DDN
Drink and Drugs News
9 February 2009
www.drinkanddrugsnews.com

PARTNERS IN CARE
Families and carers may be a drug worker's best asset

CALMING THE STORM
Understanding ADHD and its role in substance misuse

CHOOSING LIFE
Implementing a smoking ban in residential detox

FIGHT BACK

The only effective way to tackle hepatitis C is together

Your fortnightly magazine | jobs | news | views | research

University of Kent

CHSS
University of Kent
Centre for Health Services Studies

Training for Drug & Alcohol Practitioners

Programmes from 2008/09

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

Certificate in Substance Misuse Management (Stage 1)

This access level Certificate provides a broad introduction for practitioners who work with problem substance users, or expect to in the near future. The programme is delivered in Canterbury and across the UK where there are cohorts of 10 or more students. It is a recognised benchmark for those seeking an accredited qualification. The programme also offers beneficial training for all social, health and education professionals whose work includes contact with problem substance users.

18 month programme from September 2008 or by negotiation

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

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

18 month programme from September 2008 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the biological, psychological and social perspectives of substance misuse, within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions, against the backdrop of current research and thinking in the field.

2 year programme from October 2008

BSc in Substance Misuse Management (Stage 3)

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

2 year (top-up of Diploma) or 4 year programme from November 2008

For further information and an application form, please contact:
Ruth Webb on 01227 827466 or r.a.webb@kent.ac.uk
For a prospectus, timetable and application form, please contact Lisa Solley on 01227 824316 or l.j.solley@kent.ac.uk
www.kent.ac.uk/chss/abg

Design & Print Centre 105884 02/08

DDN
Drink and Drugs News

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

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

Reporter: David Gilliver
e: david@cjwellings.com

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

Advertising Sales:
Faye Liddle
t: 020 7463 2205
e: faye@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
Charlotte Middleton
t: 020 7463 2085
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Sebastian Kaulitzki

DDN is an independent publication, entirely funded by advertising.

PUBLISHERS:

CJ Wellings

PARTNER ORGANISATIONS:

fdap
Federation of Drug and Alcohol Professionals

wired in

SUPPORTING ORGANISATIONS:

Adfam
Alcohol Concern
The Alliance
ANSA
drugs and alcohol today
EATA
European Association for the Treatment of Addiction
The Federation
UDCM
Mentor
RELEASE
SMMGP

Editorial – Claire Brown

Voicing choices

Our second service user gathering was even livelier!

If you came to Birmingham for our Voices for Choices conference last week, thank you for helping to make it such a lively and enjoyable day. If you couldn't make it this year, we've snapshots of the action on our website, www.drinkanddrugsnews.com, including clips from the video booth – a fascinating insight to regional concerns and priorities.

We were thrilled with the response from the service user groups around the country to the invitation to come along and set up a display. It was a lively bazaar in there and we'll definitely be expanding that part of the event next year. The debates were even livelier than last year and our trusty band of volunteers (a huge thank you to all of you) had a great response to the consultation exercise that ran throughout the day. We're having the results analysed to provide a picture of service user involvement throughout the country, and will be sharing these findings in a special issue of *DDN* in a few weeks' time. There's so much interesting material we thought we'd take time to examine it in detail, so we can feed back to you what's working and what's not, and get your input on moving the user involvement agenda forward.

The question time sessions were very vigorous – and please remember we want your feedback to continue beyond the event. So much was packed into one day in Birmingham, but we've just started up our website forum, so we can look at issues as they come up and help to challenge where there are obstacles. We'll be including some online opinions on our letters page in the hope you will join in (see page 8).

Another new feature is the postcard from Cumbria, an idea that came from Martin Roberts during a chat at the conference. And that, for me, was the real buzz of the event – talking about ideas for DDN as well as next year's conference. More voices will lead to more choices, so let's get to work on the next one!

This issue


Page 10


Page 14

News in Brief

Different class

The government finally reclassified cannabis from a class C drug to class B on 26 January, despite a last minute attempt by scientists to persuade the House of Lords to block reclassification (*DDN*, 1 December 2008, page 5). The move is in response to concerns about the mental health of users and the effects of 'skunk', says the Home Office. Those caught with cannabis for the first time are likely to receive a warning, while subsequent offences will result in an on-the-spot fine of £80 and those 'with three or more offences on their record will face arrest if found with cannabis'. A conviction for possession could carry a five-year sentence, while selling the drug could mean 14 years in prison, with 'stiffer penalties' for selling near schools, mental health facilities or prisons. Release has described the on-the-spot fines as 'little more than a cynical money raising exercise, which will likely serve to punish those least able to pay.'

Barnsley beak

The first of four new pilot drug courts has been launched in Barnsley, with others to follow in Salford, Bristol and Cardiff. The dedicated drug courts are for offenders who commit low level crimes to finance their drug use and are designed to facilitate closer working between criminal justice agencies and treatment providers. The sentencing magistrate or district judge will also review the offender's DRR progress and, wherever possible, review breaches and deal with resentencing, with the idea that familiarity can build trust and confidence between judge and drug misuser. 'Offenders who are sentenced in the drug court will have committed crime to fuel their addictions,' said justice secretary Jack Straw. 'Many of the offenders concerned come from chaotic backgrounds where stability has been lacking, so continuity and accountability in the court is especially important. These dedicated drug courts will benefit the entire community.'

Evidently effective

A new report looking at what works best in effective substance misuse treatment for young people has been launched by the NTA. Aimed at practitioners and commissioners providing services for those under 18, the report looks at the evidence for effective treatment, with examples of good practice, and has been produced as part of the cross-government Youth Alcohol Action Plan. *Young people's specialist substance misuse treatment: exploring the evidence* available at www.nta.nhs.uk/publications/documents/yp_exploring_the_evidence_0109%5B1%5D.pdf

More monitoring needed to cut overdose risk

Arrangements for monitoring and supporting service users after they are discharged from detox need to be improved to minimise the risk of overdose, according to a report from the Healthcare Commission and the NTA.

There is a 'significant risk' of overdose if a patient resumes taking drugs after detoxification because their tolerance levels will be lower, and drug partnerships need to do more to minimise the risk according to *Improving services for substance misuse: diversity, and inpatient and residential rehabilitation services*. The report found that 68 per cent of partnerships did not monitor rates of overdose after discharge and 34 per cent did not ask community based services to carry out risk assessments for patients who had left detox services unexpectedly.

However 15 per cent of England's 149 local drug partnerships – where treatment is commissioned and managed by PCTs, local government, the police and probation services – were rated 'excellent' and 72 per cent 'good' overall in the report. Thirteen per cent scored 'fair', while none had an overall score of 'weak'. The NTA is 'working intensively' with the lowest performers, it says.

Around 16,000 people are estimated to access NHS inpatient detox or publicly-funded residential rehab each year, with the review rating 34 per cent 'excellent' and 59 per cent good. However 28 per cent of inpatient services and 41 per cent of residential services were either not reporting data or reporting incomplete data to the National Drug Treatment Monitoring System (NDTMS). Addressing this is a 'national priority' stresses the report, as NDTMS information is essential for effective strategic planning.

The document also found a 'commissioning shortfall' in terms of residential rehab services, with just 44 per cent of partnerships increasing their funding above the rate of inflation over the last five years. 'Some partnerships need to address shortfalls in their treatment planning to ensure there is appropriate access to this type of treatment for those who need it,' says the report. Partnerships scored highly on diversity issues, however, with 99 per cent carrying out needs assessments and meeting statutory obligations around diversity, and 91 per cent having access to a range of interpretation services.

'It is excellent to see drug treatment providers are serving their diverse local communities well, and that the quality of treatment is of such a high standard,' said Healthcare Commission chief executive Anna Walker.

'Having said that it is important to note that partnerships still need to ensure the risk of overdose after discharge is assessed and minimised for every patient, and to make sure that residential rehabilitation treatment is available to all who would benefit from it.'

Report available at www.nta.nhs.uk/areas/ standards_and_inspections/2007-08_review/hcc_nta_review_docs_jan_09/2007_8_substance_misuse_national_report_diversity_tier_4.pdf

No alcohol for under-15s, government advises

Children under 15 should not drink alcohol at all, according to new government guidance out for consultation.

The guidance states 'an alcohol free childhood is the healthiest and best option'. It also advises that, for 15-17 year olds, alcohol consumption 'should always be with the guidance of a parent or carer or in a supervised environment' and should be infrequent, 'certainly on no more than one day a week.' Support services must be available for young people with alcohol-related problems, as well as their parents, it states, and parents and carers also need advice on how to respond to their children's alcohol use.

'This guidance aims to support parents, give them the confidence to set boundaries and to help them engage with young people about drinking and risks associated with it,' said chief medical officer Sir Liam Donaldson. 'More than 10,000 children end up in hospital every year due to drinking and research tells us that 15 per cent of young people think it is normal to get drunk at least once a week. They are putting themselves at risk of harm to the liver, depression and damage to the developing brain.'

The guidance document, which has already drawn criticisms of 'nanny statism' from sections of the media, is based on the latest medical evidence and the input of a panel of experts – the Department for Children, Schools and Families is now asking for the views of young people, parents and professionals.

'Drinking among young people is a major concern for parents, many of whom have previously had no clear guidance on how to approach what can be a sensitive issue,' said Alcohol Concern chief executive Don Shenker. 'The guidelines will especially help parents who want to establish clear boundaries with their children and clarify that drinking above these guidelines carries increased health risks.'

President of the Royal College of Physicians and chair of the Alcohol Health Alliance, Professor Ian Gilmore, meanwhile called the consultation a 'unique opportunity to have a sensible public debate about the issues surrounding youth and alcohol'. 'It is also time for a much more holistic approach to tackling young people's alcohol consumption that brings together education, treatment and enforcement and public awareness of the potentially harmful long-term implications of heavy drinking during adolescence,' he said.

The consultation document is available at www.dcsf.gov.uk/consultations/index.cfm?action=conDocument&consultationId=1579&menu=1 until 23 April.

Twenty years later 'a third' still unaware of hep C risks

Around one third of people don't know how hepatitis C is passed from person to person, according to new research commissioned by the Department of Health. Nearly one in four people questioned in the ICM poll did not know that the virus can be transmitted by sharing needles, but one in eight thought it could be passed on through kissing.

