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DDN
Drink and Drugs News

11 September 2006
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RELAPSE PREVENTION
Gorski on improving patients' chances of recovery

PASS OR FAIL?
We ask two alcohol experts for their verdict on MoCAM

THEM AND US
Overcoming prejudice within treatment services

GOING SOLO
Tier Zero – do users tackling addiction alone deserve more support?

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We want to know what the users of treatment services think. Their views will help us all make their treatment better. Please encourage your clients to complete the questionnaire.

If you need more copies of the questionnaire for your clients, please contact NTA Research on 020 7261 8959, or by email at research@nta-nhs.org.uk

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Federation of Drug and Alcohol Professionals

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Drink and Drugs News in partnership with:

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Editor's letter

We're back from our August break, and it's good to be hearing from you again!

As the heatwave becomes a dim memory the conference season is revving up with new vigour and planning is underway for next year. With this autumnal burst of energy in the air, it seemed appropriate to feature the theme of empowerment.

With the constant emphasis on affording and allocating treatment places it's easy to overlook that many people – in fact most people, according to Anthony Hewitt in his cover story – tackle their addiction themselves, without seeking help from services or self-help groups.

It makes a lot of sense to look out for these people, offering brief interventions and support as and when they need it. We spend a lot of time helping clients to remove themselves from everyday life to give themselves the best chance of complete uninterrupted recovery – and then more time working out how to reintegrate them to society and support services.

Fitting the jigsaw of support around them before they give up and fall apart not only makes economic sense; it's can also be magnificent affirmation to the individual that they have power over their destructive behaviour – that they have done something amazing to change their life.

The other obstacles to many, of course, are the currents of prejudice that turn their treatment episode into an experience of stigma. This is a different scenario when someone is forced to 'go it alone' because they feel excluded because of their race, religion or sex. On page 8 George Morris shares the experiences of Project 8 in Liverpool, where lessons have been learned from those entrenched in the 'them and us' syndrome to make sure that others in the community get a fairer chance.

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

Cover: VISUM Foto GmbH

In this issue

News in brief

Welsh helpline established

Wales' first free and bilingual drug and alcohol helpline is now fully operational. The helpline provides 24 hour advice to drug and alcohol users, providing them with information on reducing the risks associated with substance misuse and how to access local treatment and support services. The helpline is being provided by substance misuse service provider Cais Ltd, in partnership with the Welsh Assembly Government. The helpline number is 0800 633 5588.

Cocaine drug deaths on rise

Cocaine was present in more Scottish deaths than ever before, according to figures released by the General Register Office in Scotland. The class A drug was present in 44 deaths in 2005, up from 38 in 2004. Heroin remains the most common drug involved in deaths, present in 58 per cent of drug-related deaths. But the overall news is positive, with the number of drug-related deaths falling to 336, down 6 per cent on the 2004 figures and down 12 per cent on the 2002 figures.

Online resource for recovery

A new website for people recovering from drug or alcohol dependency will be launched later this month. The Recovery Café will offer people in recovery a safe space to share experiences and learn more about the process. The website is part of the Drug and Alcohol Recovery Network, which was founded by Richard Carus. 'As a recovering alcoholic, I really missed the friends I had met in treatment, and I could no longer associate with certain people from the "old days" and felt it was important to develop a circle of new friends,' Mr Carus said. 'I spent many hours in internet cafes searching for a UK site where addicts could talk to each other…eventually I realised there were no suitable online sites for drug and alcohol support, and so I decided to form DAARN.' www.recoverycafe.co.uk

Phoenix House chief exec leaves

Bill Puddicombe has announced that he will leave the drug and alcohol research charity after nine 'thoroughly enjoyable' years, having decided to take a career break. 'I had always promised myself that if I get the opportunity to spend some time doing a bit less for a while I would,' he commented. Phoenix House's Chair, Dick Holland, said Mr Puddicombe had been 'outstanding'.

Quay Project set for launch

Broadreach House will launch its pioneering project in Plymouth on 21 September. A partnership between Working Links, Trevi House, the Workers' Education Association and Family Matters, the project offers practical support to bridge the gap between drug and alcohol treatment and mainstream society. Contact Broadreach House at www.broadreach-house.org.uk

New action plan to reach drinkers

There is a 'tremendous opportunity' to identify and help problem drinkers within GP surgeries and other primary healthcare settings, according to a new report.

The report, published Alcohol Concern and compiled by the Primary Health European Project on Alcohol (PHEPA), calls for primary healthcare professionals to identify those most at risk, and provide them with on-the-spot advice and support to encourage them to reduce their alcohol consumption.

It proposes the widespread implementation of a screening and brief intervention strategy, under which primary healthcare professionals are charged with asking patients about their drinking habits, and providing immediate support for those who need it. The report sets out an eight-point plan for action, which includes a national training scheme for doctors, nurses and other practitioners to identify problem drinkers and a financial incentives scheme to encourage healthcare professionals to carry out the work.

'Members of primary health teams in the GP surgery, where problem drinkers present twice as often as others, need to be familiar with problem drinking patterns and need to be able to offer initial support to enable patients to make informed choices about alcohol and their health,' said Prof Mayur Lakhani, chair of the Royal College of Physicians. 'The implementation of this strategy will not only increase the skills and confidence of NHS staff – particularly primary health care teams – in treating patients with alcohol problems, but it will also play a large part in arresting problem drinking patterns before they cause further damage to patients, their families and communities.'

Nick Heather, report author and Emeritus Professor of alcohol and other drug studies at Northumbria University, agreed, and noted that if the majority of GPs routinely gave advice to heavy drinkers visiting their surgeries, there would be a large improvement in the health of the general public. Don Shenker, director of policy and services at Alcohol Concern, called on the government to act swiftly to ensure primary healthcare professionals had the necessary training and resources to carry out the screenings and interventions.

Health Interventions for Problem Drinkers, available at www.alcoholconcern.org.uk/files/20060815_123248_PHEPA%20Summary.pdf

Charities call for national inquiry

A coalition of welfare charities and academics has called for a government inquiry into the issue of parental alcohol misuse in the UK, and its impact on children. Led by Turning Point, the coalition has written to children's minister Beverley Hughes calling for an examination of the widespread implications of parental alcohol misuse and the subsequent development of new services that will help both children and parents rebuild their lives. Eleven organisations signed the letter, including Alcohol Concern, Adfam, Barnardo's, DrugScope and the National Association for Childrens of Alcoholics.

'The government cannot ignore the children and families affected by alcohol misuse any longer. We are dealing with a major social and public health challenge which devastates hundreds of thousands of lives,' said Lord Victor Adebowale, chief executive of Turning Point. 'The strength of support from leading organisations and from the general public is giving the profile of this issue a great boost. We hope to see imminent commitment from the government to assess the scales of the impact of parental alcohol misuse and begin to work with agencies to find new ways to support families.'

The letter is part of Turning Point's campaign – Bottling it up – which aims to raise public awareness about how parental alcohol misuse can affect children. It is estimated that 1.3 million children in the UK are affected, and this can cause behavioural, emotional and school-related problems. For example, many children in this situation are more likely to express anger through antisocial behaviour and develop alcohol problems themselves.

Obituary

Richard Parsons – (1966-2006)

Richard Parsons died in a surfing accident in New Zealand on Saturday 2 September.

Richard was a skilled and respected drugs worker and educator. From 1997 to 2004 he worked for Dorset County Council as a senior practitioner. He established the county's drug service for young people and was a key contributor to Dorset's success in gaining Beacon Council status for its work in this area.

Richard also conducted research on substance use among looked after children; designed a screening tool for use in the county; pioneered treatment for young people in primary care; and developed services for children with drug using parents.

Richard will be remembered by many for the educational work he did on the issue of substance use. He was responsible for training a wide range of local agencies from housing associations to the Army. His presence and delivery as a trainer were inspiring, and although his views and analyses could challenge audiences, no-one ever failed to respect his intellect and commitment.

In 2004, he moved with his family to New Zealand to work as an alcohol and drugs therapist with Taranaki Health Board.

Outside of work, Richard's passions were his family, surfing, and vintage Volkswagens. He is survived by his wife Kate, and his children Liam, Megan, and Jack.

Eye-catching accessory for a girls night out

An eye-catching information leaflet on the dangers of female binge drinking has won accolades for the West Lothian drug action team. The leaflet, which is in the shape of a handbag, has been nominated for an Association of Public Service Excellence award in the category of best healthy living initiative. *Everything you need for a good night out* was produced by the team in response to the growing number of young women who are drinking to excess. The leaflet folds out to reveal a comic strip that illustrates the health and personal safety risks associated with binge drinking.

'We are extremely pleased to be nominated for this award,' said Hilary Smith, research and development officer for the West Lothian team. 'The leaflet has proved extremely popular with young women, and we have attracted interest from other drug action teams that are keen to publish our leaflet in their area.' The leaflet was produced in partnership with West Lothian drug and alcohol service and the Lothian and Borders police.

Truant teens more likely to drink and take drugs

Children who skip school are more likely to smoke, drink and take drugs, according to the latest government statistics. The results, from a 2005 survey of 9,000 secondary school students aged 11- to 15-years-old, were published in August by the Information Centre for Health and Social Care.

The figures show that more than half of students who had truanted in the last year reported they had drunk alcohol in the week before the survey, compared to 17 per cent of non-truants.

Around 43 per cent of truants had smoked in the week before the survey, compared with just 7 per cent of non-truants, and 37 per cent of truants had taken drugs during the month before the survey, compared to just 6 per cent of non-truants.

The patterns were similar for those students who had been excluded from school in the last year. Forty-one per cent of these students said they had drunk alcohol in the last week, 40 per cent said they had smoked in the last week and 36 per cent said they had taken drugs in the last month. This compared to 20 per cent, 10 per cent and 8 per cent respectively of students who had never been excluded from school.

