DDN
Drink and Drugs News

11 February 2008
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THE RIGHT TREATMENT
Clouds House becomes more responsive to women's needs

ART COMES TO LIFE
Occupational therapy and a creative way to recovery

WE DID IT!
Daren Garratt on the DDN/ Alliance service user conference

DEADLY SERIOUS
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In addition, the conference has the pleasure of hosting the UK launch of the new, international Taylor and Francis journal *Mental Health and Substance Use: dual diagnosis* and an opportunity to meet the Editor and members of the Advisory Board. All delegates will receive a year's subscription to the journal and a copy of the first issue in their welcome pack.

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Editor's letter

Back to London, and a flurry of activity to get this issue together after our DDN/Alliance service users' conference in Birmingham. The response to the event has been so encouraging: it was such a busy day that it was difficult to step back and see what the experience was like for those attending. But we couldn't have hoped for a more positive reaction. As Daren Garratt says in his article on page 14, we plunged in knowing what we wanted to do at the outset, but had to adjust and improvise to keep the growing event interactive.

Whatever the lessons for next year, the main thing is that we have a wealth of enthusiasm to build on. The team of Alliance volunteers was amazing, and the network of friends and service user groups is growing, alongside the professionals who want to make positive treatment experience and active user involvement happen in their area. We're reading each and every comment jotted down at the interactive session in the afternoon, and are teasing out key issues for our conference special issue, next DDN. Whatever the tricky issues are, pinning them down in print must surely be a constructive step towards tackling them. To all our speakers – some of whom did not have the easiest remit, but who participated excellently (a special mention, NTA chief executive Paul Hayes!) – a massive thank you.

Issues don't get more difficult than our cover story this time. It was hard to accept the picture on the front of the magazine, and I was at first inclined to vote for a more subtle illustration that didn't make me flinch. But that after all is the point: it's an unpalatable issue and you will be left appalled by the state of affairs described on page 6.

Closer to home, Maggie Semmens and Claire Clarke take apart their treatment offered to women to examine if there are better ways of responding to their specific needs. The research and active response is an excellent example of changing things for the better whenever you can.

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In this issue

News in Brief

NOMS merges

A merger between the National Offender Management Service (NOMS) and the prison service has been announced by lord chancellor and secretary of state for justice Jack Straw. The new structure will improve efficiency and allow NOMS to 'build on its success' in reducing re-offending rates and increasing the number of successful drug treatments, he said. NOMS North East Area, meanwhile, has commissioned an information booklet from the Lifeline Project to address the problems of Subutex misuse by prison inmates. Visit www.lifeline.org.uk for more information. (For an eight-page special on the outcomes of the last NOMS conference see *DDN*, 5 November 2007, page 8.)

EMCDDA evaluation

The results of an EC-commissioned external valuation of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have been issued, covering two of the agency's three year work programmes (2001-03 and 2004-06). The study looked at the effectiveness of the centre, whether it was achieving its goals and what benefits it provides for the EU and its member states. Evaluators at the UK-based Centre for Strategy and Evaluation Services (CSES) found the centre to be performing well. Results available at www.emcdda.europa.eu

Off the hook

A free email forum to help service users get peer support has been launched by Northampton-based Off The Hook. The forum is an extension of the drop-in services offered by the organisation since 1992. Visit www.offthehooknorthants.org.uk/forum

Gum slingers

Heavy cannabis use can be a significant cause of gum disease, according to a study published in the Journal of the American Medical Association. The research monitored the dental health of 1,000 people born in New Zealand in the early 1970s and found that heavy cannabis use was responsible for more than one third of new cases of gum disease in the group before the age of 32, with even those who smoked cannabis but did not smoke tobacco developing the disease. Researchers believe the most likely cause is that toxins absorbed into the body via the lungs affect the body's ability to heal gum inflammation.
Available at jama.ama-assn.org/cgi/content/full/299/5/525

Young cannabis users 'insulated' from drug markets

The overwhelming majority of young people who use cannabis buy the drug from friends and members of their social network rather than unknown dealers or 'overtly criminal drug markets', according to a new report by the Joseph Rowntree Foundation.

Although more than 2.5m young people in England and Wales aged between 16-24 have used cannabis, very little research has been carried out into how the criminal justice and education systems deal with young people caught supplying or helping others access the drug without profit to themselves, according to *Cannabis supply and young people*. Just 6 per cent of the 182 young cannabis users interviewed for the study had bought the drug from an unknown seller, so most were 'insulated or distanced from overtly criminal drug markets,' it says. Nearly all, however, said the drug was easy to get hold of, with more than three quarters claiming they could acquire it in less than an hour.

Most of those interviewed pooled their money to buy the drug with friends, while 45 per cent said they had been involved in transactions but did not see themselves as dealers, although they were aware that they could be arrested if caught selling.

'While the public stereotype of the drug dealer may be of an adult stranger "pushing" drugs to young people, in the case of cannabis this is very rarely the case,' said director of the Institute of Criminal Policy Research, Professor Mike Hough. 'Most young people get their cannabis from other young people – often without a profit being made.'

Available at www.jrf.org.uk/bookshop/eBooks/ 2174-supply-cannabis-youth.pdf

Smith sanctions police to get tough on underage drinking

Extra powers for police to confiscate alcohol from under-18s drinking in public have been announced by home secretary Jacqui Smith, and a new £875,000 campaign to confiscate drink from those underage will begin this week.

An independent review of how well industry standards on responsible sales are being met was also announced, along with a pledge to 'continue to punish those few irresponsible retailers that flout the law by persistently selling to children'.

There would be wider use of 'parent contracts' in instances where poor parenting had been identified as an issue in confiscations, she said, along with a new public information campaign on binge drinking and safe drinking levels to launch in the summer. More than 3,700 litres of alcohol were seized from young people under 18 during a month long police crackdown last autumn (*DDN*, 28 January, page 4).

'Government must lead the way and I am determined to use all the powers at my disposal to bring about change,' she said. 'But in order to do this we also need the support of industry, enforcement authorities and communities – we all need to meet our responsibilities to make a difference.'

Alcohol Concern chief executive, Srabani Sen, said that while her organisation applauded those drinks retailers and producers that were actively working to reduce alcohol-related harm, too many companies were still putting profits first.

'We hope that the Home Office review will pave the way for a genuinely constructive dialogue between government, the industry and alcohol experts about the contribution of the drinks industry to reducing alcohol harm,' she said.

Target regeneration funds at drugs problem, says SDF

A significant proportion of Scotland's billion pound regeneration budget should be used to directly tackle the social and health inequalities underlying the country's drugs problem, the Scottish Drugs Forum has said in its submission to the 2008 Scottish drugs strategy consultation.

The SDF wants to see innovative regeneration schemes developed to create meaningful employment opportunities and undermine local drug economies, as well as new investment to ensure high quality drug services that are not 'doomed to inadequacy because of lack of resources'. It has also called for the creation of at least 750 support worker posts to help people with employment, housing, family and treatment issues 'which frequently conspire to undermine their resolve – and ability – to overcome problematic substance use.'

Only an intensive and individually tailored action plan – rather than 'conventional mass media and drug education campaigns' – stand any chance of having an influence on the young people in deprived communities who are the ones most likely to develop serious drugs misuse issues, it says. The SDF also calls for the effective integration of existing drug services with mainstream services to make sure that housing, employment and outreach services can respond to individual needs.

'The vast majority of Scotland's high levels of damaging drug use has its roots in, and is perpetuated by, poverty and inequalities such as income, housing, amenities, jobs and health which can span several generations of a single family,' says the submission. 'Tackling the deep-rooted social ills associated with these inter-related issues will, therefore, require very substantial and widespread will among Scotland's civil society. This must be underpinned by wide-ranging, well-resourced and widely targeted support across a large spectrum.'

Submission available at www.sdf.org.uk/sdf/files/SDF%20Strategy%20Response%20Final.pdf

EATA launches online CRB service

A new tool allowing people to fill in their Criminal Records Bureau (CRB) applications online has been launched by the European Association for the Treatment of Addiction (EATA).

The CRB provides a central service for carrying out police and identity checks, and all organisations whose employees or representatives may come into contact with children or vulnerable adults are now required to comply with its disclosure process.

As well as providing access to the online application, the service answers common questions about the disclosure process and includes information on why disclosures are required, who will receive them and how to challenge the information if it is incorrect. The disclosure service was set up by EATA in conjunction with Atlantic Data Ltd, and there is a discounted administration charge for EATA members.

'The new online CRB checking service will provide EATA members with a faster, cheaper and more effective service,' says Ghada Osman of EATA. 'It is expected to provide a faster turnaround time due to fewer application errors occurring online. EATA has systems in place to track your CRB application.' *The service is at www.eata.org.uk*

Drug and alcohol courts up and running

A groundbreaking drug and alcohol court has heard its first case in the UK. Based on the American model, the courts aim to provide support to families affected by substance misuse problems, so that children in care can return home.