A third of those questioned thought there was a vaccine to protect against the virus, while about one in six thought it could be transmitted through food or water. Meanwhile around four in ten were unaware that it hepatitis C could be transmitted via unsterile tattoo or piercing equipment.

It is estimated that around 100,000 people in the UK are unaware that they are infected with hepatitis C, and many infections are the result of drug use dating back decades – 'a legacy of our past behaviour', according to the Health Protection Agency (*DDN*, 12 January, page 4) – The Department of Health has launched a wide ranging awareness campaign – including radio and newspaper adverts – to coincide with the 20th anniversary of the virus being identified.

'Twenty years down the line, it's worrying to see the public still believe so many myths around hepatitis C,' said Hepatitis C Trust chief executive Charles Gore. 'Education is absolutely essential to eradicating this problem. We are pleased to see the Department of Health campaigning on this issue, but it's now time for both the public and health professionals to take action. We'd urge anyone who feels they might be at risk to get tested, and health professionals to be vigilant to diagnosing patients.'

Getting the message across: delegates made their voices heard at *Voices for Choices*, the second national DDN/Alliance service user conference. More than 600 service users, treatment providers and policy makers gathered in Birmingham to discuss the way forward for user involvement. Video footage, presentations and discussion are at our website, www.drinkanddrugsnews.com Full reports will be in our conference special issue, out on 23 March.

New Scots sponsorship guidelines for alcohol

The Scottish government and Alcohol Industry Partnership have drawn up new guidelines to protect young people from irresponsible drinks promotions. Scottish drinks companies and retailers have agreed to make sure alcohol brands are not used to 'sponsor teams, brands, celebrities or events with particular appeal to under 18s.'

Drinks companies have also agreed to carry responsible drinking messages 'on all point of sale communications'. Formed in 2007, The Alcohol Industry Partnership brings together representatives of the major brewers, distillers and retailers with members of the government.

'The Scottish Government has always recognised that the alcohol industry has an important role to play in the drive to create a culture where responsible consumption of alcohol is the norm,' said public health minister Shona Robinson.

'We also appreciate that the industry makes a significant contribution to the promotion of sports and the arts in Scotland, but this comes with responsibilities.'

The measures go further than the Portman Group's code of practice, and the government would monitor their progress 'with interest' as they were rolled out, she said.

Ms Robinson added however that 'self regulation by the industry alone will not be enough to get to grips with the spiralling problem of alcohol misuse in Scotland' and promised that new measures would be announced shortly.

Alcohol death rate drop after a decade increase

The trend in alcohol related deaths in the UK could be levelling out, according to new figures released by the Office for National Statistics (ONS). It follows more than a decade of sharp increases.

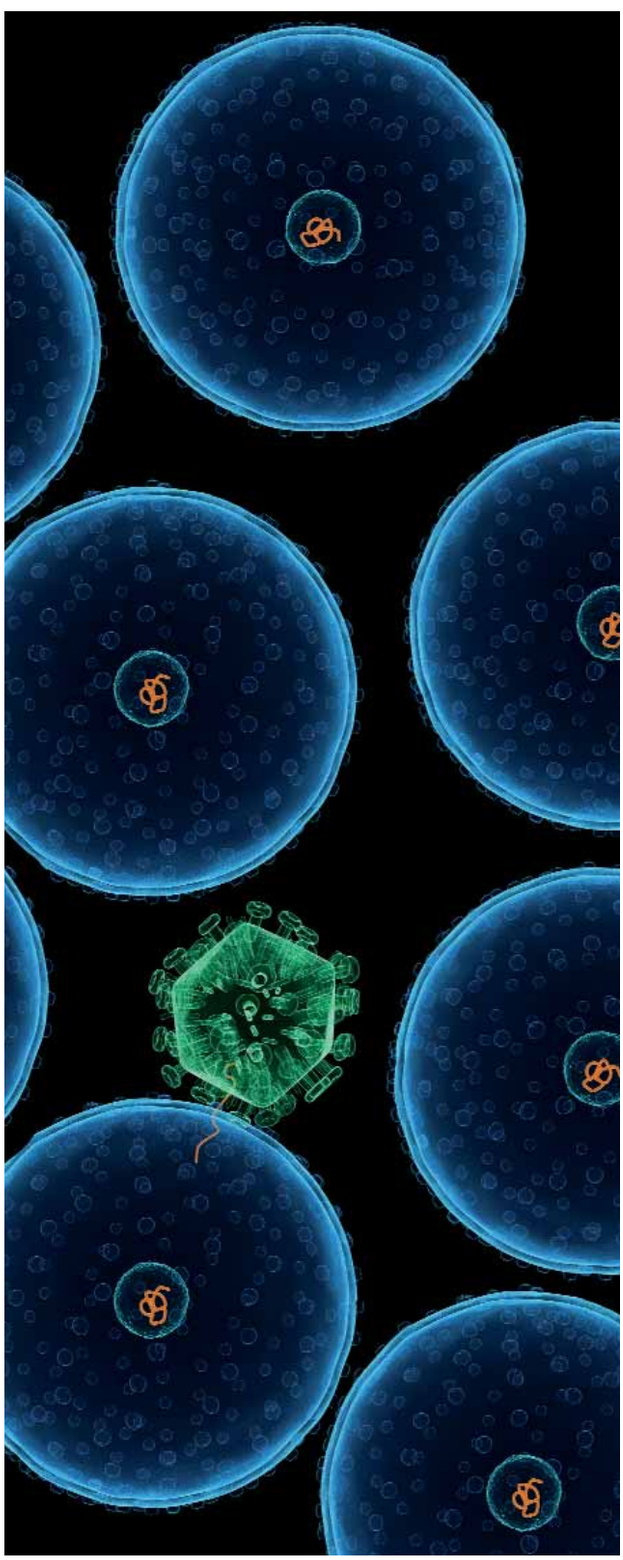
There were 8,742 alcohol related deaths in 2007 – a 0.1 per cent decrease from 2006. However the figure is still more than double that recorded in 1991. In 2007 the alcohol related death rate was 13.3 per cent per 100,000 population, compared to 6.9 per cent in 1991. The male alcohol related death rate was more than double that for women, at 18.1 per 100,000 (or 5,732 deaths) compared to 8.7 per 100,000 (2,992 deaths). The death rate for women has been steadily rising from 5.0 per 100,000 in 1991 while the male death rate has more than doubled in the same period. The figures are based on 'a harmonised definition of alcohol related deaths that has been agreed across the UK' says ONS.

The ONS has also released alcohol consumption figures from the 2007 General Household Survey that show a slight fall in rates of heavy drinking among men since the late 1990s, although rates are still much higher than among women. Alcohol related death rates for men are higher than for women across all groups, with the highest rates for both genders in the 55-74 age range. This is likely to be the result of 'drinking patterns several years ago,' says Alcohol Policy UK. 'Current levels of alcohol consumption are more likely to affect mortality rates in the years to come.'

www.statistics.gov.uk

Hep C: Fighting back

Greater Manchester has made hepatitis C a health priority by harnessing local services to work together. **Kathy Oxtoby** reports



Just three years ago, hepatitis C was not even on the health radar of the Greater Manchester area. Now it is one of the top 20 health priorities being tackled by the region's primary care trusts (PCTs), thanks to an ambitious programme that aims to improve services for an estimated 20,000 people living with the condition in the region.

The Greater Manchester hepatitis C strategy is funded by all 10 PCTs in the area, who work together to develop a collaborative and coordinated approach to developing local services. The strategy group is involved in several projects to improve services across the region, focusing on such areas as bloodborne virus prevention, testing, treatment, research, workforce development and communication.

Dr Erika Duffell, a consultant in health protection, helped to set up the hepatitis C steering group in 2005, which included representatives from the PCTs, drug services, DAATS, infectious disease services and the Health Protection Agency (HPA). Back then she recalls that while hepatitis C was a big issue for clinicians, drug services and DAATs, the condition 'hadn't hit the radar' of the PCTs and health commissioners.

'At that time, not much was known about hepatitis C and there was a lot of confusion surrounding it,' she says.

What was clear, however, was that Greater Manchester had among the highest prevalence of hepatitis C in England and Wales. A health needs assessment commissioned by the steering group in 2005 estimated that 0.8 per cent of people in the region had chronic hepatitis – higher than other areas where the prevalence is thought to be 0.5 per cent. Many of those individuals were undiagnosed and unaware of their condition.

The assessment looked at the whole remit of hepatitis C services – from testing through to treatment. For the steering group overseeing the work, 'that was when we realised we were dealing with an epidemic and a serious public health threat', says Dr Duffell.

The group realised that if action was not taken to halt this epidemic, in 20 years time the already stretched health service in the region would be unable to cope with the growing demand for resources and services to treat hepatitis C and associated conditions, such as chronic liver disease.

Based on the results of the needs assessment, a strategy was developed to address this 'hidden epidemic'. The directors of public health from all of Greater Manchester's PCTs gave the strategy the green light and financial backing – a move that Siobhan Fahey, the programme manager of the Greater Manchester hepatitis C strategy describes as 'exceptional'. 'It was the first time in England and Wales that so many PCTs had put their heads together to work on hepatitis C,' Fahey says.

One of the main thrusts of the strategy is prevention – so increasing the numbers of people being tested for the virus is seen as vital. For people with difficult venous access, which is a particular problem for substance misusers, a new dry blood spot test was developed. The test involves pricking the patient's finger and taking five drops of blood onto a special card.

The card dries for 30 minutes and then is posted to a local hospital laboratory where it is put into a solution and the liquid screened for antibodies. If this is positive, the lab will do a second test – a PCR – on the card to find out if the patient has the virus. The process, Fahey says, is simpler and easier than other testing methods and consequently means more people are being tested.

The test is now being rolled out in drug clinics across Greater Manchester, and it is hoped that by the end of March around 300 drug workers will have been trained to carry out the test, offer pre and post test counselling and give out general hepatitis C information.

By increasing tests, it is also hoped more people will receive treatment. The health needs assessment showed that just 200 people a year were being treated for the condition and feedback from drug agency workers showed greater need than there was capacity to offer treatment.

'It was clear that the majority of people with the condition were not in contact with treatment services,' says Dr Duffell, who as chair of the Greater Manchester hepatitis C strategy continues to oversee its development.

To help address this, the strategy group is looking at embedding services in hospitals and GP surgeries and is also considering outreach provision so that hard-to-reach groups get the testing and treatment they need.

