DDN
Drink and Drugs News
24 May 2010
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INCLUDE ME IN
A year working in service user development

IN COMMISSION
One DAAT gets to grips with alcohol commissioning

'I believe this group of citizens is as vulnerable as any in our society. If we are serious about providing appropriate support, this new model should empower the individual to take some control of their therapeutic journey.'

MADE TO MEASURE

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Society for the Study of Addiction

Annual Symposium - 2010

Thursday 11 and Friday 12 November

Park Inn hotel, York

Themes:

'Dissemination and implementation of addiction research'

'Addictions and commonly co-existing problems'

Professor Sally Casswell will give the Society Lecture: *'Alcohol marketing policy, and the global context for alcohol policy development'*

Speakers will include:	
Dr Duncan Raistrick	Implementing research on service user participation
Professor Kathy Carroll	The challenges of implementing EVTs in routine practice
Professor Susan Michie	Identifying effective behaviour change techniques in smoking and alcohol interventions
Dr Jane Marshall	Evidence-based treatments for alcohol problems: are they being implemented?
Professor Mats Berglund	Interpreting outcomes data for the purpose of implementing research in practice
Professor Gerard Hastings	'They'll drink bucket loads of the stuff': An analysis of internal alcohol industry advertising documents
Dr Alasdair Forsyth	An investigation into the environmental impact of off-license premises on residential neighbourhoods
Dr Jeremy Segrott & Ms Heather Rothwell	The role of parents in preventing alcohol misuse: An evaluation of the Kids, Adults Together Programme (KAT)
Dr Henrietta Bowden-Jones	Implementing research on gambling in practice
Dr Julia Sinclair	Self-harm/suicide and substance use
Dr Owen Bowden-Jones	The treatment of personality disorder and addiction - clinical judgment
Professor Christine Barrowclough	Treatments of patients with schizophrenia and alcohol misuse
Dr Søren Dalsgaard	The relationship between attention-deficit/hyperactivity disorder and substance use disorder: Evidence based treatment and clinical implications
Dr Ed Day	Misdiagnosis and mistreatment

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Editorial – Claire Brown

Smart thinking

When the going gets tough... keep a step ahead

The personalisation agenda (cover story) might seem a long way off as we wait for the axe to fall on public services. So much of this issue is about working 'smarter' to give our our essential services the best chance of survival. Lancashire's work with tier 4 services is about making sure personalisation initiatives can go hand in hand with logical and necessary improvements, rather than being seen as a luxury that could be cut. 'It's caused tier 4 providers to look at what they offer,' said county coordinator Maggie Leybourne. Providers had the opportunity to review and replace the repetition in their programmes to make real improvements – clients now have the chance of a treatment journey that links much better with mainstream services.

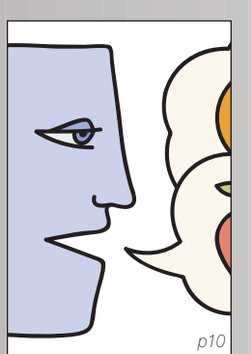
Success also depends of being good at demonstrating client outcomes, as Peter Mason explains (page 14). In simple terms you need, more than ever before, to be able to show exactly what your clients will get for the money you invest. This might involve seizing local opportunities – as commissioner Max Vaughan is trying to do (page 12) by responding creatively to Birmingham's recognition of the need to invest in tackling alcohol problems. And let's not forget, as Richard Lukehurst points out on page 8, that building service user involvement into every step should give an informed perspective and a solid return on investment.

The other part of the equation, of course, is not to disregard what's known to be effective, while trying to attract funding by following the latest government buzzwords and phrases. Alan Joyce's comment (page 10) is a reality check that under no circumstances can we afford to let new government thinking replace tried and tested life-saving practice that works for so many people, and without which he would have 'been dead a long time ago'.

Let us know, in these difficult times, what's working for you.

This issue

p08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FEATURES

REGULARS

News in Brief

Anthrax outbreak still ongoing

There have now been 40 confirmed cases of anthrax among drug users in Scotland including 13 deaths, according to new figures released by Health Protection Scotland. The cases emphasise that contaminated heroin appears still to be in circulation, says the agency, and that 'further cases may come to light'. Seven of the deaths have occurred in the Greater Glasgow and Clyde NHS board region, two each in the Lanarkshire and Tayside regions and one each in the Fife and Forth Valley regions. 'There is no way to tell if your heroin is contaminated and there is no way to take heroin which we can advise is safer or less likely to result in illness or death if it has anthrax contamination,' said head of the National Outbreak Control Team, Dr Colin Ramsay.

Med message

Drinkaware has joined with Club 18-30 to promote responsible holiday drinking on the theme of *Why waste your week being wasted?* Club 18-30 reps at 12 European resorts will receive training and there will also be Drinkaware posters and banners by hotel pools, in communal areas and on airport transfer coaches. 'Challenging the culture of Brits boozing abroad is a difficult task and tackling the preconception that you must drink to have a good time on holiday is the starting point,' said Drinkaware chief executive Chris Sorek. 'It's important we remind people that holiday drinking can lead to more than just a hangover. Excessive drinking can put people at increased risk of sunburn, dehydration, committing or being the victim of a crime, compromised personal safety and injury. A criminal record, an STI or a broken bone aren't the type of souvenirs anyone wants to take home from their holiday.'

EU wine lake

Harmful and hazardous alcohol consumption is the third biggest health risk factor in Europe, according to a new EU report. Europe has the highest per capita alcohol consumption in the world, says *EU citizens' attitudes towards alcohol*, which puts the estimated economic cost to the EU at around €125bn per year. *Available at www.alcoholconcern.org.uk/index.php?id=470*

Coalition sets out plans for legal highs and alcohol

'Early warning' bans on new legal highs, a ban on below-cost alcohol sales and an overhaul of licensing are among the proposals set out in *The coalition: our programme for government* document launched late last week, which details the new government's policy plans.

The government states that it intends to introduce a system of 'temporary bans' on legal highs, allowing harm issues to be properly debated by independent experts. 'We will not permanently ban a substance without receiving full advice from the Advisory Council on the Misuse of Drugs,' it says.

The document also states that the government will 'review alcohol taxation and pricing to ensure it tackles binge drinking without unfairly penalising responsible drinkers, pubs and important local industries' as well as overhaul the Licensing Act to give local authorities and the police stronger powers to 'remove licences from, or refuse to grant licences to, any premises that are causing problems'. It will also allow local authorities to permanently close shops or bars found to be persistently selling alcohol to those underage, and double the maximum fine for underage sales to £20,000, as set out in the Conservative manifesto (*DDN*, 26 April, page 11).

'We welcome the coalition government's clear commitment to consult with the Advisory Council on the Misuse of Drugs before making any moves to ban emerging "legal highs",' said DrugScope chief executive Martin Barnes. 'While there is a case for introducing temporary bans on substances while evidence on their use and potential harms is reviewed, careful thought will need to be given to the process and the criteria involved. As any change will require new legislation, there may be an opportunity for a considered review of the effectiveness of key provisions in the Misuse of Drugs Act.'

Full document available at www.direct.gov.uk/en/NI1/Newsroom/DG_187877

International efforts needed to stop death penalty for drug offences

International attention needs to be focused on stopping the use of the death penalty for drugs offences, the International Harm Reduction Association (IHRA) has stated, as it launched a major global survey on the subject. 'Those governments that think this issue doesn't concern them need to think again and work to end the practice,' said the report's co-author, IHRA deputy director Rick Lines.

The number of people executed for drug offences each year 'very likely' exceeds a thousand when those countries that keep their death penalty statistics secret are taken into account, says *The death penalty for drug offences: global overview 2010*, launched at the UN Commission on Crime Prevention and Criminal Justice in Vienna. The document – the first global study of its kind – reports that 32 nations have the death penalty for drugs offences on their statute books and that in many cases the majority of those executed are foreign nationals.

The report looks at both national legislation and whether or not the laws are actually enforced – a small minority of countries remain 'highly committed' to the practice, co-author Patrick Gallahue told delegates at IHRA's recent annual conference (*DDN*, 10 May, page 11). According to the report, of the 32 countries retaining the death penalty for drugs offences, only six have enforced it on a scale that 'could be described as indicating a "high commitment" to the practice': China, Iran, Saudi Arabia, Vietnam, Singapore and Malaysia. Singapore and Malaysia have both greatly reduced the number of people they execute each year, however, and Vietnam 'may be giving serious consideration to its policy and practice'.

The report also argues that drug users are prevented from accessing treatment and HIV services because of the climate of fear the death penalty instills. Iran, for example, has been praised in recent years for its adoption of needle exchange and substitute prescribing, with the highest opioid substitution therapy (OST) coverage outside Western Europe, at 52 OST recipients for every 100 people who inject drugs. According to the report, however, almost half of the death sentences carried out in the country last year were for drugs offences – at 172, double the number for the previous year.