The idea is being piloted by three London councils – Camden, Islington and Westminster – who realised that two thirds of their care proceedings stemmed from parental drug and alcohol problems. Family court judge Nick Crichton has been working with drug, alcohol and social workers from across the boroughs, specialist lawyers, the Children and Family Court Advisory and Support Service and representatives from Brunel University to drive the initiative forward, with the aim of avoiding lengthy and expensive court proceedings.

Piloting the scheme for three years will cost £1.6 million, for which external funding is being sought. The DfES has committed £450,000 for research and evaluation and there is some funding from the three councils, which expect a reduction in expensive placements for children with complex needs, as well savings in costs caused by street crime.

Cllr Sarah Richardson of Westminster City Council said the courts would avert crises from many court cases involving drink and drug abuse being brought too late.

Rethink: 'stop wasting time on cannabis...'

The government has been urged by mental health charity Rethink to 'stop wasting time and money' debating cannabis classification and focus instead on educating the public about its associated mental health risks .

Its report, *Educating reefer* found that the classification of the drug made no difference to its levels of use and that only three per cent of people would stop using it because it is illegal.

The Advisory Council on the Misuse of Drugs is reviewing the drug's classification because of concerns about links with mental ill health. Rethink, however, wants to see the drug remain class C but for products associated with it, such as 'king size' rolling papers, to carry warnings about mental health effects.

'Given that the classification of cannabis has little impact on how much it is used, we would urge the Advisory Council on the Misuse of Drugs to recommend that the government keeps cannabis at class C,' said Rethink's head of campaigns, Jane Harris. 'Changing the class would be pointless and expensive – government should put their money into a public health campaign to educate people about the mental health dangers.'

'Educating reefer' available at www.rethink.org

'Vital signs' launched

New planning guidance containing the first alcohol indicator for the NHS has been issued by the Department of Health – part of its Operating Framework for 2008/09.

The document sets out how performance will be managed against three tiers of 'vital signs', with central performance management limited to national priorities and to areas and organisations where performance is weak, to allow for more decision-making at local level.

The vital signs will clarify measures of progress against national priorities and help PCTs make local choices. All PCTs are required to develop an operational plan by the end of March, and will be expected to engage with their local communities, staff and stakeholders in an 'open and informed discussion about priorities and performance' says director general of NHS finance, performance and operations David Flory. The 'vital signs' represent a new approach to planning and managing priorities both nationally and locally, says the department. *Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542*

Service user success!

The first ever national service user involvement conference – organised by DDN and The Alliance – has earned positive feedback from those who took part.

More than 600 people attended the conference in Birmingham on 31 January, which featured a mix of high profile speakers from the field and lively interactive debate on the issues central to meaningful service user involvement.

DDN will be producing a special issue on 25 February with a full round up of the conference and an in-depth focus on the issues service users most wanted to be addressed by policy makers and service providers. Speakers' presentations will also be available at: http://www.drinkanddrugs.net/suiconference.html

See page 14 for Daren Garratt's report.

News in Brief

City anniversary

A series of events are being planned to mark the 30th anniversary of London's City Roads residential crisis intervention centre in May. As part of this, anyone who has been associated with the service in any way and would like to share memories, thoughts or stories to share is invited to send them to Katy Porter or Maria Robinson at info@cranstoun.org.uk or by post to 352 City Road, London EC1V 2PY.

Never too old

Following our report that the UK's oldest drugs worker, Jack Metcalfe, had retired from his post at DISC in East Durham aged 67 (*DDN*, 14 January, page 5), a reader has written to tell us about Bernie Brencher who works three days a week at Redbridge Drug and Alcohol Service and, at 70 years old, beats Jack's record by three years. Bernie started working in drug services in 1969 at St Clements DDU. Do any readers know of a drugs worker older than Bernie?

Street scenes

More than 1,500 people watched a group of actors perform binge drinking scenarios to encourage them to think more about the risks associated with excessive alcohol consumption. The performance in Nottingham at the end of last year was part of the Home Office's *Know your limits* campaign. Of those that filled out surveys on the day, 62 per cent said they would think more about looking out for themselves or their friends on a night out and 36 per cent said they would consider drinking less.

Going global

A global strategy on alcohol has come a step closer with the WHO's Executive Board (EB) agreeing on an expanded mandate for the WHO on alcohol. The wording is now recommended for adoption by the World Health Assembly in May. Consensus was also reached on a draft resolution requesting the WHO director general to submit a draft global strategy to reduce the harmful use of alcohol to the EB in 2010. This will include recommended measures for states to implement at national level, taking account of the circumstances of each country. The WHO report is available online at www.who.int/gb/ebwha/pdf_files/EB122/B122_R2-en.pdf

Deadly serious

Almost half of the 64 countries worldwide that retain the death penalty impose it for drugs-related offences. In some places this is restricted to large scale trafficking, or offences with 'aggravating features' like use of violence or involvement of minors. In many others, however, it can be imposed simply for possession, while in Sudan a café proprietor can be put to death if someone is found in possession of a hashish pipe on his premises.

At the end of last year, the International Harm Reduction Agency (IHRA) launched its report The death penalty for drug offences – a violation of international human rights law, the first from its new human rights research and advocacy programme, HR2 (*DDN*, 14 January, page 4). 'One of the things that surprised me when I started doing the research was just how little I could actually find on the topic,' said its author, IHRA senior policy officer Rick Lines. 'Amnesty document a lot of executions, but they hadn't really issued any legal or human rights analysis of the death penalty in drugs cases at that point.'

To IHRA, the lack of focus on this area is symptomatic of a fundamental and widespread attitude towards human rights when it comes to drugs issues. 'One of the challenges of the harm reduction movement generally is to break out of this whole area of stigma and demonisation around drug use,' he says. 'I've mentioned the human rights of drug users in some places and you could almost hear the intake of breath – as though people somehow give up their entitlement to human rights when they use or traffic illegal drugs. There is this great vacuum when it comes to discussing the human rights implications of drug policy.'

Part of the intention with the report was to try and bring other organisations into the debate and engage them on this issue. 'Certainly on a strategic level we saw it as a way of building working relationships with the more mainstream human rights sector and interesting them in drug policy, and we've had very positive feedback from people like Amnesty and Human Rights Watch,' he says.

Simon Shepherd is known to the field as chief executive of FDAP but last year set up Deathwatch International to campaign for the abolition of the death penalty for all offences worldwide. 'There is a resonance with the field here because in many countries the death penalty extends to possession,' he says. 'People are getting executed for just having drugs on them, and a lot of people simply don't know that drugs offences can lead to the death penalty. Some might say "murderers should be executed", but there would be very few people who would defend the wide range of things that can lead to executions across the world.'

So given the closed nature of many of the countries involved, is there any way of knowing just how many people are being executed for drugs offences each year? 'It's very difficult to quantify,' says Rick Lines. 'While almost half of the countries with the death penalty have legislation allowing for it to be used in drug cases, it's more difficult to tell how many of those countries are actually using it for that. It's hard enough for human rights monitors to get an idea of how many executions are being carried out in countries like China, let alone how many are for drugs offences.'

China still marks the UN's international anti-drug day by carrying out executions, while more than 70 per cent of the executions carried out in Malaysia in 2004/05 were for drugs offences. One of the most shocking

In some countries you can be legally put to death for possession of an amount of drugs that might not even merit a custodial sentence elsewhere. **David Gilliver** looks at how the field and human rights campaigners are coming together to try and tackle this 21st century barbarism.

aspects of the report, however, is the sheer inconsistency between countries regarding what constitutes a drug crime serious enough to warrant execution.

'One of the standard rationales that countries use, particularly in South Asia and parts of the Middle East, is that they're geographically situated as drug producing or trafficking areas so they need these super-harsh penalties to protect them,' says Rick Lines. 'But when you compare legislation you see that bordering states will have completely different definitions of what a capital drug crime is – you might get the death penalty for possession of an amount of drugs that would be a minor offence across the border. That undermines the key rationale that it's an effective criminal justice response. If that were the case then countries that share borders would harmonise their death penalty legislation, because you wouldn't want to have the weakest provision. It really pulls the rug out from under the argument.'

When not being justified on utilitarian grounds – as the most effective way of protecting a country from the drugs trade – the death penalty is justified on the grounds that drugs are a moral affront to that country. 'That can be part of why human rights language gets ignored when it comes to drugs policy, and often the mainstream human rights movement has fallen victim to this same thing,' he says. 'People who traffic or use drugs are portrayed in terms of moral failure, or as cancers on the state or peddlers of death - this very strong language to dehumanise the people involved.

'If you look at what is legally constituted as a death penalty offence in international law, it's basically culpable homicide,' he continues. 'But when it comes to issues of drugs – even large scale trafficking – it's very difficult to make the case that the purpose of the drug dealer is to kill their customer. With any drug there's always the possibility of death, but it's very difficult to argue that the reason the person trafficked this drug was to kill. So given that that logic isn't possible within drug enforcement you get this moral panic language instead.'