As the strategy has developed, new schemes have evolved. A prison project has been set

up, where instead of inmates having to visit hospital under guard to be treated, a hepatitis C treatment specialist nurse is now in post to treat inmates in the four prisons across the region.

A research and workforce development project is also underway, which involves conducting a more detailed healthcare needs assessment and examining the training needs of those working with people with hepatitis C to help them carry out services more effectively.

Improving both professional and public awareness of hepatitis C is a key part of the strategy. 'Professional awareness-raising involves cascading out information to key professional groups, such as GPs, to increase their knowledge base about hepatitis C. It's a huge part of our work and we hope it will smooth the care pathway for service users,' says Dr Duffell.

To make more people aware about the facts of the condition, regular newsletters are produced and a website is about to be launched. The strategy's communications project also includes research into ways that target audiences, such as ex injecting drug users, would like to be communicated with. 'We hope to gain some interesting insights that allow us to really tailor our messages and how we put them across to people, so we can raise awareness,' says Fahey.

To support and sustain local hepatitis C support groups in the region, the University of Manchester, which is involved in a research project for the strategy, has employed community development worker Steven Miles. Part of his role is to help existing support groups become better organised – for example, helping them make the most of funding opportunities – and to encourage more groups to be set up.

Support is vital for people with hepatitis C and their needs, he says, are sometimes neglected because they lack the influence and power of other patient groups. 'Hepatitis C is a chronic condition that affects every aspect of an individual's life, so it is vital to have support groups to help give them a voice,' Miles says.

Jane Bird, from Sale, South Manchester, established a support group when she was diagnosed with hepatitis C in 2007. 'I wanted more support, but there was nothing in place. So I set up a group so that others in a similar situation can meet for a chat, and share experiences.'

Jane attends the Greater Manchester hepatitis C support group forum meetings along with representatives from other support organisations, to discuss ideas. Services user representatives also attend some of the steering group meetings to air their views on what improvements might be made. These meetings, Jane says, are 'really useful because they include the service users' voice and hopefully that means we can change things'.

Already, in the three years since the health needs assessment was carried out, so much has changed. The number of patients being treated has more than doubled from 200 to well over 400, while testing for hepatitis C is expected to raise diagnosis in the region. And treatment services are being embedded in more peripheral hospitals across the region, which Dr Duffell hopes will reduce inequalities in service provision.

Having a cohesive group of PCTs working together on the strategy is one of the main reasons it has been successful Fahey believes. 'Everyone is working together, which helps it to run smoothly,' she explains. The support of different professionals – drug workers, DAAT teams, patient representatives and specialist nurses – has also been essential to making the strategy work.

One of the biggest obstacles the strategy group faces is the lack of data about hepatitis C in the region, but there are proposals for a database on the condition and an audit to establish more detailed information.

Increasing the number of hepatitis C treatment nurses in Greater Manchester, offering more peer support for service users and making sure all key professional groups are appropriately trained are priorities as the strategy moves into its next phase of development.

And while Dr Duffell says raising hepatitis C from an unknown issue to the top 20 list of health priorities for the region's PCTs 'is a fantastic achievement', she stresses the drive to improve understanding of the condition across the region must continue – or the consequences will be dire.

'Raising awareness is at the heart of our strategy. It is fundamental to prevention. And without prevention we are never going to halt this epidemic.'

For more information about the Greater Manchester hepatitis C strategy contact Siobhan Fahey, programme manager. Email: siobhan.fahey@hmrpct.nhs.uk

For more information about support groups in Greater Manchester contact Steven Miles, community development worker, University of Manchester. Email: steven.e.miles@manchester.ac.

'It was clear that the majority of people with the condition were not in contact with treatment services.'

'I was badly in need of support'

Carl Curphey, from Whalley Range, Manchester, was diagnosed with hepatitis C in 2001. He believes he contracted the condition through injecting drugs such as heroin.

At the time he recalls there was little information about chronic hepatitis. 'I didn't know anything about the condition. So I just got on with my life,' he says.

It was several years before Carl was offered treatment, when his viral load increased dramatically. After 72 weeks he has just finished treatment. That course of treatment affected him 'profoundly', he says.

'There were constant side effects. I had to stop work. I had headaches and felt so tired it was hard to reach out for a glass of water when I was thirsty. I couldn't concentrate and felt depressed.'

Living on his own Carl says he was badly in need of support when he started treatment, but that no help was available. So he invited friends who also had hepatitis C to form a support group. This led to his being invited to take part in the Greater Manchester hepatitis C support group forum to meet with other groups and share ideas.

Carl has also taken part in a steering group meeting, along with key professionals and other service user representatives, to talk about the problems those with the condition have encountered and discuss the support they need.

The strategy, he believes, has had a positive impact on the region. 'It's helping to standardise treatment around different hospitals in Greater Manchester, it's trying to inform more people about hepatitis C and it's making waiting times for treatment shorter.

'And those involved with the strategy seem to be genuinely trying very hard to sort out problems for service users.'

POST CARD FROM CUMBRIA

Hello everyone, we are Cumbria Users Project, or CUP for short, a service user group that covers the whole of Cumbria, a place famous for the majestic landscape of the Lake District, Kendal Mint Cake, William Wordsworth and one of the Hairy Bikers, (the one with the glasses), as well as Beatrix Potter and the Pencil Museum at Keswick.

We have been in existence for nearly six years now. In that time we have been able to organise training and attendance at conferences for service users on a range of subjects including advocacy, overdose prevention, safer injecting, drug related deaths and hep C. Just recently nine of us attended the National Service User Conference, Voices for Choices, in Birmingham – we thought it was superb, we met some old friends and made many new and valuable contacts. Many thanks to everyone who worked so hard to make this conference such a success.

We meet up as a county-wide group every six weeks, and quite often representatives from service providers attend our meetings. Generally speaking there is much communication between service users and providers – quite a lot of it positive, it has to be said!

One of our main aims at the moment is to provide advocacy for service users – we were lucky enough to have Bill Nelles over from Canada last October to deliver a three-day training course in advocacy. We now need to put this into practice for as many people as possible.

We are funded by the Drug and Alcohol Action Team in Cumbria – it was obvious at the Birmingham conference that some local DAATs don't operate in the same way, so we would like to take this opportunity to thank Cumbria DAAT for taking service user involvement seriously.

We send our best wishes to all other service user groups up and down the land.

Martin Roberts – on behalf of Cumbria Users Project.

p.s. if you'd like to get in touch we're on the following email addresses:

allerdale@cabnet.org.uk (Maggie Messenger – Workington)
cup@edencab.cabnet.org.uk (Seth Gibson – Penrith)
martin.roberts.1@hotmail.co.uk (Ulverston)

Online opinions

A taster of our website forum at www.drinkanddrugsnews.com

I have just read the statement released yesterday by Paul Hayes, chief executive of the NTA (*Polarised debate is not taking drug treatment forward*).

So Paul thinks that all us professionals are so busy working in a polarised fashion that it is getting in the way of real progress. He seems to be of the impression that we are at opposite corners in the boxing ring (no doubt with the NTA acting as referee). Judging by these comments what he has failed to comprehend is that we, as a unified group of professionals, have real and valid concerns about the polarised approach to treatment that the NTA seems to be taking.

How can he state that 'it is incumbent on us to make sure that all is being done to open up routes to recovery' and, at the same time, create a treatment system where every client is fed through the same funnels in the same way? Why is it that when clients first access treatment and state they would like to be abstinent, they are instead put on a stabilisation programme?

How is this placing the needs of the client first? Why is it that abstinence based interventions seem only to be offered as a last resort? What would be so wrong in offering residential rehabilitation first, to those who want it, and then substitute prescribing for those who are not able to maintain abstinence? I realise this would be costly but what about the long-term benefits? Why can't we, at least, run some pilot schemes?

As for his accusation that our professional protestations mean we fail to see the 'bigger picture', we see it very clearly Mr Hayes, and we will not be silenced through tactical attempts to put a 'spin' on the issues by pitting us against each other.

I would be interested to hear what other people think.

Posted by KT

'Some truly horrific stories were read aloud without realisation that this can retraumatise the client, "triggering the hyper arousal" mentioned by Fran Miller.'

Big bang appreciation

I was overjoyed to read Fran Miller's 'The Big Bang' (*DDN*, 12 January, page 14). I worked in addiction treatment from 1991 and became perturbed by some traumas revealed in life stories – required assignments to be read to the group by newly detoxed vulnerable clients, with lack of knowledgeable support.

Some truly horrific stories were read aloud without realisation that this can retraumatise the client, 'triggering the hyper-arousal' mentioned by Fran Miller. Subsequent relapse or discharge results in repeated visits to A&E departments and all manner of labels. In addiction treatment, the entreaty to clients to 'let yourself feel the feelings' and other feedback is concerning, not to mention lack of the right support for opening up trauma never previously mentioned. Can we be aware that most client's defences do serve a purpose at the time?

This is a specialised treatment area which is only now coming to the awareness of agencies and thank goodness for Fran Miller's article. There have been articles about treatment for returning war veterans; possibly not half the story. Children growing up with addicted/alcoholic parents are traumatised by the effects of domestic violence between parents or towards themselves, either or both parents way out of control. Childhood sexual/physical/emotional abuse and bullying, accidents, abandonment are only a few possible triggers. Much depends on circumstances and support available at the time. Peter Levine's book *Awakening the tiger* is seminal.

If trauma has been revealed or suspected, clients need specialised treatment, mentioned by Fran Miller. Essential support is imperative; please never let a client feel ashamed or excluded if they relapse under the circumstances. Be aware of the content of life-stories with group facilitators and counsellors trained in the subject. Hellinger's Constellation workshops are documented to be very helpful if the leader has had training/experience, and literature abounds on the subject.

The experience of trauma is very often the trigger for addiction/alcoholism. Thank you very much for publishing this article.

Christine Wilson,
Hemel Hempstead, Herts

Criminal inconsistency

I would like to know exactly what's going on at prisons up and down the country regarding methadone prescribing for inmates, particularly inmates who are new arrivals and on relatively large amounts of this medication.

Just recently, I spoke to a service user who anticipated being 'sent down' following their impending court appearance. They were prescribed over 100ml per day of methadone, but had been advised that the limit within this particular North West of England prison was 40ml per day.

It's easy to see the potential problems here – someone who is stable on their medication suddenly gets only a third of what they need and they then start desperately seeking an illegal alternative in prison, as their stability and health status nosedive.

