DDN
Drink and Drugs News

6 November 2006
www.drinkanddrugs.net

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Prioritising life skills in Adapt's Norfolk rehab

TURNING OFF THE TAP
An ex-user's journey through methadone withdrawal

WORKING LIVES
Service user involvement officer with Derbyshire DAAT

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We ask what YOU would like to put to the policymakers

1996 - 2006

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Lee Vallis, Euromed Bursary winner 2006

(details here in DDN on page 4)

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Published by

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Drink and Drugs News

6 November 2006

Editor's letter

Two years ago we started Drink and Drugs News to provide information to the drug and alcohol field. There are thriving and highly respected bi-monthly journals, with research based articles, but nothing very frequent that would access all areas of the UK by being free of charge.

We were astonished by the rate at which DDN took off. It's been such a busy two years that we've barely had time to stand back and realise how quickly it grew. The circulation rapidly reached 11,000, so confirming that workers wanted the magazine was the easy part of the equation. We were determined that it should link people working in all areas of the drug and alcohol field, and that's an ongoing challenge to make sure we find those who provide housing support, health advice, social care – basically everyone who can link those with substance related problems back to the outside world.

Our partner organisations are an inspiration, which is why we began with them in starting our reader consultation exercise. We know from recent Home Office research that practitioners want input to policymaking. You form a network of readers receiving information every fortnight and creating an active letters page: what could be a more logical next move than focusing on readers' 'big issues' and putting them to policymakers? We hope you will be ready with your feedback when we launch our readers' questionnaire later this month.

As well as looking ahead, we'd like to take this opportunity to thank our partners for their support and contributions – and to thank all our advertisers over the past two years. Every advert you place funds the production of the magazine and keeps it free of charge.

And of course huge thanks to readers for all your much valued correspondence, feedback and encouragement.

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Website maintained by wiredupwales.com

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ
Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Andrew Paterson

In this issue

Notes from the Alliance

How can we do anything meaningful to promote user involvement when the decision-makers ignore us, asks a frustrated Daren Garratt.

User involvement in this country has failed. Why? Because the only people who've wanted and fought for true, effective involvement have been the users themselves. Local partnerships and national bodies may have spoken of involvement, and many have probably, genuinely thought they were being sincere in their expressed desire, but they didn't really mean it. What they meant was User Representation and what they wanted was merely to be informed by users; they didn't want users actually integrated and doing things.

If they had, why do we still hear of the roundly discredited 'two-year myth'? The Treatment Effectiveness Strategy plainly states that long-term maintenance is a viable treatment modality and the provision of employment options is an essential component of a holistic treatment journey. One could argue, therefore, that any agencies insisting that users have to have been out of treatment for a minimum of two years before they'll even consider them for employment are unable to fulfil their required therapeutic duties, and should be decommissioned. However, until our friends at the NTA issue a swift, final, definitive statement or gesture to put this unethical, discriminatory bad practice to bed, many users will still have to rely on offending as their only viable earning option. But, hey! It's good for the retention figures…

And herein lies the rub: How long can organisations such as ours continue to promote effective involvement with any sense of belief or credibility, when services contradict us and the decision-makers ignore us? How much longer can we really talk about empowering users when in reality, empowerment only leads to more discrimination? How many users have been the favoured ones in their DAT or NTA Region until they became vocally sceptical about some of their area's widely publicised and highly-lauded 'achievements', and suddenly found themselves frozen out and unable to attend local, regional or national events? This is User Exclusion in action.

And I know that the NTA used to make rail fare available to such excluded users in order to attend the NUAG, but that was because the NUAG was an NTA event that needed representation from ex, current and non service users. Now that the NUAG has been formally disbanded and the independent National User Network has emerged with a remit 'to promote and support User Involvement in all aspects of care, Treatment and Service Development', the NTA's gesture of offering rail support for excluded users has been withdrawn. Instead, any users wishing to become involved have been advised to approach their DATs or Regions. Hmmm….

Surprised? This is a target-driven economy. The targets on getting users into treatment has been achieved two years early and workforce expansion has been one of the most tangible, measurable successes in this field over the last few years. Do you really think there's an honest, political drive to get disenfranchised users to turn a concerned, challenging, critical spotlight on an established career machine and system flushed with its own success?

Wake up and smell the pay rise.

Daren Garratt is executive director of the Alliance

Call for higher alcohol taxes follows binge research

Health Secretary Patricia Hewitt has called for higher alcohol taxes in the bid to tackle underage drinking.

In her letter addressed to the Chancellor last week, Ms Hewitt asked to 'really increase taxes on alcohol and particularly things like alcopops and some of the stuff that quite a lot of teenage boys and girls are drinking'.

Her request follows the figures from the Institute of Alcohol Studies that 55 per cent of teenagers were binge drinkers in 2003 and a quarter of 15 and 16-year-olds have been late-night binge-drinking at least three times a month.

Director of policy and services for Alcohol Concern, Don Shenker, said: 'We welcome the fact that Patricia Hewitt has stepped into the debate at this critical time. The levels of underage drinking continue to rise and we are now at a point where nearly half of all 15-year-olds consume alcohol regularly.'

Mr Shenker added: ' There is compelling evidence to suggest that lifting price levels through taxation would reduce the amount of alcohol that young people are able to buy. However, it is crucial that pupils are provided accurate, credible and consistent information about the hazards of drinking.'

Tough decision produces bursary winner

A panel set up by *DDN* has selected the first Euromed Training and Accreditation Bursary winner of this year. Lee Vallis has secured £1000 towards the Clouds Foundation degree.

Euromed set up the bursary to help practitioners train and gain necessary evidence for FDAP Accreditation as a Drug and Alcohol Professional. Funds for the 2006 bursary have been spread across the Bath University/Clouds Foundation Degree in Addictions Counselling, the Open College Network/Addaction Drug and Alcohol Workers Core Competencies Certificate and the OU/FDAP Competences for Drug and Alcohol Professionals Award.

Mr Vallis, who won the bursary against stiff competition, thanked Euromed for giving him the chance to follow his ambition to work with children affected by substance misuse.

'Financially it was going to be very difficult for me to get to the finish of this degree,' he said. 'Euromed's bursary means I can concentrate on studying without having to worry about funding issues. This is going to be a great help.'

Ruth Raymond has joined DDN on the team's second anniversary. With a background of journalism and publishing, Ruth will increase DDN's capacity to cover a wider range features and events, as well as helping the team to respond to an ever more responsive readership. At the end of her second week in the DDN office, she said: 'I feel very enthusiastic about working with DDN and am looking forward to writing articles and getting to know readers.' Meet Ruth with the rest of the DDN team at the FDAP conference on Wednesday 8 November.

Locals have their say on nuisance binge-drinkers

A pioneering scheme from a local community organisation, will give residents of Brighton and Hove the green light in tackling alcohol related issues over the Christmas period.

Through the Message in a Bottle scheme, Safe in the City is asking for enthusiastic locals, ranging from police to taxi drivers, to run small projects that they feel could help to eliminate anti-social behaviour brought on by binge-drinking.

Launched this week, the campaign has three main concerns: anti-social behaviour and nuisance in the area; drinkers getting injured, attacked or harming others; and drinking among young people.

Community safety manager for Brighton and Hove, Linda Beanlands, said: 'Tackling alcohol misuse is a priority and we are working hard to make a safer, cleaner city. We now want to tap into the experience and energy of people working in, and residents affected by the alcohol business to come up with new solutions.'

She invited anyone who wanted 'to do something about the nuisance and harm that too much drinking causes,' to get in touch.

Suggestions from locals are invited by 8 November. Email Dan Farag at daniel.farag@publicinnovation.org.uk

UK shares responsibility for cocaine effects in Columbia

A groundbreaking Columbian campaign against the illicit production and consummation of cocaine, launched by the country's vice president, held its first international launch events in London, Birmingham and Basingstoke last week.

Shared Responsibility aims to show users the implications of buying cocaine by putting emphasis on the ordeals many Columbians have to face as a result of their drug money. It hopes to encourage UK users to not only think about the damaging personal effects of the drug, but to look at cocaine as a worldwide problem.

Five Columbian women attended the events, all of whom have suffered either kidnapping, bombings or forced displacement at the hands of guerrilla organisation, FARC (Fuerzas Armadas Revolucionaries de Colombia – The Revolutionary Armed Forces of Colombia) who are funded by the trade and production of cocaine.

Dave Reilly, strategic manager for Birmingham DAT, which hosted one of the events, said: 'We hope to be able to share our working practices to help make a difference in other parts of the country and the world.'

The campaign has been supported by Mentor UK, whose chief executive Eric Carlin visited Columbia last year and saw the 'devastating effects' of the cocaine market first hand.

'Any move to counter the continuing "glamourisation" of recreational drug use, and to highlight the very real and destructive consequences of this for people and communities across the world, should be heartily welcomed,' he said.

'Blaming the prohibition of these harmful substances for this global damage is far too easy.'

For information on Shared Responsibility, visit www.sharedresponsibility.gov.co

One in twenty-five London injectors infected with HIV

Widespread use of crack cocaine has been identified as a primary reason for the recent rise in HIV among injecting drug users. Around one in 25 IDUs are infected with the virus in London alone, with many unaware they are carrying it.