Overall, only 11 per cent of students said they had taken drugs in the last month, a similar proportion to previous years. As in previous years, the most common drug consumed was cannabis, with 12 per cent of students reporting they had taken the drug in the last year. Only a small number of students – 4 per cent – said they had taken class A drugs in the past year.

'We need to bear in mind that children who use drugs are in the minority,' said Prof Denise Lievesley, chief executive of the information centre. 'Equally we need to be aware of the effect drug use can have on the more vulnerable young people in society and this data can help us identify those most at risk.'

Drug use, smoking and drinking among young people in England in 2005 can be downloaded from www.ic.nhs.uk/pubs/youngpeopledruguse-smoking-drinking2005/report/file

Alcohol Focus Scotland's national licensing conference

Patrons playing safe in Glasgow

Recent initiatives to promote responsible drinking are having a positive effect on Glasgow's nightlife, according to Willie Caie, programme manager of the Glasgow City Centre Alcohol Action Group (GCCAAG). Speaking at Alcohol Focus Scotland's national licensing conference, Mr Caie summarised the successes of the GCCAAG's Playsafe in Glasgow scheme.

Along with launching a major communications campaign on safe drinking in October last year, the group has created the Nite Zone scheme, under which action group partners worked to improve the environment and safety of the city centre. Additional lighting was installed, CCTV coverage was enhanced, and concerted efforts were made to help patrons from local licensed venues to make their way home safely – for example, marshals were employed to monitor taxi queues. These measures, Mr Caie said, have contributed to a 13 per cent reduction in violent crime in the city centre, and a 61 per cent increase in arrests. Taxi waiting times have also been reduced from one hour to 15 minutes.

Mr Caie also detailed the successes of the Best Bar None awards, launched in July last year, which are open to all licensed venues in the city centre to give them the opportunity to prove they meet certain standards. The award has won the support of the sector, and to date, 39 awards have been granted. Mr Caie said that the awards had prompted some venues to become more diligent in complying with their licensing conditions, and he noted there had been a notable reduction in the number of irresponsible drinks promotions.

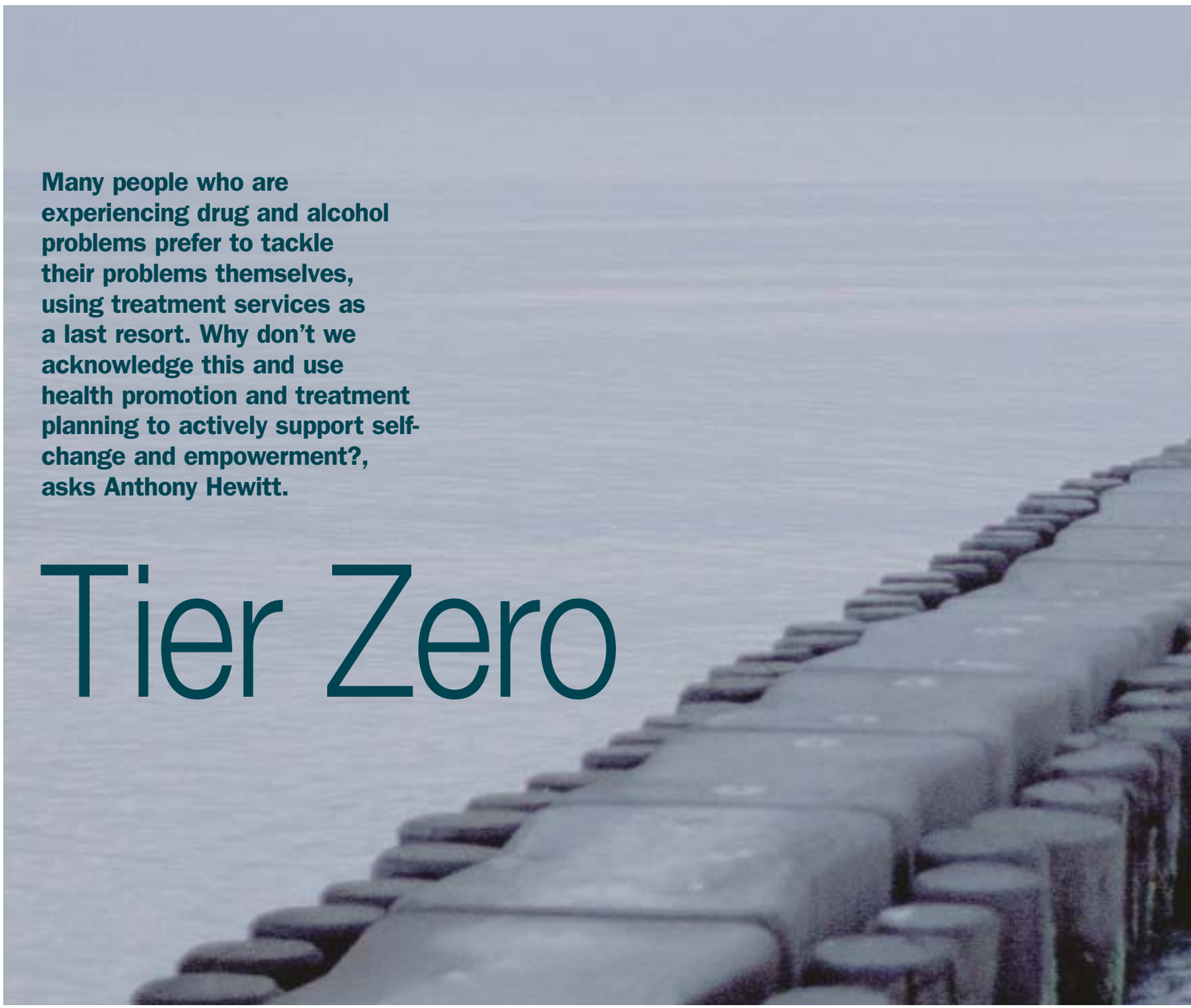
But while these successes were to be celebrated, Mr Caie said there were still significant challenges to be addressed. 'Alcohol is cheaper than ever before, it is easier to obtain than ever before, and alcohol consumption levels are increasing,' he said.

Police crucial to licensing process

Police officers will have a key role in enforcing the Licensing (Scotland) 2005 Act, and the force must be prepared to deal with the coming challenges, Superintendent John Farrell, of Strathclyde police, told delegates at the Alcohol Focus Scotland conference.

The next two years, he said, would be 'business as usual' but between February 2008 and August 2009, more than 7,000 premises would submit applications for a liquor licence. Under the new laws, stakeholders and public bodies, such as the police, will have greater grounds on which to lodge an objection. The objectives of the act included securing public safety and preventing crime and disorder, he noted, meaning the police were under an obligation to become involved in the licensing process, and ensure that, for example, any incidents of antisocial behaviour or offences were taken into account when a premises' licence was up for renewal.

Supt Farrell emphasised the necessity of promoting responsible drinking and licensing laws when he pointed out that Home Office reports estimate that 40 per cent of all violent crimes, including 78 per cent of assaults, are committed while the offender is under the influence of alcohol. In addition, he noted that 20 per cent of all violent incidents occur in or around pubs and clubs.



Many people who are experiencing drug and alcohol problems prefer to tackle their problems themselves, using treatment services as a last resort. Why don't we acknowledge this and use health promotion and treatment planning to actively support self-change and empowerment?, asks Anthony Hewitt.

Tier Zero

If a DAAT has managed to establish that there are 5,000 problem drug or alcohol users in their area, does that mean they need 5,000 treatment places? No, it does not, and it never will.

Our beliefs as drug and alcohol workers about addiction and dependency are heavily influenced by our work experience: it takes years of struggle; considerable resources are required; abstinence is the only safe end-option, *etc*. But as we often forget, the reality is that we only see the tip of the iceberg, and it would be a mistake to think that we can develop an understanding of substance misuse problems based only on what we see presenting to services.

The fact is, most people (research shows as many as 50 to 80 per cent) who experience significant problems with drugs or alcohol (or for that matter eating, gambling, smoking) manage to get on top of these problems without professional help from either drug or alcohol services or self-help groups.

Natural recovery, spontaneous remission, self-change: there are many terms used in relation to this phenomenon – but what are its implications? What can we learn from the studies of those who managed to overcome their problem without specialist help?

Much of the research in this area asks why people didn't seek specialist help, and there is clearly much we can learn from this to improve take-up of services, particularly for groups such as stimulant users and ethnic minority users who could benefit from services but do not appear to be taking them up.

Reasons for people not seeking help include: the stigma associated with being labelled; belief that the need the person has does not match the services on offer; and the conclusion that they would rather handle their problems on their own.

Self-recovery offers a number of immediate benefits. There is less cost, less disruption to the person's life, and less addict identity and stigma.

They can gain an increased sense of self-efficacy and a feeling of individual empowerment.

Interestingly, self-change may be more common among women than men, and there may also be differences between cultures. Natural recovery from alcohol problems also seems to be more difficult than that from illicit drugs, probably due to the ready availability of alcohol.

In general, the more severe and complex the addiction, the more professional help may be needed. But self-change is possible and can and does occur with any kind or level of addiction.

Much self-change does not result in abstinence, but can result in sustained, long-term, controlled usage without apparent problems – a different scenario to that offered by many treatment settings and self-help groups. This finding has caused a great deal of controversy in some countries (particularly North America), where it challenges prevailing ideologies on the nature of addiction.

Related to this point, research also indicates that there are broadly two groups (among dependent users) who cease problem use. The first – who we tend to see more in treatment – tend to have had worse problems for longer, regain control at a later age and tend towards ultimate abstinence. The second generally had less severe problems over a smaller length of time, managed without specialist help, overcame their problems at a younger age, and tend not to be abstinent. This reinforces the view that interventions aimed at controlled usage are less likely to succeed for those with a severe dependence, who may need to be supported more towards abstinence.