The prison staff have a much more difficult individual on their hands and the demand for illicit gear in prison moves up another notch.

And it's easy to see the solution too – why can't the prescribing doctor on the outside contact the prison doctor so medication levels can be matched? This would ensure consistency of care and be beneficial to everyone concerned.

I hope this matter gets resolved quickly, both locally and nationally.

Martin Roberts, Cumbria Users Project, Ulverston, Cumbria

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity.

Obituary

Andy McWilliam

The perspective of distance even though it is still only just over two months since Andy McWilliam's untimely death means that the we are able to begin to appreciate properly his immense contribution to the drug treatment field, both nationally but particularly in the West Midlands region.

Andy was not a local and as a result was not weighed down by some of the tribal tensions that are still a feature of many parts of this county. The Midlands, and Birmingham, was his adopted home and he was fiercely proud of the city, its people and their indomitable spirit. He was a fearless advocate for the rights of the disadvantaged, including their right to quality services and this light never dimmed and informed all his work. This light, often with a mischievous twinkle would surface in strategic meetings and could assist in bringing people back into the real world, inhabited by real people. He was not always an easy colleague as he insisted at all times in trying to view things through the service user's spectrum. He was an unapologetic advocate of harm reduction long before the concept became acceptable.

Andy's path into drug treatment work was not a conventional one. Andy was in almost at the beginning of Birmingham Drugline becoming their – and the city's – first outreach worker in the mid 1980s. From here he moved to set up and manage the Mary Street community drug team in the Balsall Heath area of Birmingham. From here he moved to Warwickshire in the late 90s helping to shape services in this area winning many friends in the process with his dogged persistence and warmth.

Returning to Birmingham in 2001, Andy became service manager for the range of community based services managed by Birmingham & Solihull Mental Health Trust. His knowledge and experience were immensely valuable in helping to ensure that partnerships took hold and he was fiercely committed to ensuring that individuals received the correct treatment irrespective of who was providing it.

From here it was no surprise when he secured an important position within the commissioning arena with Birmingham DAAT, and his vision and energy helped to ensure that care coordination became integral to the treatment system across the city.

In 2007, and keen to return to the coalface, Andy became the criminal justice development and operations manager for inclusion drug services. Reinvigorated at having the opportunity to shape things from scratch he was instrumental in helping secure additional contracts locally and nationally. He also took pride in the work that he was co-opted to do as an 'associate specialist' with the NTA and Healthcare Commission and his expertise was much sought after.

His death deprives his family, friends and the field of a loving husband and father, a loyal friend and a gentle human being. The outstanding turnout at his funeral on 6 November saw colleagues old and new come together as testimony to the man and the worker. He was, as we already knew, the very embodiment of that over-used phrase, a people's person, who recognised frailty and celebrated and worked hard to develop potential. A large number of staff with 20 years plus in this field acknowledged his guidance, generosity and plain talking as pivotal in shaping their decision to work in the substance misuse field, and to continue working when energies were sapped for whatever reason.

Angela McKenna-Hylton, Birmingham DAAT

Partners in care

Drug and alcohol workers will provide much better support to their clients when they finally acknowledge that carers can be their best asset, say **Alex Fox**, **Drew Lindon**, **Vivienne Evans** and **Oliver French**

Family members and other unpaid carers remain under-involved in substance misuse treatment programmes, and are frequently under-valued as a helpful resource in the rehabilitation process. While a number of organisations including The Princess Royal Trust for Carers and Adfam have called for more appreciation of carers' expertise and contribution, they remain under-identified and under-supported by drug and alcohol services, often feeling that they are left with huge responsibilities and no commensurate rights or entitlements to support.

Carers can be a significant asset to recovery. Indeed, involving carers as partners in the treatment process is a key message of last year's national Carers Strategy. Even carers that have been harmed by contact with a family member's substance misuse may nevertheless hold insight and experience that could be invaluable. With so many people with substance misuse problems never reaching formal treatment, offering support to carers can be a means of reaching hidden clients and offering them a more supportive environment.

If these benefits can come from supporting and involving carers, why are carers rarely identified locally? Some services feel that family involvement is at odds with being user-focused rather than embracing 'whole family' practice. However, the Social Exclusion Task Force's report *Think Family* (2008) argues that individual needs should be 'looked at in the context of the whole family, so clients are seen not just as individuals but also as parents or other family members.' Moreover, the National Treatment Agency's *Orange book* (2007) states that carers' and families' needs for information and support 'should not be overlooked'.

In some cases, dysfunctional family relationships are perceived as a barrier to recovery, or even as partly responsible for the substance misuse. Where this is true, a whole-family approach should be seen as more, rather than less relevant. Even families facing huge challenges may have the

potential, with the right support, to transform themselves from part of the problem to part of the solution. Achieving this may require a much more holistic approach, with substance misuse services working in partnership not only with carers' and families' organisations, but also with a range of housing, health, youth, training and employment services that can together tackle the root causes of the multiple pressures many families experience. Of course, in some instances, such as where there are immediate child protection concerns, protecting the safety of vulnerable children or adults must take precedence over developing the family's capacity to self-support.

Recently, there have been positive moves towards a better understanding of how carers relate to drug and alcohol services. For example, the 2008 Drug Strategy aims to make treatment more effective by:

'supporting and involving young people and their parents and carers more in the planning and process of treatment for young people, and involving carers' and users' groups in the design and planning of treatment services.'

We can look to mental health services as a model for development for substance misuse services, particularly given the overlap between clients with dual diagnoses. Similar to substance misuse services, it is fair to say that mental health services have traditionally lagged behind other health and social care provision in involving and supporting carers. However, while this remains broadly the case, there have been striking changes over the last ten years, which drug and alcohol partnerships could emulate.

Firstly, the *National Service Framework (NSF) for Mental Health* (1999) included a core standard on carers, underlining that carers of people with intensive support packages should have assessments and their own support plans in place, and offering funding for mental health carers' support workers across England and Wales.

Many areas now have some form of mental health carers' support in place, though some regions remain woefully under-served. A number of local carers' centres in the network of The Princess Royal Trust for Carers have specific projects and workers around mental health and there is a national development programme. In 2004 the Royal College of Psychiatrists' and The Princess Royal Trust for Carers' joint campaign called Partners in Care (www.partnersincare.co.uk) made training on carers mandatory for junior psychiatrists, and similar training has now been included in a number of approved social worker courses. However, this is less explicit in training for the new approved mental health professional classification under the new Mental Health Act for England and Wales.

Nonetheless, the Mental Health Act 2007 has also increased the onus on professionals to provide carers with support and information. Both its Code of Practice, and Scotland's Mental Health (Care and Treatment) Act 2003 outline that carers should be routinely offered general information about mental illness, treatment and support for themselves. This is a small step towards thawing the long-frozen issue about confidentiality and carers.

Overall, while there is still a long way to go to change attitudes and provision, carers are increasingly recognised as 'experts by experience' in mental health services, as well as having their own support needs recognised and addressed. Carers are increasingly involved in the planning and development of services which affect them and their families, as well as appreciated as an integral part of promoting consistent support to, and recovery of, service users.

For substance misuse services, some comparable developments are already in motion. In addition to carers' visibility in the 2008 Drug Strategy, the NTA released its revised carers' guidance for commissioners in October 2008, with involvement from Adfam and The Princess Royal Trust for Carers. Crucially, this guidance highlights that local substance misuse services should involve carers more in the development of services, as well as in the treatment of the person cared for. Likewise, it asserts that carers should receive information and support in their own right and notes that supporting the carer is often a path to better recovery prospects for the substance misuser.

Similar to the steady expansion in mental health carers' support, there are also signs of a slow growth in local support services for families caring for people with substance misuse problems. Adfam now lists well over 300 support groups on its national database, and some family services that started out as coffee morning meetings have expanded to offer respite care, training, crisis intervention, alternative therapies and grandparent carer groups.

Between 2007 and 2008, Adfam website traffic increased by 20 per cent and the size of orders for support materials and literature more than doubled, indicating a general rise in interest and capacity. Likewise, local

In some cases, dysfunctional family relationships are perceived as a barrier to recovery, or even as partly responsible for the substance misuse. Where this is true, a whole-family approach should be seen as more, rather than less, relevant.'

carers' centres within The Princess Royal Trust for Carers' UK network are developing their support with these carers, with a number of centres now employing specific substance misuse carers' support workers, such as Wandsworth, Islington and Hertfordshire. Other voluntary and statutory/voluntary partnerships are also available in some areas, such as the Harbour Project (Bolton) and Regents House (Nottingham).

However, generic carers' services recognise that in many areas they have a long way to go towards offering effective support services to substance misuse carers. These carers have been missing from the wording of past government policies, and are almost always ineligible for carers' allowance, no matter how much caring they do. As a result, in the past there has been confusion as to the eligibility of substance misuse carers for statutory carers' assessments, support from carers' services and carers' breaks vouchers which are part of the carers' offer in many areas. Grassroots family groups have missed out on funding from carer-specific funding streams such as the carers' grant, which is a feature of carers funding in every local authority in England.

More positively, the new National Carers' Strategy is explicit in including substance misuse carers within its proposed pan-government definition of 'carer'. Guidance on carers' rights (available at www.carersuk.org.uk) is also clear that local authorities have a duty to offer carers' assessments to substance misuse carers as they would to other carers. Where before substance misuse carers have felt excluded from some generic carers' services, the good practice mentioned shows that there is huge potential for partnerships between organisations with carers' expertise and those with substance misuse and families expertise.

Improving support for carers within treatment services is also in line with the wider personalisation agenda. Personalisation, as set out in *Putting people first* and the accompanying Local Authority Circular LAC(2008) 1, is now the driving agenda for adult social care. *Putting people first* recognises that increasing numbers of people will be called upon to contribute to care, and commits local authorities to deliver a 'universal offer' of information and advice to all service users and carers. Carers' needs must be taken into account when services plan and offer treatment for substance misusers – given not only the impact on their lives, but also the benefits that their input can have. What's more, given their role carers should (and increasingly will) expect services to be offered to them, and for those services to be responsive to their individual needs for information, training, or emotional support.

Naturally, the development of better and more personalised substance misuse carers' support requires both money and will from local drug and alcohol commissioners, as well as from local authorities overall. Nothing will change without recognition that across the field of support for people with long-term conditions, more care and support is provided by carers than by paid professionals. In attempting to provide the best support to substance misusers, drug and alcohol services ignore carers at their cost.