According to a report by the Health Protection Agency, elsewhere in England and Wales has seen a steep climb in the HIV virus from one in 400 in 2003 to around one in 65 in 2005. One in 50 IDUs in the UK is now infected with HIV and almost half with hepatitis C.

The report blamed the sharing of contaminated needles, syringes and other injecting equipment for the rise in infections, as well as an increase in injecting into the groin. Many people were unaware they were carrying infection because of late symptoms of both HIV and hepatitis C, highlighting the importance of needle exchange services. The prison vaccination programme had been effective in increasing protection against hepatitis B among IDUs.

Compiler of the report, Dr Fortune Ncube, said links between crack cocaine use and virus infection were a concern as use of the drug increased. HPA Chairman, Sir William Stewart, added: 'There is an immediate need for research and development programmes to evaluate the required mix and coverage of interventions that aim to prevent infections, including specialist drug treatment, needle exchange schemes and targeted outreach.'

The full report, Shooting Up, is online at www.hpa.org.uk

Many ignorant to the devastating effects of Hepatitis B

A government campaign addressing the health problems of Hepatitis B, has revealed that almost 90 per cent of respondents know very little about the illness.

YouGov, who commissioned the survey for the campaign B Aware, demonstrated that out of 2,279 adults, 86 per cent were unaware of its existence, 89 per cent did not realise it could eventually lead to cancer and 83 per cent were in the dark as to whether the hepatitis B virus is more infectious than HIV.

A typical survey question asked: 'Can hepatitis B be prevented through vaccination?' to which the respondents had to state whether they strongly agreed or not. Almost half were unaware that this statement was true.

With about 180,000 UK citizens acutely infected with the virus and an estimated NHS annual expenditure of anything from £26 million to £360 million, the campaign stresses the importance of public awareness.

Chairman of the Hepatitis B Foundation UK, Professor Arie Zuckerman, said: 'We are calling on the Department of Health and chief executives of the NHS to take action, by introducing universal vaccinations against hepatitis B in line with most of Europe and other countries improving public health education and providing better facilities for treatment of the disease.'

For more information on hepatitis B visit www.hepb.org.uk

Media Watch

Aberdeenshire has seen a recent rise in pregnancies among women using crack cocaine. According to the Children First Project, midwives have been referring one pregnant crack cocaine user every month since May this year. Project service manager, Elaine Chalmers, said that the rise is due to the drug's association with increased risk-taking and sexual activity. 'All their babies born so far have been addicted to opiates and spent between three and seven weeks in hospital after birth,' she added.
Community Care Live Scotland News, 1 November

Horwich Town council are tackling underage drinking through an innovative two-month campaign targeted at adults who buy booze for teenagers. Staff, within the town centre shops, will wear t-shirts inscribed with a slogan informing shoppers that buying alcohol for teens is a crime. Bernard McCartin, Town Mayor, said: 'I think the campaign will make a difference and will remind people what they are doing is wrong. I cannot understand why adults do this. We have a lot of alcohol related anti-social behaviour in the town centre which we need to stamp out.'
The Bolton News, 25 October

Wardens working at an historic park in Abington have to pay extra attention to their litter crisis as a group of youths leave behind dirty needles and cannabis butts. Workers at Christ Church say that the area has become a meeting point for users injecting drugs and smoking cannabis. Colin Best, who works as a warden has resorted to personally collecting the needles and installing a sharps box in the church hall: 'The children who come to church run around here and could pick anything up, and often the women in the congregation wear open-toed shoes,' he said.
Northampton Today, 1 November

Scottish pupils have devised a case to demonstrate to the members of the Scottish parliament how ridiculously priced alcohol is in comparison to soft drinks. The MSPs, who have agreed to take into account the concerns of the school pupils, heard how booze in Glasgow can be cheaper than that of a soft drink. One of the pupils who worked on the case, 17 year-old James McKee, said: 'at these prices, kids can buy alcohol with their lunch money.'
Scottish Evening Times, 31 October

A Freckleton teenager, who broke into a derelict prison officers' club to steal alcohol, gave himself away by leaving his mobile at the scene of the crime. After triggering the alarm system at Kirkham Prison, the 19-year-old fled the scene, but failed to notice he had dropped his mobile phone, which was later traced back to him through forensic evidence. His defending solicitor, said: 'It is quite bizarre to have someone enter a prison to commit an offence. I have not heard anything like it.'
Lancashire Evening Post, 30 October

Tell it like it is!

What are the big issues for the drug and alcohol field? What affects you? What would you like to put to policymakers? As DDN hits its second anniversary issue, we want to know.

Over the past two years we've seen progress, optimism and deep frustration in equal measure.

Getting to know our readers has brought us close to problems that have led to closure of some much-valued services, and to near closure of others. Some areas of the drugs field have seen the carpet of funding pulled from under them; alcohol services are still holding out hands for support that was never easily offered in the first place.

On the other side of the fence, we've talked to policymakers in government and the NTA to hear why the political machinery works as it does – why some services are cash starved, why budgets are delayed and what might happen in the future.

Every fortnight more than 11,000 copies of *DDN* are posted out, with over 30,000 readers, according to our readership survey at the end of last year. From government departments, to treatment agencies, to family support units, to prisoners in recovery and right round the criminal justice field, our network of readers has grown.

Research recently commissioned by the Home Office has shown that practitioners want more dialogue with policymakers and more input to development of policy. *DDN* and FDAP will work together to address this need and will be launching a readers' questionnaire in the next issue. Hearing your views on the issues you want tackled will enable us to frame questions for policymakers starting in the new year.

Home Office research also showed *DDN* at the top of a list of the field's information providers: we want to build on that role to give you a truly interactive communication channel. Recently we've been finding out more about what happens to people leaving treatment; what takes them out of the revolving door of addiction and crime and into society where they can have a home, a job, decent neighbours – a chance of self-support and self-respect.

We want to address challenges facing the field in an open and constructive way, and we'll need your input. We aim to get to the heart of the issues that matter to you by opening debate through the pages of the magazine. **DDN**

Our partner organisations are active in diverse areas of the drug and alcohol field, supporting and advising service users, families, young people, treatment services, medical professionals and local networks. They lobby for fair treatment and better standards and represent people from all walks of life affected by substance use. We asked them to get the ball rolling by telling us about their key concerns.

FDAP:

Workers have to be competent

The biggest challenges currently facing the field from FDAP's perspective are the NTA's workforce qualifications targets and 'up-skilling' first-line managers to be able to use DANOS and related occupational standards in developing the competence of front line workers.

Workers can demonstrate their competence through FDAP's Drug and Alcohol Professional Certification, the OU/FDAP Professional (Competence) Awards, or the NVQ in Health & Social Care – but the first priority for the field as a whole should be on developing the competence of the workforce by making sure their managers are skilled. To this end, FDAP has joined forces with a number of leading consultants and trainers in the field to set up the Competence Group – to help find ways of supporting managers to perform their roles more effectively, to the benefit of both frontline workers and the clients they work with.

LDAN:

Funding must back up treatment successes

Top of the agenda is funding, given the ending of the drug strategy and ongoing lack of funding for alcohol treatment. LDAN is continuing to press local authorities and government for adequate funding for drug and alcohol services, by demonstrating with members' help, that treatment works.

Diversity is also on our agenda. It's a big issue for London especially, and we have plans to promote the diversity agenda through a special publication and forum. But by diversity, we are not just referring to minority groups. Treatment needs to focus on the needs of families and carers, as well as individuals.

The Federation:

Give alcohol the priority it deserves

Over the last year The Federation has involved itself in workforce training and developing relationships with mainstream organisations, to help them address equalities and diversity. From our work nationally, it is clear that alcohol is seen as in need of priority, in balance with other substances. Despite the impact of alcohol misuse being equally if not more devastating than other substances, it is evident that strategically alcohol continues to be given a secondary (or even tertiary) position.

Another area for all of us to prioritise is that of new communities that are being formed in the UK. The changes and issues that have already occurred between first, second and third generation migrants to the UK are well documented. Many of these changes and issues are mirrored across cultures, and targeted work needs to take place to prevent future problems and to demonstrate that we have actually learnt something from the vast array of research that exists.

Mentor UK:

Young people's needs can shape policy

Mentor UK will continue to channel its energies into preventing today's young people from becoming tomorrow's problematic drug users. We work directly with policy makers, academics, government and international organisations, local community groups, children and families.

We will soon be publishing findings from 12 pilot projects on mentoring and parenting in coastal and ex-mining areas, and we are developing support for grandparents who care for children in families with substance misuse problems, in partnership with Adfam and Grandparents Plus. In September 2006, Mentor held its first Alcohol Misuse Prevention Awards Ceremony, supported by Diageo Great Britain. The Awards scheme will run again in 2008. Our work in protecting children from drug-related harm is as crucial as ever.

Our Young People's Reference Group will make recommendations to policymakers and MPs to make sure their voices are heard.