Research broadly suggests the more severe the problem, the more intensive the intervention that may be needed, supporting the concept of Stepped Care. When considering incorporating self-directed change at the strategic planning stage in relation to drug or alcohol problems, there are several principles to bear in mind: interventions should be the minimum necessary to accomplish the aim; they should be evidence-based, individualised, and acceptable to the consumer.

This perspective supports a range of processes used for managing drug and alcohol problems, from self-change, to assisted self-change (such as bibliotherapy or internet-based interventions), to guided self-change with brief interventions, to more intensive out-patient and inpatient treatment and care. An alternative view is that all recovery is essentially 'natural recovery' and that the role of treatment is to support this process – and indeed, that this is all treatment can hope to do.

This would imply that in the first instance people should try and manage their problem themselves, without recourse to professionals or specialists, which is what happens in practice for many people. But is there a role for professionals that can encourage and support this process of self-change without undermining it?

The Motivational Interviewing Cycle of Change grew from research with both the treatment and non-treatment population, which aimed to understand the process of change for all people. The beginning of this process is the moving of the person from pre-contemplation to contemplation; research with both treatment and non-treatment populations consistently points to a process of cognitive appraisal of the pros and cons of continuing a behaviour as being at the heart of most people's change attempts.

The drug and alcohol fields have done much to make use of this knowledge in developing the role and ability of non-specialists (such as GPs) in encouraging people to become more aware of the impact of their use of drugs and alcohol. But is there more that can be done?

One important intervention that supports self-change, is to develop the social climate that sustains it. Societal beliefs about addiction are powerful, but these can be changed. These beliefs influence individual attitudes about what is possible, both within treatment and without. Crucially, the biggest factor associated with maintaining recovery is social support, particularly from friends and family, and expectations will also affect this support.

The fact is, most people who experience significant problems with drugs or alcohol manage to get on top of these problems without professional help from either drug or alcohol services or self-help groups.

There have been health promotion campaigns in Switzerland and Canada that have been successful, both in increasing awareness of the potential for self-change, and in directly supporting that change by promoting contemplation. They have provided avenues to access relevant materials either on the internet or in book form, and have been shown to be highly cost-effective.

For example in Switzerland there has been a 1997 drugs campaign based on self-efficacy, a 1999 alcohol campaign based on stages of change, and an internet-based 1999/2000 tobacco campaign on significant life events triggering the decision to change smoking habits. An example from the 1999 campaign was a series of TV adverts with minor mishaps related to drinking (*eg* a woman about to accidentally go in to the men's toilet), asking the question 'everything under control?'

The scale of problems with drugs and alcohol means that even at the problematic end, most people manage without specialist services. But there is much that can be done with health promotion campaigns to support and trigger change earlier and more effectively than otherwise may happen.

There are considerable benefits in including the potential for self-change in our planning around drug and alcohol problems at both the local and national level – which ultimately may lead to better focusing of the resources and efforts of drug treatment providers.

Anthony Hewitt has worked in the drugs and alcohol field for 20 years as a practitioner and manager, a researcher, and lately on a freelance basis. He lives in Bristol.

‘empowerment, empowerment, empowerment!’

George Morris is part of the assessment referral team based within Project 8, a specialist substance misuse unit for black and visible minority service users. He shares his team’s vision for conquering the ‘them and us’ syndrome.

Our project opened in 1998 after three black people within the community died from overdoses in quick succession. They were in their late thirties and had never accessed or engaged with services to address their substance misuse issues. When views within the community came to light it was found that Black and Visible Minority (BVM) users felt unable to access mainstream services for many reasons; the ‘can’t or won’t’ debate ensued, and the seed of Project 8 was sown. The Department of Health and Lancashire University funded some research into diversity issues within the Liverpool community.

The term visible minorities is used to refer to people who are discriminated against in a racist way, largely on the basis of various physical characteristics – in particular the colour of their skin as well as other stigma such as refugee status, religion, dress and language.

The preference for this term is no mere eccentricity. There are practical and political reasons for avoiding terms such as ethnic minorities. The problem with using the word ‘black’ as a generic term is that it is not always clear who among non-whites is included and who is not. Therefore, while accepting the impossibility of finding a term acceptable by all, we have taken a leaf out of the report *Preventing racism at the workplace* (European Foundation for the improvement of living and working conditions, 1996) and opted for ‘visible minorities’.

The most visible characteristic displayed by the people that the project teams work with in our community is that they are poor. Add the stigma of addiction/substance misuse to the issues of being black or a woman, and there are some very real complex needs that need to be met. How do we enable these service users to achieve their aspirations and goals, become drug free and maintain a drug-free lifestyle?

We feel the answer lies in the article *Focus on the margins* (EEC Geneva, March 1999), which states:

‘A community that has adequate community capital can offer treated drug users /addicts more resources and opportunities to rebuild a normal social network, thereby helping them achieve post treatment harm reduction or even abstinence.’

It is agreed by most that the best chances of recovery and achieving abstinence for many individuals with substance misuse issues is a safe and secure environment. For many people, relocation further improves their chances of recovery and a network of support can be another vital tool, especially in the first two years.

Project 8 tries to the best of its ability to maintain and build bridges with other organisations and services; it is our experience that a multi agency approach in helping

address many issues that service users encounter is beneficial to the client.

'I can't, but we can' is a well-known treatment slogan that we fully embrace.

We have an equal opportunities committee that draws on the experiences of service users to produce an ongoing, living document. We believe that if we can be seen to be keeping our own house in order it can be recognised as good practice and help other organisations with their diversity and cultural issues and equal opportunities procedures, to the benefit of our community. We also provide training, guidance and advice for our staff and other organisations in these matters.

The project also has a volunteer programme that helps to train local unemployed men and women as drugs workers with the required accreditation, and assists them to find employment here or in other mainstream services. The capacity of Project 8 is growing with a view to the long-term goals we have set ourselves. These are set around the gaps in the service we have identified, and meeting the very real special needs with regards to BVMs and substance misuse within our community in the Merseyside area.

It is a bit like David and Goliath being a small community-based project, but bigger isn't always better and we are not here to fight the giants with the big budgets and lots of resources. We are here to complement them and our primary purpose is to make a positive difference to people's lives, by ensuring that they can feel confident about taking advantage of such services.

The service user is first and foremost our main priority: it is about allowing them to make informed choices. What we expect and demand for our clients within the community is that regardless of class, religion, gender, sexual orientation and disability, they get a fair crack of the whip.

We, as a team at Project 8, have a knowledge and empathy as to why some of our service users would choose to escape their realities. The drugs are just a symptom of many different things. Many of the things service users feel they have to escape or hide from can be changed – such as bad education, unemployment, poor housing, and moral belief systems.

My three key words are empowerment, empowerment, and empowerment. Our team waits for the day when we can say to a service user who presents with the 'us and them' syndrome: 'where's your evidence? Is that rational?' – and for them to believe that it probably isn't. Roll on the day!

George Morris and the Project 8 team can be contacted at: Project 8, BVM/DAT, Assessment/Referral Unit, 129 B Lodge Lane L8 0QF. Tel: 0151 735 0009.

'National drug services remain increasingly biased towards opiate users; there are surprisingly few innovative services to effectively engage and achieve long-term benefits for stimulant or occasional drug users.'

Drug death stats slow to show truth

Office for National Statistics (ONS) figures published on 30 August show that the government failed to meet its targets in reducing drug-related deaths between 1999–2004 and highlight rises in deaths of young people and users of cocaine and ecstasy. This sad news reopens issues that have still not been fully addressed.

National drug services remain increasingly biased towards opiate users; there are surprisingly few innovative services to effectively engage and achieve long-term benefits for stimulant or occasional drug users. The ONS figures underline the need to put some serious thinking into providing support for these client groups.

Using figures already two years old, the ONS report shows new trends in the profile of people who are dying from drug related incidents. How can drug treatment agencies and drug action teams, responsible for planning and commissioning drug services, possibly make informed decisions about strategies and service delivery without real-time, up to the minute information about local and national trends in drug related deaths? Some areas, such as Berkshire, have set up local multi-agency steering groups, including strong relationships with local coroners, Ambulance Trusts and emergency health services, to provide this kind of information and to inform local practice. Other areas still regard it as unnecessary.

Commissioners throughout the country must now seriously question how they monitor deaths and 'near-miss' incidents, in order to actually take steps to reduce those deaths through education, information and harm reduction interventions.

Fran Clayton, consultant,
The Centre for Public Innovation

Creating danger zones?

I read with interest about the new innovations at the Anchor project in West Bromwich (*DDN*, 3 July, page 10). It appears that staff there have adopted a three-zone system in a bold attempt to deal pro-actively with problems caused by having insufficient treatment space available to meet local need. We have considered using similar approaches in Cornwall but not been brave or decisive enough to do so thus far.

Finding ways of encouraging clients to move through treatment, so freeing up slots for others, seems a worthwhile goal. Our hope in Cornwall is that improved access to training opportunities and social rehabilitation will help clear the log jam of clients in long-term treatment. Few would argue with this approach, which appears to have an important role in the zone model, except that it is carried along by an element of wishful thinking. Although it is very appealing as an idea, in practice the impact may be slight.