Alex Fox is director of policy and communications and Drew Lindon is policy and development officer – mental health and substance misuse. Both are from The Princess Royal Trust for Carers. Vivienne Evans is chief executive at Adfam and Oliver French is Adfam's policy and communications coordinator).

Would patients in a residential detox unit see a total smoking ban on the premises as a logical part of treatment or a step too far? Richard Curtis **explains the campaign**

Choosing life

With the smoking ban imminent, the team at Baytrees, a residential detox unit which is part of Portsmouth's substance misuse service, decided to introduce a smoke-free protocol. We chose 1 January – a day when people tend to make resolutions like quitting smoking.

Baytrees is a newly converted NHS detoxification unit that offers a choice of structured therapeutic interventions alongside a range of medical regimes, to provide supervised withdrawal from drug and alcohol dependency. Referrals are made by community drug teams locally and across the UK.

We called the smoke-free campaign 'Choose Life'. At first there was a great deal of trepidation – would patients leave treatment early if they weren't able to smoke? Would they decide not to come in to treatment at all? Or would they just light up and ignore it completely?

The campaign's success depended on preparation. First, we gave stakeholders sufficient warning of the impending ban. We consulted service user and carer groups, and printed leaflets highlighting the dangers of smoking and the advantages of quitting.

Keyworkers from community teams were invited to use care plans as a way of identifying smoking habits and treatment options to help patients take control of their treatment.

The smoke-free protocol made it clear there would be no smoking anywhere on the ward, and patients were only able to smoke when they left the hospital grounds during social hours. A key part of Baytrees' treatment regime is confining patients to the ward for the first four to five days, during the initial supervised withdrawal stage, so to help them comply with the smoking ban free nicotine replacement therapy (NRT) was made available under the supervision of the ward doctors.

A smoking advisor was recruited to offer one-to-one counselling, group work and advice to help patients cope with the problems of quitting. We also introduced complementary therapies in the form of yoga, aromatherapy and tai chi, to enhance the feel-good factor gained from abstinence.

An obvious challenge was to ensure the protocol had 'legs'. We realised from the outset that it was no good announcing a ban and then turning a blind eye to infringements. However, we were clear that breaches would not mean discharge before treatment had been completed, as we knew this would increase risk of relapse and work against the service's 'patient-led' philosophy.

Patients that try to smoke on the unit are challenged by staff. A contract is then drawn up, agreeing that they will attend counselling sessions to explore the underlying reasons for wanting to smoke and look at how to maintain abstinence. Further infringements mean more of these sessions, and the only time patients are discharged from them is if the therapeutic relationship completely breaks down. The aim though, is to work with relapse rather than against it.

One of the main challenges was changing entrenched attitudes of staff as well as patients. Smoking is very much part of the culture in substance misuse services and it was common to hear statements such as 'it's unfair to expect drug users to give up tobacco as well as class A drugs – one thing at a time.' Concerns were also raised that it would lead to violence and aggression towards staff. Others questioned the morality of 'forcing' people to give up cigarettes, and the potential threat to the therapeutic relationship – turning staff into enforcers to ensure compliance.

Overcoming challenges

The campaign addressed issues around the ban by focusing on evidence. Drugscope's 2007 research, *Tobacco control and the role of drug treatment services*, showed that tobacco control initiatives, far from being a distraction from the core business of treatment services, may actually improve drug treatment outcomes and reduce the risk of relapse.

Training was key to the campaign's success, as it allayed many concerns while providing vital knowledge. Training sessions were provided for the detox staff as

well as the community drug teams, service users and carers, to inform them of the damage caused by tobacco. It also dispelled myths around smoking: 'It doesn't calm people down. Smoking actually exacerbates stress, anxiety and sleep disorders – it is likely to be detrimental to mental health, not the other way around.' When faced with this evidence, attitudes started to change and a culture of support developed for the programme.

One year on

Fears that patients would not come in for treatment with the ban in place were groundless. In fact, Baytrees has seen an increase of 10 per cent in the number of referrals in the past 12 months. During this time, the retention rate has increased and the number of successful completions has improved by 18 per cent.

Over the past year, patients have reported tremendous gains in their recovery – such as a large reduction in smoking, with 262 patients on NRT giving up smoking for a total of 722 smoke free days. Six patients even quit during their programme.

Comments that we received from patients included:

> *'I found the smoking rules made my detox more stressful, but I have cut down significantly, so I can't really complain!'*
>
> *'I forced myself to think of coronary blockages… excellent service.'*
>
> *'I think the information is very helpful and the education aspect of the dangers was quite shocking.'*

Taking advice from DrugScope's consultation paper on the future of tobacco control (published in September 2008), we wanted to incentivise efforts on smoking cessation by celebrating success. This was well received by patients, with feedback like 'awarding a certificate, keyring, or a mug is a good idea – small things but they can make a difference.'

Karen Morris, Baytrees' clinical manager, sums up: 'The campaign has been a real challenge, which at times we could have done without. Full of apprehension and foreboding to begin with, it has turned out brilliantly. Nicotine addiction has the same characteristics as the other addictions we treat in the unit, so drug services are best placed to provide treatment.

'There is a real sense of holistic care on the unit,' she adds. 'And this has only been possible with commitment, preparation, proper investment, training, and a service that is dedicated to taking treatment provision to a higher level.'

Richard Curtis is service improvement and development manager at Portsmouth City tPCT

Policy notes

GOING DOWN

What could recession mean for the drug and alcohol field?, asks **Sara McGrail**

I came into the drugs field in Liverpool in the 80s as a needle exchange outreach worker for three large social housing estates. The links between poverty and drug use for the people I worked with were undeniable.

It wasn't just financial poverty but poverty of expectation, experience, ambition, and opportunity. In one area it was reckoned over 85 per cent of the 18-25 year old age group were using gear and it was exceptional not to be on heroin. When in 2007, I was asked to do some work to look at the potential impact of an economic recession, it wasn't clear that a recession was inevitable and I was glad of that. Sadly there's no denying it now – so what might it mean for our field?

There isn't much science to this, but what might happen is that those drugs that last a short time and make you spend a lot of money (like crack and other stimulants) may lose some popularity and those drugs that last for a long time, but cost less money, may increase in prevalence. Depressants – like heroin, some prescription drugs, alcohol and cannabis – are relatively cheap, eat time and give comfort, initially at least, and this is one of the reasons we think their use increased massively during the last period of high unemployment.

We know it's the people at the margins of society – the unemployed, people in unstable housing, people who've grown up in care – who suffer disproportionately from problems related to substance use. This is not necessarily because people in these situations use more drugs, but because they lack the protective factors like having a job, a home and a supportive family, that can help someone keep experimentation with drug use under control. At a time of economic recession, the margins of society get wider. More people lose their jobs and their homes – under the strain families break up.

When money gets tight in an already disadvantaged area, the informal economy booms, with more people wanting to buy things for less. Acquisitive crime and fraud become more attractive propositions for people struggling to keep their heads above water. This might bring more people into DIP schemes, but increased engagement in borderline criminal activity may also increase people's vulnerability to developing drug problems. The relationship between crime and drug use is complex and difficult to map with any certainty. But living in poverty, engaging in crime or selling sex, are anxiety-provoking ways to live. For some people, taking drugs becomes a rational coping mechanism.

We know – and government acknowledges – that helping someone out of poverty saves money on drug treatment, crime and healthcare. We understand that treatment on its own doesn't 'work' in terms of helping people out of poverty – that it's just the first step and that poverty itself can undermine the gains from treatment. We also know that employment, housing and support for families and communities, critical as they may be, cost money.

And here's the rub. What have we seen so far in terms of investment in services for people with drug or alcohol problems, to help them survive the harsh economic climate? Nothing. The only new investment has been £9m for job centre staff to apply the convoluted benefit-sanctioning regime of the Welfare Reform Bill.

The strategy claims that new investment in reintegrative projects will come from efficiencies elsewhere in the system. But how? The reality is that DATs are commissioning more services against a budget that's shrinking in real terms.

If we don't spend on getting some better support in place now for the most vulnerable individuals and communities, we may see treatment services with diminishing pro rata budgets jammed to the rafters with people whose problems have become intractable. People whose problems need not have reached this point if we had the resources to intervene earlier and with more appropriate services. Waiting times could increase and we could end up with a larger out-of-treatment population than we had in 1998. With unemployment growing and social housing under pressure, drug users will be way down the list for mainstream support or jobs. And the problems will deepen.

Over the next few months, working with the London Drug Policy Forum, I'm going to be looking at how we can increase the financial security of people who have experienced drug problems. Some of the options we want to look at are access to credit unions and alternative sources of financial support, improving experience of the benefit system and the reality of routes back into employment. If you'd like to contribute, or have any thoughts about the likely impact of the recession on your clients or community, please get in touch with me via DDN or on sara@saramcgrail.co.uk

Sara McGrail is a drug policy specialist. Her website is at www.saramcgrail.co.uk

Calming the storm

ADHD is thought to affect around 500,000 schoolchildren in the UK and can often lead to substance misuse problems in later life, as people self-medicate to alleviate its symptoms. In the third of our series on the aetiology of addiction, Dr Anthony Lloyd **explores its roots and treatment**

Steven Spielberg, Mozart, Einstein, Henry Ford, John F Kennedy, Elvis Presley, Charlotte Brontë, Abraham Lincoln, Picasso and Olympic gold medallist Michael Phelps. These very talented individuals share one thing in common – they were all thought to be affected by Attention Deficit Hyperactivity Disorder (ADHD). ADHD is the most prevalent behavioural condition in childhood, affecting between 3 per cent and 5 per cent of the UK, with the ratio of boys to girls estimated at approximately 4 to 1. While symptoms of ADHD can lessen in late adolescence, it remains a life-long condition that can affect adults. But what exactly is ADHD?

ADHD symptoms include hyperactivity, inattention, frustration, anxiety, intolerance, aggressive behaviour, the need for stimulation and excitement and an inability to regulate the emotions. Many of us would recognise these symptoms as similar to those of post-traumatic stress disorder, and it is estimated that approximately 25 per cent of children with ADHD also have dyslexia.

The impact of ADHD on life chance trajectories can include school failure, loss of status and self-esteem, rejection by peers, sustained levels of stress and depression, relationship breakdown and increased risk of involvement in offending and substance misuse. All of this can result in a lack of emotional resilience, leading to increased anxiety and even despair. An estimated 50 per cent of the prison population have ADHD, among whom levels of substance misuse is also clearly high.