'It is sadly ironic that some countries with the worst record on the use of the death penalty for drugs at the same time recognise the need to address drug-related harms as a health concern and to act to prevent HIV/Aids among drug using populations,' said IHRA's executive director, Professor Gerry Stimson. 'They are scaling up needle and syringe exchange and opioid substitution therapy, as our *Global state of harm reduction 2010* (*DDN*, 10 May, page 9) report shows. But harm reduction can never be fully delivered in a climate of repression and fear. The two positions are incompatible.'

Countries using the death penalty for drug offences are not only violating international human rights law – as according to the UN the offences do not fall under the definition of 'most serious crimes' – but 'clinging on to a criminal justice model that is both ineffective and 'unnecessary', said Rick Lines. 'IHRA is calling for an immediate moratorium on all executions for drugs offences, and an amendment of legislation to remove the death penalty for all drugs offences,' he said.

Report available to download at www.ihra.net

White House: new 'balanced approach' for US drug policy

The US government has released its first drug strategy since the inauguration of President Obama last year. *The 2010 National Drug Control Strategy*, says the White House, sets out a collaborative and balanced public health approach that emphasises 'community-based prevention' as well as the integration of evidence-based treatment into mainstream health care and the strengthening of early intervention efforts. It also promises the expansion of community treatment and action to break the cycle of drug use and crime.

The strategy contains five-year targets for reducing rates of drug-related deaths, the number of chronic drug users and rates of youth drug use – all by 15 per cent – and cutting rates of drug use among young adults by 10 per cent. While law enforcement, border control and international cooperation against trafficking remained essential they 'cannot by themselves fully address a challenge that is inherently tied to the public health of the American people' says the document. It also states the importance of using imprisonment 'judiciously' – 'incarceration is appropriate for drug traffickers and drug dealers,' it says. 'For some lower-level offenders, however, intense supervision in the community can help prevent criminal careers while preserving scarce prison space for those offenders who should be behind bars.'

The strategy was developed by the Office of National Drug Control Policy (ONDCP) following extensive consultation with treatment providers, law enforcement agencies and people in recovery, among others. It is, says the White House, 'responsible, realistic, and informed by experience'. 'We will implement a balanced public health and public safety strategy that recognises that the demand for drugs and, increasingly, their production are within our own borders,' it states.

'The strategy calls for a balanced approach to confronting the complex challenge of drug use and its consequences,' said President Obama. 'By boosting community-based prevention, expanding treatment, strengthening law enforcement and working collaboratively with our global partners we will reduce drug use and the great damage it causes in our communities. I am confident that when we take the steps outlined in this strategy we will make our country stronger and our people healthier and safer.'

Obama: '...we will make our country stronger and our people healthier and safer.'

Writing on the *Huffington Post*, executive director of the Drug Policy Alliance Ethan Nadelmann stated that the new strategy was 'both encouraging and discouraging'. 'There's no question that it points in a different direction and embraces specific policy options counter to those of the past 30 years, but it differs little on the fundamental issues of budget and drug policy paradigm, retaining the overwhelming emphasis on law enforcement and supply control strategies that doomed the policies of its predecessors.'

In the UK, meanwhile, Release said that while the strategy built on the Obama administration's movement 'away from drug war rhetoric' and repeal of the ban on federal funding for needle exchange, there remained 'large areas of continuity with the drug war', not least in the fact that two thirds of the budget remained committed to law enforcement. 'A more profound and significant break with the failures of the past would be demonstrated by a strategy aimed not so much at stopping or reducing drug use as such, but at minimising the harms associated with both drugs and drug policies. These harms are tightly interwoven with the mass incarceration of US citizens for non-violent drug offences.'

Iraq and Afghanistan troops more likely to have alcohol problems

UK military personnel deployed to Iraq or Afghanistan have a 22 per cent higher risk of alcohol misuse than troops who have not been deployed, according to research from the Institute of Psychiatrists at King's College London.

The Ministry of Defence (MOD) – funded report examined the consequences of deployment on the mental health of almost 10,000 armed forces personnel between 2003 and 2009. Although alcohol is banned when troops are deployed, cheap alcohol is available to troops stationed overseas. 'Our present analysis showed an effect of deployment on the reporting of alcohol misuse, and alcohol misuse continues to be greatest in those holding combat roles,' say the report's authors, Professor Simon Wessely and Dr Nicola Fear.

'Reducing the harmful use of alcohol is a challenge for the general population but alcohol does seem to be a particular problem in military culture,' said Professor Glyn Lewis of the University of Bristol. 'There is increasing realisation that the modern military must look after the minds as well as the bodies of serving and no longer serving members of the armed forces.'

Available at www.iop.kcl.ac.uk

News in Brief

Down in one

Alcohol can still be sold in test tubes following an enquiry under the Portman Group's code into whether test tube packaging causes people to drink more quickly. Alcohol Focus Scotland had brought complaints against four brands of test tube alcohol – Shootaz, Quivers, Shot in a Tube and Shoeyz Shots. The group's code prohibits companies from encouraging customers to 'down in one', but the panel found that despite the fact that this was how most people consumed the products, it had more to do with the small volumes they held – 20ml of liquid and 0.3 units of alcohol – than the packaging itself. 'The independent complaints panel was persuaded that this style of packaging was not causing harmful drinking,' said Portman Group chief executive David Poley. 'You could have ten of these test tube drinks and still be within the government's recommended drinking levels.' However, a previous complaint from Alcohol Focus Scotland against test tube drink Mwah! was upheld by the panel on the grounds that people were likely to drink the contents in one, as it could not be put down on a flat surface. 'The industry shouldn't be encouraging this potentially harmful style of consumption,' said David Poley at the time (*DDN*, 19 October 2009, page 5).

Nurse interventions work

Nurse-led alcohol interventions could help 40 per cent of dependent drinkers achieve abstinence, according to findings presented at the Royal College of Nursing's 2010 research conference. A six-month study of two groups of 100 alcohol-dependent adults – one of which received brief interventions from an alcohol specialist nurse at regular intervals – showed that 40 per cent of those receiving interventions reported total abstinence on completing the course. 'The study demonstrates just how useful interventions by alcohol specialist nurses can be in reducing alcohol dependence,' said research fellow at the University of Liverpool, Dr Kathryn Cobain. 'It is a simple approach but it clearly works and should be considered as a treatment option for dependent drinkers.'

The personalisation agenda – putting choice and purchasing power in service users' hands – is taking shape in different settings all over the country, with the pilots raising many complicated issues. In the first of a series of articles on personalisation, **DDN** talks to Maggie Leybourne to find out more about Lancashire's initiative with tier 4 services

EVERY SERVICE USER MATTERS

'Lancashire has always been a place where everyone matters,' says Maggie Leybourne, who is the county coordinator for substance misuse, working for Lancashire County Council and LDAAT. 'So the personalisation of social care for the people of Lancashire poses challenges for both providers and commissioners of services. Traditional targets for service change have usually focused on older people's services, and people with physical or learning disabilities, and all too frequently we see people with substance misuse issues being placed in the "too hard to do" box.'

A personalisation pilot, implemented last December, has offered a fresh opportunity to put people with substance-related issues at the forefront of the transformation of social care.

'I believe this group of citizens is as vulnerable as any in our society,' says Leybourne. 'If we are serious about providing appropriate support, this new model should empower the individual to take some control of their therapeutic journey.'

The setting Lancashire has been working with is tier 4 – residential rehabilitation – perhaps a relatively straightforward context for helping the client to look at their treatment journey and work out what they need to support their integration back into society. Initially just two rehabs participated, but this is now being rolled out to include many of the 14 preferred providers commissioned by LCC.

It's long overdue, according to Leybourne, who also sees the exercise as an opportunity to modernise tier 4 provision and make it more responsive. 'Residential rehabilitation – "the house on the hill" – with its dated philosophy of one size fits

'If we are serious about providing appropriate support, this new model should empower the individual to take some control of their therapeutic journey.'

all, has evolved over the past 20 years in an ad hoc manner, with no clear strategic commissioning guidance or effective performance monitoring,' she says. 'While treatment services in tiers 2 and 3 are being modernised to embrace the "recovery model" it seems timely for tier 4 to look to the future and ensure the model is modernised to reflect the more person-centred holistic treatment journey that people seeking help with substance misuse issues deserve.'

'This is proving to be a very positive move,' she adds. 'It's caused tier 4 providers to look at what they offer. They have had to break down the content of their therapeutic programmes and be clear about what they actually provide in the first three months, and reflect on what they offer differently in the second three months to ensure goals are achieved and progress is continuous. Some providers have realised they are just repeating the first three months and have had to ask themselves whether this is an effective use of anybody's time.'

We know from all that's been written and discussed about personalisation that it aims to give clients greater say in their treatment. But how does it work in practice in a tier 4 environment?