Release:

Government should listen to expert advice on drug laws

In October the government took a late u-turn in its proposed presumption of intent to supply thresholds. We believe this highlights the need, identified by Release in our parliamentary briefing on the Drugs Bill back in February 2005, for early consultation with experts in the drugs field and the criminal legal profession. Perhaps this might lead to a situation where ill-considered proposals are not made to look foolish in the tabloid press?

Home Office junior minister Vernon Coaker rejected claims that the current drug classification system is outdated and not fit for purpose, expressing his view that it is effective and coherent and allows for 'clear and meaningful distinctions' to be made between drugs. How can this be when magic mushrooms and crack cocaine are together in the most dangerous group? And alcohol is advertised enticingly to the young and cigarettes are legal for children to purchase?

Alliance:

Treat users with respect

The key campaigning priority of the Alliance remains to promote the right of users to be treated with dignity and respect, and to ensure that an individual's unique needs are the central influencing component of any treatment plan. And this will remain our priority as long as we receive calls from users who are being threatened, compromised, bullied or punished by those very professionals that they have turned to for help.

The challenge is always turning the empty rhetoric of political support into the essential reality of financial security, but we'll get there. The Alliance simply has to survive.

SMMGP:

Momentum must continue on advising GPs

The past year has been busy, exciting and full of successes for SMMGP. The project has matured and strengthened in many ways, responding to the New NHS, the GP contract, the NTA quality agenda and the Healthcare Commission Reviews. But many of these have been overshadowed by ongoing uncertainty about future funding.

Our position in being able to provide good information about our sector of work has been further enhanced by *Network* with its increase in high quality clinical articles and inclusion of shared care and pharmacist columns. The SMMGP website is now the leading clinical site in this field in the UK, with a massive increase in visitors since its launch four years ago.

Our advisory work to areas has had to stop immediately because of lack of funds and our greatest challenge for the future is maintaining a high-quality practitioners' network on reduced funding. We will certainly give it our best shot!

WIRED:

Give a voice to those affected by substance misuse

WIRED believes in empowering and creating a voice for those affected by drug and alcohol misuse. We are taking up the challenge of developing a national programme of multimedia personal stories and developing an empowerment web community to provide information, support and tools for users, ex-users and their families and friends.

We want the experiences and views of those affected to help shape practice and policy, and increase awareness and understanding.

Our world leading service Daily Dose, and collaboration with *DDN* will support these aims. We want to encourage service users, providers and others to get involved.

Adfam:

Help services to support families

Adfam has moved to new premises in Old Street and continues to expand – we will have 17 staff by the end of the year. Despite the growth, funding remains a real issue – especially for core campaigning and lobbying activities.

Adfam's priority for next year will be highlighting and helping commissioners implement the NTA Commissioning Guide for Carers Services and the NOMS Toolkit for working with offenders families. Coupled with continued campaigning to have the importance of working with families recognised, especially families of alcohol misusers, and a broadening of the training we offer substance misuse professionals, 2007 promises to be exciting year.

Contradictory NTA

I am writing in response to Paul Hayes' letter (*DDN, 9 October, page 8*), which seems to make some strange and contradictory statements.

He says 'unfortunately it is difficult for us to act'. But the NTA is acting. They are actively supporting the current process of allocating capital funding to increase capacity in the Tier 4 sector. I would suggest that this is possibly the 'bizarre' and 'ill-judged' behaviour that should be challenged and reviewed.

Throughout his letter Paul refers to opportunities to increase capacity, problems of ineffective commissioning and concerns about the use of existing provision. So concerns do exist about the use to which this element of the treatment system is put. He even makes reference to 'access to an adequate and reliable revenue stream'. Where is this additional revenue going to spring from in the current funding climate within the NHS?

Why is it in the face of apparent confusion around the use of existing capacity, the apparent reliance on data reported to Bedvacs, and the admission from Paul that there are problems with commissioning tier 4 services at a local level, that we are still looking at spending substantial amounts of public money on creating more beds that will be under-used and ineffectively commissioned?

As a professional care management company operating predominantly in the private treatment market, we come into contact with a number of Tier 4 providers who provide services across both the private and publicly funded market. It has been our experience that some of the highest quality providers in the country, providers that the NTA should be promoting nationwide as examples of practice to be mirrored, are struggling to engage with local commissioners, struggling to engage their NTA regional manager with their service provision and confused as to why they are finding it so difficult to maintain houses at a workable level of occupancy.

Anecdotally it would seem that as well as there being a lack of understanding about Tier 4 provision amongst community workers (the letter following Paul's) there is a great deal of ignorance of the Tier 4 provision among commissioners and, dare I suggest it, the NTA nationally and regionally.

Having worked in treatment provision, DAAT management, commissioning and strategic planning arenas for the past 11 years, I have watched as the development of community services has been driven from the centre. I have watched as budgets have been increased and the NTA expanded to drive the message of quantity, quality and effectiveness – but with little focus on Tier 4 provision across the country. There has in fact been a noticeable lack of guidance, drive or focus on the provision of residential/in-patient services until very recently.

The blame does not lie solely at the feet of the NTA. However, as the 'performance managers' of the sector, surely there is a responsibility to address matters of capacity, quality and commissioning realistically? The Tier 4 sector is difficult for individual DAATs to engage closely with. Often provision is a distance from the DAAT and few DAATs have sufficient knowledge of it to be able to assess quality effectively. Surely the NTA also has an interest in ensuring that additional funding being made available is being used as effectively as possible.

£54.9m may not be a huge amount of money in the bigger scheme of things but I and many people I have contact with regularly are concerned that it is not being used effectively to address the issues that undoubtedly exist within the residential treatment arena.

Quality residential treatment exists. Capacity can be increased by ensuring that revenue is targeted at those centres of excellence that will then re-invest this revenue and expand naturally to cater for commissioners' needs, and ultimately a better understanding of the sector needs to be promoted by the NTA.

Spend the money where it is really needed. Commissioners will of course be developing bids that appear to indicate there is a need locally; the money is there and people are very well aware that if it is not spent it will be lost. I have sat in on a number of meetings recently where the nonsense of the whole process is frightening, as providers and commissioners paint a picture of juggling with revenue streams to justify bidding for something that already exists in neighbouring areas, or at least within reach.

Slow the process down, develop a clear picture of the system, educate the workforce (commissioners and community providers), consult far more widely with the Tier 4 providers, promote quality that exists – and please ensure that patient need is raised to the fore when considering this extremely effective treatment modality.

Ben Hughes, operations director, treatment-now.com

NTA: No Treatment Available?

I have tried to resist getting into a tit for tat argument with Paul Hayes but his response (*DDN*, 9 October, page 8) to my piece on the residential funding crisis (*DDN*, 25 September, page 9) was not entirely satisfactory. If you have known about a problem for five years or so, but done nothing about it, it does suggest that somebody should be asking why this should be so. Similarly, since the NTA's Business Plan for 2005/6 drew attention to the likelihood of disinvestment by social services departments and PCTs, why were steps not taken to minimise this identified risk?

Turning to another topic, it may be interesting for others to know about our experience in respect of the Tier 4 capital bids. I had already identified the problems around the so-called consultation process in the South West region and, in particular, the severe time limitations and partnership support requirements. Having been in a position where we were actually able to put a proposal together in the few days allowed for expressions of interest, we submitted to the North Somerset DAT our plans (fully costed) for improvements in the dining, catering and recreational facilities at Barley Wood. About a week later we received a rejection on the basis that our proposals did not fit with current DAT priorities.

Perhaps this is hardly surprising, since most providers were not involved in the consultation process. We thought we would enquire as to the reason for this instant rejection and subsequently received feedback from the NTA's South West regional office. This told us that our proposal for a gym/sauna would enhance client experience and promote health, but it was not supported by anybody. This left us a little confused, since we had not asked for monies to develop a sauna in the first place. To find also that questions were being asked about what difference the sauna would make to retention rates and outcomes, was even more perplexing.

On a more serious note, this is quite ridiculous and illustrates the inherent shortcomings in the Tier 4 capital programme. It is rushed, poorly managed and, as far as the non statutory sector providers are concerned, can be pretty well self-defeating. If the agency cannot get the support of local bodies who have not consulted the agency in the first place about establishing priorities, the expression of interest, let alone the bid, will fail. Additionally, if the body responsible for managing these funds is capable of coming up with a bid that did not exist to start with (in our case, the sauna), this does not instil a great deal of confidence in their financial management.

There is a need for an immediate curtailment of the capital programme as it currently stands and the implementation of a properly thought-through and professionally managed system for assessing priorities and distributing the funds that the Department of Health has been persuaded to release for this purpose. In the meantime they might also wish to consider if this money might be better used to ensure the continuation of current services.

Brian Arbery, chief executive, ADAPT

Victim of the 'Danos effect'

A huge round of applause for Kevin Flemen, for highlighting the 'DANOS effect' (*DDN*, 23 October, page 6). I have recently moved from my home town of Nottingham to a different city, after handing in my notice at a well known drug and alcohol rehabilitation clinic. My plan, or so I thought, was to find another job in the same field with ease, based on my extensive six and a half years experience in my previous role.

I have knowledge and practice (from scratch) in assessment of client suitability for treatment (detoxification and group therapy) using a variety of audit tools and common sense. I have knowledge and practice of motivating clients for treatment and also in mini-interventions, conflict resolution, family therapy, legislation, drugs and the effect it has on the client and society, care planning, keyworking, and liaison with relevant agencies – to name but a few.