No unique genetic marker or definitive neuropsychological diagnostic has been identified for ADHD. Though some researchers claim to have identified some of the genes that may be responsible, it remains an umbrella term for a range of behaviours. ADHD is considered 80 per cent heritable, with 20 per cent of those affected having 'acquired' ADHD. Diagnosis relies on the subjective observations of teachers, parents and GPs, arguably with endorsement from overstretched paediatric and psychological services. Inevitably there is symptom overlap with other comorbid conditions such as anxiety, depression, psychological trauma or dissociation resulting from adverse life events like family breakdown, bereavement, bullying or exam-related stress and which are often mistaken for ADHD. Misdiagnosis inevitably results in the underlying causes of ADHD type behaviours remaining untreated and so increasing the risk of self-medication with food, alcohol or drugs.

For some, drugs like caffeine, nicotine, cocaine and amphetamine enable them to focus and follow through on tasks and goals. Others use drugs like alcohol and cannabis to soothe overactive 'alarm response' and hyperkinetic ADHD symptoms. Attempts to self-medicate feelings can seem to help at first but often result in addictions that create other problems and lead to a potential spiral of decline. Those working with addictions need to consider whether they are also working with ADHD – something that can be difficult to diagnose until the client is on the way to recovery, when many of their drug related ADHD type symptoms start to disappear.

Psychological trauma has an impact on emotional processing, often manifesting as repeated intrusive memories, re-experiencing of the original emotions, sleep disturbance, tearfulness, distress, cognitive dysfunction and challenging behaviours that communicate what the sufferer is unable to assimilate or articulate – typical behaviours in children with ADHD. Impulsivity is linked to the development of executive function – the ability to plan and monitor working memory. Executive function develops as the brain matures, and greater impulse control is evident in the increasing interpersonal intelligence we see in young adults who have a developed anterior attentional system in the pre-frontal cortex of the brain. With ADHD the executive function of working memory is underdeveloped so the ability to utilise working memory to analyse and plan their behaviour is undermined.

A 2008 report from NICE evaluated interventions and detailed the new national service framework to support children and families affected by ADHD, stating that multi modal, family support and group based psychological interventions are likely to be more cost effective than medication, which should be reserved for children with the most severe symptoms. Prescriptions for psychostimulant medication to treat ADHD in the UK have grown alarmingly from 2,606 in 1992 to 456,909 in 2006.

There is overwhelming evidence that stimulant medication alleviates symptoms – moderating impulsive and inattentive behaviours and resulting in improved school performance and, for some adult users, ability to perform at work. However, the need for alternatives to medication is becoming recognised, as we begin to realise that drugs like Ritalin are not the neurological Eldorado the pharmaceutical companies once claimed. Indeed research now suggests these drugs are potentially harmful to long-term cardiovascular health and may exacerbate mental health problems.

Feedback from parents seeking support from the ADHD Foundation in Liverpool suggests that medication is often the only support offered by GPs. The ADHD Foundation, however, offers educational programmes to help children and parents understand and manage their condition and its related behaviour. Other successful interventions for ADHD include the use of computer based biofeedback games that enable those affected to literally train their brain to regulate emotional impulsivity,

improve their thinking skills and even their cardiovascular health through daily 20 minute breathing and focusing exercises.

So what causes ADHD? Unusual regulation of neurotransmitters such as dopamine and norepinephrine have been identified as biological signatures for ADHD. As to whether this problem is evident at birth remains controversial. Recent research offers compelling evidence that stress experienced during pregnancy increases the risk of the child developing ADHD. This suggests that stress reduction programmes for working or pregnant mothers could offer one strategy for reducing the cognitive impairment associated with ADHD. Substance misuse including alcohol and smoking during pregnancy has repeatedly been cited as a risk factor and sleep and breathing disorders may also be causative factors in the onset of ADHD symptoms. Some research also suggests that excessive watching of television has a negative impact on cognitive development.

Nutrition is also considered by some to be an important factor. The UK Food Standards Agency has raised concerns about food additives and their potential impact on behaviour and ADHD in children, yet NICE cites insufficient evidence for the inclusion of nutritional regimens in its recommended interventions for ADHD.

Research suggests that, ultimately, genetic potential must be evident for environmental factors to trigger the onset and severity of ADHD symptoms. Leading ADHD researcher Stephen Farraone offers the alarming suggestion that ADHD may be the result of cultural transmission – an adaptive biological and evolutionary response to modern lifestyle. This view is supported by Sue Gerhardt in her book Why Love Matters, which analyses a wealth of research and explores the necessity of healthy nurturing for children and the implications for psychosocial development if nurturing needs are not met. Does this suggest that the potential for addiction is rooted in early childhood experience? Or is it the combination of genetic disposition combined with environmental factors in a similar way to ADHD?

Research suggests that we can learn emotional regulation as a result of brain plasticity – our brain's ability to rewire itself. Research on brain development, particularly in early infancy and adolescence, suggests that emotional intelligence – the biological correlates of emotional regulation – can be learned throughout our lives, with multiple benefits for wellbeing and potentially less reliance on psychostimulant medication for those affected by ADHD. Groundbreaking research by Allen Schore is being corroborated in very recent studies employing magnetic resonance image scanning which proves the brain can be trained to activate positive emotions and thoughts in a way that actually changes its structure and functioning. A growing body of research also highlights the 'system wide dynamics' of the body in the optimum functioning of health and learning.

Emotions are a highly evolved and advanced information system that cross-phase all other body systems with an impact on cognition, autonomic function and immune response. Health is controlled by three interdependent realms – biochemical, structural and psychosocial elements that interact in a complex, highly intelligent manner, a system wide coherence across bodily systems integrating and organising the distribution of energy. 'Positive psychology' – the 'psychology of happiness' attempts to harness the energy of the emotional system through techniques and strategies designed to self induce sustained positive emotions.

The paradigm shift for those working with addictions is based on the question of how the human system – or any system, from a single cell to a human being, organises itself. How does this system stay adaptable in order to respond to environmental influence, maintain stability and thrive? Research suggests that the intelligence in human physiology is not a linear, hierarchical construct – rather it must be viewed as a potentially dynamic, non linear, self-organising and self-regulating system that also responds to multiple systems within and outside of itself, where cultural transmission manifests in an evolutionary biological shift. Understanding the biological set point for learning/recovery, and how to optimise this, must become one of the basic tenets of therapeutic intervention, acknowledging the centrality of emotional processing systems in this process of balance (or coherence) across all bodily systems.

Those affected by addiction need to understand why they have been addicted – the reasons are often complex and multiple. Reflexive self-awareness is the reference point of our behavioural compass – however, working with physiology as the primary conduit and biological set point for recovery of addictions is often potentially a more efficient starting point for behavioural change than working with the client's self-awareness. The value of an holistic approach to working with addictions is now widely accepted but there is still some work which needs to be done in recognising how ADHD can factor into our understanding of why some people develop addictions, and how this can influence therapeutic interventions when dealing with recovery and relapse.

Dr Anthony Lloyd is a psychotherapist and executive life coach working in education and youth offending, and chair of Liverpool ADHD Foundation.

'The impact of ADHD on life chance trajectories can... result in a lack of emotional resilience, leading to increased anxiety and even despair. An estimated 50 per cent of the prison population have ADHD, among whom levels of substance misuse is also clearly high.'

Stabilisation Services
Hertford/Harlow

In April 2009 a new detoxification and rehabilitation facility will open in Harlow Essex called Passmores House, which will be operated by Stabilisation Services who also run Vale House in Hertford. Passmores House will provide 12 places of high quality detoxification treatment for both male and female drug and alcohol users, and six places of rehabilitation, run on the highly successful Vale House programme. Passmores House represents a significant new option for residential detoxification, stabilisation and rehabilitation facilities for drug and alcohol dependent people, as well as those with eating disorders, gambling problems, post traumatic stress, etc.

Please Call 01992 553173 for further information.

Stabilisation Services, 43 Cowbridge, Hertford, SG14 1PN

www.stabilisationservices.org

Drug and Alcohol Treatment – Caring for Young People

Nettleton Top, Nettleton, Lincolnshire, LN7 6SY

www.middlegate.co.uk

E: Middlegate@middlegate.co.uk

T: 01472 851540 F: 01472 859413

Middlegate, based in the Lincolnshire Wolds, has been in existence since 1995. It provides, unique, flexible, individual treatment services and behaviour management for young people, sensitive and appropriate to meet the needs created by the harmful effects of drug, alcohol and solvent abuse.

We offer young people aged from 11 years the opportunity to become substance free and to also begin to address any health, personal or family issues whilst on an individually focused residential programme which normally lasts for twelve weeks. For young people not yet ready to stop their substance use but who want to address their health issues and remove the more risky behaviour from their lives we offer a stabilisation programme.

PCP

a new beginning

Drug & Alcohol Teams, Social Services

LOOK NO FURTHER!

No waiting lists – immediate beds available

- **24hours, 7 days a week care**
- **25 beds quasi- residential primary - £450 per week**
- **12 week primary care and 12 week secondary care**
- **Detox facilitated**
- **12 step and holistic therapy**
- **NTA & HCC Registered**
- **Monthly reporting to the NDTMS System**

For further information please contact Darren Rolfe

CALL FREE 08000 380 480

Email: Darren@pcpluton.com

Web: www.pcpluton.com

Cranstoun drug services

Trelawn House

Cranstoun offers crisis intervention/detox at City Roads (CSCI registered), drug/alcohol treatment at Oak Lodge and Trelawn and supported housing services. Oak Lodge and Trelawn are CSCI registered and deliver an evidence based relapse prevention programme, life skills, aftercare and complementary therapies. Specialist support includes a dual diagnosis service, a group for survivors of sexual abuse, fitness facilities and tuition on basic skills and IT.
In supported housing we offer support that includes access to education, training and employment schemes as well as resettlement and aftercare. All our residential services offer highly trained and qualified staff within safe and comfortable environments to support clients through their treatment journey.
Contact our team on 020 274 4035
or request a referral form by e-mail: referrals@cranstoun.org.uk

City Roads (Crisis Intervention)
E: edoyle@cranstoun.org.uk
T: 020 7843 1640/020 72788671
Contact: Admissions Team, 352-358 City Road, London EC1V 2PY

Drug detox programme. Treatment: three weeks for men and women over 18. Crisis intervention.

