 'everyday' things under the influence of the drug.

'The second thing that makes managing the transition out of drugs so difficult for addicts is the

unrelenting nature of the task of ensuring that they remain abstinent.'

In establishing a new identity, addicts have to distance themselves from their past lives and their drug-using networks. Interviewees emphasised that a continuing desire for drugs – which does abate over time – and a lack of confidence in being able to resist, makes them vulnerable. They wanted to put as much distance as possible – socially and physically – between themselves and those who might seek to tempt or pressurise them into using again.

Recovering addicts also have to develop a range of new activities and relationships both to replace those that they have given up and to reinforce and sustain their new identities.

One of the major problems that addicts face when giving up drugs is how to occupy their time. The drug-using routine – getting the money, acquiring and then taking the drug – take up a major part of the day.

Interviewees recognised how important it was to keep themselves as fully occupied as possible, both mentally and physically. However, simply occupying their time was not enough. They want to do something that provides a sense of purpose and gives their life some meaning. The ideal solution is paid employment.

Recovering addicts also need to develop new social relationships in order to fill the social vacuum. These relationships must reinforce the new identity, support the alternative lifestyle, and help provide the recovering addict with a new sense of purpose.

The acceptance by non-addicts of the recovering addict's new identity is especially important in sustaining its development and, thereby, maintaining abstinence from drugs.

Once the person's new life begins to develop – with new activities, relationships and commitments – this creates a powerful barrier against temptation to revert back to drug taking.

New activities and relationships impart a sense of normality and progress and help to reinforce faith in both the desirability and in the probable success of rehabilitation. They also provide positive reinforcement for the recovering addict's attempt to develop a more positive sense of self and self-worth.

The new life provides a stake in the future.

*Recommended reading:*  
*James McIntosh and Neil McKeganey (2002) Beating the Dragon: The Recovery from Dependent Drug Use. Prentice Hall.*

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# Training for Drug & Alcohol Practitioners

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18 month programme from September 2006 or by negotiation

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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.

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# Commissioning News

Investing in services for drugs, health, crime and social care First Issue - June/July 2006

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For informal enquiries please contact Teresa Barnshaw, Team Manager on 0121 464 2699.

For an application pack or to apply online, please visit [www.birmingham.gov.uk/jobs](http://www.birmingham.gov.uk/jobs). If you do not have internet access, please telephone 0121 464 1111 (8am - 8pm Monday to Friday), quoting Ref: 57204DD.

Closing date: 6th June 2006.

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 Applicants must be able to use a range of approaches and resources in working with young people who use substances/ alcohol and their families. This post will work in partnership with the Young People's Substance Misuse Service, "r u-ok?".  
 Closing date for applications: **Tuesday 6th June 2006**  
 Interviews on: **Friday 9th June 2006**

**Substance Misuse Worker (Female\*) full-time**  
 This post will join our Adult Services Team who offer a range of Tier 2 and 3 non-medical treatment services to women substance misusers and their children, including Open Access, Key-Working, Structured Day Care, an Activities Programme and After-Care Support. Applicants must have an understanding of substance misuse or therapeutic interventions alongside proven practice experience, a minimum of one year's experience or working in a related field and an ability to plan and review integrated programmes of care for women substance misusers.  
 Closing date for applications: **Tuesday 20th June 2006**  
 Interviews on: **week beginning 26th June 2006**

**Salary for both posts between NJC points 26 to 29 (£20,895 to £23,175)**  
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 Both posts will be subject to CRB Check at the enhanced level.  
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 \*These posts are exempt under para 7 (2) of the Sex Discrimination Act

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Or e-mail: [recruitment@edp.org.uk](mailto:recruitment@edp.org.uk) quoting the reference number. For an informal chat about this post, please ring Michelle Dolbeer, Learning and Development Manager on: 07951 341126 after 12.00.00. Please request application pack first as this would answer most questions.



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
Bedfordshire DAT is responding to the current agenda around the integration of the Drugs and Crime agenda. A new post has been created in the team to facilitate partnership working around crime, community safety and drugs issues. This post will lead the strategic vision for implementing both the Communities and DIP agenda, and will be responsible for ensuring Bedfordshire DAT delivers on the drugs and crime agenda and will ensure that the drugs crime and community issues are driven forward through the Local Area Agreement structures.

Do you have at least 3 years' experience of working in the criminal justice system, the substance misuse field or community development, and the skills to work at a strategic level? If so, we would like to hear from you.

For an informal discussion please contact Barbara O'Rourke on 01234 406110.

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