So should the human rights activists be campaigning for the death penalty to be abolished for drugs offences? 'The human rights movement focuses on either the death penalty *per se* or on young people facing the death penalty,' says Simon Shepherd. 'If you're going to deploy your resources to the maximum effect then you need to concentrate on simple messages. Obviously, if we can get rid of the death penalty full stop then we'll get rid of it for drugs offences. It's whether or not there's a case for a specific campaign on the death penalty and drugs crimes – is there any mileage in trying to persuade those countries to get rid of it for drugs crimes even if they refuse to for other crimes?

'If you don't work in the drugs field it, it might be quite hard to get worked up about it,' he continues. 'The average member of the public is likely to find executing people for crimes they committed as children or for adultery abhorrent, but if you try to get them excited about drugs-related offences you're likely to have less success. The specific campaign to get rid of the death penalty for minors was successful in almost every country in the world – those are the kind of areas where campaigners do actually get somewhere when they're arguing with governments, so by doing that you're chipping away at it in the best way you can.'

But, all questions of the morality of the death penalty aside, does it actually work as a deterrent? 'There's no evidence that it's an effective deterrent, no' says Rick Lines.

'It's a moot point,' says Simon Shepherd. 'All of the available research shows that it is no deterrent in terms of murder. If you kill somebody there's a very strong force that makes you able to transgress the basic rules of humanity, whether it's that you're so angry, or frightened, or drunk or whatever. The last thing you're thinking about is what the consequences are going to be. But with an economic crime like drugs, people make a judgement call based on how desperate they are for the money against how likely they are to be caught and what the consequences will be.

'Countries have the death penalty for drugs offences because they believe it will reduce the scale of drug problems in their country and they may have some justification for believing that,' he continues. 'It's hard to persuade them that it doesn't act as a deterrent – it's easier to persuade them that it's immoral to take someone's life, and we are slowly moving towards that. Every year, the countries that retain it are restricting the range of crimes to which it can be applicable. In this country we stopped executing people for sheep rustling long before we stopped executing them for murder, and that same process is going on in countries all around the world. The argument we need to focus on is one of ethics – to say that it's not acceptable full stop.'

The report, however, makes the point that the UN finds itself in an awkward position as both an upholder of human rights and enforcer of drug control policy. 'That is a tricky situation,' says Rick Lines. 'The UN is the organisation mandated by the international community to promote human rights around the world, but at the same time is the organisation tasked with enforcing international drug control policy. The death penalty is one of many human rights issues where those two agendas come into conflict in terms of how law enforcement for drugs gets prosecuted in many parts of the world. All too often the logic of drug control has been allowed to take human rights protection off the table, and one of the things we're trying to do by highlighting the death penalty issue is to point out the problems with that. Promoting human rights is one of the purposes of the UN according to its charter – drug control is not. There's no parity between the two agendas.'

So, is there a sense that things are improving? 'There was a very significant victory in the UN General Assembly in December when they voted for the worldwide moratorium on all executions,' he says. 'And, although it can be very difficult to do human rights work in some of the countries where the death penalty is used most often for drugs, human rights monitors are really starting to speak out. One of the things we'd like to see is some kind of system-wide coherence to encourage branches of the UN involved in a drug law enforcement role to be more proactive in engaging with human rights issues as well. We say to them that it's all well and good to provide technical assistance and funding for drug law enforcement, but at the same time you have a human rights obligation as part of your mandate and you can't ignore that. They can engage in law enforcement assistance in a way that also promotes proper human rights standards.'

Report available at www.ihra.net/uploads/downloads/NewsItems/DeathPenaltyforDrugOffences.pdf

To find out more about Deathwatch International and how to support its work visit: www.deathwatchinternational.org

'When my father came home from the last war, a pint of beer had an alcohol content of between 2 and 2.5 per cent... [Today] it is the industry that is deliberately encouraging the consumption of alcohol by selling much stronger drinks. Why? Because the booze producers – like every other business – want to sell more'

The strength of the alcohol lobby

In your excellent article by Kevin Wilson (*DDN*, 28 January, page 9), he gets close to a solution to so-called binge drinking and all the attendant evils of boozing. Unfortunately, he doesn't go all the obvious way and neither does our frightened-of-losing-votes government.

When my father came home from the last war, a pint of beer had an alcohol content of between 2 and 2.5 per cent. As a result when he celebrated the victory, he had 'one over the eight' – *ie* nine pints, which was then the acknowledged level of entry to oblivious irresponsibility.

Today, because of the drinks industry's increase of alcohol content to a minimum of 4.5 per cent and with some beers at 9 per cent, the ecstatic state of thoroughly p****d is reached after the fourth pint. In addition, so-called 'happy hours' encourage even earlier, cheaper and faster indulgence.

In fact, it is the industry that is deliberately encouraging the consumption of alcohol by selling much stronger drinks. Why? Because the booze producers – like every other business – want to sell more, and they believe that a client with a stronger pint of Best already inside him will lose some of his judgement and will therefore irresponsibly drink and buy more rounds more quickly.

It's called 'marketing', and this drinks strength factor applies equally to wines and spirits.

However, by statutorily reducing drink strengths – in the case of beer back to the 2 to 2.5 per cent of the 1950s – my old man would hit his bladder limit on far less alcohol content, and would be arriving at coming home time while still in a more sober condition.

In other words, it's not a question of selling less drinks, but one of selling less alcohol. The industry would likely sell just as many drinks and the chancellor would collect just as much tax. But the hard-pressed police, ambulance services and street cleaners would have an easier job with less cost to the local ratepayer. But what does a mere woman know about such things?

Elisabeth Reichert, school head.

Tarred with the same brush?

Regarding the article 'Uncharted Waters' by David Gilliver (DDN, 28 January 2008, page 10): As a hypnotherapy practitioner of over ten years, and one who has worked with drink and drug support services for the past four years, I am grateful to David for highlighting some of the popular misconceptions about hypnotherapy.

Firstly, I must point out that a distinction needs to be made between 'alternative' and 'complementary' services. Hypnotherapy is a complementary service, *ie* it has been recognised by the government as suitable for working within the NHS (2004). Anything not officially recognised as such, is 'alternative'. This is a point often misunderstood by the lay public, and, unfortunately, many healthcare professionals!

As regards regulation, I would like to inform you that the hypnotherapy industry IS currently going through the regulation process. In the meantime, most hypnotherapy organisations have their own independent ethical regulation process. Anyone looking to find a fully qualified and fully insured practitioner needs to look no further than the General Hypnotherapy Register web-site. This is the UK's largest register of Hypnotherapy professions and it ensures that all its members are educated to certain standards, and fully insured each year. They are also the organisation that wrote the hypnotherapy chapter in the NHS Complementary and Alternative Medical Services (CAMS) directory.

It is true that many local drink and drug services do not use any complementary services, such as hypnotherapy, and there are many reasons for that. One is naturally wary of anything 'new' – even though hypnotherapy was approved by the BMA back in the 1950s, and is a normal part of many countries' healthcare provisions. This may be another reason why many hypnotherapists steer clear of the drink and drug sector, just as many counsellors do. Personally, I think that hypnotherapy is an excellent match for the this clientele; however, it isn't for all therapists, and not all hypnotherapy training schools offer specialist substance misuse training.

So the problem is threefold:

- Misconception about what is complementary and what is alternative – hopefully, regulation and time will increase people's awareness of successful services.
- Shyness on the part of hypnotherapists to enter into the drink and drugs sector – as stated, this is true of all healthcare professionals!
- The lack of places that will take on hypnotherapy professionals – it must be realised that the only way forward is to work with the client's counsellors, and healthcare professions; after all, we are there for the client's benefit! I work to the local support services guidelines, and regularly meet with the counsellors and attend team meetings to update counsellors of new developments within the industry, and (of course) keep full case notes on the counsellors' file. All counsellors have my full contact details and can contact me if they have any concerns of questions regarding appropriateness of hypnotherapy for such a client or issue.

Going back to David's article, no hypnotherapist should or would suggest withdrawal or stopping of any prescribed substances. At most they would refer them back to the counsellor or GP for such action to be considered. Hypnotherapists are not a substitute for GPs or other healthcare professionals – they are an additional resource.

Please don't tar all therapists with the same brush. Our client group can be difficult enough without infighting! However, I hope I have shed some light on an often-misunderstood area, and am happy to answer any emails forwarded to me.

Anthony Gravestock, LifeWorks, Surrey

More than ready for it

David Wright's assertion (*DDN*, 28 January, page 8) that 'not everyone wants abstinence' is correct and confirms the findings of drug user surveys taken over recent decades. These reveal that 70+ per cent of individuals who have been addicted for three or more years not only seek an effective abstinence programme, but have at that time already made one or more serious attempts to become abstinent.

'Abstinence works' says David, and goes on… 'but people have to be ready for it'. Well, with over 70 per cent of three-year users desperate to quit, any impartial observer would recognise that the vast majority of people are more than ready for it.