Oak Lodge
E: referrals@cranstoun.org.uk
T: 020 3274 4035
Contact: Referrals Team, 136 West Hill, London SW15 2UE

Drugs and alcohol therapeutic community. Treatment: up to six months for men and women over 18. Literacy, fitness and aftercare schemes.

Trelawn House
E: referrals@cranstoun.org.uk
T: 020 8660 4586
Contact: Referrals Team, Trelawn House, 30 Russell Hill, Purley, Croydon CR8 2JA

Drugs and alcohol therapeutic community. Treatment: up to six months for men and women over 18. Dual diagnosis and sexual abuse therapy.

Sisters Avenue
E: referrals@cranstoun.org.uk
T: 020 3274 4035
Contact: Referrals Team, 30 Sisters Avenue, London SW11 5SQ

Drugs and alcohol supported housing programme. Treatment: up to two years for men and women over 18. Educational, training and employment (ETE) scheme and resettlement support.

Project 37
E: referrals@cranstoun.org.uk
T: 020 3274 4035
Contact: Referrals Team, 37 Ritherdon Road, London SW17 8QE

Drugs and alcohol supported housing programme. Treatment: up to two years for men and women over 18. Educational, training and employment (ETE) scheme and resettlement support.

Project 85
E: referrals@cranstoun.org.uk
T: 020 3274 4035
Contact: Referrals Team, 85 Trinity Road, London SW17 7SQ

Drugs and alcohol supported housing programme. Treatment: up to two years for men and women over 18. Educational, training and employment (ETE) scheme and resettlement support.

Project 235
E: referrals@cranstoun.org.uk
T: 020 3274 4035
Contact: Referrals Team, 235 Balham High Road, London SW17 7BG

Drugs and alcohol supported housing programme. Treatment: up to two years for men and women over 18. Educational, training and employment (ETE) scheme and resettlement support.

CONFERENCE CONSORTIUM Presents...

Drugs Alcohol & Criminal Justice

Drugs, Alcohol and Criminal Justice

Interventions – how do we make a difference?

The Conference Consortium in partnership with DDN, CNWL Health Trust and Coventry and Warwickshire Partnership Trust announces the above conference on:

Thursday 25th June 2009 (10.30 to 4.30)

Venue: Friends House, Euston Road. London

The aim of the conference

The Conference will focus attention on Criminal Justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, looking at both 'what is working' and the 'pinch points' in the delivery of services.

Who should attend

The conference will be aimed primarily at DIP and Service Managers, Practitioners and Staff from arrest referral, courts teams, Probation Officers who manage the DRR's and those who run the programmes. Health Workers and Doctors who deliver rapid prescribing and triage interventions, Police Officers and Magistrates.

The cost – £145 plus VAT

info@conferenceconsortium.org
www.conferenceconsortium.org

RHOSERCHAN

Addictions Counsellor

Full time, 5 days per week

Rhoserchan is looking for an enthusiastic and dynamic person to join our counselling team. Our ideal candidate will have a thorough understanding and acceptance of the 12-Step programme and extensive experience of working with clients who suffer from chemical dependency. Persons who are themselves in abstinent recovery from chemical dependency are welcome to apply provided they have been in recovery for 4 years or more.

All Rhoserchan counsellors are required to be qualified to Diploma level. An applicant who is not yet qualified will be considered for the post of Trainee Counsellor if s/he meets all other requirements and is willing to undergo a course of study and training which leads to a Diploma qualification.

The successful applicant will be based in the First Stage building but may be required to work at times in Second and Third Stage. A willingness to be flexible and to work as part of a team committed to providing a service of excellence to all Rhoserchan clients is necessary. Duties will include:

One-to-one counselling ● Facilitating Group Therapy ● Delivering workshops and lectures ● Carrying a case load of up to 6 First Stage residents ● Implementing care plans and keeping case notes ● Producing Progress and Discharge Reports ● Liaising with Care Managers and writing reports ● Having input into residents' Resettlement and Aftercare plans ● Driving the Rhoserchan minibus to transport residents

A full driving licence is necessary, and the ability to work with residents in Welsh is highly desirable.

Please send a full CV to: Anette Rumble, CEO, Rhoserchan, Blaencastell, Penrhyncoch, Aberystwyth, Ceredigion SY23 3EX

Email: a.rumble@rhoserchan.org.uk

MSc/PgDip/PgCert

ADDICTION PSYCHOLOGY & COUNSELLING

Part-time programme – September 2009 entry

The leading training programme for addiction counsellors in statutory, independent & voluntary sectors.

Enhance your career prospects in addiction counselling. This programme prepares students for work in a wide range of organisational and therapeutic environments.

Apply now to secure your place.

- Equal emphasis on addiction psychology and research, and professional practice
- Units include models of working, professional development and ethics, strategies and techniques, treatment contexts, personal development and robustness, psychological concept of addiction, development of addictive behaviours, theories of addiction and research methods
- Part-time, 1 day per week – MSc 2.5 years, PgCert 1 year
- Successful completion of the Diploma fulfils the formal training requirements for FDAP Counsellor accreditation (NCAC) leading to UKRC registration, and confers Drug and Alcohol Professional accreditation (DANOS based)
- Fees support for accepted students may be available via the Alcohol Education and Research Council

For full information and application forms, please contact the Course Enquiries Office on **020 7815 6100** or email **course.enquiry@lsbu.ac.uk**

www.lsbu.ac.uk

LONDON SOUTH BANK UNIVERSITY

Phoenix Futures

Ending dependency, transforming lives

INVESTOR IN PEOPLE

TRANSFORMING LIVES

As one of the most diverse substance misuse organisations in the UK, Phoenix Futures brings positive change in the lives of individuals, families and communities affected by drug and alcohol misuse. With our extensive prison contracts in England and Scotland, we are the largest not for profit provider of prison-based drug treatment. Could you play a key role in our successful and innovative prison team?

North West Prison Services Manager

£29,970 - £34,466

Joining our well-established prison management team, you will be responsible for HMP Styal, HMP Lancaster Castle, HMP Wymott and HMP Garth. Working within clearly defined service specifications, you will have the responsibility of managing a range of drug intervention services in the North West area. You will be required to liaise with the relevant prison senior management teams across the area, and to supervise team managers to ensure all contractual agreements are being adhered to and services are meeting the required performance. Previous management experience and a background of working within a criminal justice setting is essential, as is a high degree of self-motivation. Ref: 09/01/582.

Treatment Manager

HMP Ranby £24,350 - £28,003

You will lead a dynamic and committed team delivering a five-week accredited Prisons Addressing Substance Related Offending (PASRO) programme to substance misusers. Working closely with our prison management team and senior prison staff, you will be responsible for ensuring the programme is correctly delivered and identified targets are met. You will be a highly motivated and forward thinking individual with previous experience in facilitating accredited drug treatment programmes. Ref: 09/01/583.

We offer a generous range of benefits including a final salary pension scheme and ongoing training to support your personal and professional development.

For an application pack please visit **www.phoenix-futures.org.uk** or email **recruit@phoenix-futures.org.uk** Alternatively telephone 020 7234 9772 quoting the relevant reference number. Closing date: 23 February 2009. Interviews: TBC.

Registered charity in England & Wales 284880 and Scotland SC039008.
Committed to a policy of equality and diversity.

For details of all

Phoenix Futures

vacancies see

www.drinkanddrugsnews.com

INVESTOR IN PEOPLE

Phoenix Futures

Ending dependency, transforming lives

Bracknell Forest Council

EXPRESSIONS OF INTEREST

Bracknell Forest Council on behalf of Berkshire East PCT, Bracknell Forest DAAT, the Royal Borough of Windsor and Maidenhead DAAT and Slough DAAT would like to invite expressions of interest from organisations interested in providing a range of Tier 3 Drug and Alcohol Services in Berkshire East. The services that are included in this process are as follows:

Specialist Prescribing/Dual Diagnosis – Drugs and Alcohol
Psychosocial Interventions – Drugs and Alcohol
Shared Care – Drugs only.

The services will commence in January 2010 and the contracts will be for a period of 3 years 3 months with a possible extension of 1 further year. The drug specific contracts will be held by Bracknell Forest Council and the Alcohol Specific Contract will be held by Berkshire East PCT.

Organisations can express interest in all or some of these services but should be aware that contracts will only be awarded for services covering the whole of the Berkshire East Geographical area.

Expressions of interest should be made by 20th February when PQQ's will be dispatched for return on 23rd March to: Jillian Hunt, DAAT Manager & Commissioner, Bracknell Forest DAAT, 4th Floor North, Time Square, Market Street, Bracknell, RG12 1JD. Email: jillian.hunt@bracknell-forest.gov.uk

OJEU: 2009/S23-033446

bubic

bringing unity each into the community

BUBIC is a small scale charity that was founded in 2003 by former addicts who now provide peer support groups for those individuals whose lives have been affected by substance misuse. Each group provides a safe and confidential environment where those attending can air and share experiences as they progress along the sometimes long and arduous road of recovery. The peer support groups are also aimed at providing advice and referral on to mainstream services. BUBIC works in partnership with mainstream services such as the Haringey Drug and Alcohol Action Team, Haringey Drug intervention Programme, Haringey PCT and the Drug Advisory Service Haringey (DASH).

As part of its on-going development and sustainability strategy BUBIC is currently recruiting the following posts:

Peer Support Outreach Workers x2

£26, 885 Part time, pro rata (2.5 days per week).
12 month fixed term contract.

To provide effective group work facilitation and comprehensive outreach work. One of the posts to be a female worker to run the BUBIC women's group

Closing Date: Friday 20th February 2009 (5pm)

For a job application pack please telephone Magnus on 020 8808 6550 or email info@bubic.org.uk or write to: Magnus Chendo, BUBIC, 9 Bruce Grove, Tottenham, London N17 6RA

Substance Misuse Staff

For new 12 bed detoxification unit opening June 2009

caleb

alcohol & drug services

Are you...

- Passionate to see addicts recover
- Brilliant at keyworking
- Experienced at planning & leading sessions
- A team player
- Willing to work shifts

Salary between £20 & £24k depending on experience

Closing date: 13th March 2009

Contact Pat Johnson on 01274 720101 or info@calebbradford.org

www.calebbradford.org

Expressions of interest

NHS North Lancashire

are invited for an Integrated Drug Treatment Service in North Lancashire

Expressions of interest are being invited by the North West Collaborative Procurement Hub on behalf of NHS North Lancashire.