But alas it would seem my knowledge is totally and utterly irrelevant, due to my lack of DANOS qualification. Until recently I was a member of FDAP. Again irrelevant! What am I to do? I have no job and

am unable to gain access into my chosen field because apparently I don't have that shiny piece of paper that gives employers a glint in their eye in assuming that all people must be employable because they have DANOS!

I have worked with some awful DANOS trained people who are (wrongly) safe in the knowledge that they are 'good' at their job because they learnt it from a book! Whatever happened to common sense, and in the words of Kevin Flemen, 'personal attributes'? It all counts for making a good employee and should not be based on the fact that you are DANOS qualified.

All people working in the drugs field should be given the opportunity to work towards DANOS and not be pushed into it. Its a case of 'teaching your grandma to suck eggs' for a lot of people and a bloody insult to be turned down for employment based of the misconseption that you are 'unqualified' without DANOS.

So where does that leave me and my six and a half years experience working as a frontline employee? It would appear that I will now have to go back to the drawing board and re-evaluate my future career as it doesn't look very likely that it will be in my chosen field!

Regards to Kevin Flemen.

Caroline Knight, Midlands

PS (Somebody giz a job.)

Power struggles nothing new

It was with mixed feelings that I read Kevin Flemen's commentary (*DDN*, 23 October, page 6). There are a number of areas where I both share Kevin's concern, but also where I fear we may well disagree strongly.

The tensions that exist between qualification and competence; accreditation; and the freedom to practice, are not new. The power struggle to define who has the authority and expertise to deliver practice (and indeed who has the power to ratify what should be practiced) is one that has been experienced by our colleagues in most other fields. The accreditation and achievement of qualifications are central to the power struggle. They are, as Kevin recognises, the currency by which membership and inclusion can be purchased.

Establishment of competencies means that someone has to establish quality standards, so that expertise can be recognised and rewarded. The key issue is that expertise is recognised in an inclusive way. The value of a formal system of qualification and standards lies in its ability to be inclusive and to be critical.

I have no expectation that the formation of this system will be comfortable. Everyone involved in the field has a significant investment in their current status, and this investment is both emotional and financial. Do I like the fact that financial investment dictates service provision and standards? No! Do I accept that this is the way it currently has to be until significant political change occurs (on a global scale)? Of course I do!

Kevin rails against money being fed into 'key bodies'; those of us who train, educate and accept the validity (not uncritically) of accrediting bodies. However my response to this is straightforward: I currently teach at both FE and HE levels; both courses are brand new, neither existed when I was a full-time rehab worker. It took me two years of 'learning on the job' to understand that which my students learn in a matter of weeks. How many clients lost out as the result of the lack of a formal training and qualification system when I was a rehab worker? I shudder to think!

The argument surely is not whether organisations and practitioners should be 'motivated' to attend the courses and achieve the accredited qualification; the argument should be how we ensure that the courses are delivered with appropriate rigour. For this to be achieved, an accrediting body is vital.

There certainly is a mechanistic quality to the DANOS we currently have, but that is not the only quality. If DANOS were conceived to be the one and only qualification without reference to any other, then I would agree with Kevin. However, my experience as a member of a workforce planning group, and my experience with FDAP (seeking accreditation for the HE course I lead) have given me no indication that this is the case. DANOS addresses core competencies but they do not preclude other skills. They are the starting points upon which (at last) wider skills and knowledge are being slowly constructed.

Expecting practitioners to know intimately the full range of interventions is a recipe for disaster! DANOS enables key basic knowledge to be put in place first. Once this has happened then practitioners can look at building deeper theoretical knowledge and practice skills. The support by the Sussex regional DA(A)Ts for the course I lead at University of Brighton, is a clear indication that the developmental process aims beyond just DANOS.

Unfortunately it can be real, and sometimes wilful, lack of participation that limits the process. Will organisations and practitioners have to question their assumptions when they undertake DANOS? Yes! Is this for the purpose of creating unreflective, uncritical, limited and unskilled practitioners? Absolutely not – not on the courses I, or any of my colleagues, deliver!

Daren Britt, Senior Lecturer in Substance Misuse, University of Brighton

Learning to tick boxes

Good luck to Kevin Flemen in his fight against so called qualifications that are more to do with learning how to tick boxes, than helping people to come off of drugs (*DDN*, 23 October, page 6). Training in assessment, and screening for alcohol, and/or drug addiction, whilst learning the differences between addiction and dependency, together with training in the application of the Cycle of Change, and the different models of therapy, including 12-step facilitation, that the authors recommend at each stage in the cycle, are what is required rather than politically correct psycho babble.

I wish Kevin well, and admire his integrity and courage in his endeavours.

Peter O'Loughlin,
The Eden Lodge Practice

Anchor project clarification

I am replying to Dr Rupert White's letter 'Creating danger zones' (*DDN*, 11 September, page 9). I would like to clarify a few issues that may have been either misunderstood or possibly ambiguous in my original article.

First of all, in the case of risk, no pregnant woman, women with young children with or without social work involvement, would be discharged from the Red Zone or taken off a methadone prescription in our Tier 3 service, however badly they are doing in treatment. There have to be extreme circumstances. Everything possible is done to engage the extremely vulnerable, such as clients with physical health problems, those who are HIV positive and those with blood borne viruses such as hepatitis B and C. Clients with a diagnosed mental illness can remain indefinitely in Red Zone and on a prescription and will also receive the support of MIND and assertive outreach CPNs from the Mental Health Services.

The probation service requires that criminal justice clients attend appointments with a worker twice a week in line with their own Drug Rehabilitation Requirement (DRR) or Drug Treatment and Testing Order (DTTO). This group remains in the Red Zone all though treatment. Some take a while to engage and still longer to give clean samples but if they drop out of treatment, they are likely to be breached. We still continue to work with people who have been breached and are expecting a prison sentence.

With regard to generic clients in the Red Zone, no-one who loses their prescription is left without treatment of any kind. After their prescription has been stopped, they are offered the services of Addaction, the Tier 2 Service. This provides one-on-one counselling support, enabling the client, after a period of four weeks or more, to re-engage with the Anchor Project, if appropriate.

The old model, of allowing all clients to come and go as they pleased in the erroneous and costly belief that 'something would stick one day' did the client no favours and caused horrendous bottlenecks and high caseloads for overwhelmed staff. In addition, methadone spilled over into the street and some years ago there were quite a few cases of methadone deaths in Sandwell. It was mooted that as clients were not on supervised consumption, a number of them were selling their methadone prescription for heroin.

As things are now, supervised consumption in Phase 1 of Red Zone limits the risks and is more focused on compliance with medical treatment. A comparison audit of the old and the new systems using the Christo questionnaire has indicated a considerable improvement in treatment compliance in the zoning approach and improved psychological and social stability. The reason that the NTA in the Midlands endorses the zoning system is because it is safer and because it works.

Jane Benanti, chartered counselling psychologist/ lead psychologist in substance misuse, The Anchor Project, Sandwell Mental Health NHS & Social Care Trust

I came across your magazine on the web and want some advice. I suspect my teenage son is taking drugs, something he vehemently denies. I need to know the truth and have heard about drug-testing kits (and seen them advertised online). Can your readers advise me if this is a sensible approach?
Ruth, by email

Guilt, shame, denial

Dear Ruth,
Your situation is tricky and obviously one that has you in emotional turmoil. Although many substance users are in denial of having a problem, there are many that would admit to being a user. Yet admitting to your mother that you are using drugs would be a very difficult decision due to many factors including guilt and shame.

The approach of using a drug testing kit could have adverse repercussions regarding your relationship with your son. You could take a step back and offer your son the normal support he needs in a mother to son way without discussing drugs. Being there for him and supporting him would give him the confidence to ask for help if he does find himself with a drug problem.

As you did not give any reasons for your suspicions it is difficult to advise regarding this issue, and I was also wondering if you considered that your son may be telling the truth.

You are obviously a very caring mother and if you feel you need support yourself you can log on to 'Talk to Frank' on the internet to find organisations where you can get this support.
Ian Bowerman, Full Sutton

Keep talking

Dear Ruth
It is a positive sign that you are having doubts over the drug testing kit and asking for advice. Situations like this can cause major family problems.

I think that trying to discuss the problem would be a better option than going down the drug testing road. Your teenage son is turning into a young adult and honesty and trust would help him to open up to you.

I work with young people who sometimes face being accused of taking things they have not and it can cause serious conflicts and mistrust in relationships – even professional ones.

In some cases young people are put under pressure that may tempt them to try illegal substances. As a result, one option is to try and discuss the situation, or to contact your local young person's substance misuse service for a drug and alcohol awareness session or advice in general.

I hope my advice helps in some way and good luck. I work for Drug Sense, a young persons service; if you get stuck give me a ring on 01484 353 353 and I will try help you out the best I can.
John, Lifeline, Kirklees

Mutual consent

Dear Ruth
You can't stop your son taking drugs. But you can help him make better decisions.