As part of a team which works every day with people addicted to the main ranges of illicit, licensed and prescription drugs, I help them achieve comfortable lifelong abstinence in well over two-thirds of cases and will continue to do so 'while there is still breath in my body' – not on the basis of having them march to the beating of an abstinence drum, but because wiser users than David are beating a path to our door.

A drug-free 'abstinent population' is also a goal for over 70 per cent of the non-drug-using public because they are the taxpayers who are paying not only for methadone and Subutex users' daily doses but also for their unemployment benefit, income support, housing allowance, intensive usage of the NHS, and greater loading of our police, court, prison, probation and customs and excise services, as well as for the higher levels of accidents, acquisitive crime, prostitution, marriage and family breakdown, injuries, absenteeism and violence engendered by users of drugs of every sort.

The Big Issue reported a professional survey conducted over three major cities and confirmed what David says – namely: 'people have and always will use mood-altering chemicals'. But he is not talking about ALL the people; just a minority to whom the application of so-called harm reduction practices can be beneficial as well as of advantage to the society at large – but never as effective as their abstinence can be for the majority.

Kenneth Eckersley, CEO of Addiction Recovery Training Services (ARTS)

MMT: Myths and facts

David Wright's views on Methadone Maintenance Treatment (MMT) while using other drugs (*DDN*, 28 January, page 8) appear to convey the idea that it's an unimportant issue compared to injecting drug use.

Research shows that a large majority of heroin addicts, who are receiving methadone treatment, are regular users of cannabis and cocaine (*Irish Medical Times* April 2006). A study of 851 methadone patients in north Dublin, carried out by the Royal College of Surgeons in Ireland found that cocaine abuse is emerging as a 'major problem', among opiate users receiving methadone treatment. Cocaine accelerates methadone elimination, and is therefore counter productive. Cannabis is a psychotropic agent, and when used with MMT it has unpredictable reactions.

Research from Edinburgh University (Professors Bell and Bustill), discovered that young heroin and methadone addicts sustained a level of brain damage normally only seen in much older people, and similar to early stages of Alzheimer's disease. This would bear out reports from the Netherlands that special homes have had to be set up for pre-senile methadone drug addicts.

The BMA view on dosage is noted; however research indicates that increasing a patient's methadone dose increased the craving for heroin (UCL and Institute of Psychiatry, 1999).

David's implied view that abstinence is a political issue is baffling. If an individual has made it clear that he/she has no wish to enter into recovery, that is a choice that should be respected, and hopefully is the outcome of so called 'informed choice'. Since the problems that occur with MMT are rarely, if ever, stated by its proponents (David being no exception) it is difficult to see how users presented with the choice of MMT or abstinence, without a full disclosure of all the relevant facts, can actually make an 'informed choice'.

I have no problem with MMT as a stepping stone to recovery, but David's claim that for every £1.00 spent, £10.00 is saved on criminal issues, is a gross distortion of the facts. MMT is an effective therapy intervention, but it does not show a statistically significant effect on criminal activity (The Cochrane Collaboration, 2007).

The addictive potential of methadone can lead to swapping one addiction for another – thus we have the situation of where the addiction, rather than the addict is being treated. Treatment of this nature alone is hardly ever successful (Department of Psychiatry, University of Massachusetts Memorial Health Centre, April 2006). If users are to make a 'fully informed' choice, they need to be made aware of the latter.

Recovery, a lifetime process, is possible, and a significant number of people achieve it. However we also need to recognise that conditions which drugs may have suppressed, such as severe anxiety and depression, are a major cause of relapse. Willpower on its own is not enough to beat addiction, nor is it enough to remain drug free. Ongoing therapy is essential – whether that be residential, or otherwise. Nor, for those who want it, should we overlook the role of Narcotics Anonymous in helping people to achieve and maintain a drug free life.

Peter O'Loughlin, The Eden Lodge Practice

Contrite corner

Apologies to Action on Addiction, whom we rebranded as Action of Addiction in our last issue, in a news story about graduates of their foundation degree course (news, page 5).

We welcome your letters

Please email letters to the editor, claire@cjwellings.com or post them to the DDN address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.

Media Watch

Eighty per cent of newly diagnosed psychiatric cases are linked to heavy cannabis use, according to scientists who presented a dossier to Whitehall drug advisors. The government's Advisory Council on the Misuse of Drugs (ACMD) will consider the evidence before advising ministers on whether to reverse the downgrading of cannabis.

Daily Mail, 28 January

The Archbishop of Canterbury has called the 24-hour drinking culture 'the tip of the iceberg' of alcohol abuse. 'I would be interested to see why anyone should think of it as a success,' said Rowan Williams. 'I think it has had an effect of making less safe and less civil our public spaces in many contexts, including Canterbury.'

The Guardian, 31 January

Britain's failing mental health care is turning it into a 'Prozac Nation' according to Liberal Democrat leader Nick Clegg, who called for doctors to cut the amount of anti-depressants they prescribe to patients. ' This trend has gone too far,' he said. 'Pills must not be a crutch for the wider issues in our society which cause mental health problems.'

BBC News, 8 February

Don't punish the majority of responsible drinkers, the Wine and Spirit Trade Association (WSTA) has urged Chancellor Alistair Darling, adding that raising tax on wines and spirits would not address the problems of binge-drinking. Chief executive Jeremy Beadles said 'Our research shows that any such increases will do little to address problem-drinking while hurting the economy and the Treasury. It simply does not make any sense.'

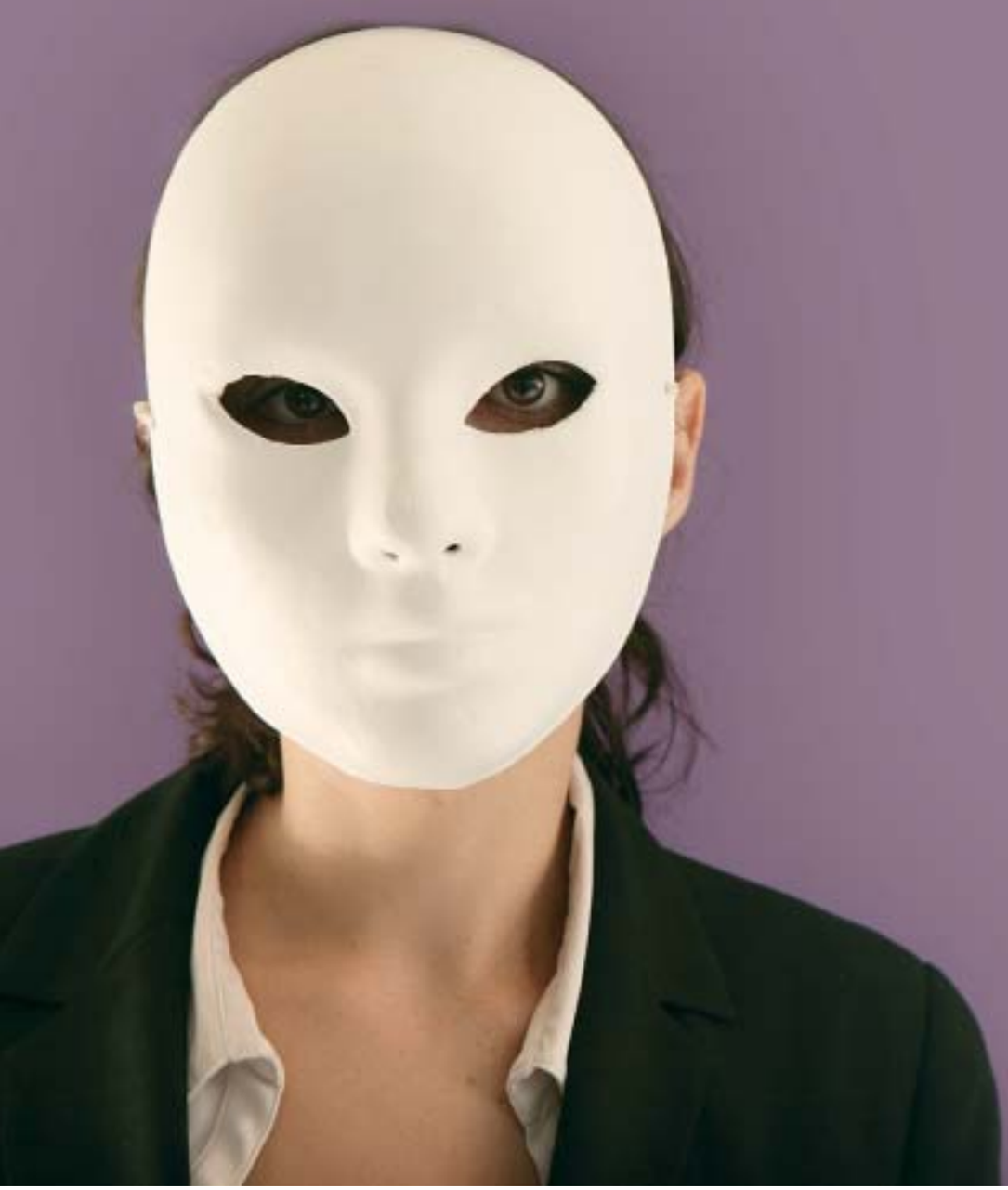
The Publican, 4 February

Ex-crack and heroin user Charlie, aged 41, is the first contributor to artwork on the cell walls at Swindon Police Station. A mural will tell the life stories of former offenders, with the aim of showing how they turned their lives around, and is aimed at a captive audience: 'If you're sitting in a cell for 12 hours you will read every scratch on every tile to stop you going bonkers,' said Sue D'Amico, drugs intervention co-ordinator.