An Integrated Drug Treatment System (IDTS) is being introduced to HMP Lancaster Castle and HMP Kirkham during 2009 with the aim of providing an effective drug treatment service in prison which is an equivalent service to that in the community, principally by:

- *Delivery of clinical treatment, in particular the provision of national standard stabilisation, detoxification and substitute opioid prescribing regimes.*
- *Multi-disciplinary work alongside CARAT provision, with the objective of joint care planning for drug misusing offenders and delivering a full range of treatment options according to need.*
- *Delivering services in partnership with other prison interventions including offender management, education and training, work and resettlement.*
- *To work collectively to strengthen links between drug treatment in prison and the community to ensure continuity of care. Delivery will include partnership work with Primary Care Trusts, Drug Intervention Teams, Offender Managers and drug treatment providers.*

NHS North Lancashire will award the contract to the successful bidder for up to 3 years and expect the service to be operational by mid 2009. Prospective service providers should be aware of the wider context within criminal drug treatment services and an on-going national project, 'System Change' pilot. This may have an impact on the duration of this contract.

Interested parties should visit the North West Collaborative Procurement Hub website www.nwcph.nhs.uk to register on Bravo and download a copy of the Pre-qualifying Questionnaire (PQQ) and other information for potential bidders to complete.

For any other queries, please contact Kathryn Farquhar Kathryn.farquhar@nwcph.nhs.uk

Please note, the deadline for completion of PQQ responses to arrive is 17:00 23rd February 2009.

St.Helens Council

Substance Misuse Worker (2 posts)

SCP29-31, £24,331 - £25,940 (subject to pay and grading review) • Ref: CEY8 • 37 hours per week

St.Helens Young People's Drug and Alcohol team are a high performing team and you will help develop and deliver a range of substance misuse services to young people and their families in order to reduce drug misuse and risk taking behaviour.

You will work with young people up to 19 years of age, who are involved with the Youth Justice System or have been identified as at risk and vulnerable, due to their drug or alcohol use. You will also assist other agencies in the delivery of planned support programmes to young people.

Holding a relevant qualification, you will have a background in criminal justice, health, youth work or social care with up-to-date knowledge of substance misuse and related issues. The desire to help young people overcome substance misuse, along with enthusiasm and a genuine commitment to improve life chances are essential.

For an informal discussion, please contact Helen Jones on 01744 677990.

For an application pack, visit www.sthelens.gov.uk
Alternatively, email: CX@sthelens.gov.uk or call 01744 456708.
Closing date: 27 February 2009. Interviews: 13 March 2009.

St.Helens Council is committed to equal opportunities.
The Council is committed to providing a smoke free environment.
Flexible working practices are in operation.

INVESTOR IN PEOPLE

Beacon Council 2003 - 2004 Reshaping Construction

RATED A COUNCIL

For further information on the above job or to view a full list of current vacancies, visit our website at:

www.sthelens.gov.uk

THE SALVATION ARMY

For an application form, please apply to:

The Secretariat,
The Salvation Army,
Logos House,
Wade Street,
Bristol
BS2 9EL
Tel: 0117 955 2821

CV's will not be accepted

Registered Charity No.215174, and in Scotland SC037691

Promoting equality in the workplace

THE SALVATION ARMY SOCIAL SERVICES

Do you want to be involved in supporting people towards change and independence? Are you interested in working as part of a multi-disciplinary team? The Salvation Army has vacancies within its homelessness centre, Logos House, in central Bristol.

LOGOS House provides 'various services under one roof' to homeless people, including Emergency Accommodation, Residential and Community Drug Treatment, and Resettlement Support. We are currently seeking staff to support the Bridge Drug Treatment Programme. The Bridge Programme is integral to the overall treatment plan in Bristol, and is funded until December 2010:

Team Leader / Principal Project Worker (40 hrs)

Salary: £23,236 per annum
Closing date for Principal Project Worker applications: February 23rd 2009

Working closely with our centre management team, you will lead a team of Residential Substance Misuse Workers, and be responsible for ensuring the programme outline is correctly delivered. You will be a highly motivated individual with previous experience in the residential drug treatment field, able to support and develop staff, maintain high standards in quality assurance and governance, and negotiate decisions around client's complex needs and care pathways.

Tier 2 Outreach Worker (40hrs)

Salary: £18,965 per annum
Closing date for outreach Worker: February 23rd 2009

You will be a motivated person, able to work well as part of a team and in lone working situations. You will have excellent people skills, and be responsible for promoting the service, assertively engaging with prospective service users, and developing effective links with partner agencies.

For further information and specific job descriptions, please apply for a job application pack.

Doctor (Up to 2 sessions per week)

We are looking for a locum doctor to work alongside the Bridge Programme staff and the Rapid Prescribing service. You will support clients addicted primarily to opiates, to stabilise or prepare for abstinence. Ideally you will have an RCGP1 Qualification

For further information, please call the Centre Manager.

Wandsworth Carers' Centre

The Princess Royal Trust for Carers

Are you energetic and passionate about enabling and supporting Carers?

If so this is your opportunity to join a dynamic team that provides a range of support services to unpaid Carers in Wandsworth.

We require creative and proactive self-starters for the following post:

Carers Support and Development Worker – Substance & Alcohol Misuse

Salary: £28,403 (inc. LW)

Required to develop this new service supporting people in Wandsworth affected by someone else's substance or alcohol misuse. This will involve direct provision of services, collaborative work with statutory and voluntary sector agencies, outreach, training and information and advocacy to Carers.

The successful applicant will have knowledge and experience in the field of substance & alcohol misuse, understanding of the issues as they relate to Carers, excellent communication and IT skills, and a commitment to working in the voluntary sector. In addition they will have experience of project development and delivering frontline services.

The post is initially for an 18 month period and is funded by Wandsworth DAAT

For an application pack please contact: Wandsworth Carers Centre, 181 Wandsworth High Street, London SW18 4JE
Tel: 020 8877 1200 Email: info@wandsworthcarers.org.uk

Closing date for completed applications: 5pm 25th February.
Interviews: 6th March.

Registered Charity No. 1053121

Cyngor Sir Gâr Carmarthenshire County Council

Social Care, Health & Housing Department

Substance Misuse Team

Social Worker (Hidden Harm)

£24,331 - £29,628 (SO1/2/POA) Ref.: SMH 012/03

This is an exciting opportunity for a social worker with a background in childcare or substance misuse to work as part of a new service with families affected by substance misuse in Carmarthenshire.

The service, developed in partnership between the Substance Misuse Team, Education & Children's Services & Barnardo's Cymru will provide a specialist service to families at risk of breakdown.

The post will form part of the substance misuse team and provide advice, information and specialist assessments to those families at risk.

Social Worker

£24,331 - £29,628 (SO1/2/POA) Ref.: SMH 006/03

Due to the promotion of the existing postholder within the team an opportunity has arisen for a social worker to join the Substance Misuse Team.

The post will form part of a specialist team which provides a social work service to adults with substance misuse problems. This post provides an opportunity to work creatively with a diverse client group.

You will work closely with a range of colleagues across the statutory and voluntary sector in a challenging but rewarding environment.

For both posts you will receive regular supervision, opportunities for training and peer support within an established team. Initially, funding is available until March 31st 2011.

For an informal discussion please contact Kelvin Barlow (Team Manager, Substance Misuse) on 01554 779649.

A criminal record disclosure will be requested.
Closing Date: 23rd February 2009

Application forms are available from 01267 234567 or e-mail direct@carmarthenshire.gov.uk or apply on-line at www.carmarthenshire.gov.uk

Adran Gofal Cymdeithasol, Iechyd a Thai

Tîm Camddefnyddio Sylweddau

Gweithiwr Cymdeithasol (Niwed Cudd)

£24,331 - £29,628 (SO1/2/POA) Cyf.: SMH 012/03

Mae hwn yn gyfle cyffrous i weithiwr cymdeithasol sydd wedi gweithio ym maes gofal plant neu ym maes camddefnyddio sylweddau, fod yn rhan o wasanaeth newydd sy'n gweithio gyda theuluoedd yr effeithir arnynt gan gamddefnyddio sylweddau yn Sir Gaerfyrddin.

Bydd y gwasanaeth, a ddatblygwyd drwy bartneriaeth rhwng y Tîm Camddefnyddio Sylweddau, yr Adran Addysg a Gwasanaethau Plant a Barnardo's Cymru, yn darparu gwasanaeth arbenigol i deuluoedd sydd mewn perygl o chwalu.

Swydd yn y Tîm Camddefnyddio Sylweddau yw hon a fydd yn darparu cyngor, gwybodaeth ac asesiadau arbenigol i'r teuluoedd hynny sydd mewn perygl.

Gweithiwr Cymdeithasol

£24,331 - £29,628 (SO1/2/POA) Cyf.: SMH 006/03

Gan i ddeiliad presennol y swydd yn y tîm gael dyrchafiad, dyma gyfle i weithiwr cymdeithasol ymuno â'r Tîm Camddefnyddio Sylweddau.

Mae'n swydd mewn tîm arbenigol sy'n darparu gwasanaeth gofal cymdeithasol i oedolion sydd â phroblemau yn sgil camddefnyddio sylweddau. Mae'r swydd yn gyfle i weithio'n greadigol gyda grwp cleientiaid amrywiol.

Byddwch yn gweithio'n glòs gydag ystod o gydweithwyr ar draws y sectorau statudol a gwirfoddol a hynny dan amgylchiadau sy'n her ond sy'n rhoi boddhad.

Cewch oruchwyliaeth gyson, cyfleoedd hyfforddi a chymorth gan gymheiriaid mewn tîm sydd wedi ei sefydlu'n dda. Mae cyllid ar gael ar gyfer y swydd ar hyn o bryd tan Mawrth 31 2011

I gael sgwrs anffurfiol am y swydd, cysylltwch â Kelvin Barlow (Rheolwr y Tîm, Camddefnyddio Sylweddau) drwy ffonio 01554 779649.

Gofynnir am ddatgeliad o gofnod troseddol yr ymgeisydd llwyddiannus.
Dyddiad Cau : 23 Chwefror, 2009.

Mae ffurflenni cais ar gael oddi wrth 01267 234567 neu e-bost galw@sirgar.gov.uk neu ceisio ar-lein ar www.sirgar.gov.uk