The important thing is to keep talking. If you do prove that he is taking drugs – or he proves that he isn't – what will be left of your relationship? You will need to be strong and clear-headed whilst he will need to feel safe and trusted, if the pair of you are going to be successful in addressing issues.

The nature of the drugs test tends to imply guilt before proving innocence – so unless done by mutual consent it is easy to create more problems than are solved.

How much do you know about drugs? There is a world of difference between a joint at a party and developing dependence. If you are coming across indicators of drugs misuse, be aware that they may be due to other reasons. If you suspect injection is involved then get in touch with your local DAT for immediate advice and referral.

We have collated a range of approaches to intervention alongside drugs information in our CD-ROM – The Drugs Box Intervention Toolkit. If you contact me (mal@thedrugsbox.com) I will send you a copy free of charge to help you look at ways in which you could approach a further discussion with your son.
Mal Williamson, The Drugs Box

Alienation risk

Dear Ruth
Teenage behaviour can be difficult to understand. You are not alone in concluding that problem behaviour must somehow be attributed to drug use. Parents are often frantic and feel that testing will confirm their worst fears; if proved right, what then?

As a drugs worker for a young person's drug service, this request is often raised by a parent at their wits' end. However, if there is strong evidence, then my advice to you is to assume that there is every possibility that a test would be positive. Communication and trust are vitally important within the parent to child relationship and an enforced drug testing is most likely to push your son away.

Contact your local drugs service as they should be able to provide support for you in your own right; also written information that could be given to your son will provide him with options of a confidential service.

Hang in there! The fact that you are looking for advice says that you are a caring parent seeking solutions.
Val Appleton, drug worker, Better Deal Young Peoples Drugs Service, Doncaster

Home testing

Dear Ruth,
Some of the kits available over the internet are very unreliable and I personally would not recommend going down that route. Yet, if you do choose to go ahead with testing your son, we have a home testing kit, which is the same accuracy as the ones used in drug treatment centres.
Joseph Boyle, Quantum Diagnostics Ltd

Tread carefully

Dear Ruth,
Tread carefully. You are obviously keen to know if your son is using drugs but maybe not so keen to listen to his answers. Some drugs stay in the body longer and therefore, by asking your son to take a test it could give you either a negative or positive result – he could be using and give a negative result if the drugs have left his system or could abstain from using if he knows a test is imminent.

However if your son vehemently denies using drugs, could he be telling the truth? It is worth contemplating on the message you are giving your son if you test him; it is quite clearly a message saying you don't believe or trust him. You did not say what leads you to suspect drug use. Could there be problems in your son's life that is changing his behaviour?

Even if your son is using, the secret is not to panic. It's not uncommon for young people to experiment with drugs and it doesn't always lead to addictive use. Forty per cent of young people try cannabis but not all go on to use it.

It is important to create a climate of trust and honesty to enable him to talk about his problems. I think this is how you find the truth and not through a drug test.

If he feels that he is trusted, he is more likely to disclose any problems. An open conversation showing your concern is likely to achieve far more than a drugs test, which may give you a result – but at what cost to your relationship with your son?

Tread carefully and show him your care and concern, but don't lecture him. Let him know that when he is ready you will be there for him. Trust him to tell you what is wrong when he is ready.
Mel Riley, counsellor and drug worker, Wolverhampton

If you don't like the answer...

Dear Ruth
Rather than offer advice, which would not be specific enough because the dynamics of your relationship are unknown, I wish to pose some questions that may help.

The first question you should ask yourself is: 'What will I do with the information gained from the test?' The reason for this question is because it is the same question your son asks and answers in his head when you ask him if he is using drugs.

What do you think your son's response would be and do you think his answer would be the same as yours; if not, what could change that? A drug test will only give you one answer to one question. Therefore, if your son does not want you to know that answer, then what damage does this answer do – and how productive would it be in terms of your relationship and the effect it would have on his drug use?

Another question would be: 'How much knowledge do you have about drugs, and do you think your son is using?' The more knowledge you have, the more discussions you and your son could have about drugs and their effects. As a result, rather than the topic 'drugs' being a challenge to him, it might turn into a non-judgemental discussion which would help your son feel more confident about talking to you when he is ready – and not when you catch him out.
Scott, DIP senior practitioner

Reader's question

As a worker in the drugs field I sometimes suspect that clients may be behaving in a way that poses a risk to themselves and to others – behaviour that could mean that they or I do not have the protection of our confidentiality policy. For example, I suspect that at least one of my clients has hepatitis C and may be sharing their works, or is sexually active in a way that may put his partner(s) at risk. Can readers give me any advice as to whether I should be reporting this to someone, and if so, who? Please don't say 'my manager' as I'm sure she would have the same question.
Jane, by email

Email your suggested answers to the editor by Tuesday 14 November for inclusion in the 20 November issue of DDN. New questions are welcome from readers.

Carol & Mike Werner

Towards a state of **independence**

Giving people the skills they need to live and work in the community is Adapt's purpose from the minute they enter 'The Diana' centre in Norfolk. DDN visits a rehab with a mission.

Down wide corridors of a former TB sanatorium, light airy bedrooms house residents at Adapt's Diana Princess of Wales Centre in Norfolk. There is an air of optimism and independence about the place; some clients are relaxing, some catching up with the personal paperwork of answering family letters. Others are bustling back and forth with ladders and paintbrushes, or on their way to the kitchen. One young woman is using her professional hairdressing skills to give other clients a trim in a room set aside as the salon.

All the signs are of a functioning community, and chief executive Brian Arbery bristles with fatherly concern as he introduces his clients by name, praising them on their progress and nagging them gently to stay on the straight and narrow.

The man with the paint pot, he explains, illustrates Adapt's mission. Plucked from a life in the criminal justice system, he has been given new purpose by the team at 'The Diana'. Progressing through his stages of treatment, he now also has a much-needed job repairing the outside fabric of the centre. He knows he's needed; he stops by only long enough to explain the maintenance work he's doing – and to add that the centre has saved him from a life of perpetual incarceration.

At the end of the corridor from reception, unit manager Michelle Prentice unlocks the door to the detox rooms. This is where clients begin their voyage of self-discovery, face-to-face with a doctor who will support their detoxification and integration to the main house.

This first stage usually takes three or four days – 'or a bit longer if they are in psychologically poor shape'. One new client looks weak and confused as Arbery engages him in gentle conversation about seeing his brother at Adapt's sister centre, Barley Wood. The other recently admitted client shifts uncomfortably from bed to sofa and back. Later in the afternoon it emerges that they have both tested positive for continuing to take drugs at the centre, so will need further intensive support in detox before they are ready to embark on the rest of the programme.

In the main, clients join the rest of the community as quickly as possible so that they grasp the idea of rehabilitation – and the possibilities that go with it for them as individuals. Once they come into contact with counsellors the hard work begins, using a combination of cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR), and 12-step themes.

'We usually have a limited time and a chaotic client,' explains head of counselling, Anna McGee. 'There are huge underlying trauma issues… we look at their limits. There's often a blind spot and CBT can help to identify what drives drug-taking behaviour – attitudes such as "I believe I'm not worthy", "I believe I will always fail", or "I can't win without cheating".'

With support from their peers to help sustain abstinence, the goal of self-reliance draws nearer through 12 weeks of the primary programme. Then, at the outskirts of the sprawling building, many clients stay for another three months of extended care. This is where clients learn to take on independent living, honing their skills, getting training, remaking bonds with families and finding the support networks they need. They have guidance on how to access the employment system, finding their way through job seekers' allowances and 'new deal', until they are on their feet.

Arbery has a longer term vision for a 'treatment village', where volunteers gradually move to paid jobs. 'The Diana' has 24 acres of Norfolk countryside rolling towards the coast, and there are more buildings on site that could be converted – if the money was there. Adapt is struggling through the funding crisis alongside so many other residential rehabs; the admissions office explains how phones have been quieter, accompanied by a drop in places.

The ongoing mission is to make sure that even if funding ends suddenly for a client, the charity does not let them fall. Having given them new expectations of life, the responsibilities are huge: 'Many people come here with debts and heavy responsibilities. It's a massive task to sort out all parts of their life', explains Arbery. 'Even the basics like getting a building society account or a copy of their birth certificate… life is very hard for them to engage with, without any support.'

'Often clients are shunted onto a day programme without having a chance,' he adds. 'Here they use their skills – painting, plumbing, making window frames, hairdressing, cooking.' At this aftercare stage, clients 'grab a counsellor when they need to' and ties with the centre are loosened.

While the culture at the house is not punitive, there is a structure of senior peers and a house leader, and incidences of relapse invoke an inquiry that could be followed by discharge if there is no serious interest in sticking to the rule of abstinence.

'There have to be boundaries within the chaos. But we don't like to be authoritarian, we work as a community,' says Michelle Prentice, the unit manager. 'We give clients trust and have expectations in return.'

It's all part of the programme of kick-starting their independence.

'Drug addicts have learned helplessness,' says Prentice. 'They need to learn being responsible for their actions. We're into motivational interviewing – getting people to think about their recovery and where they're going.'

Talking to a client who's packing his case to leave the extended care wing, the optimism is obvious. 'I came here with a tracksuit, a plastic bag and 50p, referred through Hackney DIP,' he says. 'I'd been in rehab before, but then I went back through the system.