BBC News, 8 February

Getting it right for women

Ignoring women's specific needs can leave them highly vulnerable to relapse. **Maggie Semmens** and **Claire Clarke** describe how the team at Clouds House set about becoming more responsive to the women in their mixed-sex treatment centre.



There is ongoing debate about whether treatment services are sufficiently well organised to respond appropriately and effectively to the needs of women. Research evidence supports women-only treatment models and mixed gender programmes. It is clear that not all women need to be treated in female-only environments – some do not want to, and some will positively benefit from mixed sex units. But whatever their treatment setting, we need to ensure we are responding as effectively as possible to their particular needs.

Clouds House has been treating men and women in a mixed-sex facility for nearly 25 years. As part of our organisation's commitment to the continuous improvement of all of our services, we undertook a project to evaluate how responsive our treatment programme is to its female clients. We wanted to learn directly from women who had used the service whether we were being as helpful as we might be. We formed a working party of nurse team deputy managers, Rowena Barnett and Louise Black; and the two of us (Maggie Semmens, senior counsellor, and Claire Clarke, head of treatment services at Clouds House).

We held in mind that women have a number of issues specific to them which relate closely to their vulnerability to relapse. We were also aware of the evidence that many women can benefit from mixed-gender treatment if adequate attention is given to female specific issues. We included abuse, eating disorders and self-harm in this category.

A questionnaire was devised which covered seven areas: pre-treatment experience; therapeutic care; medical care; the treatment environment; family issues and visiting arrangements; post-treatment arrangements; and suggestions for improvement. There were four questions in each section, with room for additional comments. We intended for the questionnaire to take an average of 30 minutes to complete.

Since the start of the project in December 2006, questionnaires were sent through the post to 90 of the women who had been admitted into treatment in the last two years and were easily contactable. Some were living at home while others were still in secondary residential treatment. Just over half of the questionnaires (49) were

returned. Some women felt unable to fill out the forms by themselves and we spoke to them over the telephone to collect their responses. In addition we gave out questionnaires to women currently in treatment, and continue to collect feedback via this questionnaire, but this article covers the findings of a survey conducted over one year.

The respondents reflected the usual mix of clients to be found in treatment at Clouds House – women ranging from 18 to 65 from different socio-economic and cultural backgrounds. Some of these were pregnant women (the subject of a previous article by our medical consultant, Dr Gordon Morse, in *DDN*, 6 December, page 6) and the questionnaires suggested that they appreciated the sensitive and professional way that their detox was handled. We also received praise from an elderly blind lady who successfully completed her treatment with us.

In collating the responses to the questionnaire, it was gratifying to record satisfaction with much in our established approach. However, one theme in particular emerged that indicated a need for improvement: the women wanted their single-sex groups to be held more frequently and to be longer. At the time the questionnaire was issued, the women's group was held once a week and for one hour only. Feedback showed their strong appreciation of the time allocated for them to talk specifically with other women about the problems they have encountered throughout their lives. Many of them reported that residential treatment was the first place where they felt safe enough to talk openly. There were comments from some women about how much they had learned about humility from each other in this setting.

Taking this feedback on board, the time allotted to women's group therapy was increased in June 2007. The group was divided into two and the time extended to one and a half hours, ensuring that each of the women had much more time in which to make use of the group.

One of the female clients commented: 'When we asked the counsellors to reduce the size of women's group by splitting into two, this was agreed and dealt with in a week's time. The result was fantastic.' Our current female clients report that these groups are very empowering in terms of the installation of hope and the opportunity to change 'old behaviour'.

Women often come into treatment telling us that they do not have any supportive female friends and that they 'get on with men better'. They go on to describe these relationships with men as 'abusive'. It is as if they are unable to break the cycle of abuse and seem unaware that they can learn to improve their self -worth independently of men.

We recorded the following comments from female clients on this subject: 'Women in addiction don't ever really relate well together and generally mix mainly with men or tend to be alone'; 'women are less likely to be able to manipulate each other'; and 'women are under pressure to please men and miss out on communications and friendships with women'.

We were interested to note that despite such comments, none of the women responding said that they would have preferred to have been in a single sex unit. In fact 68 per cent of those responding said they rated the experience as good and 30 per cent said it was excellent. Some of the comments were about the age difference between women, particularly where some had had problems with their mothers. There was a view that the mixed unit provided an opportunity for women to build back their trust of men and for men and women to learn to be around each other in a non-sexual way.

'Women often come into treatment telling us that they do not have any supportive female friends and that they "get on with men better". They go on to describe these relationships with men as "abusive". It is as if they are unable to break the cycle of abuse and seem unaware that they can learn to improve their self-worth independently of men.'

Some women said that although it was somewhat unusual for them to be 'sharing a bedroom at my age', they actually gained a lot from this by developing the kind of close friendship that many of them had not experienced before. An alcohol-dependent woman said she 'wouldn't like to share with an (drug) addict'. This prejudice was challenged when she experienced the support of her roommates (who were addicted to drugs) in resolving some of her problems in treatment – something she had previously felt she would never be able to do.

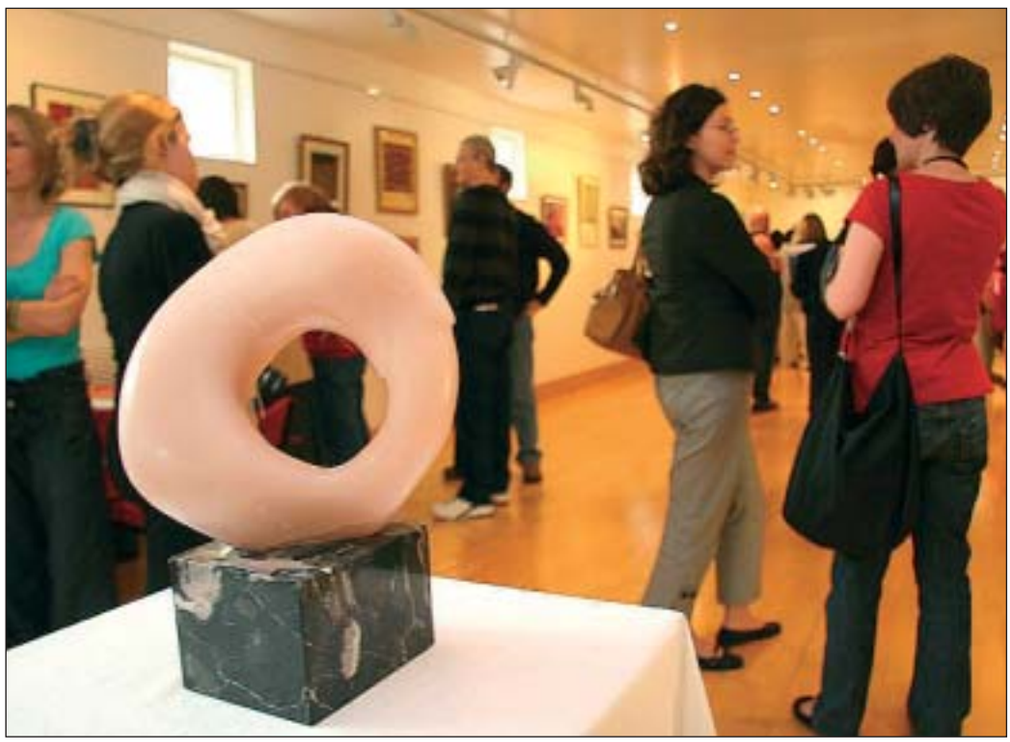
Some women told us that they appreciated the support and understanding offered to them around the issues of sexual abuse and self-harm. These issues are principally addressed in one-to-one counselling, mini-groups and in the women's group. As part of our ongoing training programme for the treatment team, we have revisited these areas with recent one-day workshops on addressing the issue of self-injury and of working with survivors of childhood abuse in residential treatment. We are holding another training day on eating disorders for members of the counselling and nurse teams.

Sunday visiting is an important part of the treatment timetable. There is an opportunity to have family meetings, and some children will be invited to take part in one or more of these sessions. On a practical level and as a result of the feedback, we have now improved our facilities for visiting children and we have a baby changing area and a stock of toys and games at hand.