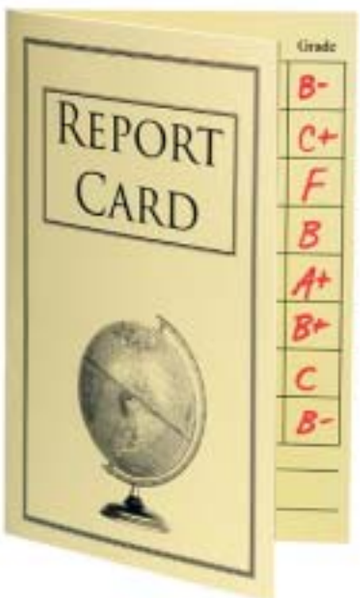
The other bigger problem is the strategy of discharging clients who fail to engage with services during the first three months of treatment, which is integral to the West Bromwich zone model, and very controversial. Taking this hard-line is no doubt effective at limiting the numbers in treatment. The danger though is that this aspect of the zone system 'weeds out' the most needy and damaged individuals, so denying them the opportunity to get better. There is usually a reason why clients fail to engage properly, and quickly, and this gets lost in a 'one size fits all' system.

In addition the reason for substitute prescribing is to reduce harm caused by heroin misuse to society and to the individual. Even the most chaotic individuals can be shown to reduce their heroin use and criminal activity once they receive a script, and there is extremely good evidence to show that this is why methadone is such a highly effective treatment.

These are some of the issues we have struggled with in Cornwall. Though the zone system seems fascinating, there are problems with it that would prevent us from adopting it wholesale in Cornwall. Indeed I would go so far as to say that I am surprised that commissioners and NTA in the Midlands are willing to endorse such a model. My own view is that there may be different, lower intensity, ways of keyworking clients that allows for increased capacity in the system, and that this, together with a less punitive 'staging' or zoning system may be the way forward.

Dr Rupert White, consultant psychiatrist, Cornwall

Does MoCAM **pass or fail**?



Models of care for alcohol misusers was launched by government at the end of June, following a lengthy consultation process and much anticipation. Does it pave the way for more effective and integrated alcohol treatment services? DDN asked two alcohol experts for their verdict.

'Another missed opportunity', says Don Shenker, director of policy and services at Alcohol Concern.

The good…

MoCAM does some things well. It sets out the key criteria for commissioning by itemising core standards as defined by the Department of Health's *Standards for Better Health* (2004), and gives armour to services that argue that access to treatment remains inequitable, because services locally are patchy and demand heavily outstrips supply.

MoCAM successfully covers the need for implementing screening and brief interventions to identify problem drinkers at the hazardous or harmful stage, before patterns of dependency occur. It provides a good basis for describing individual assessment systems; and describes care planning equally well to take into account both treatment journeys and integrated care pathways.

The bad…

MoCAM lets alcohol treatment services down badly. After months of consultation and various drafts, it now reads more like an introductory guide to alcohol misuse and treatment, rather than a principle of effective commissioning. Commissioners who really care about stemming the growing tide of alcohol related deaths must be sick to the teeth about another government document that fails to answer the basic question of how to reduce alcohol harm without releasing extra funds.

In fairness, MoCAM was never going to promise any extra cash for additional alcohol treatment, but very little has been provided about how to make the most of local health systems that are already stretched to the maximum. Worse still, the focus of 'treatment' is still seen within a strict mono-cultural, individualistic and bureaucratic top-down model, passing only scant reference to the needs of Black, Asian and other ethnic groups; women (including survivors of domestic abuse); children and families; and crucially, the voice of service users themselves.

Nothing is mentioned about how integrated care pathways are going to be mapped and how to close the real-world gaps between statutory and voluntary services as they currently exist. There are often gaps in referral protocols, communication and policies locally – between alcohol services and community mental health teams, social services, housing probation and prison services, where clients frequently fall through the net.

An added essential criterion that Local Alcohol Planning groups are set up within DA/AT and PCT commissioning structures would have been extremely useful, comprising commissioners, senior managers of statutory services, alcohol service providers and users, and reporting to PCT Boards.

Very little is offered to persuade local strategic planning groups to ensure alcohol treatment is on their agenda as equally as drugs. It is assumed commissioners will do this in isolation. Equally, MoCAM assumes that implementing screening and brief interventions (SBI) will occur happily without any discussion on how to engage with, and provide incentives for, primary care or other tier 1 staff. In fact no mention is made of the possibility of targeted screening across all statutory services, including the criminal justice system or housing.

There is no discussion of where treatment funds should actually come from to commission local systems of alcohol intervention and treatment. Assuming that commissioners will simply use existing funding streams lacks imagination – especially when some commissioners have had success with a variety of streams, including community safety monies, local area agreement budgets, local enhanced service budgets (PCT), area probation funds, policing budgets, domestic violence budgets and Connexions funding.

It is also not made clear what planning processes will involve and what actual involvement service users and providers will have. Planning on the basis of ANARP will be limited, as figures are regional and not local. It would have been better to point to planning guidance already provided in the Local Alcohol Strategies Toolkit, which uses expert practitioner, management and service user groups to plan a local strategy based on knowledge from the ground. Alternatively, consultancy could have been suggested to carry out a detailed local needs assessment.

In terms of monitoring, there is no consideration of the plethora of monitoring requirements already in place, or how these could be married together to form a unified and efficient system. Alcohol services need to consider what additional resources would be needed to allow them to monitor outcomes.

One of the biggest problems providers will see with MoCAM is the lack of attention paid to the needs of women and non-white service users. No examples, suggestions or guidelines are given on how to engage with diverse community groups to help plan, develop and run discrete and

specialist services for those who need them. It is a great disservice to all those that took part in the consultation process that after so much energetic and useful feedback, the published document fails to take these issues seriously.

Although there is a small section on the needs of family members, much more could have been provided on setting up services for the whole family to safeguard children. MoCAM provides no discussion on the need for statutory children and families services, schools, parenting teams and alcohol services to meet regularly, carry out joint training, and establish local protocols and referral systems. Neither is there any guidance for commissioners to encourage alcohol or children's teams to work jointly by sharing staff or developing new unified services.

Other points that worried me include the fact that the criteria for residential care appear very tight, excluding those who (after assessment), simply need a break from their high relapse-risk environment in a safe setting in order to achieve abstinence; and the omission of any apparent link between residential and community services in the 'treatment journey'.

Ultimately I found reading MoCAM a grave disappointment and couldn't quite see how it might benefit alcohol treatment services or commissioners. Until we resolve the primary issue of resources, most commissioners will rightly argue that no matter how crippling alcohol misuse is in their locality, their hands are tied. To improve access and equity in relation to alcohol treatment they will need more that just a model of care, however good it is.

'MoCAM is a muddle', says Mary Longley, non-executive director of Broxtowe & Hucknall PCT and director of SASSI Direct Ltd.

The good…

What do I like about MoCAM? Long awaited and consulted over, it promises to locate services in a comprehensible framework and to help end the 'planning blight' doldrums in which alcohol services have long drifted.

Its categorisation of drinkers into hazardous, harmful, moderate and severe dependence is useful in terms of triage and care planning decisions – although I should have liked consistent adherence to WHO definitions, which would help the standardisation of assessments that MoCAM aims to effect.

There is excellent encouragement to develop local protocols for screening, assessment and triage, and for the sharing of information and protection of confidentiality within and between different service providers. It points the way to an unbeatable equality of access and choice of treatment method.

Importantly, it gives a solid basis to arguments in favour of joined-up aftercare services, psychosocial interventions which sustain abstinence, the provision of new peer groups and intelligent housing support.

The bad…

Compared with the previously issued draft version, the final MoCAM offers much greater coherence in terms of terminology and conceptual analysis, but here and there the old inconsistencies resurface, provoking the suspicion of multi- and disparate authorship. Lack of clarity, fence-sitting and fear of creating offence sabotage what might have illuminated many a client journey: some clear guidance on goal setting.

For instance, whereas in section 1.3.9 we read 'alcohol treatment… should always be designed to meet needs and reduce risks', section 2.4's 'stepped care model to assist commissioning' contains the unquestioned assumption that what a service user 'wants' should determine interventional goal. Certainly the word 'appropriate' seems to be missing from all this. Clearly there is often a distance between 'wants' and 'needs', in which professional ethics would seem to demand some action on the part of the alcohol worker in terms of providing mainstream research-based evidence, motivational therapies, self-efficacy support and outlining of consequences for the self and others, if inappropriate goals are adopted.

Uncontroversially (it would appear), brief interventions are recommended as a means to achieve both a reduction in drinking and a reduction in harm. There is even a shy but unarticulated implication that they are not suitable for people with 'moderate to severe levels of alcohol dependence', where 'abstinence will be the preferred goal for many problem drinkers…' although I have to question the word 'preferred' here. Preferred by whom, I wonder? Not so easily perhaps by those still wrestling with their internal ambivalence, not by those who are unable to recognise the problematic nature of their usage, not by those who are frightened to acknowledge that they might have lost their internal locus of control over the drug alcohol.

But worse follows: '…abstinence will be the preferred goal for many problem drinkers… particularly for individuals whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate their drinking without success.'

So now, as if a classification of dependence were not enough to recommend an abstinence-based goal, not only is the 'double whammy' of dependence with organic damage called on, but a further category of dependence in 'those who have previously attempted to moderate their drinking without success'. Not only can this group not be an additional sub-set of dependent drinkers, but the thesis is dangerously misleading. Permanent organic damage is a sufficient justification for abstinence on its own, whether or not the drinker is dependent!

Consultant hepatologists around the UK are constantly wringing their hands at the numbers of young women in their 20s and early 30s who have developed cirrhosis within two or three years of regularly drinking marginally above sensible limits. Indeed, one of the risks of delivering brief interventions with a reduced drinking goal to non-dependent drinkers is that anyone who does so without first ruling out the possibility of permanent liver damage may be liable to be sued for professional negligence, whether or not they are medically qualified. Brief Interventions have no more automatic equation with reduced drinking goals, than does reduced drinking with 'harm minimisation'; if a person has cirrhosis, any level of continued drinking will lead to an exponential rate of increase in damage.

And still MoCAM digs itself in deeper. The overlapping categories of 'low to moderate' and 'moderate to severe' dependence show no real understanding of the difference between dependent and non-dependent drinking, no recognition of the research evidence highlighting the discrete and distant categories they represent (in adults at least), and no articulation of the rationale for goal-setting which flows from that difference.