Service users only join the project after they have been in treatment for 12 weeks, so they have the chance to experience the first building blocks of recovery. Then a specialist social worker will assess their progress to see if they are ready to make choices about the next stage, both within their immediate setting and also by linking to mainstream services where appropriate. Those in 12-step programmes will need to maintain the compulsory elements of continuing their step work, but there is plenty of scope for a personal approach alongside this structure.

In Lancashire, funding is available for each service user for up to 12 months if they need it. The care plan must identify goals to be achieved by both staff and service users, and be reviewed every three months to make sure there are active objectives, without any blockages to progress. After the initial three months in the fixed programme, and the review to confirm that they are ready to make onward choices, service users are offered a menu of options.

'It's a more person-centred journey,' says Leybourne. 'People can maximise this opportunity and tailor it to their individual needs. This model has also created flexibility – at the moment you're either resident in a rehab and receiving support or or you're out. This model will allow you to access tier 4 services, but if you have a very stable home life you can return home – after 12 weeks – and carry on purchasing some of the elements that you feel are working for you.'

It was a culture change for tier 4 providers to demonstrate the financial breakdown of their care provision, but once they had got used to the idea, they were excited at the prospect of change. 'At the outset I imagined a lot of resistance from providers,' says Leybourne. 'But the notion of modernisation has been embraced fully by the rehabilitation providers in the pilot and by the ones now coming online in Lancashire.' The provider forums which are being developed to share obstacles and solutions should also help the modernisation process, she believes.

The initial exercise of looking at what therapeutic interventions were being provided, at what cost, has been useful in many ways. Not only has it created the menu of options for service users, but it has also disrupted any complacency in providing the same programme year on year, without any creative thought about what clients really wanted. Consultation carried out by Leybourne and provider managers began to get service users thinking about their own individual needs and learning styles.

For service users, the culture change offers opportunity for a 'person-centred' journey – something that was viewed with suspicion at the outset. During the initial consultation with them, some were anxious about the idea, because 'they were used to being almost indoctrinated into programmes rather than thinking about their own individual needs and learning styles.'

Once the scope of the project had been properly explained, participants realised that not only could they make decisions about their treatment, 'but the increased flexibility and individualisation meant they had the best chance of achieving their objectives while in the relative security of tier 4 services,' says Leybourne. 'Also by being empowered to take some control and make choices while in rehab, they may be better equipped for reintegration back into society on discharge.'

For those who have embarked on the pilot, it seems to be working very well, she says. The menu of options is being expanded all the time with input from participants, and is resulting in unforeseen benefits. She gives the example of one young man with alcohol issues who wanted to learn relaxation techniques to help him stop drinking. 'It made the rehab look outward and find a local library which was running two free relaxation courses a week. On attending he was also exposed to IT equipment which meant he could build on his literacy skills. At absolutely no cost this young man was able to meet his needs through using universal services.

One question that hung in the air from the start of the pilot was that of flexibility – at all levels of the programme. What would happen if a resident made a wrong choice in identifying a solution to a particular need? And how long would they have to maintain this before they could reselect? It made those involved in the pilot realise that there needed to be much closer consultation between the keyworker in the rehab and the social worker in the community, as well as more responsiveness to individual need, rather than relying on the rigid three month review.

Other questions surrounded the flexibility of the personalised programme. One service user wanted to know if he could use part of his allocated budget to purchase counselling for his partner – after all, he had travelled a substantial distance during his nine months in rehab and felt like a very different person, but his wife still viewed him with all the distrust she had had when he first entered. In such a case it made perfect sense to carry out relationship work with them both to ensure successful reintegration to the family home.

While this kind of reintegration work has often taken place in an ad hoc manner, the personalisation model means for the first time this work will be on a formal footing with identified needs and demonstrable outcomes. For Maggie Leybourne and her team, the teething troubles are being outweighed by the zest for modernisation that has filtered into rehabilitation services: 'For many years tier 4 providers have functioned in competitive silos, failing to understand that they all have a contribution to make towards the recovery of the substance misusing population.'

Against a backdrop of scepticism about personalisation, she firmly believes the model has the potential to use the structure and support of tier 4 to help people achieve their goals. The fundamental principle of choice and control is embedded in the personalisation agenda and Leybourne states 'as the tier 4 lead for Lancashire, I believe this empowering element has been missing for a long time within substance misuse treatment services and notably so within tier 4'.

On top of that, she says, the pilot has energised service user involvement: 'We are looking to the experts – the users of the service – to help us determine the strengths and opportunities in the newly modernised tier 4 services.'

We will be looking at implications for the wider treatment field in the 21 June issue, with results of The Alliance's personalisation agenda consultation.

Include

Clients are integral to every aspect of delivery, says Richard Lukehurst, **as he reports on a year working in service user involvement**

When I first saw the 'service user development worker' job advertised on the intranet at work it immediately caught my attention, although I had to find out what 'service user development worker' actually meant. 'To be responsible for the successful establishment, and further development, of service user involvement in influencing the design and delivery of housing related support services, in partnership with Northamptonshire Supporting People Team.'

The post is funded by Northamptonshire Supporting People and was advertised as a two-year project. I felt that in two years it could be successful, and I believe success will be measured on how it affects changes in services and how the clients who participate improve their chances of moving towards independence.

Reading the job spec I felt I had the necessary requirements. An ex-service user myself, I had first-hand experience of accessing services, and had since built up seven years' experience of working in the field. I applied and I've now been in post a year. It's been a real learning curve in terms of how to get clients involved in helping to shape and improve services. The primary aim is to involve clients from socially-excluded groups and establish a shadow core group made up of clients from these backgrounds, such as people with drug and alcohol issues, young people, ex-offenders, BME groups, teenage parents and women fleeing domestic abuse. The aim is to shape Supporting People funded housing services by feeding in their experiences, views and opinions to those whose job it is to commission and deliver.

Since coming into the post my own personal development has continued to grow as a result of meeting so many different people and learning how to build rapport, which is crucial if you want people to get involved. Selling the project – making it sound attractive, worthwhile and meaningful – takes quite a bit of thought, something I have to take into account when meeting clients in their projects and places of residence. Building rapport is a skill I've learned after working in the drugs/alcohol/homelessness field for seven years – in that time I've realised that addiction, health and social issues do not discriminate and the ability to be non-judgemental is fundamental.

Clients need to know I have their best interests at heart and that I'm coming from a client-centred perspective rather than a service-centred perspective. The client needs to feel that the project is meaningful, worthwhile and will benefit them and others if they decide to get involved. Over the past year we have continued to visit clients in their homes, in cafés and at other projects, and continued to build rapport and inform them about our aims, hopes and ideas.

Before starting this role I had been a drug and alcohol worker for CAN for nearly two years. I saw the new role as a challenge and, after a year, I'm coming to believe more and more in the power of involvement and how it helps people not only improve their lives, but the lives of others. If I want to know how a service could be improved I ask the customer – a simple and effective process, but customers need to see change happen if they are to continue giving their time and ideas.

Change produces and instils belief in the client but it's important to highlight that not all suggestions and proposals can be implemented. What is vital is that the reasons are explained, so individuals feel they are being listened to. One of the biggest barriers to getting clients involved is lack of communication.

I have made it my duty to inform clients of any upcoming events and training, making sure they are in a position to contribute. When working with vulnerable adults, tactfulness and consideration are key and I've found through experience that clients' health can change from one week to the next. It's vital to remember this when asking clients to give up their time.

The first objective was to introduce myself to service providers and service users across the county and find out what client involvement meant to them. It became clear that many services had been involving clients in their services for quite some time, yet

ME in

there was plenty of room for improvement. It took between three and four months of networking across the county, meeting clients and service providers and sharing with them what Supporting People's aims were and how clients could help shape services by having a platform where they could be heard at the very top.

Meeting the clients it became apparent that they had a range of skills, strengths and assets that would be suited to different roles within the forums, and many felt that they would benefit from some training. The majority of the clients I met had low self-esteem and lack of confidence and it was decided that, prior to setting up the shadow core group, we would run workshops to help build confidence, assertiveness and communication skills.