In terms of their relationships with their children, the main source of the women's guilt appears to be around the lack of parenting skills and the behaviour that the children may have witnessed. Feedback from the questionnaire told us that coming face-to-face with family and friends for the first time when not under the influence of drugs or alcohol was a frightening experience for some women. They felt grateful to be in a safe place where they could process their thoughts and feelings after the visitors had left. Some of the women told us that they set up their own groups on a Sunday evening following these visits, and they can also access the in-house AA meeting held the same night. We now check in with them about this on a Monday morning and may follow this up with a meeting with a family counsellor to clarify the direction they would like to take in working with their families. They have reported that this has allowed them the chance to offer support to each other in coping with any difficult feelings and emotions they had felt. Again, this experience appears to have brought the women closer together.

One woman stated that she was very lucky that she had the support of parents who were able to look after her child while she was in treatment – if she had not had their help she would not have been able to go on to further treatment. It seems that funding is not always available for these women to consolidate their recovery as they are expected to return home to take up their child care, and this can be a major stumbling block in the provision of drug and alcohol treatment for women. Since the formation of Action on Addiction through merger, we now have the opportunity to offer a care plan that includes referral to Hope House, a women only service in London. We also work closely with the Nelson Trust as part of our co-operative 'Treatment Link' project.

In working on this project the wide range of support we do offer our female clients at Clouds House has come more sharply into focus and it is reassuring to find from client responses that we have generally been on the right track. We have watched the ratio of men to women in treatment shift from 2:1 to almost equal numbers in the past year, and we welcome this shift – part of which we believe may be the result of our increased sensitivity and responsiveness to women's needs. We have started off this year with the firm intention of continuing to collect the views and suggestions of our female patients, and hope to be able to respond to their feedback by making the changes needed to keep actively improving our service.



Art comes to life

Occupational therapy can open up a more creative route to recovery, as **Jenny Lancaster** explains.

The National Treatment Agency for Substance Misuse (NTA) stresses the importance of providing opportunities for service users to move through treatment towards employment, enhanced social functioning and community integration. Occupational therapists can play a key role in supporting service users to take steps along this treatment pathway towards greater independence.

One such route is through introducing workshops to promote positive lifestyle and health gains through the development of new interests and skills, away from drugs and alcohol. These projects aim to offer a supportive but non-medical context for the exploration and production of art, and can provide stepping-stones towards mainstream arts involvement.

In September an exhibition called 'Inside Out' was held at the Bhavan Centre in West London. This was a mixed-media exhibition of original artwork produced by users of substance misuse services within Central and North West London NHS Foundation Trust, and showcased work from 15 different projects including woodcarving, jewellery-making, stained glass, plaster relief, encaustic wax painting, mosaic, sculpture and batik. The project is a result of joint-working between service users, occupational therapists and Artspace – an innovative community based arts project that works with people with mental health or substance misuse problems. It is part of ACAVA (Association for Cultural Advancement through Visual Art), which is one of the largest arts organisations in London providing support for artists, and community and educational projects.

The Inside Out exhibition is evidence of many socially excluded service users making this transition. Participants have reported that art projects have helped to build self-confidence, a sense of belonging and increased responsibility, as well as helping to achieve personal goals related to education, vocational and leisure activities.

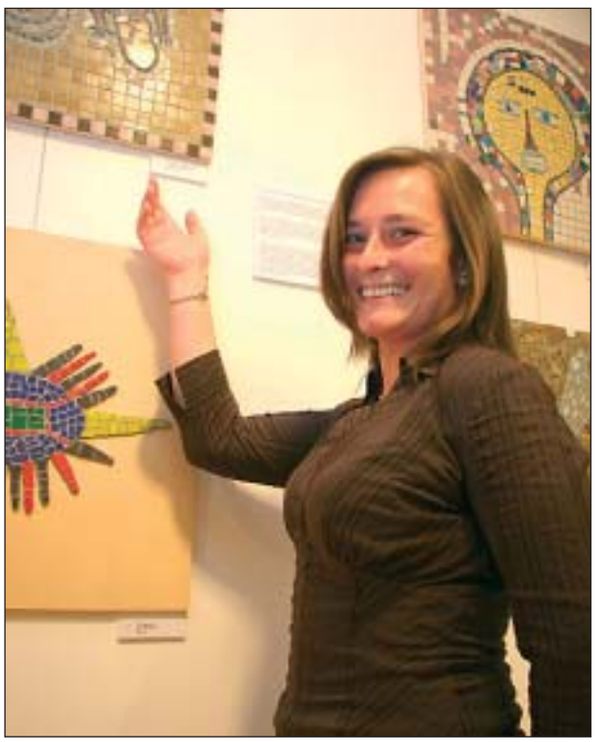
A service user's picture

Gillian Mowberry (pictured, right) found that substitute prescribing was not enough to make lasting changes to her drug use, until occupational therapy and the Artspace programme helped her to redraw her horizons.

'When I came to the clinic I was not the person I am today. I wanted to give up drugs but every attempt had failed miserably. I had attended a treatment clinic before, but all they gave us was medication, and after a few months I was using again. Since I have been with this clinic I have had huge support and help from everyone who's worked with me, but especially my occupational therapist.

'I went to her initially to start a gardening project, which began shortly after. From that day, she and I had regular meetings in which we talked and tried to assess what might help me back on my feet again. From the day I met my OT my life has got better and better. I have been involved in numerous OT and Artspace groups and each one has given me something new. The sense of self-respect and self-belief I now have is something I never thought possible, and I can say in all honesty that I would not be the person I am today without the help and support of my occupational therapist and Artspace.

'These services help people who want to change their lives and become productive members of society. A life that consists solely of getting money to keep an addiction to drugs or drink is an all-encompassing thing. To try and stop using drugs and drink is an awful lot



harder than it sounds – without proper help medically and mentally, it is a near impossibility for some, which is why such services as Artspace and OT are critical. Many people think that it is just a waste of public money, but the help they provide is as vital as the medication.

'The OT-Artspace projects help in ways you wouldn't even imagine: something as simple as getting you out of the house and facing life, instead of sitting alone brooding, which in turn creates boredom or depression – both of which can lead straight back to drugs or alcohol.

'Giving people a routine to stick to, and a goal to aim for, are among the most basic things that will put someone on the track to recovery, and a new and better life. Not only does it help in that way, but meeting people and socialising also gives confidence and self-belief – all of which is taken for granted in most people. But they can be the hardest things to instil in someone whose life has been on the fringe of society for the length of their addiction, which in most cases is years, if not decades.

'To go to a group and be given a task to do with a professional, and have all the materials at hand; to decide with the whole group or individually what you will do, and to actually create a piece of art at the end is an amazing achievement. And, I know from personal experience that the confidence and self-respect it can give are second to none in making a person believe in themselves, and convincing them that whatever they put their minds to, they can achieve with a lot of hard work and self-motivation. This encourages them to believe that holding on to those feelings can beat their addiction and help them become the person they so desperately want to be.

'I have so much confidence in this system, and now in myself, that I am about to start an access course in occupational therapy, and then go to university to get my formal OT qualification. If I can help one person as much as these services have helped me, I will be a happy woman. I know I'm not the only one whose life has been literally saved by the occupational therapy service and Artspace, and I'm sure I won't be the last.'

Jenny Lancaster is senior occupational therapist at Westminster Treatment Centre, London.

FACT FILE

Service User Groups

This issue: Ron Overton from Rotherham Service User Forum

When and why did you start your group?
The group was formed after a consultation and training event on service user involvement. The event brought together service users and carers, service provider managers and key workers and commissioners of Rotherham. It finished off with a commitment between all who attended to drive service user involvement in Rotherham.

How many members do you have?
Membership ranges between eight and 12, with on some occasions meetings reaching 16.

How did you obtain funding?
Funding is provided by the Rotherham DAT.

Where and how regularly do you hold meetings?
Meetings are held fortnightly.

What do you hope members get from attending?
Members attend to find out what is happening with the action plan agreed at the consultation event. They have been involved in developing Rotherham's service user involvement strategy and are involved with any planning and development taking place within the services. They help with surveys and feedback by giving service users points of view, and once a month a service manager attends to discuss activity within their provision and answer any questions members have.

How do you keep it going?
The DAT employs a service user involvement co-ordinator who works with the group, arranging meetings, organising events, and supports the group with developing itself.

What have been your highlights so far?
The service user strategy has been ratified by all providers and the DAT. We have members who attend strategic planning groups, and we are becoming involved at all levels. We have done this in the last 12 months of being formed.

How do you communicate with your members?
We communicate through our regular meetings, and by email and mobile phone.

Have you any tips for others starting a group?
Keep going and don't get disillusioned if things seem to take a long time. Until you get to know the system, you don't see the work being done behind the scenes.

We did it!

Our regular columnist **Daren Garratt** takes a moment to reflect on our first user involvement conference on 31 January, when service users from all backgrounds came to Birmingham with professionals and policymakers for a lively day of debate.

I don't know how but *DDN* and The Alliance managed to pull off a not inconsiderable feat last week by successfully organising, hosting and delivering the Nothing About Us, Without Us Conference in Birmingham; and what a conference it proved to be.