Last but not least, we are advised that 'moderation can also be used as a goal with problem drinkers for whom abstinence would usually be advisable, but for whom this goal is not currently acceptable. A reduction in alcohol consumption will be likely to confer benefits and may offer a stepping-stone to abstinence in the future'. Conversely, of course, it could be considered unprofessional to endorse a goal which is by (mainstream evidence- based) definition unobtainable for a given client, and to fail to do everything in one's power to encourage a client towards an appropriate one. Will an increasingly litigious society come back to haunt therapists who are drawn into colluding with a client's self-deception or into setting them up to fail?

And the plainly bizarre..?

There are three mentions of Alcoholics Anonymous in MoCAM; all of them rather curious. Locating it in the schema of interventions at all seems questionable, but it appears particularly out of place at tier 2. It is true that it has 'open meetings' which anyone can attend, but it also has closed meetings, where custom and practice requires a self-assessment of severe dependency as the criterion for admission. AA does not offer brief interventions, reduced drinking goals, or assessment and referral for care planned treatment.

Finally, MoCAM suggests that AA and other complementary mutual aid services may need to be specifically encouraged or commissioned in each area, to offer choice and an appropriate range of provision. Difficult to envisage with the former, given its fierce financial and ideological independence; with the latter this sounds like an expensive Utopian vision whose success might be measured in internecine wars!

MoCAM can be viewed online as a pdf document. Visit www.dh.gov.uk/assetRoot/04/13/68/09/04136809.pdf

Relapse Prevention: A Treatment Method Comes of Age

Terence T. Gorski explains how understanding and responding to relapse-prone patients can dramatically improve their chances of recovery.

ImageState / Alamy

People with substance use disorders are at high risk of relapse once they have stopped using alcohol and other drugs and started to recover. Many studies over the last 35 years have documented high rates of relapse among patients completing treatment for substance use disorders.

Studies of lifelong patterns of recovery and relapse indicate that patients who relapse are not hopeless. About a third achieve permanent abstinence from their first serious attempt at recovery; another third have a series of brief relapse episodes that eventually result in long-term abstinence. The remaining third have chronic relapses that result in eventual disability and death from chemical dependency. Around half of all people who are prone to relapse eventually find permanent abstinence; many others improve in spite of their periodic relapse episodes.

Of the patients entering treatment for the first time, at least 60 per cent are at high risk of becoming relapse prone. Relapse is a serious problem that increases the overall cost of treatment. Many alcohol and drug abusers are admitted to treatment a number of times before they are able to achieve long-term abstinence, and those admitted to substance abuse treatment more than once tend to generate significantly higher expenses.

As the number of repeat admissions increase, three things tend to happen: the severity of addiction and the number and severity of coexisting psychiatric and medical disorders tend to increase, driving up the cost of each subsequent treatment episode; the patient's social and economic stability tends to decrease; and the use of public funding for treatment and to meet basic survival needs tends to increase.

The 1990 National Drug and Alcohol Treatment Utilization Study (NDATUS) estimated that the United States spent a total of $4.08 billion on treating people with substance use disorders. Since 40 per cent of these patients were relapsers, the nation spent $1.63 billion treating relapsers in 1990. Unfortunately, most of this money was spent on recycling patients through treatment that had already failed.

In 2002 and 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) completed two important studies. The first was a snapshot of all patients in treatment on a typical treatment day. The second study compared patients in treatment for the first time with relapse-prone patients who had multiple admissions. These studies clearly demonstrate both the high cost of relapse and the need for the systematic application of effective relapse prevention methods within existing treatment programs.

To contain the costs of treatment, a new emphasis on implementing specialty relapse prevention (RP) approaches is needed that will lower relapse rates and rapidly intervene with patients who relapse. Such RP approaches exist, and there is a growing body of evidence of their effectiveness. When appropriately matched to individual patient needs, RP methods tend to reduce the duration, severity, and consequences of relapse episodes. As a result, the cost of treatment can be significantly reduced by effectively integrating relapse prevention methods into the treatment process. Let's briefly explore the developmental history of these RP methods.

Since the mid-1970s an increasing emphasis has been placed upon developing and using RP methods. The work of Marlatt, Gorski, and Daley was influential in motivating clinicians to use, research, and continue to develop and apply relapse prevention methods in a wide variety of settings with many different specialty populations. After nearly 30 years of progressive development, RP has become a recognised and effective treatment method, with a wide array of proven programme models.

The evolution of RP methods has set the stage for the development and use of manualised treatment methods that can be quickly, inexpensively, and effectively deployed to clinicians.

RP is a systematic method for teaching recovering addicts to prevent relapse by recognising and managing early relapse warning signs. It also teaches patients to stop relapse quickly by using early intervention methods, and becomes the primary focus for patients who are unable to maintain abstinence from alcohol or drugs after receiving primary treatment.

Twelve key themes distinguish RP from other treatment methods:

- Clients learn to identify high-risk

situations that can cause relapse and develop strategies for dealing with them.
- They are educated to understand relapse as both a process and an event.
- They begin to deal with alcohol and drug cues and cravings.
- They understand and deal with social pressure to use substances.
- They build a social support network.
- They develop methods for coping with negative emotional states.
- They identify and receive treatment for coexisting psychiatric disorders related to past relapse.
- They make the transition from residential and inpatient treatment to normal living, with follow-up outpatient treatment and aftercare.
- They cope with cognitive distortions that can increase the risk of relapse.
- They work towards achieving a balanced lifestyle that promotes effective stress management, sober and responsible living, and physical and mental wellbeing.
- They evaluate their need for and appropriate use of medication.
- They develop effective plans for stopping a lapse or relapse should it occur.

There is evidence that RP does help improve recovery and reduce relapse rates. A review of 26 published and unpublished studies of RP programs, representing a sample of 9,504 participants, found that RP was generally effective, particularly for alcohol problems.

Randomised controlled trials on the effectiveness of RP with smokers, alcohol abusers, marijuana abusers, cocaine abusers, opiate addicts, and other substance abusers showed that there is good evidence for the effectiveness of RP approaches, compared with 'no treatment' controls. RP was also shown as most likely to be effective when used with patient treatment matching procedures. The most notable positive outcomes across studies of RP included maintaining abstinence and positive changes from treatment, and reducing the severity of relapse when they occur.

All addiction treatment facilities are providing treatment to patients who are either relapse prone or in treatment for the first time with a high risk of becoming relapse prone. The problem is that many treatment programs lack specialised science-based treatment for relapse-prone patients, leaving them less likely to recover. This is unfortunate because it is no more expensive to treat patients using relapse prevention therapy than it is to use traditional recovery methods – and the difference in improved outcomes with relapse-prone patients can radically increase recovery rates, while lowering the long-term costs of treatment.

Studies of lifelong patterns of recovery and relapse indicate that patients who relapse are not hopeless. About a third achieve permanent abstinence from their first serious attempt at recovery; another third have a series of brief relapse episodes that eventually result in long-term abstinence.

Relapse Prevention Counselling (RPC) is available as a two-day workshop and is being offered by Lifeworks Community on 2-3 October 2006 at Regents College, London. For more information on this workshop please contact Lifeworks Community Ltd. Tel: +44 (0) 1483 757 572, email: elinzell@lifeworkscommunity.com or log onto www.lifeworkscommunity.com

Post-its from Practice

Sun, Surf and Schengen

Experiencing the hassles of checking in for her flight amid heightened scrutiny and security, Dr Janet Gillespie considered how much more stressful if must be to travel with the fear of your methadone being seized.

In the middle of August I travelled through Stansted, passport and purse to hand in their regulation clear plastic bag. Surrounded by tired infants, brittle nerves and raised voices, I pondered how much more anxious I might be if I had prescribed methadone in my hold baggage and a UK export licence in my clear plastic bag.

The current UK export licence scheme is long established: we apply to the Home Office on behalf of the patient, giving information about their prescription, and the Home Office sends a personal export licence direct to the patient. (The Home Office contact details have changed recently – see [1] below.) The export licence only applies to leaving the UK but, it is argued, its existence supports the arriving traveller's claim of legitimate possession. Unfortunately, we have found that some countries (in particular, Italy) do not subscribe to this opinion and several of our patients have had their medication seized by immigration. This is a pity – because it doesn't need to happen...

Surfing the net is so often a process led by intention but guided by chance. So it was that I discovered a German website for substance misusers that reminded its readers to obtain their Schengen certificate in good time for their forthcoming summer holidays. In Norway, the certificate is available through the dispensing pharmacist, although the Netherlands have decided that the matter should be controlled from a central government office. Here in the UK, the House of Lords Select Committee on the European Union, nominated the Home Office as 'the competent authority to issue Schengen Certificates'. (15 February 2000)

A Schengen Certificate authorises the holder to carry up to 30 days supply of prescribed controlled medication for personal use AND to travel freely across national borders within the 'Schengen states' [2]. In 1999, the UK chose to implement 'those measures of the Schengen acquis, now integrated into the EU Treaties, that relate to law-enforcement and criminal judicial co-operation, including the SIS.' This includes Article 75: Schengen Certificates, whose primary aim is to keep those carrying prescribed medication out of the criminal justice system. However, the certificates inadvertently also help us in our strategy of harm reduction.

When emailed recently about Schengen certificates, the Home Office stated that, as the present system works, there was no immediate intention of changing their current practice. In a further reply to our experience with the Italian authorities, the Home Office pleaded ignorance but are happy to receive information on any future incidents.

As I took off my shoes before being frisked by airport security, I decided that, on balance, I would prefer to have a Schengen certificate, rather than an export licence, in my plastic bag. If providing evidence to the Home Office is 'what it takes' to get them for our patients, then please email the helpful Mr Evans on MichaelAnthony.Evans@homeoffice.gsi.gov.uk with any travel problems that have come to your notice and enclose my best wishes.