We have now run two workshops and feel ready to set the date for the first of our shadow core group meetings. Here are just some comments from clients who attended the recent training:

- *'I enjoyed the training and feel more confident in my role. I enjoyed the workshops on assertiveness.'*
- *'I am so pleased I attended the course on team building. I feel I have many assets to share with the group which simply needed to be highlighted.'*
- *'I now feel that I have gained some useful skills that will assist me when the shadow core group starts. The workshop on effective meetings was most beneficial.'*

Many providers report that client involvement adds value to service planning, development and delivery. It helps ensure services reflect the needs and wishes of the people who use them and creates a sense of ownership when involvement initiatives are sustained by action. Here are some quotes from clients regarding the benefits of participation/client involvement:

- *'Being involved in the forum has boosted my confidence and self esteem. I feel more equipped to talk to professional people.'*
- *'I enjoy the social aspect being a member of the group. We have a very supportive group of people who have become close friends.'*
- *'I feel a sense of belonging, which has been integral in overcoming my alcohol problem.'*
- *'While attending the group I have learned many skills which I can take with me into my chosen career. I want to work with people and feel that the skills I have gained while participating in the groups will assist me in my chosen career.'*
- *'My future job prospects have improved. I know how to give a good account of myself in job interviews.'*
- *'I have learned how to communicate with people from all walks of life and to be able to deal with different opinions and views. Remembering that it is important to listen to people's ideas and as a result become more open minded.'*
- *'I have been on some really useful training and have sat on interviewing panels employing future employees for the organisation.'*

Clients are the people that services affect on a daily basis and obviously therefore the most appropriate people to comment on the services they receive. They are experts by experience and as such their perspectives are valuable assets in all areas of planning, development and evaluation of services. Ensuring that client views are heard encourages positive inclusion at all levels and can help with service delivery for disadvantaged groups. Although we are still in the first year and it's very early days, we believe as a county we are helping improve housing related services but most importantly helping clients achieve their goals, feel empowered and become independent.

Richard Lukehurst is client involvement development worker at CAN Northamptonshire

Post-its from Practice

Final choice

Alex lost his fight but left with no fear, says Dr Chris Ford

Last week we attended Alex's funeral (see *DDN*, 15 March, page 13). He had died peacefully a week earlier in the company of his long-term partner and her mother. Hospital staff had been very supportive, immediately responding to my suggestion of a self-controlled heroin pump, recommended after I spent time with Alex in obvious pain awaiting analgesia.

During my last visit to see him a few days before he died, we talked, laughed and cried. He knew he didn't have long and he was at peace. He was happy with the choices he had made and his only regret was that he wouldn't get to see his two sons grow up. It was a privilege to know him and he touched all who came close to him.

The funeral was truly a reflection on Alex's life. On arrival I was hugged by his partner who introduced me to her mother, who was beside herself with grief. She told me of her love for Alex and explained how he had cared for her during a recent illness, even though she had recognised that he was getting ill.

Alex's mother was a complete contrast to him. She had not seen him for years until his final illness. She was solemn but critical of Alex and his life. She had come with her ex-husband, other two sons and one daughter. None of them had seen Alex for years, not even during his last illness.

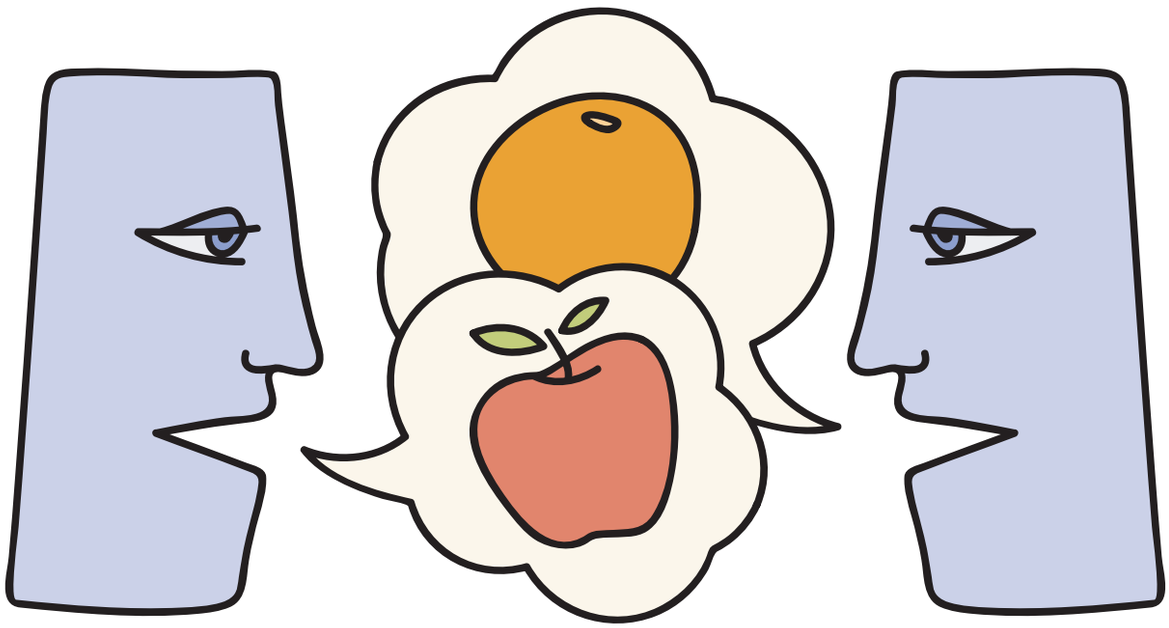
Upon entering the church, his blood family seated themselves on one side and all others congregated on the other side, which was packed. His blood family had overridden others' plans for the funeral and insisted on a traditional Catholic funeral, conducted by a priest who on one occasion even forgot Alex's name. The service seemed to me to have nothing to do with Alex the person.

But I was able to celebrate his life in my own way surrounded by his real family and friends. Among the crowd, perhaps because of my own prejudice, I noticed three elderly grieving Caribbean women, one of whom I knew. I enquired how they knew Alex and they proudly announced that he had been their wonderful neighbour.

I hope Alex's family got to see the truth behind the real Alex on the day of his funeral and witness the love that surrounded him. I hope they know or will realise that Alex was so much more than 'a drug user'. I hope that they, and any others who may hold a prejudiced view of what 'a drug user' is, will think twice before judging a person who uses drugs.

Alex, in his leaving message to us, wrote: 'Don't grieve for me, for now I'm free. I'm following the path God has chosen for me; if my parting has left a void then fill it with remembered joys...' I will grieve but remember the joys.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP. To become a member of SMMGP and receive bi-monthly clinical and policy updates and be consulted on important topics in the field visit www.smmgp.org.uk.



We should be wary of the role of talking therapies in any new government direction on treatment, says **Alan Joyce**

Talking heads

I AM A PASSIONATE ADVOCATE of GP-led care, as good GPs are the obvious candidates to provide treatment for concurrent mental health conditions and drug/alcohol use.

At the same time I fear that the evidence base for the effectiveness of psychosocial 'talking' therapies remains far from compelling and the long history of such therapeutic interventions could be read as a catalogue of passing fads. From the Scientologists' 'e-meters' to cognitive behavioural therapy, one could be forgiven for asking what good and what harm has been inflicted on many of my most vulnerable predecessors and peers in the name of 'treatment'.

A major problem I have with the evidence base for talking and abstinence based 'treatment' modalities is the lack of long-term follow-up studies that track patients over many years. What few studies there are have been with very small patient cohorts and utilise deeply flawed methodology – nothing like the rigorous studies and methodology that methadone and other agonist/partial agonist therapies have been subjected to across the world.

Moreover, talking therapies generally focus on the personal and exclude the social and the political. How could group therapy sessions – de rigeur in the early 1980s – have insisted we left outside the therapist's door the geopolitical (Thatcher, unemployment, the Afghan war, the Iranian revolution) that facilitated the flow of junk in our blood and song in our veins.

No, it was 'daddy, mommy, me' and the more knowing among us just played the game for laughs – you could see the therapist's eyes light up as you pressed the right buttons. In reality such groups helped augment and develop contacts and networks of users/user suppliers. Attending was good for business and good for scoring.

In essence, the abstinence obsessed, anti-maintenance practices of a number of the major drug dependency units of the past – the practices of 6-12 week methadone tapering which were deemed to convey the virtues of 'the short sharp shock of involuntary withdrawal' provided fertile grounds for the seeds of an impending blight that any reader of *Gay News* or *The Guardian* could foresee was heading our way and soon – about as long as it took a jet to fly from SF or NYC to the UK. And so Aids ripped the heart out of my generation's most gifted, young, talented and bright – now all dust. If only the clinicians of the time had dared open the blinds on the clinic's windows they would have seen the world outside – the one that 'therapy' precluded.

Those who could voted with their cash and sought sanctuary in private practice and the lifeboat of maintenance – so long as the GMC didn't, as in my case, come along and withdraw your private doctor's accreditation. The rug of stability was pulled from beneath me and many like me. By 1984 it was too late – the genie was out of the bottle and heroin was running rampant in the council estates and tower blocks, as millions became 'surplus to economic requirements', just so much dehumanised flotsam and jetsam.

My fear is that we now face the very real possibility of a zero tolerance style drug policy – zero tolerance for drugs, drug users and 'morally indefensible' agonist maintenance treatment. So as the cuts begin to bite what should we prioritise? Talking and other 'alternative' therapies or tried, proven maintenance treatment?

I fear that there lurks within the seemingly 'inclusive' recovery movement a beating heart of malice, rightly identified as the 'new abstentionist' agenda. Indeed I suspect that the emergence of the 'recovery movement' enabled those that coalesced around the University of Stirling and the Centre for Social Justice to re-brand and re-present themselves.