I still can't get over how truly overwhelmed, humbled and excited I was by the turn-out, energy, commitment, passion and belief of so many delegates, and I honestly don't think I've experienced such a rollercoaster ride of emotions since I watched my daughters being born, or heard the playback of the Nightingales' *Out Of True* cd for the first time. One of our primary reasons for taking on such a ludicrous venture was because we were worried about the future of user involvement post the ten-year strategy; however, the user presence and contribution last Thursday has largely laid those fears to rest and I want to take the opportunity to thank all those users present for what they achieved.

You were the ones that proved that effective, targeted user involvement works. You were the ones that showed that users can move on, bring about change and make a difference. You were the ones that evidenced that treatment works, and that it works best when the ones that are receiving the treatment are listened to, respected and trusted to take control over their own health, lives and futures. You were phenomenal.

From our perspective, and by us I mean the Alliance and *DDN*, we know that as successful as the day proved to be, there were still some shortcomings and some things we'll need to put right in time for next year's conference, should users want us to host such an event again.

The facilitated discussions in the afternoon, for instance, may seem, to some delegates, to have lost focus and become confusing. But they got strangers talking, swapping stories and ideas, and hopefully gave enough people enough positive suggestions to see loosely directed chat translated into effective action when they get home. In conceiving this format we had a specific purpose that came to fruition: to gather hundreds of post-it notes with thoughts on all aspects of user experience. These will be taken beyond the conference and fed into the special issue of *DDN*, out on 25 February.

Similarly, with hindsight, we should have had evaluation forms available for people to share their ideas, thoughts and feelings at the time, while they were fresh. So can I ask that when all the delegates do receive their evaluation forms – either electronically via email or, where possible and appropriate, in the post – you fill them in as honestly and openly as you possibly can, and try and remember, and draw upon, the feelings you had at 4pm on Thursday 31 January, rather than the ones that come with the safety of distance; because we need to know what did and didn't work if we're going to run one of these things again.

Which is where we need to acknowledge the unbelievable work, effort and belief of Claire and Ian at *DDN*. They didn't need to organise this conference but they wanted to, despite having no conference organisation experience before. They worked to a delegate list of about 250 people being an indicator of absolute maximum, top-limit success, so when it nudged 600 and it STILL ran seamlessly and professionally without losing its way and descending into chaos, you know wholeheartedly that you picked the right partners to make your vague dream a fantastic reality.

We also need to acknowledge the hard work and commitment of the Alliance staff and our volunteer group of table facilitators and thank them for the role they played in bringing the various strands of the day together, alongside all the speakers and panellists who hopefully provided everyone with a range of ideas to chew over!

Despite all the positive feedback we're getting, I know the conference won't have been viewed so successfully for everyone in attendance. With such an ambitious remit, you expose yourself to the risk of not matching everybody's expectations – there are bound to be disappointments and even some charges of unprofessionalism and tokenism. But as a bedrock on which we can build, grow and embed effective, targeted user involvement into core strategic and operational procedures, I think we all surpassed our wildest expectations.

Most importantly though, as a vibrant, passionate celebration of what users can achieve when encouraged and allowed to work in true partnership with medical professionals, and as an unprecedented example of users from all modalities – be they street users, long-term maintained patients, or abstinent followers of the Fellowship – coming together to support each other and hear and share each others concerns with tolerance, dignity and respect and promote a united, articulate and unarguable voice, I think YOU pulled off the greatest coup of all.

Daren Garratt is executive director of the Alliance.

Treatment of substance use problems: Reflections

Before starting a new series of Background Briefings, Professor David Clark reflects on a variety of aspects related to treatment of substance use problems.

Most people who try illicit drugs or drink alcohol do not go on to experience problems. However, a significant minority do experience problems that eventually impact negatively on their physical and mental health and their social circumstances.

This harm can arise from the direct negative effects of drugs (*eg* long-term alcohol causes liver damage), indirect effects arising from repeated withdrawal symptoms (eg depression from long-term cocaine use), and the negative effects arising from the lifestyle associated with illegal street drugs (*eg* homelessness).

Long-term drug or alcohol use can lead to dependence or addiction. In simple terms, addiction can be seen as an impairment of a person's ability or power to choose. The substance becomes more important than other aspects of their life, which the majority of people would consider as essential. Addiction drives forward heavy and persistent substance use, ultimately increasing the incidence of harm.

Addiction is a complex condition involving biological, psychological and sociological components that represents a major challenge to treatment practitioners. Unfortunately, there are no magic bullets or simple interventions that are all embracing in the treatment of addiction.

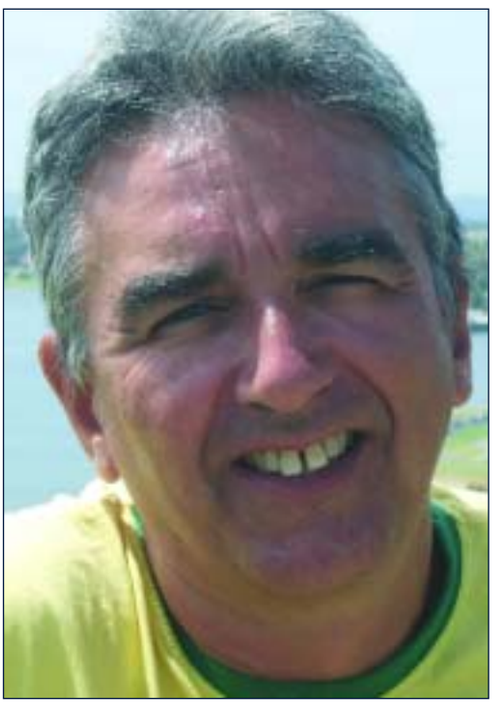
Drug and alcohol treatment services exist primarily to help and support those people who develop problems from their use of drugs and/or alcohol. A range of services and agencies have evolved that aim to reduce the harm that individuals cause to themselves.

Treatment may involve clients abstaining from drugs or alcohol completely, or may involve a form of harm minimisation, such as encouraging clients to use clean needles to inject in order to minimise the risk of infections, such as HIV or hepatitis.

People present for treatment, advice and support at various stages of their substance-using career. Therefore, treatment agencies need to be able to respond to a variety of different situations that may involve different interventions.

Some people who use drugs recreationally may only require information and advice from a treatment agency. Others can be helped by a brief intervention. For example, a brief intervention may involve the assessment of alcohol intake and alcohol-related problems, followed by information about how to cut down on drinking and use a drink diary.

Some people present for treatment with severe substance use problems. A significant proportion of these people will present with a variety of other intimately related problems. They may be homeless, jobless and experiencing problems with personal relationships, have a history of criminal activity, and have a physical and/or mental health problem.



'People present for treatment, advice and support at various stages of their substance-using career. Therefore, treatment agencies need to be able to respond to a variety of different situations that may involve different interventions.'

People with severe substance use problems often require an extensive package of treatment and aftercare, sometimes involving medical, psychological and social interventions. The importance of aftercare should not be under-estimated. It is much easier to stop, than to stay stopped.

It is widely accepted that the best approach to treating a person with a serious substance use problem is to treat the individual as a whole (holistically), rather than simply focusing on trying to reduce his or her intake of substances.

Thus, in trying to help people overcome their substance use problem, treatment services may need to help clients access other forms of support, such as housing services, social services, mental health services, education and vocational training.

Practitioners must also be aware that addiction is a relapsing condition. Some people remain abstinent for many months or years before initiating substance use again, while others continue to periodically pop in and out of treatment agencies over long periods of time.

Other people who visit a treatment agency permanently abstain from drugs and alcohol and go on to lead full and healthy lives. In fact, their recovery may represent a better life than they had prior to developing their substance use problem.

Many people seek out treatment services because they want to stop using substances, but believe they cannot do it themselves. They look to other people to help them overcome their substance use problem.

Some of these people find they cannot just stop using, so it is essential they receive support that helps them minimise the harm that drugs and the drug-using lifestyle cause them.

They may decide after an initial visit to an agency to use needle exchange facilities, and at a later stage feel ready to engage in a methadone programme. Some time later, they may decide that they want to be abstinent from all substances, but this process may involve various stages. Some people access treatment because they are seeking relief from the discomfort or pressures of a drug-using lifestyle. The day-to-day existence of someone with a serious substance use problem can be tough and the person may look to others for help in dealing with problems in their life.

Treatment agency workers can support users through periods of crisis, *eg* helping them deal with homelessness, problems receiving benefits, or health problems. Often their role will involve facilitating access to others who can provide more direct help.

In these circumstances, agency workers can take the opportunity to engage users in other services, educate the user about harm minimisation, and try to enhance motivation for behavioural change.

Tameside Metropolitan Borough
"An excellent council"

Tameside Metropolitan Borough Council

Tender for Tameside Criminal Justice Treatment Service

The Tameside Crime & Disorder Reduction Partnership acknowledges that reducing substance misuse is a key factor in tackling crime and disorder.

The Tameside Crime & Disorder Reduction Partnership invites suitably experienced and qualified organisations to work in partnership with the Council to play an integral role in the delivery of a substance misuse treatment service in Tameside as part of the Drug Intervention Programme.