Dr Janet Gillespie is a GP at Lonsdale Medical Centre

References:

[1] Home Office, Drugs Branch 6th Floor Peel Building, 2 Marsham Street, London SW1P 4DF Telephone 020 7035 0484 Fax 020 7035 6161

[2] The following countries fully implement the provisions of the Schengen acquis: Austria, Belgium, Denmark, France, Finland, Germany, Greece, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain and Sweden. The newly acceded EU countries (Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) are not expected to fully implement the Schengen acquis until the end of 2007.

One of our DIP workers, a nurse by profession, is a Special Constable who works at night in uniform. Am I being naive in thinking that this raises serious questions about confidentiality and conflict of interest?
Paul, West Yorkshire

Assets rather than problems

Dear Paul
I am in a similar position as your DIP worker.

I am a full-time prison officer CARAT worker in a high security prison. I work Monday to Friday 8am until 5pm dealing with my clients' (who are all long-term prisoners) drug and alcohol issues on a one-to-one basis. I also do overtime shifts in my capacity as a uniformed prison officer on the prison landings.

I too was worried about the confidentiality and conflict of interest. I have had no problems at all. The prisoners accept me in both roles. In fact I am often approached for advice on substance issues when I am on the landings and on security matters when I am working with my colleagues in the drug support unit.

As for client confidentiality, I do not breach this when acting in my capacity as prison officer or CARAT worker. It's as simple as that.

I personally think that the dual role of your colleague should be seen as an asset to both the DIP team and the police force. The knowledge and experience gained as a drug worker can be used positively within the police force without breaching client confidentiality. Similarly the knowledge and experience gained from working with the police can be used within the DIP team, providing that boundaries are set regarding confidentiality.

I think that you will find that your colleague will act very professionally in both roles. Look upon both roles as being an asset rather than a concern.
Ian Bowerman

Committed but misguided

Dear Paul
Firstly your colleague should be commended for their efforts. Nursing is a stressful enough profession as it is. To work as a Special Constable as well, unpaid, shows a tremendous amount of commitment to the local community.

But yes, I think that there might well be a conflict of interests here. If nothing else, there's a good chance your friend might be too tired during the day to effectively carry out their nursing duties. We all need time out of work to unwind and relax.

I'd approach your colleague in a friendly way and suggest they knock the police work on the head. Maybe they could do some charity work at the weekends instead or even the odd evening manning the 'phones at the Samaritans.
Ian, Harrogate

The wider contribution

Dear Paul
I read your question with interest. I have had similar concerns myself when coming across those who work as specials during their free time and work in or alongside the drug treatment system during the working week.

When I raised the question locally regarding this issue, one sister agency offered the same line (verbatim) that I received from the NTA:

'I am not sure that there is an ethical issue regarding (name omitted) being a special constable. Many organisations encourage their staff to become involved as magistrates or special constables, or engage in other forms of voluntary work, as part of their wider contribution to the community. My personal view is that it is not incompatible for the director of (name omitted) to be a special constable. Indeed, it could be argued that he will be more aware of the legal niceties of data protection than many other people with similar levels of responsibility.'

As a former service user I have a somewhat different perspective and would like to see the debate offered up for user consultation. How many service users would be comfortable knowing that the sensitive data they share with a confidential service is accessible to people who serve in the police force?
Liam Pickford, area manager, CAN, Bedfordshire

Shaken to the core

Paul,
I can only say one thing to this and it must surely be in the minds of most, if not all, readers.

This is possibly one of the worse cases of conflict of interest I have heard of. Without attempting to be flippant – I understand the term police intelligence is a contradiction – but in this case it's at the crux of the matter. They have personal knowledge, which will not be appropriate in each role.

The situation is an absolute disgrace and I hope I am not being narrow-minded, but it shocks and shakes me to the core that this sort of thing/practice is permitted.

This cannot – and I feel I must put this in the strongest terms – be allowed. This special constable will be tested to the nth degree in their commitment to service user and human rights, and without a doubt will lead to compromise on the side of the easy running of their service – in this case a police force.

I have an opinion that the person is being forgotten, along with the idea of care. We are all becoming, if off-guard, 'officers', not caregivers. This will fit nicely I am sure with the present direction we seem to be, worryingly, going in.

Keep these people/officers away from the vulnerable. Please.
Tony B, Gloucestershire.

Reader's question

My son aged 17 has been using cannabis since the age of 15, which has affected his career path. Up to this age he was with a professional football club and he was due to sign a contract, which would have taken him to 18, and he would have had the opportunity to develop a career. The effects of cannabis have completely changed his life, as he has become verbally and physically aggressive, which resulted in him being arrested and moved from our home. He lived in a hostel for three months but was evicted due to violence and drug abuse and has returned home. We have little or no support from the YOT team (Social Services) or GP, his behaviour has deteriorated and he rarely leaves the house. The stress this has caused my wife, daughter and myself has affected our whole life. Does anybody have similar experiences or advice so we can take our life and his forward?
Ashley, by email

Email your suggested answers to the editor by Tuesday 19 September for inclusion in the 25 September issue of DDN.

New questions are welcome from readers.

Some more of my favourite reads

Professor David Clark completes his perusal of his bookshelves and describes some of his other favourite reads in the field.

As in my last Background Briefing, I have chosen various books as recommended reading that are related in some way or other to drug and alcohol misuse. The order is random – I've just picked up books from various places in the house.

Theory of Addiction by Robert West (r.r.p. £24.99 or £21.24 from the *DDN* bookshop).

If there was ever a major challenge in this field, it is to critically evaluate the large number of theories about addiction and try to bring together the diverse elements into a comprehensive theory. Robert West has taken up this challenge and done a brilliant job. While the theory focuses on the mind of the addict, it also looks at the social and cultural forces that influence behaviour. The author makes recommendations for the development of effective interventions for addiction.

Promoting Self-change from Problem Substance Use: Practical Implications for Policy, Prevention and Treatment by Harald K. Klingemann, Linda C. Sobell and others (r.r.p. £14.72)

It is often forgotten that many people with drug and alcohol misuse problems overcome their problems without professional assistance or without using traditional self-help groups. This book is based on the first major international conference on self-change/natural recovery. It presents the process of self-change from several different perspectives – environmental, cross-cultural and preventive – and interventions at both an individual and societal level. It provides strategies and suggestions for how professionals and policy-makers can aid and foster self-change. This book is an essential guide.

Working with Substance Misusers: A Guide to Theory and Practice edited by Trudi Petersen and Andrew McBride (r.r.p. £20.99 or £19.54 from the *DDN* bookshop)

A practical handbook for students and people who work in the field, it covers an impressive range of topics. The book also contains activities designed to reinforce learning, including discussion points, case studies, role plays and group exercises. I used this book as the core text for my undergraduate students studying substance misuse.

Tackling Alcohol Together: The Evidence Base for a UK Alcohol Policy by Duncan Raistrick, Ray Hodgson and Bruce Ritson (r.r.p. £17.95)

The leading researchers and practitioners in the UK provide an authoritative and independent analysis of the country's experiences with alcohol. The book examines alcohol problems, alcohol policy and makes specific policy recommendations. Published in 1999, the ideas are still relevant today.

'I hope that my selection both inspires you and helps you in your work.'

Get Your Loved Ones Sober: Alternatives to Nagging, Pleading and Threatening by Robert J. Meyers and Brenda L. Wolfe (r.r.p. £6.84)

This is an important book for families and friends affected by substance use problems of others. It describes a programme based on the Community Reinforcement And Family Training (CRAFT) therapeutic model, which has been evaluated on a number of occasions and found to be an effective intervention. Although the book primarily focuses on alcohol, the principles are relevant to situations where illicit drugs are a problem. An engaging read, with clear and helpful exercises to be followed.

Modernising Australia's Drug Policy by Alex Wodak and Timothy Moore (r.r.p. £11.39)

This book may focus on Australia, but its provocative arguments are just as relevant to the UK. The authors argue that mood-altering drugs are primarily a health and social issue, rather than a problem to be tackled by law enforcement agencies. The book contains a variety of interesting facts, a ten-point plan to reduce the problems caused by the drug economy, and a call for a new realism in Australian drug policy. A thought-provoking read.

Motivational Interviewing: Preparing People for Change by William R. Miller and Stephen Rollnick (r.r.p. £26.98 or £25.50 from the *DDN* bookshop)

Motivational interviewing (MI), first described by Miller in 1983, is a directive, client-centred counselling style for eliciting behaviour change by helping clients explore and resolve ambivalence. The use of MI in this country has grown considerably in the past decade. This book describes the spirit of MI and the techniques that are used to manifest that spirit. It incorporates emerging knowledge on the process of behaviour change, a growing body of outcome research, and discussions of novel applications. This is a must-read book.

Cognitive Therapy of Substance Abuse by Aaron Beck, Fred Wright, Cory Newman and Bruce Liese (r.r.p. £17.96 or £16.96 from the *DDN* bookshop)

This book comprehensively details the cognitive model of substance misuse, the specifics of case formulation, management of the therapeutic relationship, and the structure of therapeutic sessions. It discusses how to educate clients in the treatment model and procedures, and manage their cravings for drugs and alcohol. Methods for working with dual-diagnosis patients are also described.

Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours by Dennis M. Donovan and G. Alan Marlatt (r.r.p. £32.50)

This is the revised and updated second edition of the classic by Alan Marlatt and Judith Gordon on relapse prevention. This book provides an empirically supported framework for helping people with addictive behaviour problems develop the skills to maintain their treatment goals – even in high-risk situations – and deal effectively with setbacks that occur. It is an essential clinical resource and text that reflects two decades' worth of advances in research and practice.