'This time it's been different – I realised it's all down to me. I want my life to be different now.' **DDN**

Turning off the tap

Many drug users want to detox but can't face a difficult withdrawal from methadone. *David Wright* shares the difficult journey from his decision to become drug free.

Dirk v. Mallinckrodt

Waiting for a simple reply from Home Office for my diamorphine script had drained nearly all of my life's energy. My consultant had helplessly watched my mental and physical health deteriorate over the last two and a half years as my methadone had simply stopped working on me.

Four years before, after a meeting with a past consultant and my GP, the Home Office/Department of Health instructions were, 'we don't want to go down the diamorphine road yet, so raise his methadone from 150 to 200ml, then if that doesn't work 250ml, and if that doesn't work he can have a diamorphine script.' Or words to that effect.

Eighteen months later I was feeling ill on 250ml of methadone. In the past, methadone had saved my life by getting me off shooting up street heroin, most of the time in filthy conditions. It had given me time to get my head together (well as together as it can get) by becoming a trained drug advocate working for a voluntary 'open drug clinic' in Cardiff called Inroads. I was writing a newsletter for drug users called the *Heroin Herald*, which seemed to be well accepted, all of which could not have been done without methadone.

However, now I was at the end of my rope. The diamorphine was not happening and I was becoming clinically depressed – so much so, that I was admitted into St Madocs psychiatric hospital as a mentally ill patient suffering from a dual diagnosis depression and anxiety caused, I think, by a physical and mental reaction to my methadone. I was a desperate, lucky man – lucky because there were only two detox beds in this hospital, which happened to be empty.

I was so relieved that I would no longer have to suffer this living hell my life had become; at last I was given a chance to make my life better. But to do it, I had to become opiate/opioid free. Seeing as I was on around half a pint of methadone a day, things were not going to be easy. However I was in for a pleasant surprise.

The last time I did an opiate detox

in this hospital, eight or nine years ago, I was under a different consultant. He relied heavily on a drug called Lofexidene, which in theory slows the brain from producing adrenaline. You see, when you are taking opiates daily (heroin, codeine, morphine) or methadone which is an opioid, your body stops producing endorphins, its natural pain killer, because you are putting external painkillers into your body. When you stop taking the heroin or methadone it takes the brain around nine days to realise you have no painkillers inside you and that it must start producing the natural endorphins once again. During this time you have at least nine days of the sheer hell of being in a body with no painkillers, so your nerve endings just throb with that terrible pain.

Because opiates suppress your brain's production of adrenalin, people who get stoned on gear sit still and generally don't move around too much. But when you stop, the brain's adrenalin floodgates open and you can't sit still. The drug Lofexidene is supposed to help by slowing down the adrenalin rush. But methadone is such a strong drug that I find all the Lofexidene does is prolong the rush so you still end up agitated and not being able to sleep or keep still. My last detox I was doing laps round the TV room at 2.00am to help burn up the adrenalin. The night staff ignored me when I was going through this hell.

My new consultant did things a different way, so I would not need to fight a noradrenalin storm. He told me that we had 80mls of valium to play with, but I must leave some for PRN ('pro re nata', meaning 'as the occasion arises') – *ie* when the patient needs medication outside the four medication times, which would be 8.00am, 1.00am, 5.00pm and finally 10.00pm bedtime medication.

So I thought from past experiences of methadone reduction that I was OK with my meth holding me till around 4.00pm. Therefore I decided to have a high dose of 40ml of valium at teatime and leave out morning and lunchtime meds, which would give me 40ml of PRN left over. After a lot of juggling around, the consultant wrote me up for 20ml for around 7.30pm and 20ml for 9.30pm PRN, if I needed it.

As for my methadone, the consultants gave me the power to choose my own reduction rate. I had been on 250ml so I decided to come down 5ml every two days, which is just over 15ml per week. This at first was no trouble at all. In fact the first couple of weeks I was gouching out all day in the baking hot weather, lying on a hospital sheet and with a pillow, outside in their lovely garden. I had a room to myself so I could read (if I could keep my eyes open enough) write and meditate. Things were looking good and I felt very positive.

Things started to feel uncomfortable when I was down to 190ml. I began to struggle with the withdrawals, which started around 4.00pm with the wave of sweats running through my body. I then started to get the cramps in my stomach and my mood was agitated. So the nice nurses not only gave me the medication for the cramps, but also gave me my 40ml of diazepam an hour early. At this time I found that I needed one PRN of 20ml of diazepam about 7.30pm. So I had 60 ml of diazepam inside me, which did the trick.

Then it was 10.00pm and time for my nighttime meds, which at first consisted of one 5ml tablet of Nitrazepam, and 15ml of the antidepressant Mirtazapine. I was also given Ibuprofen to help with the aches and pains – although when your legs are aching to the bone with opiate withdrawals, Ibuprofen does not scratch the surface. Only one opiate-based drug would stop the aches, which of course would defeat the object of the detox.

When I hit the difficulties at 190ml my consultant doubled my nitrazepam to 10ml, which made sure I got a good night's sleep. I also froze the methadone dose for a period until my body caught up with the reduction.

At St Madocs they have two detox beds. The rest of the beds are for the mentally ill having psychotic episodes. Most are on some kind of restraining order that means if they leave the ward grounds the police are informed and sometimes they even send the helicopter to find them. I am classed as a voluntary patient, which means I can discharge myself if I want to. This in a way makes it harder for me when I am going through a bad time knowing I can walk out at any time – and believe me there have been times where I have had to get out of the place for a few hours.

Being in one of the only two detox beds, I was at the time the only patient that did not suffer from psychotic episodes. Because of the lack of specialised detoxification wards, we drug users have to make do with trying to detox on acute psychiatric wards surrounded by psychotic patients. If that's not bad enough, for a while I was surrounded by psychotic patients stoned out of their minds on dope. There was one patient bringing in the weed and she was totally open about it: 'I have smoked weed everyday for over 30 years and they ain't gonna stop me now.' The typical hospital small dingy smoking room got full of dope smoke, so people were getting stoned without even having a toke. Passive smoking was the order of the day.

'I had been on 250ml so I decided to come down 5ml every two days, which is just over 15ml per week. This at first was no trouble at all. In fact the first couple of weeks I was gouching out all day in the baking hot weather, lying on a hospital sheet and with a pillow, outside in their lovely garden. I had a room to myself so I could read (if I could keep my eyes open enough) write and meditate. Things were looking good and I felt very positive.'

This had serious implications for me; if I gave a positive urine sample for cannabis I would be discharged. So I tried to avoid the smoking room as much as possible and smoke in the garden. I was not always able to, as sometimes we were locked in if a patient had gone off their head.

I am in total control of the rate of reduction of my methadone. When I start to hurt I can either stop the reduction or slow it down. If I feel on top of things I can speed up the reduction. Making me the controller is just pure common sense: I am empowered to make my detox as comfortable as possible, therefore I have far more chance of having a successful detox than if I had no input. Twenty-first century medicine in practice, at last.

I am now at the intermediate stage of my detox, which I am doing as an outpatient. I will still be reducing, but at a much slower rate. Here again the choice is mine on how fast I come down. At the moment I am on 120ml which is just below the halfway mark I started from. In hospital I have managed to reduce 130ml in just under four months.

The plan is to stay on 120ml for a couple of weeks until I adapt to living on the outside. You see, at the hospital I had everything done for me, I was fed good food, cups of tea were brewed up every few hours and I had my drugs brought to me. On the outside I have to do my own shopping, adapt to being on my own in my flat and walk into town everyday to pick up my script. Getting back to the very basics of survival is a drastic culture shock.

The hardest thing is creating a new life for yourself and you have something to do everyday. So I have gone back to my voluntary work in Cardiff as a drug advocate and am gathering stories for my next Heroin Herald newsletter.

There is so much us drug users have got to fight for: adequate pain relief; making sure people don't have their methadone scripts stopped for using heroin; getting better treatment for hepatitis C. But I know that if I can achieve what I have done in the last six years, other drug users can as well.

David Wright is a freelance drug advocate in South East Wales and volunteer with WIRED. DDN published his 'diary of a heroin user' from 21 March–30 May 2005, which can be viewed in back issues on our website, www.drinkanddrugs.net
To get in touch and see the latest issue of Heroin Herald online, enter 'Heroin Herald' in your search engine.

Working lives:

Manjit Singh Johal, service user officer in Derbyshire

Manjit Singh Johal is a service user involvement and advocacy officer at Derbyshire DAAT. He shares a career that transformed his personal desperation into far-reaching peer support.

I will start at the beginning of my recovery, on 4 December 2002. I had been accessing treatment in Derby city, trying to get in to residential rehab. I had tried getting clean through methadone, but kept using crack and smack. I was then told there was no funding, so I was made homeless. My wife and my children did not want to know me, so I left Derby to get clean. I found a bedsit and went cold turkey.

I was being supported by an ex-user that I knew, who was volunteering for a aftercare project. I was going to Narcotics Anonymous meetings every day and being supported by ex-users. My friend who was a trained counsellor worked on my underlying issues; I also got a sponsor to help with my addiction.