The Service Provider will offer access to drug treatment and support to adults (18 years +) who commit crime to fund their drug misuse, whilst working in partnership to make Tameside a healthier and safer place.

It is proposed that the Contract will commence on 1st August 2008 and will run for a period of three years to 30th June 2011, subject to annual reviews.

The award of the contract will be in keeping with a Best Value approach, which will jointly evaluate quality factors and price.

The closing date for the return of tender documentation is noon on Monday 10th March 2008.

A decision on this contract will be made on Monday 14th April 2008. The successful Organisation will be notified on Tuesday 15th April 2008.

Organisations interested in applying should request a Tender Application Pack, which can be obtained via the following methods: In writing to: Nichola Thompstone, Community Safety Unit, Tameside MBC, Wellington Road, Ashton-under-Lyne OL6 6DL. Via email to: nichola.thompstone@tameside.gov.uk Subject line must be headed up as follows: 'Tender Application Pack request – Criminal Justice Treatment Service'.

A CD is available to assist you to submit a typed response. Please give clear indication in your request if this is required.

Environmental Services Department

PROLIFIC OFFENDER AND DRUG INTERVENTION STRATEGY MANAGER

Post no: ES-NSDA-004
Scale PO 11-14 £34,991 - £37,543 p.a. Subject to Job Evaluation
Hours: 37 per week
Base: Unity House, Westwood Park Drive, Wigan WN3 4HE

Wigan is on a journey from excellent to outstanding and we are looking to transform the way in which we provide services to our communities. One of the Community Safety Partnerships key priorities is to reduce re-offending in particular amongst those offenders who cause our communities most harm. We are therefore looking to recruit an outstanding individual who will drive the delivery of our Prolific and Priority Offender and Drug Intervention Programme strategies.

We are looking for a skilled and innovative individual with proven leadership and performance management skills to deliver sustainable performance improvements in how we manage our offending population. Working on behalf of the Community Safety Partnership, using your excellent visioning and influencing skills you will continue to develop our strategies, motivate and enthuse partners and providers to work together to provide premium services to those who are most in need of our support. You will have experience of influencing policy and managing in a multi agency setting and be a true team player who is resilient, confident and motivated by a desire to improve. You should have management experience in a related field and be fully conversant with commissioning services to best value principles. The ability to work in a political environment, and using evidence of what works to achieve best results are key qualities we are looking for.

This post is subject to Standard Disclosure procedures.

For further information or an informal discussion, please contact Nicola Yates, Assistant Director, Community Safety on 01942 488301.

To download an application pack visit: www.wigan.gov.uk/pub/jobs or email: jobs@wigan.gov.uk quoting the job reference number or telephone 01942 827678 (24 hour). Minicom: 01942 827186.

Closing date: 29 February 2008.

"The Council is committed to Equal Opportunities in employment and welcomes applications from all sections of the community"

Wigan Council

BBT are specialists in Social Care recruitment

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- **Substance Misuse Nurses**

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Criminal Justice Drugs Practitioners

Birmingham

Our client requires criminal justice substance misuse practitioners to work within a DIP setting. The applicant must have held a case load of class A adult users and have experience conducting assessments and designing and developing care plans. Any experience working with substitute prescriptions and working in an outreach capacity would be beneficial.

The applicant will be required to work as a member of a multi disciplinary team within a Drug Intervention Programme, working towards the reduction of re-offending and drug related harm. The candidate will be delivering a range of direct interventions to individuals on the caseload who have a DRR in addition to key working these clients. The applicant will also be involved in referrals and may be providing harm minimisation advice to chaotic substance misuse clients.

The initial posts are temporary offering excellent hourly rates, however there may be opportunities for permanent positions.

If you have any queries please don't hesitate to call Chris Musgrove on 0800 3112020 or email chris.musgrove@servicecare.org.uk

www.drinkanddrugs.net

Drugs and Homeless Initiative

"Meeting the Needs of the Individual. Making a Difference in the Community"

The Drugs & Homeless Initiative is an award winning charity that seeks to assist people to address problematic drug and alcohol use, with particular regard for those who are socially excluded as a result of poor housing, lack of employable skills or other means.

Director of Operations (based in Bath or Swindon negotiable)

Salary scale: NJC pt 50-55 (£40,965-£45,407)

This is a new and exciting opportunity for a dynamic individual to lead and develop upon DHI's operational management structure.

The ideal candidate will possess excellent leadership, negotiation and interpersonal skills. They will have experience of senior management including, overseeing operational development, performance management, monitoring and auditing and quality assurance systems. Ideally you will have an understanding of current practice and trends in substance misuse and housing; to ensure DHI's commitment to operational excellence and development of best practice. A professional qualification in management, health or social care is desirable.

Interviews for this post will be on 6th and 7th March, candidates will need to be available for both days.

Senior Support Worker (Wiltshire based)

Salary scale: NJC pt 26-29 (£21,412-£23,749)

We are looking to recruit a Senior Support Worker based in Corsham. Community4 is a consortium of four organisations, including DHI, working together to provide housing related support to people living in Wiltshire.

You will have a comprehensive understanding of assessment and support planning systems and the ability to provide case management to workers. The successful candidate will ideally have sound experience of providing effective support to people with differing needs. You will be responsible for the electronic referral and allocation system and will therefore need excellent IT skills.

Housing Support Workers (Positions in Bath, Swindon and South Gloucester)

Salary scale: NJC pt 22-26 (£18,895-£21,412)

DHI is looking to recruit several positions across its housing services. Applicants should have experience of support working, preferably in the housing field and have an understanding of issues facing vulnerable people and those with substance misuse problems.

Benefits include 25 days annual leave, a commitment to training, and an optional contributory pension scheme.

Application packs and further information can be downloaded from DHI's website at: www.drugsandhomeless.org.uk or by calling 01225 329411.

Closing date for all posts: 20th February 2008 at 5pm.

DHI is striving to be an equal opportunities employer *Registered charity no. 1078154*

Cumbria Partnership NHS Foundation Trust Tel: 01228 602386 NHS

YOUNG PEOPLE'S SUBSTANCE MISUSE HEALTH PRACTITIONER

• AFC Band 6, £23,458 - £31,779 p.a. • 37.5 hours per week
• Based in Connexions, Carlisle • Permanent • Ref: 10/08CP

An exciting opportunity is available for a suitably qualified individual to work with young people who misuse substances. You will be employed by Cumbria Partnership NHS Foundation Trust but will work into and liaise with the staff of Straightline.

You will provide individual support for young people who misuse substances, provide comprehensive assessment, care planning, risk assessment and treatment interventions in the community.

You will work within a multi disciplinary approach with young people suffering from multi-complex needs and work within a model of Shared Care, working with and advising GPs and enhance GP skills in detection and management of young people with substance misuse problems and working directly with a Consultant Psychiatrist with expertise in drug and alcohol issues.

You will reduce referrals to the specialist services for patients with less complex medical needs and problems and hence enable the patient to be treated in primary care for as long as possible.

We are looking for an individual who is highly motivated and has the ability to work under their own volition. You will need to have excellent communication skills and the ability to work in what can be a challenging environment.

You are required to have an RMN Level 1 or equivalent training, or/and a professional knowledge acquired through degree supplemented by a diploma or equivalent. Skills and competencies gained post registration in a health care service provision and working with young people who misuse substances is also essential.

For informal enquiries, please contact Jonathan Comber, Operations Manager on 01228 603017 or email: jonathan.comber@ncumbria.nhs.uk

Closing date: 25th February 2008.

APPLICATION INFORMATION

Apply online now at **www.jobs.nhs.uk**

Cumbria Partnership NHS Foundation Trust

For further details/application form, email: recruitment@ncumbria.nhs.uk or tel: 01228 602386 (24 hr answerphone). CV'S WILL NOT BE ACCEPTED.

We are committed to Equal Opportunities, Improving Working Lives and operate a No Smoking Policy.

For more details on these and other vacancies please visit: **www.cumbria.nhs.uk**

An exciting career opportunity in alcohol treatment

MOUNT CARMEL

South London

Salary Scale: £24196 - £28589

(plus health and pension package)

Mount Carmel is a successful, innovative and expanding abstinence based treatment centre based in Streatham SW16 providing residential care, day care, aftercare, family support and move-on accommodation.

We require one new staff member to join our established team

We are looking for an enthusiastic, motivated person with an interest in alcohol addiction who is able to use their experience and qualifications as an counsellor, project worker or RMN to work as part of our team. You will be responsible for facilitating group and individual therapy sessions, and for general duties involved in the running of a busy treatment centre. Ongoing training will be provided as required.

The package includes a salary of up to £28,589 inclusive of London Weighting, depending on experience for a 37 hour week. Salaries are reviewed annually, and we offer both a useful healthcare scheme and a generous non-contributory pension.

For an application pack please contact the Administrator Tel: 020 8769 7674
Email: mountcarmeluk@yahoo.co.uk

Closing Date: 25 February 2008