I may appear to have veered off topic, but any 'zero tolerance' regime will be predicated on talking therapies and coercive 'treatment', including involuntary withdrawal. Some decry the fact that there is an increasing cohort of patients aged 45 and over 'parked' on methadone maintenance. But most, including myself, would have been dead a long time ago (I will be 51 this year) if it were not for the self-empowerment provided by a good maintenance prescription and practice – GP-led in my case.

Those who feel abstinence meets their best interests at any given time should have access to high quality, well-managed facilities. But such provisions should proactively track patients' progress and offer post-withdrawal support.

Many users' needs change over time – some cease using then start again, and later decide that maintenance best meets their needs. Some on maintenance may feel they wish to undertake managed withdrawal and stop using – these are not mutually exclusive 'polarities' but nodal points in an ever-changing matrix of desire, the personal, the political, the neurological, physiological, clinical, social and cultural.

So talking therapies, for me, remain unproven. The jury is much out and thus far I see little to convince me that they are of benefit to all. Of benefit to some, certainly – but a replacement for pharmacological-based treatment? Never.

Alan Joyce has 35 years' experience as a user, service user, harm reduction activist and advocate. He is currently editor for the National User network (NUN)'s website www.nationalusernetwork.org and Facebook page

LETTERS

Backward step

I am extremely alarmed by the article *Paradigm shift* (*DDN*, 26 April , page 12).

Although I believe that alternative therapies and fresh thinking are welcome in our field, the fundamental basis for introducing any new approach should be its evidence base.

I think that you have made extremely poor judgement in publishing this article; it is essentially an advertisement, but is not credited as such. To blindly endorse approaches that are untested and have no evidence base is a significant step backwards.

Matrix reimprinting (MR) and emotional freedom technique (EFT) are contentious and potentially dangerous therapies to say the least. It is inherently dangerous to encourage workers in this field to take up new approaches that claim to be a panacea for some very sensitive problems in our service users' lives. We have a significant body of evidence which guides our practice in what is effective and what is not. MR and EFT may sound very impressive, but do not have any evidence to substantiate them, and are not endorsed by any reputable body.

DDN is read widely in the field. Articles should include editorial caveats when they are not from a recognised source, and content at the very least should be checked for accuracy. I hope that in future, you consider the implications of allowing a free reign to contributors and question the validity of their message.

James Varty, by email

Thank you for your comments, which I would like to address. Firstly, there is an editorial caveat at the front of the magazine that we are not responsible for the accuracy of contents, nor do contributions necessarily represent our views. But quite apart from this, as I have stated before, the purpose of *DDN* is to allow free reign to different ideas and points of view. So publishing a contribution is not a sign of endorsing its contents, it is allowing the reader to examine what's on offer and make a judgement for themselves.

In the case of this article, the introduction states that the author 'describes a new technique that he believes has the potential to fundamentally change the treatment field.' It is presented as the author's view and it is up to the reader to decide whether the technique merits interest. He is honest about the context in which he writes – 'I am not a cellular biologist nor do I pretend to be one – to be totally honest I used to be a scaffolder and a drug dealer from a council estate in Carshalton'. I do not see how this could be construed as an advertisement that we blindly endorse, as you suggest.

***DDN* was conceived with the belief that our readers need a variety of articles – news, information, comment and new ideas. They come from contributors from all kinds of backgrounds who know they are not submitting their paper to be peer reviewed – a process that would take months.**

Our free fortnightly magazine is about exchanging information, experiences and ideas and knowing that those ideas might be challenged by other readers. If I exercised the kind of editorial control you suggest and published only articles that mirrored received wisdom, it would be a very different magazine indeed.

Claire Brown, editor

'CENTRE STAGE' CORRECTION

In our 10 May issue (page 19) we incorrectly gave David MacKintosh's job title as 'independent consultant'. In fact David works for the London Drug Policy Forum, which is funded by the City of London. We apologise for this error.

We welcome your letters...

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

COUNTDOWN TO REGISTRATION

Are you ready for registration with the Care Quality Commission? asks **David Finney**

This summer there will be a major change in the regulation of services for people with substance misuse problems, and it could affect you. What's more, there is a deadline of 31 July to apply – or you could be operating illegally.

The first big change is that tier 4 services that formerly did not need registration because treatment and accommodation were offered on different sites now come within the scope of registration and, under the new Health and Social Care Act 2008, are considered to be offering 'accommodation for persons who require treatment for substance misuse'. The result is that all tier 4 services will need to be registered with the Care Quality Commission (CQC), creating a level playing field for service users and commissioners alike.

The second big change is that many community drug and alcohol services will also need to register with the Care Quality Commission. This takes a little more explaining as the law is slightly more complex, so bear with me.

Essentially, if your service provides treatment in the community you need to consider whether or not you should be registered. The technical phrase in the Regulations (Regulated Activities) is 'treatment for disease, disorder or injury'. The regulations further explain that 'mental disorder means any disorder or disability of the mind, including dependence on alcohol or drugs'. Also 'treatment' is defined as 'the ongoing assessment of a service user's mental or physical state'.

Many community drug or alcohol services may believe that they fulfil these criteria, however there is one more important aspect to bear in mind – that to be registered you need to have on the multidisciplinary team a healthcare professional (such as a nurse or doctor) or a social worker who is registered with the General Social Care Council. The likelihood, therefore, is that it is community prescribing services that will be subject to registration. This will probably rule out many community services that rely just on drug or alcohol workers. If you are not sure, then it is best to check with the CQC which has developed some good guidance on its website www.cqc.org.uk or by phoning their contact centre on 03000 616161.

The next big change is that there are standards that apply across all registered health and social services. Even NHS hospitals have to abide by these standards, as well as private providers of care homes and, of course, treatment services for drug and alcohol misuse. These are called *Essential standards of quality and safety* and can be obtained from CQC as a hard copy or downloaded from their website at *www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf*

David Finney is a social care consultant

***DDN* is running a 'masterclass in registration by CQC' in conjunction with David Finney Associates on 15 June, which will cover the key issues around getting you registered with CQC. Call Lexy on 020 73841477 or email lexy@cjwellings.com for details.**

In commission

Max Vaughan describes how Birmingham DAAT got to grips with alcohol commissioning

Birmingham, the country's second city, is facing increasing rates of alcohol-related ill-health, criminal justice and social care issues head on. This has been supported by a robust strategic framework and a significant increase in investment, especially from the city's three primary care trusts (PCTs) as well as Birmingham City Council, the Safer Birmingham Partnership and the Department of Health.

As the alcohol commissioning manager for the city, my work has mainly focused on developing the alcohol treatment/harm prevention system with the additional £2.7m of investment sourced primarily from the PCTs, realising a total alcohol treatment budget in the region of £5m. This is relatively small fry compared to the drug pooled treatment budget for Birmingham of £25m but nevertheless this level of investment is a very significant and positive step in the right direction. Taking a very structured approach, we used the Department of Health's alcohol models of care document and went about ensuring we had adequate provision at tiers one to four.

I am sure anyone involved in alcohol treatment is aware of the 'NI 39' target – reducing hospital-related and specific admissions. Having worked in alcohol treatment services for 15-odd years, predominantly in the provider sector, this is the first time there has been a strategic driver that is of some interest, especially to the PCTs. I have certainly found it very useful to start pushing the agenda forward with a strategic driver that has some real recognition.

Birmingham Local Area Agreement alcohol indicators – with a focus on offending behaviour and, more specifically, violent crime – have also been useful drivers, and all the costing exercises we have undertaken to demonstrate the financial cost of inappropriate alcohol hospital admissions have certainly turned heads at a senior and strategic level, as the figures are always indisputably very high.

Birmingham has commissioned hospital-based services in our four hospital sites with tier 2 (brief advice) and tier 3 (medical focus) services. However penetrating the acute sector and actually delivering services on the necessary scale has been far from easy. The aspiration that all A+E attendances should be screened for alcohol use seems a bit of a 'no brainer' from my point of view, given that so many presentations are statistically alcohol related, but when you look at what happens operationally I have found there is relatively little priority given to alcohol in the acute sector.

I think perseverance is probably the most important strength required, especially from a provider point of view. This needs to be applied to building effective working relationships with clinical staff and hospital management. From a DAAT point of view, I have been trying to build into acute sector contracts the requirement to undertake alcohol screening both on wards and A&E.

Some of the other challenges are to ensure that our alcohol treatment system is of the necessary scale to make a strategic difference. We are aiming to develop a treatment system that has provision for:

- *15 per cent of the city's 120,000 hazardous drinkers, by delivering 18,000 brief interventions at a tier 1 level*
- *15 per cent of the city's 40,000 harmful drinkers, by delivering 6,000 extended brief interventions at a tier 2 level*
- *15 per cent of the city's 20,000 dependent drinkers, by delivering 3,000 interventions to complex needs individuals at tier 3 and 4.*

We are also working on a wider public health communications programme for the general population.