At six months I enrolled on to the Gear Change Project, a course for ex-users. This broke me in slowly by giving me taster courses such as food hygiene, health and safety, and first aid at work. I then did basic training drug level one and two, a ten-week introduction to counselling, followed by the one-year certificate. At one year clean I was starting my level three (DANOS) advanced certificate in substance misuse.

Before starting college, my friend had asked me what I wanted to do in my life. I said 'what you do'. He had motivated me and empowered me to believe in myself, which I thank him for!

I had started volunteering with my friend, and we had noticed that not many BME drug users were staying in services. So we set up a self-help group for other BME users, which we called BAC-IN (Black and Asian Cultural Identification in Nottingham) in 2004. There was me, Sohan and Gladstone.

We needed our own forum to share and look at the cultural issues BME users face in addiction. When group members felt confident enough, they then moved into the other services with support from BAC-IN members. We set up the BAC-IN website this year at *www.bac-in.co.uk* for more information.

Sohan did the therapeutic counselling to individuals and Gladstone and I did support, advocacy and family support to the parents. The project grew to be funded by Nottinghamshire DAAT to offer support and counselling to DIP BME users. BAC-IN then worked with Lifeline to deliver the *Ask* report, which was research into the BME community in Nottinghamshire. We were also commissioned by UCLAN and the Home Office to do the *Reach* report with support from Kate Davis and Yaser Mir.

I then finished my college work and there was an opportunity to volunteer at Nottingham City DAAT as the lead on diversity for six months, which I applied for successfully. Through this I was still supporting BAC-IN, building my relationship with my children and family, and also building my own personal self, in terms of recovery. While at the DAAT I had met another ex-user who was five years into recovery, which made me feel more inspired to succeed in life.

In recovery I was given support through my journey by people such as my college tutor Christine, Sohan, Steve Youdell at the DAAT and Anna Knowles. These individuals put so much hope into my life that I knew if I kept on talking to them when my head was full of doubt, I would be OK. Things would work out for me if I did not use again.

I left the DAAT to work for Addaction in Derby city, but felt this was not for me. So I went to work for a resettlement house, working with individuals who were coming off class A drugs. I worked there for nine months, then saw a job at Derbyshire DAAT for a service user advocacy involvement officer. I was appointed and had to set up user involvement from nothing, as there was no level of involvement there.

I thank Steve Youdell for introducing me to service user involvement in Nottingham City; I used the same method he had to develop the groups I was involved with. In Derbyshire we now have five forums throughout the county.

We have a quarterly newsletter, service users sitting on the DAAT Board with carers, and service users involved in setting up the Buddies for Addicts in Derbyshire (BAD) project. This has now been funded by Awards for All to deliver buddying support to those who are affected by substance misuse issues.

These achievements are down to the experience and support I received. I just used the same skills and empowered our service users to realise that they too can overcome addiction, to be successful in whatever they want to be.

How did you get into the field? Email the editor, claire@cjwellings.com

Conditioning models of addiction: Part 3

In this Background Briefing, Professor David Clark describes how stimuli associated with the pleasurable effects of drugs can strongly influence behaviour.

In my last two Briefings, I looked at two ways that classical conditioning may be involved in problematic substance use or addiction. I described the conditioned withdrawal model, as well the concepts of conditioned drug-opposite responses and conditioned tolerance.

In the conditioned incentive model of addiction, proposed by Jane Stewart and colleagues in the mid-1980s, environmental stimuli previously associated with the pleasurable effects of drugs become conditioned stimuli (CS) via classical conditioning processes.

These CS are considered to activate the same neuronal pathways in the brain that mediate the direct pleasurable effects of drugs, albeit weakly, and they thereby elicit a motivational state that directly primes drug-taking behaviour. The CS are positive incentives that drive drug use.

Thus, when a heroin user sees the paraphernalia that they usually use for administering the drug, the paraphernalia act as a CS that elicits feelings somewhat similar to that triggered by the drug itself, which result in the person wanting to use the drug.

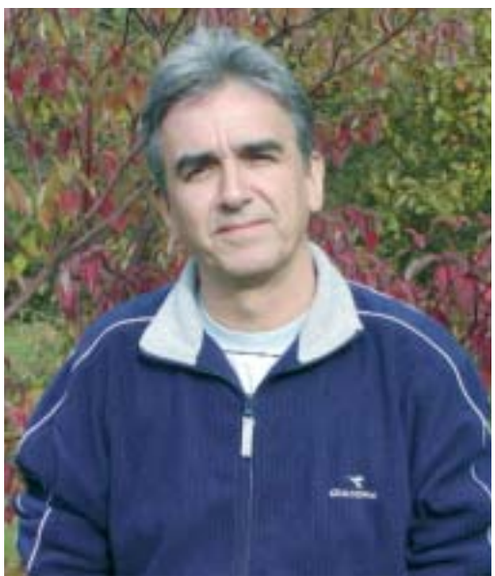
The present model is derived primarily from incentive motivation theory, which was developed on the basis of work with laboratory rats using natural reinforcers such as food. This theory asserts that organisms are motivated by incentives, stimuli that predict a primary reward. The motivation is the expectancy of the primary reward, be it food or drug.

Thus, one person may want to eat a doughnut when they see the bakery assistant who regularly sells them their favourite vice, while another person may want to inject heroin when they see their regular dealer.

There is considerable evidence from animal research that positive incentive effects of drugs motivate drug-seeking behaviour.

In the place conditioning paradigm, rats are introduced to a three-compartment box, containing two end compartments with distinctly different environments (light walls, grid floor *vs* dark walls, smooth floor), and a smaller 'neutral' central area. The time spent in each of the end compartments is measured over a 15-minute period, and one side is assigned as the original least-preferred side.

In subsequent sessions (days one, three and five), animals are administered a drug of abuse such as amphetamine and restricted to their original least-preferred side for 30 minutes. On days two, four and six, they are administered an inert substance (saline) and restricted to the original preferred side.



'Wanting' is not "liking" – a person may strongly want a drug without actually liking the experiences that it produces.'

On the following day, the rats are given free access to all parts of the box, with the time spent in each end compartment measured. When given this free choice, rats show a shift in preference towards the side in which they had received the drug – even though no drug was administered in this test session.

These studies demonstrate that a wide variety of drugs of abuse (*eg* amphetamine, cocaine, heroin), as well as natural reinforcers such as food, can induce place conditioning. Thus, environments associated with the pleasurable effects of drugs, or natural reinforcers, become positive incentives that motivate approach behaviours.

We can safely assume that animals find the effects of drugs of abuse to be pleasurable in that they will learn to perform specific tasks (*eg* pressing a lever in a Skinner box) to obtain intravenous injections of drugs of abuse such as amphetamine, cocaine and heroin. They also learn to respond to a stimulus (*eg* a light) that was previously associated with their lever presses for drug.

Brain dopamine neurons, in particular those projecting from a midbrain region known as the ventral tegmental area to forebrain regions such as the nucleus accumbens (mesolimbic dopamine neurons), are thought to play a major role in mediating drug self-administration.

Terry Robinson and Kent Berridge, two leading researchers from the States, propose that the primary role of mesolimbic dopamine neurons is to mediate what is called incentive salience.

Incentive salience is a characteristic of the mental representation of a stimulus that allows it to become attractive and wanted, thereby eliciting approach behaviours towards a specific goal. (A juicy piece of apple pie possesses a high degree of incentive salience – at least to me!)

In their incentive sensitisation model, Robinson and Berridge propose that drugs of abuse produce a long-lasting sensitisation of the neural system mediating incentive salience (mesolimbic dopamine system), so that the incentive salience attributed to drug-taking and to drug-associated stimuli become pathologically amplified, leading to compulsive drug-seeking and drug-taking.

The sensitisation of incentive salience can occur at the same time that the pleasurable effects of the drugs are diminished, due to the repeated drug administration producing tolerance to this effect.

In fact, these researchers emphasise that the neuronal systems responsible for excessive incentive salience are dissociable from the systems mediating the pleasurable effects of drugs. 'Wanting' is not 'liking' – a person may strongly want a drug without actually liking the experiences that it produces.

Moreover, it is also proposed that the wanting system can be activated and influence behaviour without a person having conscious awareness of ongoing processes.

A considerable degree of animal research has been focused on drug-induced sensitisation, and the incentive salience model is very popular among neuroscientists. While it has been argued that there is little evidence in humans supporting the model, this is in part due to a difficulty in testing the ideas.

Recommended reading:
Robert West (2006) Theory of Addiction. Blackwell Publishing. (Available at discounted rate from the DDN bookshop at www.drinkanddrugs.net.)

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Lifeline Calderdale

Lifeline Project Ltd has a national reputation for effective and innovative interventions with people who use substances.

Lifeline Calderdale's Young Persons' Service works with young people and families affected by substance use, offering advice, information, harm reduction, prescribing and diversionary activities

Team Leader Salary: Pts 32 - 38, £25,437 – £29,859

Taking a lead on service development and delivery, you will have an interest in and an understanding of young people and substance use and a creative, problem solving-approach. If you have a good grounding in young people's substance use and think that you have the qualities to lead people in developing a flexible and exciting service model then we welcome your application.