We have learnt so much in this field over the past couple of decades and I hope that my selection both inspires you and helps you in your work. Of course, there is so much more to learn. Keep reading!

To order books at discounted rates, visit our website, www.drinkanddrugs.net and click on 'drink and drugs books' to find the online DDN bookshop.

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2006/07

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 people currently working with problem substance users, or expect to be in the near future. The programme is delivered in Canterbury & across the UK where there is a cohort of 10 or more students. It is a recognised benchmark for those who seek an accredited qualification. The programme also benefits social, health and education professionals in all sectors whose work includes significant contact with problem substance users

18 month programme from September 2006 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 2006 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the nature of substance misuse and addiction processes from biological, psychological and social perspectives, and focuses on the settings and approaches within which treatment is provided. The Diploma is appropriate for practitioners working in Tiers 2, 3 and 4a services for drug users or people with alcohol problems.

2 year programme from October 2006

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 development of a research proposal. 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 OPPORTUNITIES** are also available in this area of study.

2 year (top-up of Diploma) or 4 year programme from November 2006

For further information and an application form, please contact:
Teresa Shiel, Programme Co-ordinator, KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent, CT2 7PD
Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk www.kent.ac.uk

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Externally-hosted courses by KFx

19 September 2006, LB Greenwich
Cannabis
Tel: 020 8694 7314
(Greenwich only)

12 October 2006, Birmingham
Drugs, the law and good practice
www.homeless.org.uk

17-18 October 2006, Wiltshire
YP and Substance Use
www.drugsinwiltshire.org.uk
(Wiltshire only)

19 October 2006, Wiltshire
Cannabis
www.drugsinwiltshire.org.uk
(Wiltshire only)

2 November 2006, Leeds
Cannabis
www.lafonline.org
(Book via LAF)

6 November 2006, LB Greenwich
Volatile Substances
Tel: 020 8694 7314
(Greenwich only)

22 November 2006, LB Greenwich
Harm Reduction
Tel: 020 8694 7314
(Greenwich only)

27-28 November 2006, Wiltshire
Families and Substance Use
www.drugsinwiltshire.org.uk
(Wiltshire only)

29 November 2006, Wiltshire
Cannabis
www.drugsinwiltshire.org.uk
(Wiltshire only)

Drugs Education • Liaison • Research • Training
Advice • Consultancy • Literature Development

Healthy eating for a better life

17 October, London
One day workshop

fdap DDN Drink and Drugs News

A balanced diet is important in helping maintain both a healthy body and a healthy mind.

Substance users often neglect their diets. This, together with the effects of their substance use, could mean they are lacking in some important nutrients.

Ensuring that those in treatment develop healthy eating patterns is a crucial, but often forgotten, part or their treatment.

This workshop is aimed at all those who work with substance users. It will explore why diet is so important to their physical and mental health. The workshop will focus on healthy eating related to the particular problems experienced by the individuals who come into contact with drug and alcohol workers, such as:

- Negative mood and behaviour
- Living with illness e.g. hepatitis C, alcoholic liver disease
- Eating healthily on low income

Participants will look at ways that they can introduce healthy eating into their treatment programmes, with the help of the toolkit that accompanies the workshop.

The cost for the workshop is only £110 +Vat (10% charity discount). Places are strictly limited and available on a first come first served basis.

For more information or to book your place, please contact Ian Ralph
e: ian@cjwellings.com **t:** 020 7463 2081

PCP
a new beginning

PCP Luton Ltd

Rehabilitation centre for drug & alcohol abuse

- £300 per week
- 36 beds
- Quasi residence
- 12 week primary treatment and secondary is optional
- Detox facilitated
- 12 Step and holistic therapy
- Statistical information available regarding your client on a weekly basis

Please contact: Darren Rolfe, Treatment Director or Kearon Harvey, Treatment Manager.

Tel :	01582 730 113	Tel:	00 34 951 191 115
Fax:	01582 730 114	Fax:	00 34 951 191 116
web:	www.pcpluton.com	web:	www.pcpspain.com

Relapse Prevention Counselling (RPC)

Professional Training

Faciliated by Terence T Gorski

President, The Cenaps Corporation

A Brief Strategic Approach Basic Competency Certification

2nd – 3rd October 2006
09:00am – 17:00pm

Fee: £345.00 for private sector
£260.00 for Statutory or voluntary organisations

Venue: Regent's College Conference Centre, Inner Circle, Regent's Park, London, NW1 4NS

To book your place please call: 0800 081 0700 or email Emma on elinzell@lifeworkscommunity.com

LIFE WORKS
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NORTH EAST WALES NHS TRUST

MENTAL HEALTH DIRECTORATE

COMMUNITY DRUG & ALCOHOL SERVICE, DEESIDE

SPECIALIST HARM REDUCTION OUTREACH WORKER/NURSE

F GRADE OR EQUIVALENT (A&C 5/6)
F GRADE NURSE £21,394 - £26,716 PA
A&C 5/6 £18,157 - £25,842 PA
37.5 HRS PW INITIALLY FIXED TERM UNTIL MARCH 2008 (AND THEN TO BE REVIEWED)

A vacancy has arisen in the Harm Reduction Team working with substance misusers across North Wales.

We actively seek out and work with people who are using drugs but not in touch with services, and other vulnerable groups 'at risk' in terms of the spread of disease, eg, HIV, Hep B and Hep C.

We need a person who is experienced in working with substance misuse and sexual health issues, with a sound knowledge of Needle Syringe Exchange and harm reduction approaches.

An enthusiastic approach is essential, as is the ability to work as part of a team.

For insurance purposes a current driving licence (held for at least three years) is required for the mobile unit, which is used as a work base across the region.

For further information contact Carry Burton, Harm Reduction/Needle Exchange Service Manager, on 01244 818513 or 07771 960441.

This post is subject to a satisfactory Criminal Records Bureau check being made and subject to the new terms and conditions of service to be introduced under the Agenda for Change Agreement.

The Trust operates a bilingual and flexible working policy and we are also committed to support any individual who wishes to learn the Welsh Language in accordance with our Welsh Language Scheme.

The Trust is Smoke Free in all buildings and grounds.

Applicants are encouraged to apply on-line at www.wales.nhs.uk/jobs. Alternatively, application packs are available by contacting (01978) 725317/725796 or email RECRUITMENT@new-tr.wales.nhs.uk

PLEASE QUOTE REFERENCE NUMBER: 955/006.

CLOSING DATE: 29 SEPTEMBER 2006.

To view all vacancies within the Trust, please visit www.newalesnhstrust.org.uk

"The Vocation Location"

North East Wales NHS Trust is committed to providing equal opportunities in employment.

Cranstoun Drug Services - tackling the harm caused by drugs to individuals & communities

Cranstoun Drug Services is a leading player in the substance misuse field and is committed to supporting staff to deliver effective services.

Project Workers

Cranstoun House, Esher
£20,364 - £24,702 pa inc **Ref: 397**

Would you like to be part of a new and innovative residential service for clients who may be continuing drug users and require support to achieve stabalisation, withdrawal and/or abstinence?

Your role will involve needs and risk assessment, support planning, groupwork and resettlement. You will also be part of an on call rota for evenings and weekends.

We are looking for people with experience of direct client work with drug users and a strong commitment to harm minimisation. You will have excellent communication skills together with an ability to build effective working relationships with clients, colleagues and external agencies.

For an application pack please apply online at www.cranstoun.org or call our 24 hour recruitment line on 020 8335 1831.

Closing date: 27th September 2006.

Cranstoun Drug Services, Central Office, 1st Floor, St Andrews House, 26-27 Victoria Road, Surbiton, Surrey KT6 4XJ.

We welcome applications from all sections of the community.

Cranstoun drug services

Registered Charity No. 1061582 Working towards Equality

ACT
Together, Tackling Addiction

2 x Alcohol Counsellors,

Aylesbury & High Wycombe, Buckinghamshire
£20,421 to £22,628 per annum
37 hours per week, temporary 6mths
(possibility of extension beyond this date)

ACT is the principal provider of non-statutory substance misuse services in Buckinghamshire.

This post will provide alcohol counselling/support, as well as advice, information and group work at our main offices in Aylesbury and High Wycombe. Some evening work maybe required. A qualification in counselling (or working towards one) is essential. Application closing date is 25th September 2006, interviews will be held on 2nd October 2006.

For an application pack please contact Nicola on 01296 425329 or email Nicola@addictioncounsellingtrust.com

A Company Limited by Guarantee No. 3164431 & a Registered Charity No. 1054524

Odyssey Trust
REALISING POTENTIAL

Odyssey Trust is a growing organisation delivering high quality crisis, residential and community treatment and support to drug users. We are now offering an even wider range of innovative services which provide exciting opportunities for dynamic people who have the commitment and energy to work at the forefront of substance misuse services.

Based within Milton Community Programmes, N1:

Education Advisor – Ref: EDA Salary £24,617 to £26,959 inclusive (plus pension)

Assessing, formulating, implementing and evaluating individual action plans, you will closely partner internal and external education providers and the Employment Advisor to maximise individuals 'potential. You will need at least 12 months ' relevant experience, together with detailed knowledge of educational opportunities, proven ability to deliver support and advice, and highly developed planning, time management and organisational skills.

Please telephone, or email for an application pack, clearly stating the reference, your name, address, and where you saw it advertised.
Tel: 020 7697 1311 (24hrs) or email lisac@odysseytrust.org
Closing date: midday on 29th September 2006.