In addition to this work some of the key developments we are including in our treatment system are to develop primary care provision so it is the backbone of the response to alcohol-related harms – our aspiration is that all GPs will have onsite access to at least tier 2 provision. The full range of treatment services for offenders is also being developed including a pan-Birmingham alcohol arrest referral scheme, prison inreach services and national probation service alcohol treatment requirements running alongside probation accredited programmes.

We want services to be 'family focused' as best practice dictates, so we have targeted our tier 3 services with engaging family members in 30 per cent of interventions carried out. We are also anxious to be 'intelligence driven' – it seems to me that that there are a number of very useful sources of alcohol data held by a range of partners that we need to use. Hospital admission data, for example, reveals 'hot spot' areas within the city as well as the patterns of coded alcohol-related and specific admissions.

We have a fully functioning service user group 'BARGE' who are being consulted on the alcohol treatment development programme. Finally, while working with individuals who are admitted to hospital frequently for alcohol related-reasons we are finding that homelessness and mental health problems are the two predominant underpinning factors, so we are commissioning services and developing pathways with mental health providers and Supporting People to meet their needs. Joint commissioning opportunities with these partners may be the future.

The challenge to the nation and, more specifically, Birmingham regarding reducing alcohol-related harms is enormous – I remember someone commenting that the reason central government had not fully faced the alcohol agenda was it was 'just too big'. I do now however think there is an increasing political will and commitment from the very broad range of public sector services which need to be involved in addressing the issue. I also think the general public's awareness of the negative impact of alcohol at a personal and community level is increasing to the point where action is expected.

As an alcohol DAAT commissioning manager I would very much welcome input from others who are trying to achieve the same aims. On a very specific and practical note, Birmingham DAAT is moving towards unit cost contracts and national figures for comparison in the alcohol field are not readily available – if anyone can assist in developing with me a set of unit costs I would be very interested to make contact. I am also very interested in further developing our public health information strategy and would be very interested in sharing ideas.

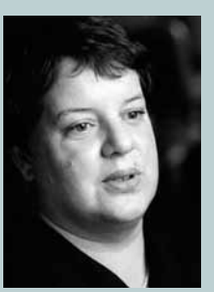
Max Vaughan is alcohol co-ordination and commissioning manager at Birmingham Drug and Alcohol Action Team. max.vaughan@hobtpct.nhs.uk

'I think perseverance is probably the most important strength required.'

The professional

Happy vocation

Let's remember why we're doing this work, says Carole Sharma



A recent *Guardian* article about methadone prescribing got me thinking – why do we focus on this when we are considering treatment for opiate dependency?

For other long-term conditions, prescribing is usually to bring about symptom relief, and it may be in our best interest to think of methadone in this way. One thing's for sure – methadone and other similar medicines are not treatment. Their function is to relieve the extremely unpleasant symptoms and cravings associated with opiate withdrawal.

Too much time and effort is expended debating the function of this medicine instead of concentrating on the main event – which is how do we engage effectively with individuals in distress and work with them to make the changes to their lives that they desire? This sounds to me like recovery. It happens at the client's pace and it is propelled by some really good psychosocial work by the practitioner, delivered in an environment of optimism.

Methadone and other medicines certainly have a role in these interactions, but to consider prescribing as treatment is naive and short-sighted. If the public (and politicians) believe this is all there is to treatment then as practitioners, managers and policymakers we have failed to communicate what treatment should really be about. And if we still have practitioners and clients who believe that getting someone onto a prescription is 'job done' then we have all truly failed and should put our efforts into remedying this situation.

When working with opiate users we need lots of different skills in our 'toolbox'. One of the most important is prescribing to alleviate the symptoms of withdrawal, so the client can feel less distressed and engage in the process effectively. Without this tool it would be very difficult to achieve anything, so we need to make sure we are not throwing the baby out with the bathwater in the debates about prescribing and treatment.

If we are finding it difficult to work towards abstinence and recovery with those on methadone then we may need to further develop competency as practitioners. Frankly, we need to be able to provide all aspects of an effective treatment service from harm minimisation to reintegration – and we need to be constantly striving to do these things well.

Much is written and discussed about 'recovery', with various factions claiming exclusive rights to the word and the concept – all of which will not help in the long run.

Maybe the first group to seek recovery should be the substance misuse field. We need to remember why we do this work in the first place, consider how we are going to provide high quality services in a time of austerity, and commit to developing our skills to deliver positive outcomes for our clients and the communities we serve.

Here's my list of reasons for working in this field – yours might be different:

- because of a commitment to the client group
- because I enjoy challenging work
- because I believe that change is possible
- because I believe that drug and alcohol users can make a valued contribution to their communities

I am sure many of you have plenty of other reasons. Let's remember them from time to time – not just to keep a balanced view of drug and alcohol treatment, but to make sure we get the best outcome for our service users.

Carole Sharma is chief executive of the Federation of Drug and Alcohol Practitioners. FDAP safeguards the public by accrediting practitioners and requiring them to practise according to a code of conduct and ethics, and is engaged with policymakers in workforce development.

For details of how to become accredited and become a member, visit the website at www.fdap.org.uk

REWARDING RESULTS

Now's the time for the outcome funding model in drug and alcohol services, says **Peter Mason**

UK public services are about to be squeezed as never before, so the time is ripe for a reappraisal of the way we invest public money. Drug and alcohol services are an example of how outcome funding can unlock value for money from the reduced funds available to providers.

Outcome funding is a way of linking client outcomes to payment. It has been applied to the drug and alcohol field since 1994 when the government used the approach to define the Department of Health's £2.4m drug and alcohol specific grants. Since then there has been increasing uptake of the model and it has influenced grant makers and commissioners in many PCTs and local authorities. The treatment field has been a pathfinder for developing new thinking in commissioning from the early days of block contracts for payment and spot purchasing arrangements.

World Class Commissioning in the NHS and best value logic in local authorities are both based on the imperative to gain real value from public money. However, there is a continuing high demand for drug treatment and the debate has started about how we prioritise outcomes within a system that has placed much emphasis on maintenance and harm reduction. In addition, public health experts are pointing to the elephant in the room – rising rates of alcohol-related harm that dwarf those of drug-related harm. Three drug and alcohol Total Place pilot sites – testing new ways to improve outcomes and efficiencies – have all called on the government to increase flexibility in the use of ring-fenced funds and relax the rules guarding drug and alcohol spends.

So how could the model be adopted? Drug and alcohol services are well placed to take on the outcome funding approach. First, the introduction of model of care frameworks has enabled practitioners to sort clients based on assessed need, define types of treatment and provide interventions based on the severity of a client's problems. Second, the introduction of the national Treatment Outcomes Profile monitoring tool (TOP) has helped maintain a focus on the result domains that will have the greatest impact on the wellbeing of clients. Third, there is a better focus on specific client behaviour changes that correlate with TOP score changes. The key outcome targets that define the results an intervention aims to achieve – such as stopping drug and alcohol use and/or reducing consumption and harm – can be

'Payment by results will force services to be explicit about who and how many people they can serve, what impact they can bring about for those people, and for how long.'

measured and verified. These outcomes and others can be defined and tracked, providing a simple means of proving that results have been achieved and sustained over time.

Already the implementation of outcome funding by some commissioners and providers – and the wide introduction of the Treatment Outcome Profile by the NTA – has been helpful in moving the field towards an outcome focus, meaning the treatment system is already well prepared to use outcome funding as a preferred commissioning and outcomes management tool. The tiered models of care approach has educated and enabled commissioners and providers to improve assessments and manage a treatment journey based on the severity of problems and the evidence underpinning the need for the intervention.

In recent years, the NTA has focused on services being able to show that a client has remained in treatment for 12 weeks. This has been used to examine the performance of a service and act as a proxy for positive outcomes – however, it is only a marker and there may be no correlation between a service keeping a client for 12 weeks and any change in the client's behaviour or condition. Outcome management would measure the effectiveness of provision over a number of variables identified in advance of treatment, and would also be well suited to measure verifiable changes such as drug free states, and how long these are maintained.

In the present system the commissioner and provider are locked in a game of paying for activities rather than results, which can bring with it the unintended consequence of keeping people in treatment for longer than necessary and rewarding harm reduction changes at the expense of far reaching life changing goals like abstinence.

It has been known for some time that the focus of the funding – what it pays for – is highly consequential in influencing provider behaviour. In one example, the impact on the project was to move the service towards longer-term aftercare support activities to enhance drug free outcomes. This knowledge may prove useful in exploring how higher payments to drug and alcohol treatment providers could be developed to nudge projects to increase efforts to bring about more drug free recovery outcomes. A bonus payment for maintaining these outcomes could unleash more innovation and partnership working in treatment systems.

Some services already use an outcome funding framework and have started to apply it to large parts of their drug and alcohol treatment systems. Their progress, and the architecture they have established to bring about large-scale change, should be appraised, and over time it will be possible to compile a tariff based payment system that would establish the average price needed to get a service user to the desired level of outcome and sustain it.