Family Worker Salary: Pts 26-31, £20,895 – £24,708 (Pro Rata, 20hrs/week)

Developing a newly commissioned family service you will have experience of working with vulnerable adults or young people and you will establish provision for parents and young people affected by substance use. You will have the ability to engage, advise and support families and take the lead on developing a flexible programme of activities, group work and training.

For an application pack please send an A4 SAE with 2 x 1st class stamps to: Helen Newby, 9, Ferguson Street, Halifax, HX1 2EE
CLOSING DATE FOR APPLICATIONS: 9am Monday 27th November 2006 | Interviews will be held w/c 4th December 2006

Lifeline welcomes applications regardless of race, colour, nationality, ethnic origin, gender, sexual orientation, marital status, disability or age. All applicants are considered on their merits and abilities for the job.

Calderdale Drug & Alcohol Action Team

Cowal Council on Alcohol & Drugs

Counselling Practice Supervisor

Ballochyle House, Dunoon
17.5 hours per week
Salary Scale AP5: £23,739 – £25,857 pro rata per annum
dependent on experience.

CCAD is committed to providing high quality practice supervision to ensure that it continues to operate within a recognised ethical framework for good practice in counselling. Your duties will include attending standards meetings, providing individual and group supervision, client assessment, and you will be expected to carry your own case load.

You will be an accredited counsellor who has achieved a nationally recognised standard of competence in counselling supervision and have a minimum of one year's recent counselling supervision experience. Your training and experience must specifically include alcohol and drug counselling.

Please phone 01369 704406 for an application pack.
The closing date for returning applications is
Friday 1st December 2006.

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Ballochyle House, Kirk Street, Dunoon, Argyll, Scotland PA23 7DP.

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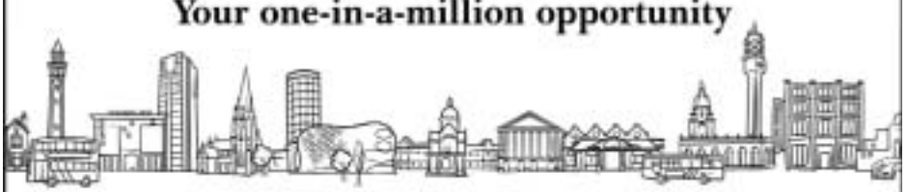

Community Services and Resilience

Drug Intervention Programme Training Officer

£29,859 - £34,986

You will be required to support the Drug Action Team (DAT) Training and Workforce Development Manager in implementing both the DAT Training Strategy and the DAT Workforce Strategy. In particular developing programmes and commissioning training for tier 1-4 drug treatment staff and working with clients accessing through care and aftercare treatment DIP provision. Along with this, you will also encourage the involvement of service users/ex-users and affected others.

You should be educated to degree level or equivalent in a relevant discipline or able to demonstrate equivalent experience in a Health, Criminal Justice or Social Care setting coupled with experience of working in the substance misuse treatment and/or coercive treatment field.

An excellent track record of devising and delivering training and education programmes within a criminal justice and/or social care and health setting is required along with demonstrable experience of working with a wide variety of statutory and non-statutory partner agencies.

Informal enquiries to Angela Hylton, Birmingham DAT Training and Development Manager, on 0121 675 1803.

For an application pack, please visit the Birmingham City Council website on www.birmingham.gov.uk/jobs If you do not have website access, please telephone 0121 464 1111 (8am - 8pm Monday to Friday) quoting reference J0893DD.

Closing date: 17th November 2006.

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Birmingham City Council

in-volve

RESPOND – AFTERCARE WORKER

Full Time Salary £27,000 per annum

Respond is an adult integrated Substance Misuse Service in Eastern Surrey. One full time Aftercare Worker is required to support clients through the challenges of living without substance misuse and strengthen the recovery process. This may involve giving support with benefits, housing, relapse prevention, rebuilding relationships and learning new skills. You will be registered as a nurse, or qualified as a health professional, or have relevant experience within the substance misuse field

For further information please ring
Sarah Watson on 01372 379739 or email
watson@respond.in-volve.org.uk
Closing Date: 24 November 2006

Mimosa Recovery

Mimosa Healthcare Limited

Due to the expansion of our Alcohol Treatment Services into Yorkshire and the West Midlands we are seeking:

Residential Unit Managers £28 – 32k

The successful applicants will be responsible for all the day to day running of the units including Finances, Health & Safety. Staff Training and Programme Management. The successful applicants will be accredited by, or working towards accreditation by FDAP or equivalent professional body. Applicants with a First Level Nursing background may apply for roles within the Detoxification Units.

Addiction Therapists £21 – 25k

The successful applicants will be required to work in a multi-disciplinary team providing 7 day a week abstinence based treatment programmes, be accredited or working towards accreditation with FDAP or similar.

All applicants will be required to apply for a Disclosure at enhanced level from the Criminal Records Bureau.

To apply please email a C.V. along with a covering letter to SueAllchurch@lynwoodmanor.co.uk

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Annual Drug & Alcohol Professionals Conference 2006

8 November

London

fdap.org.uk

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DDN Drink and Drugs News

RHOSERCHAN

Required: Counsellor

Rhoserchan has been offering 12-Step residential rehabilitation for drug/alcohol dependent clients since 1988. We are now embarking on an exciting new development and are seeking an enthusiastic and experienced counsellor to join our team.

Our ideal candidate will be qualified to Diploma level, and suitably skilled to work in first and second stage rehabilitation. The ability to speak Welsh will be an advantage.

For further details and an application form please contact: Anette Rumble, Rhoserchan, Capel Seion, Aberystwyth, Ceredigion, SY23 4ED. Tel. 01970 611127

INVITATION TO TENDER

TIER TWO OPEN ACCESS SERVICE

Buckinghamshire County Council

The Buckinghamshire Drug and Alcohol Action Team (DAAT) invites tenders for a Tier Two Open Access Service.

The contract is expected to be awarded for the period 1st April 2007 – 31st March 2010, subject to annual review and ongoing funding.

Final date for receipt of requests to participate is 5 p.m. on Friday, 17th November 2006.

Please contact: Helen Bold, Contracts Team Leader, Procurement and Commissioning, Buckinghamshire County Council, County Hall, Aylesbury, Bucks, HP20 1YG or email hbold@buckscc.gov.uk

The closing date for the receipt of tenders is 12 noon Monday, 18th December 2006

Enquiries about the service should be addressed to: James Sainsbury, Bucks DAAT Joint Commissioning Manager 01296 382780 or email: jsainsbury@buckscc.gov.uk

Kent and Medway NHS
NHS and Social Care Partnership Trust

East Kent Community Alcohol Service
St Martin's Hospital, Canterbury

Specialist/Highly Specialist Alcohol Therapist

Ref: R996

Band 6: £21,985 - £31,004 p.a. pro rata or Band 7: £26,269 - £36,416 p.a. pro rata

Part-time 18.75 hours per week

Joining our multi-disciplinary and multi-theoretical team, you will deliver alcohol services across East Kent. You will need experience in the addictions field, a core professional qualification and to be able to show evidence of a commitment to working with this client group. With a Diploma level qualification in Addictions studies, or working towards such a qualification, you will manage your own caseload of clients.

The post requires the ability to conduct treatment in individual, group and family settings coupled with the ability to work collaboratively with partners in other agencies. You will be based at the Headquarters at Mount Zeehan in Canterbury but will be required to travel in addition to our satellite clinics across East Kent. You will need to demonstrate an ability to balance autonomous working with effective teamwork.

For an informal chat please call Bill Reading, Service Manager on 01227 761310.

The Trust positively welcomes applications from people who have experienced mental health problems.

TO APPLY:

We encourage applicants to apply on-line - go to www.kentandmedway.nhs.uk or contact our 24-hour Recruitment line on 01227 812244 quoting the appropriate reference number, or write to the Recruitment Team, Eastern and Coastal Area Offices, Littlebourne Road, Canterbury CT1 1AZ.

Completed applications by: 27 November 2006.

Employment in this post is subject to a satisfactory Enhanced Disclosure from the Criminal Records Bureau.

Car owner/driver essential, subject to the provisions of the Disability Discrimination Act (1995).

For other job opportunities visit our website **www.kmpt.nhs.uk**

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Drug Action Team

Provision of substance misuse services in Warrington

Expressions of interest are invited for the supply & delivering of Tier 2 & 3 services for substance misuse across Warrington. You must demonstrate a strong commitment to delivery high quality services, with a clear focus on crime reduction.

Numbers expected to be engaged with treatment are a minimum of 900 clients in the 2007/8 financial year.
Client criteria shall be set.

This is 1 contract commencing 1st April 2007 for 3 years (subject to DAT future funding allocations).
Collaborative procurement is invited.

For further information please contact:
Amanda Finch,
DAT Co-ordinator & Joint Commissioning Manager, Units 1,2,3, Warrington Business Park, Long Lane, Warrington, WA2 8TX
Tel: 01925 631 765
Email: afinch@warringtondat.org.uk

Tackling drugs to build a better Britain

Submissions in writing by must be received by 5pm on 01/12/2006.