All posts subject to Criminal Records Bureau enhanced disclosure.
Odyssey Trust UK strives to be an equal opportunities employer.
Applications from members of black & Ethnic minority communities are particularly welcome as they are currently under represented in the Staff group. Registered charity number 275872

Ymddiriedolaeth GIG
SIR BENFRO a DERWEN
PEMBROKESHIRE & DERWEN
NHS Trust

WEST WALES SUBSTANCE MISUSE SERVICE

COMMUNITY DETOXIFICATION WORKER

F/G Grade £20,872 - £26,064/£24,629 - £28,975
(salary depending on experience)

37.5 hours per week

The West Wales Substance Misuse Service is a specialist harm reduction and treatment service within the Mental Health and Learning Disabilities Division of Pembrokeshire and Derwen NHS Trust. You will be based within the Ceredigion Locality Team working alongside locality and criminal justice substance misuse treatment workers.

The Community Detoxification Service provides the opportunity for clients to detoxify from alcohol or drugs within their own home, working closely with other drug and alcohol agencies within the locality, and with local GP Practices.

The Detoxification Service has been in place for just over a year and is still in a stage of development. Currently covering the north and mid of Ceredigion we are hoping to extend this to cover the whole of Ceredigion as funding becomes available.

An enthusiastic, registered nurse, you will join our skilled and highly motivated team. Ideally, you must have experience in working with people with substance misuse problems. However, consideration will be given to training the right individual if there is no previous experience of working in this field. Some experience in a previous developmental role would be advantageous.

The post is currently funded until 31 March 2007 but expectations are that the contract will be extended beyond that date, subject to review.

For further information, please contact Lorna Eastment, Locality Manager on 01970 636340.

An application pack can be obtained by contacting the 24 hour answerphone on 01267 239871 leaving your name, address and job reference number B126 or email jobs@pdt-tr.wales.nhs.uk

Closing date: 26 September 2006

This post will be subject to the new terms and conditions of service to be introduced under the Agenda for Change Agreement.

This organisation uses the Criminal Records Bureau Disclosure system and will apply for an appropriate disclosure on all successful applicants where the post requires clearance.

For further information about other vacancies at the Trust please visit our website at www.pdt-tr.wales.nhs.uk

The first step to change

Langley House Trust specialises in providing ex-offenders with accommodation, support and drug rehabilitation within a supportive Christian environment. Our brand new drugs rehabilitation programme centres on providing ex-offenders with improved therapies and support that stems from you.

Therapeutic Team Leader

£26,000 on appointment, £28,000 with full accreditation

Coventry Ref: MURL/379/DDN, Bury Ref: CHAT/380/DDN

Your knowledge and experience of drug treatment and rehabilitation will prove essential in making sure our substance misuse rehabilitation programme is successful. From delivering one-to-one counselling and therapeutic groups to co-ordinating workshops and education initiatives, you'll give residents the therapeutic support they need to break the cycle of substance misuse and offending for good.

With a Diploma in Counselling and at least 2 years' post qualification experience of working with substance misuse issues in an abstinence-based 12 Step or similar context, you have an understanding of the current issues in substance misuse and the energy and passion to develop and deliver appropriate therapeutic responses.

If you are a practicing/professed Christian and wish to find out more, or obtain an application pack, please visit our website at www.langleyhousetrust.org or telephone us on 01993 705888, quoting the appropriate reference number.

We also have Counsellors positions available. Please visit our website for more information.

Closing date: 27th September 2006.
Interview date: TBC.

Regulation 7(3) of the Employment Equality (Religion or Belief) Regulations 2003 applies to this post.

Charity Number 250059 and Registered Social Landlord Number H4250

EVERY DAY IS A NEW BEGINNING

NEED EXPERIENCED STAFF?

KINESIS LOCUM
Mental Health Professionals

Kinesis will provide...

- ✔ Recruitment solutions for ALL substance misuse services
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Please call us now 0207 622 4827
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We are always pleased to receive CVs from experienced candidates

Kinesis Locum Ltd. are regulated by the Commission for Social Care Inspection. We are an equal opportunities employer

MANCHESTER DRUG AND ALCOHOL STRATEGY TEAM

Manchester Drug and Alcohol Strategy Team are inviting companies to express their interest in tendering for the following Term Contract:

A Needs & Capacity Analysis of the Alcohol Treatment System for Adults. Ref:- 75-59-18

Companies interested in tendering should request in writing to **Ian Jeffery, Senior Contracts Officer, Manchester Drug and Alcohol Strategy Team, Fourth Floor, Heron House, BrazennoseStreet, Manchester M2 5EA, quoting the reference (73-59-18).**

Due to the nature of this contract, providers of alcohol services in Manchester are ineligible to tender.

Tenders will be issued electronically therefore interested companies are required to provide an email address.

Applications will only be accepted up to 27 September 2006

Manchester NHS
North, Central and South
Primary Care Trusts

MANCHESTER CITY COUNCIL

www.SamRecruitment.org.uk

LOOKING FOR HIGH QUALITY, SKILLED, SUBSTANCE MISUSE STAFF?

Consultancy, Permanent, Temporary

We Talk Your Talk…

- *A comprehensive database of specialist substance misuse personnel*
- *Providing staff for Public, Private, Voluntary and Charitable organisations*

We Walk Your Walk….

- *Recruitment consultants with many years experience in the substance misuse field*
- *Meeting all your recruitment needs for the substance misuse field: Criminal Justice; Treatment; Young People; Communities; Availability*

Contact us today: Tel. 020 8987 6061
Email: SamRecruitment@btconnect.com
Or register online

Solutions in Management Recruitment & Consultancy

TORFAEN COUNTY BOROUGH

BWRDEISTREF SIROL TORFAEN

Tender for the provision of a Substance Misuse Open Access Service and a Substance Misuse Community Prescribing Service within Gwent.

Torfaen County Borough Council, acting on behalf of the five Community Safety Partnerships in Gwent, invites tenders for the provision of the following contracts:

Part 1. Gwent-wide Open Access Substance Misuse Service
This Service will deliver psychological, social and crisis support and care co-ordination for clients with drug or drug and alcohol issues. The Service will also act as the gateway to other Tier 3 services as well as providing on-going care planning for those clients engaged with the Part 2 Community Prescribing Contract on a Gwent wide basis.

Part 2. Gwent-wide Substance Misuse Community Prescribing Service
This Tier 3 Service will provide titration, stabilisation, maintenance and community detox prescribing on a Gwent wide basis.

The contracts are expected to be awarded for the period 1st April 2007 – 31st March 2010, subject to continued Welsh Assembly Government and Home Office funding.

The indicative budget for the provision of both services is approximately £1.1million (full year). However, the split between the two contracts will not be equal and will be based on required service capacity.

Organisations interested in wishing to tender for one or both of these services should apply in writing to Karen Jones, Substance Misuse Project Support Officer, Community Safety Team, Torfaen County Borough Council, Civic Centre, Pontypool, NP4 6YB. The closing date for the receipt of tenders is 12 noon on Monday 6th November 2006.

worcestershire countycouncil

JOINT COMMISSIONING MANAGER

Worcestershire Substance Misuse Action Team

PO3: £33,315 - £35,772

Commissioning effective and evidence based adult substance misuse services to address the needs of the county of Worcestershire. This is an opportunity to develop your commissioning skills within this field or see the other side of the fence from a service perspective.

TACKLING DRUGS & ALCOHOL CHANGING LIVES IN WORCESTERSHIRE

For further information please go to:
www.worcestershire.gov.uk/SMAT

Closing date: 5th October 2006
Interviews will be held on 20th October 2006

Lead the team that's leading vulnerable people towards independence.

bcha

Direct Access Hostel Scheme Manager · Ref DAHSM

Bournemouth · £26,169 to £31,746 per annum
37.5 hrs p/w

At BCHA, we give vulnerable people much more than just a roof over their head. We provide support, a safe haven, access to training and learning, creative opportunities, links to support services - and most importantly the chance to move on to full independence.

You will be working at our Direct Access Hostel in St Paul's Lane, Bournemouth, which combines emergency accommodation and support for 40 men and women with a broad range of services in our day centre. Leading and inspiring the staff and volunteers, you will ensure effective performance, develop ideas for new services and engage funders and other stakeholders.

You will be ready to embrace the challenges of working in this environment and be skilled in all aspects of management. Most importantly, you will share our passion for making a difference, championing equal opportunities and transforming lives for the better.

Closing date: 25th September 2006
Assessment day: 12th October 2006

To apply please call our Recruitment Hotline on 01202 410500 quoting the appropriate Ref no. For further information please see **www.bcha.org.uk**. BCHA is an equal opportunities employer and welcomes applications from all sectors of the community.

drinkanddrugs.net
New searchable training database

the WAREHOUSE
DUDLEY DRUG PROJECT

The Warehouse (Dudley Drug Project) is an independent community based drug project (Charity no. 1020293) currently based on three sites incorporating both adult drug services and young people's substance misuse services. Adult services will move into new premises early next year. We have a growing portfolio of partnerships (Community Safety, Police, Health, Probation, YOS), providing a range of counselling, information and treatment services for Dudley (West Midlands).

To complete our teams of paid and volunteer staff, we require qualified workers (e.g. DipSW/Y&C, RMN/RGN, NVQ Level 3 Health & Social Care, Dip Couns) with experience in the substance misuse field, to support, deliver and develop referral and treatment services.

The Cage (Criminal Justice Services):

Drug Worker, Arrest Referral (Tough Choices)
37 hours per week on a 7 day shift pattern. (ref C1)

Drug Worker, Prison Link 37 hours per week. (ref C2)

The Zone (Young Peoples' Substance Misuse Services):

Youth Offending Service Drug Assessment Worker part time 22.5 hrs a week (3 days) (ref Z1)

Salary scale for all posts A&C 5 to 6, £18,240 to £25,956, depending on experience and qualifications for a 37 hour week, pro rata for part time.

Closing date for receipt of applications: Friday, September 22nd 2006.

For informal enquiries and job packs; Tel 01384 480058, Fax 01384 481868. Please state the reference number for relevant post.

Charity no. 1020293