Given the nature of treatment systems made up of multiple providers it will be important to ensure that each service can declare how they will enhance and/or sustain gains that have been made by other service providers. A change of mindset away from buying activities towards investing in outcomes is needed – the essential first step to gaining value for money that can be measured in life enhancing results.

The drug and alcohol treatment industry is better positioned than many other care services to adopt a payment for outcomes approach. It has a strong evidence base about what works, it is highly segmented in its model of care, it has been at the forefront of outcome monitoring, and there has been a growing pressure from the public to scrutinise the effectiveness of treatment and the wider impacts on society.

The focus on payment by results will make more transparent what our services are achieving in terms of human gain, and it will force services to be explicit about who and how many people they can serve, what impact they can bring about for those people, and for how long.

Outcome funding has the ability to shape the provider community to state precisely what can be achieved and to make part of the contract fees contingent on results. It will make a significant contribution to the search for better ways to manage in an increasingly tight financial climate. Funding will be more closely linked to results, leading to better use of financial resources, increased performance and benefits to providers, clients and society.

Peter Mason is a results and innovation consultant. He can be contacted on peter.mason20@yahoo.co.uk

Conference: ***Drugs, health, justice – perspectives on race equality***

Race against time

Against the backdrop of a new government and an as yet unclear drug policy, a major London conference will explore how drug users from minority groups are treated across the criminal justice systems of Europe

Next month sees a major two-day event looking at issues of race equality in the criminal justice system. A joint venture between T3E UK and the Connections project, the *Drugs, health, justice – perspectives on race equality* 'summer university' will study integrated responses to drugs and health across Europe's criminal justice systems, with a specific focus on race – as the organisers describe it, how the systems respond to the 'most marginalised of the marginalised'.

'We've always believed that looking at the journey of drug offenders from minority groups sheds light on general policies and practices and how they can be improved, because good practice is often neglected,' says conference organiser Kazim Khan of Middlesex University's centre for transcultural studies in health.

T3E UK is part of the EU-wide T3E network – a French acronym for Toxicomanie, Europe, Échanges, Études. 'We're the UK hub,' says Khan. 'It's one of Europe's oldest drugs networks involving professionals in the field, and we're associate partners with the Connections project.' The organisation aims to build understanding of drug use by promoting the exchange of ideas and the intention is that the event acts as a vital networking tool, forming a useful partner conference to the Connections *Drugs, alcohol and criminal justice: ethics, effectiveness and economics of interventions* event later in the month (*DDN*, 26 April, page 6).

'We realised that, like every other aspect of drug services in criminal justice, and despite EU anti-discrimination legislation, very little had been done on this and there was a dearth of information,' he says. 'So we've been carrying out studies across eight EU countries and completed all of them apart from the England one – because of the election and restrictions that placed on civil servants.'

The other countries are Denmark, France, Hungary, Italy, Portugal, Romania, Slovenia and part of the consultation process on the reports will be a major plenary session at the event. The conference will also see both presenters and participants accompanying imagined drug using offenders on their journeys from arrest to assessment, referral, sentencing and beyond. 'We'll be looking at the journey from pre-sentencing even,' he says. 'For example services in Plymouth have been working with the police to intervene with problematic drug users before they're arrested, and they're then diverted on to treatment without being charged.'

Does he feel that race issues are still given enough attention in the drugs field these days, or is there a tendency for things to fall in and out of fashion? 'That's absolutely right,' he says. 'There's often a lot of box ticking but no evaluation, and in terms of black workers in agencies there's been no movement. It becomes hegemonised and then you hear no more.

'We've got very interesting speakers who'll be talking about things like the new racism, about the French approach – which is diametrically opposed to ours – and we've got Terry Williams from the New School of Social Research in New York on the American experience. We don't know which direction UK drug policy is going to go in – people are just sitting there wondering, so it's about time we spoke up.'

For more information or to book a place visit www.raceanddrugsproject.org.uk/may2009.html

DRUGS, ALCOHOL AND CRIMINAL JUSTICE
ETHICS, EFFECTIVENESS AND ECONOMICS OF INTERVENTIONS

CENTRAL LONDON
23-25 JUNE 2010

Speakers include:

Diane Abbott MP for Hackney North and Stoke Newington and Labour leadership candidate, and **Inspector Leroy Logan** from the Metropolitan Police.

What are the links between drugs and violent crime in the UK?

Damon Barrett IHRA, **Niamh Eastwood**, Release and **Niki Adreescu** APADOR-CH, Romania

Patient or prisoner? Human rights and informed consent in the criminal justice system – an examination of the delivery of health care in custodial settings.

Paul Hayes NTA, **Eric Schneider** ACCES France, and **Diane Hilton** Phoenix Futures.

Interventions and the continuum of care – what do we mean by harm reduction and recovery, what is integrated treatment and how is it best delivered?

This conference takes place at a time of unprecedented competition for scarce resources. To be able to demonstrate value for money is critical, nowhere more so than in drug and alcohol treatment. The conference will look at a range of interventions and treatments, from harm reduction to drug-free recovery. While no single treatment modality can deal effectively with the complex range of presented needs, delegates will debate how to most effectively combine the different components to provide the best possible service for clients.

Other presentations from:

Stephen Rolles, Transform; **Mark Dixneuf**, SIDACTION, France; **Alex Stevens**, University of Kent; **Linda Davies**, University of Manchester; **Ambros Uchtenhagen**, Institute of Public Health, Switzerland.

Full details and booking at:

www.connectionsproject.eu

About DDN

DDN is a free independent publication, totally self-funded through advertising revenue.

Published fortnightly for more than five years by CJ Wellings Ltd, and with a circulation of over 11,000, the magazine provides an unbiased round-up of the latest news, features and research from the substance misuse sector.

The magazine is not affiliated to, or funded by, any of the agencies working in the field, but works closely with them to ensure that all areas of drug and alcohol treatment are represented.

We fiercely value our editorial independence and do not seek funding for the production of the publication. We provide a cost-effective targeted advertising service for the substance misuse field – if you would like to support the magazine and help keep it free of charge to all readers, please contact us the next time you need to advertise.

To find out more about Drink and Drugs News or working with CJ Wellings Ltd please contact info@cjwellings.com

looking for new opportunities?

bdp Bristol Drugs Project

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,200 individuals a year.

DETACHED WORKER

(Part-time 21 hours per week) – Job reference: DD2

BDP's Detached Service offers an outreach and inreach provision to hard-to-reach groups in need of drug and alcohol support, signposting and advice. We deliver this service to homeless hostel residents, street-based sex workers and those not in touch with drug services or find it hard to get help.

We focus on making contact and helping build bridges in to drug and alcohol treatment.

For an informal discussion contact Paul Sargent, Detached Service Senior Practitioner on 0117 987 6003

You will need experience of working with drug users & we welcome past personal experience of problematic drug use.

Salary: £17,195 progressing to £25,848. Starting salary for suitably qualified candidates: £22,926 *(pro-rata based on full-time, 35 hours a week).*

Closing date: Friday 11th June 2010 by 13:00

Interview date: Friday 18th June 2010

Please contact Angelo Curtis, quoting the job reference, for an application pack:
BDP, 11 Brunswick Square, Bristol BS2 8PE
Tel: (0117) 987 6004, E-mail: recruitment@bdp.org.uk

Safer Bristol

Funded by Safer Bristol – Bristol Community Safety & Drugs Partnership

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation.

No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

CDS SOUTH LONDON

COMMUNITY DRUG SERVICE for SOUTH LONDON

DAY PROGRAMME DRUGS WORKER

Part Time – 24 hours weekly
Grade 27, NJC Scale
(6% Employer's Contributory Pension Scheme)

The successful candidate mainly will provide the following: one to one support, group facilitation and life skills workshop within a day programme facility at CDSSL, Wallington, Surrey. Following our existing system and policies and national related guidelines and legislations.

For an Application Pack for this position, please call: 020 8773 9393

Closing date for completed applications: Monday 31st May

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

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

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PROVIDENCE PROJECTS - Helping you find the way

The Providence Projects, established in 1996, are the leaders in residential day treatment in the UK. The Providence Projects provide detox, primary and secondary treatment as well as a full aftercare and re-integration programme.

ADDICTIONS COUNSELLOR

£20,000 - £22,500 + over-time

An opportunity has arisen to join our exciting and dynamic counselling team. This post is for a qualified or part-qualified counsellor who is motivated and passionate about helping those suffering from addiction. Experience or knowledge of 12 step philosophy would be advantageous.

You will be required to manage a case load of clients, facilitate group therapy sessions and deliver workshops. You would also be responsible for formulating care plans and liaising with outside agencies and families.

The Providence Projects is an equal opportunities employer.

For further information please either e-mail paul@theprovy.org or call Paul Spanjar, Treatment Director on 01202 393030 for your application pack.

Forest YMCA is a large community organisation based in Walthamstow and a Registered Social Landlord, regulated by the TSA. We provide accommodation and support for young people along with move-on accommodation and housing for refugees. We have a newly refurbished restaurant and internet café, as well as a weights gym and spa suite. The Association also provides out of school care in the local borough and a youth club at our main site.

Supported Housing Officer (Drug and Alcohol)

Salary: £22,000 pa • 37.5 hours per week • Ref: HR392

Managing your own caseload of residents you will be able to draw upon your past experience as a support worker in a low-medium needs hostel. You will provide advice and support on a 1-2-1 basis to clients on education and training, welfare benefits and resettlement.

You will draw upon your counseling qualification to provide either CBT or 12-step based counseling to individuals and groups regarding the affects of alcohol and drugs, along with preparing individuals for submission to CDAT and other addiction agencies. You should be able to prepare and distribute relevant literature to residents and provide education programs where requested.

You will also be able to undertake assessments and support plans and have a basic knowledge of Supporting People and the QAF framework having had significant previous experience of providing 1-2-1 support to clients.

For more information on Forest YMCA please go to www.forestymca.org.uk

Closing date for applications is Friday 11th June 2010.

For an application pack please email ymca@pennatcs.com or call 0845 055 0261 quoting the reference HR392.

Forest YMCA is an equal opportunities employer.
Registered charity no. 803442

FOREST YMCA OF EAST LONDON

Compass

Compass is a rapidly expanding independent sector organisation providing services to help communities cope with problem drug and alcohol use. Due to the expansion of our services in Yorkshire, we now have the following exciting opportunities available:

Hull Services

Harm Reduction Worker 37 hours per week | £20,454 - £24,201 p.a. | Ref: 173

Young People's Drug and Alcohol Worker
37 hours per week £20,454 - £24,201 p.a. | Ref: 174

Nurse Senior Practitioner 37 hours per week | £27,212 - £29,314 p.a. | Ref: 175

Practice Nurse 37 hours per week | £21,115 - £26,470 p.a. Ref: 176

Sheffield Service

Service Manager 37 hours per week | £31,162 - £36,683 p.a. | Ref: 170

Case Manager / Trainer x4 37 hours per week | £20,454 - £24,201 p.a. | Ref: 171

Administrator 37 hours per week | £12,869 - £15,625 p.a. | Ref: 172

York Services

Criminal Justice Worker 22 hours per week | £20,454 - £24,201 pro rata p.a. | Ref: 178

We believe that a healthy work/life balance is key to a successful and rewarding career so we are proud to be able to offer:

- 27 days annual leave per year + 8 Bank Holidays
- Free Employee Assistance Programme
- Compass Group Personal Pension Scheme
- Childcare Voucher Scheme
- Excellent Training Opportunities

For more information and details of how to apply, visit www.compass-uk.org

Please see our website for closing dates of individual posts.

All Compass posts are subject to an Enhanced CRB disclosure.

www.Compass-uk.org

Charity registration No: 518048

Bournemouth Borough Council

You'll be an experienced Senior Practitioner or a Social Worker with experience in Child Care or Mental Health and an understanding of substance misuse, looking for an opportunity to work in partnership with third sector providers to help develop the safeguarding agenda for children and adults within the Drug and Alcohol Assessment Team in Bournemouth.

Senior Practitioner

Ref: AT0177, £34,549 - £37,206
plus 2 increments for AMHP, 37 hours per week

Taking a lead role within the Bournemouth Assessment Team for safeguarding vulnerable adults, you'll undertake risk assessments, providing advice and expertise on individuals who present with a dual diagnosis (mental ill health/substance misuse).

You will be providing leadership and supervision to a small team of social workers within the Assessment Team who will also be working to the safeguarding children's agenda and supporting the Think Family process. As an Approved Mental Health Professional, you'll provide support to colleagues, as well as liaise with the Social Inclusion team.

This post is subject to a pay and grading review which may result in a change to the grade, salary and enhancements.

Social Worker

Ref: 4559, £24,646 - £33,661, 37 hours per week

Taking an important role within the Bournemouth Assessment Team for safeguarding vulnerable adults and/or children, you'll undertake risk assessments, advice and expertise on individuals who present with possible safeguarding issues within this area of work. You will also be liaising with other statutory providers, such as mental health teams and children's social care teams.

For both of these roles, you'll have an interest in working with substance misuse and people with dual diagnosis. Your risk assessment and management abilities must be highly developed and you'll bring experience of care planning and reviewing packages of care, as well as knowledge of substance misuse treatment systems and models of care.

You will have experience of managing a complex caseload and be comfortable with a multi-agency approach. In-depth knowledge of Mental Health and Adult Social Care/Childcare legislation will be essential, as will an understanding of adult and children's safeguarding procedures and the impact of substance misuse/mental ill health on individuals and families. Excellent communication, supervisory and organisational skills will be key.

Social Work qualifications and registration with the GSCC are required for these roles.

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

To apply online for ANY of our current vacancies visit
http://jobs.bournemouth.gov.uk
Alternatively, contact:
e. recruitment@bournemouth.gov.uk
t. 01202 454775 or 01202 458838 (24-hour answerphone)
Closing date: 4 June 2010.

Stonewall DIVERSITY CHAMPION

The Council is committed to achieving equal opportunities and a work life balance. Bournemouth Borough Council does not accept CVs without an application form.

KENWARD TRUST

HEAD OF RESIDENTIAL SERVICES: MAIDSTONE, KENT, F/T – CLOSING DATE 7TH JUNE

This is an extremely high profile position within the Trust. You will be part of the Leadership Team, working closely with Project Managers to ensure the best treatment services are provided to all service users in various stages of treatment. You'll champion best practice, drive delivery and constructively address underperformance. You will develop far-reaching strategic relationships to enable this to happen. You will have significant proven experience at strategic management level. Your experience will span resources, people and change management and you will be an impressive facilitator and negotiator. As politically astute as you are visionary, you'll bring real insight into developing the residential services and have an awareness of current issues and challenges in the treatment of substance misuse. A broad understanding of national strategy and drug treatment is essential; you will also be fully versed in associated issues of criminal justice and social care, capable of applying considerable political sensitivity and, most of all, you will be passionate about making a difference.

HEAD OF MARKETING AND NEW INITIATIVES: MAIDSTONE, F/T – CLOSING DATE 7TH JUNE

Don't be fooled by our size, there is a world of opportunity in this high profile role. We are a changing organisation that is serious, commercially focused and committed to providing quality services. Working closely as part of the Leadership Team, you'll oversee and drive the marketing, fundraising and communications strategies as well as generate new initiatives and income streams. You'll be leading on re-branding the Trust to create a new, fresh, exciting image and will be used to working with a large number of stakeholders to do this. With your extensive marketing experience, you know how to strategically plan and manage operations, commission research and control tight budgets whilst being politically astute. What sets you apart is your ability to inspire the organisation and deliver results in a high profile, pressurised environment.

HEAD OF HR: MAIDSTONE, KENT, P/T – CLOSING DATE 7TH JUNE

We have an exciting opportunity for an experienced Senior HR Manager to join at a time of change and opportunity. The organisation has grown significantly and you will require a broad knowledge of all HR aspects to assist with the changing culture of public services both internally and externally. Reporting directly to the CEO you will form part or the Leadership Team working at strategic level. You will be passionate about learning and development and be familiar with change management to support our employees in delivering quality services whilst embedding our vision, mission and values.

DETOXIFICATION MANAGER/PRINCIPLE THERAPIST: SEVENOAKS – CLOSING DATE 7TH JUNE

You will be ambitious and not scared of a challenge! This role is for a new partnership project opening to provide much needed inpatient Detoxification services, combined with therapeutic interventions. This role is unique and exciting; you will need proven management experience along with nursing and counselling qualifications. You will be an experienced professional looking for a new challenge and be responsible for the therapeutic workers which will cover as 24/7 shift pattern.

COMMUNITY/OTHER VACANCIES: WEST KENT – CLOSING DATE 7TH JUNE

Community Detoxification Nurse – Full Time
Group worker – Part Time 24 hrs
SPI Worker (counsellor) – Part Time 28hrs
Therapeutic Workers – Part and Full Time opportunities

If you are interested in our work or would like a more up to date view on vacancies please contact us

For a full application pack or informal discussion on any of the above roles please contact:
Sam Skinner, personnel manager. Tel: 01622 814187 or email: sam.skinner@kenwardtrust.org.uk

Please note that all applicants must be sympathetic to the Christian Ethos of the Trust.
Posts are subject to an Enhanced Disclosure check from the Criminal Records Bureau

We are committed to Equality of Opportunity for everyone

To lesson the impact on the environment, applicants will not be contacted unless short listed for interview. If you are not contacted within 2 weeks of the closing date, then your application has been unsuccessful on this occasion.