12 January 2009
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DDN
Drink and Drugs News

THE BIG BANG
Time to make a fresh start in our perceptions of addiction?

BACK FROM THE BRINK
Commitment gets naloxone supplied on outreach

SYSTEM ERROR
Can drug-free treatment match the numbers game?

NEW HORIZONS
An innovative approach to aftercare

Your fortnightly magazine | jobs | news | views | research

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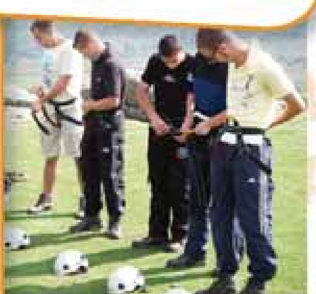

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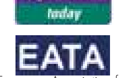

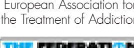

Editorial – Claire Brown

See you in Brum!

(If we can tear ourselves away from the new website)

A happy new year to you, and this month brings us to some monumental diary dates. My birthday, our second service user involvement conference, and the launch of our website. Talk about excitement.

We've mentioned the conference a few times in this issue because we're hoping you'll come up to Birmingham and be part of a very sociable and interactive day. We've been looking at ways of gathering feedback as effectively and efficiently as possible, and with the help of our trusty band of volunteers we'll be all ears to hear service user experiences from every perspective. A special issue of DDN after the event will give us chance to highlight the issues that matter to you and pass on the big questions of the day to those who need to provide answers. Look forward to seeing you on the 29th – and if you can't make it, we'll report back in DDN and on the new website.

Talking of which... have you been to www.drinkanddrugsnews.com yet? It's been a new game for us playing with so many elements of the site, so you have to humour us a bit while we're still building up the content. There's a 'your space' bit, where you can create your own page – great fun, particularly when your colleague posts you in the gallery as Wonder Woman. (Thanks Faye, I came out of that better than Ian.) There are plenty of serious reasons for doing the site – not least our well organised archive of DDN back issues – and we've taken the plunge with a forum, giving scope for discussion on anything you want. Thank you to our first brave topic posters, you have been appreciated!

Back to the mag and there's new thinking for the new year in this issue. Cathy Dixon offers a different approach to aftercare in our cover story, while Fran Miller challenges the way we look at addiction on page 14. Don't let me hold you up any longer!

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News in Brief

Winning ways
The two overall winners of the Tackling Drugs, Changing Lives awards were announced by Home Office minister Alan Campbell at a ceremony in London. Drug worker of the year 2008 went to Daniel Smyth of the Brent Centre for Young People for his work with young men with challenging behaviour, while Middlesbrough's Family First were named drug team of the year for their efforts to help children put at risk through parental substance misuse. Regional winners in the drug worker of the year category were Linda Knight (Yorkshire and the Humber), John Berridge (East Midlands), Philomena Lawrence (East of England), George Wake (North East), Liz Wallace (North West), David Stork (South West), Sue Hall (West Midlands), Alison Ede (South East) and John Frith (Wales). Regional finalists for drug team of the year were BAC-IN (East Midlands), The Spider Project (North West), Bradford Service User Forum (Yorkshire and the Humber), CASA Family Service (London), Drugs Specialist Nurse Team – Bristol Royal Infirmary (South West), RAPt – HM Prison Send (South East), the North Wales Harm Reduction Team and West Midlands Police DIP.

Meeting the need
A new facility is to be opened in Kent by the Kenward Trust in response to an acute shortage of residential rehab places for women. The Highgate Hall property in Hawkhurst, until recently a group therapy residential project, is to re-open next month as the women-only Naomi Project. 'The Naomi Project at Highgate Hall will be an intensive group work programme exclusively for women, operated by women,' said chief executive Angela Painter.

Audit advice
New advice to treatment providers and partnerships on auditing clinical governance arrangements against the 2007 Clinical Guidelines has been issued by the NTA. The advice covers the topics suitable for audit – rather than how to conduct the audit itself – to effectively implement the 2007 guidelines, considered an authoritative marker of good practice. Available at *www.nta.nhs.uk/areas/Clinical_guidance/clinical_guidelines/docs/auditing_drug_misuse%20treatment_1208.pdf*

Help employers help users

More employer support is needed to get problem drug users back into work, according to a new report from the UK Drug Policy Commission (UKDPC).

Employers need practical support to manage perceived risks and address the stigmas around problem drug use, and potentially even modest financial incentives, according to *Working towards recovery: getting problem drug users into jobs*.

Many employers are reluctant to recruit problem drug users even if they have the right competencies for the job, with concerns around risk to other employees or customers and company reputation, says the report. It is estimated that around 80 per cent of problem drug users are unemployed, and two thirds of employers surveyed for the report by the University of Manchester indicated they would be unwilling to employ a heroin or crack cocaine user even if they were otherwise suitable for the job.

The document acknowledges that getting some problem drug users 'fit for the job' can present a long-term challenge as a result of mental and physical health problems and accommodation issues, but that work is an important means of helping reintegrate problem drug users into society and reducing the risk of relapse.

Among its recommendations are a wider range of placement opportunities, including joint volunteering and placements organised by DAATs and employment services, clear guidance and information on the employment of people on substitute medication, formal risk assessment procedures to match problem drug users to employment opportunities and mechanisms to provide support to employers. Help should be particularly targeted at small and medium-sized businesses, it says.

It also calls on the government to do more to tackle stigma, perhaps by means of a public information campaign. The report wants to see programmes for getting problem drug users back into work properly evaluated and calls for closer involvement of housing organisations in drug-related partnerships. It raises the question of whether substance dependence issues should be included in equalities and discrimination legislation.

'This report highlights the formidable barriers to employment faced by problem drug users, not least the stigma faced by people in drug treatment and the concerns of prospective employers,' said DrugScope chief executive Martin Barnes. 'We can see little in the government's proposed welfare reforms which will directly address these important issues. We also support calls to consider extending discrimination laws to include recovering drug users.'

Full report available at www.ukdpc.org.uk/resources/Working_Towards_Recovery.pdf

'You're barred' say police and councils

Powers to prevent drink-related offenders from entering certain premises have been announced by the Home Office.

From the summer, police and local authorities will be able to apply to magistrates' courts for drinking banning orders to stop someone entering certain establishments if they have been involved in 'criminal or disorderly conduct under the influence of alcohol'.

The orders, which will last up to two years, are aimed at those 'whose drinking has been identified as a factor in their irresponsible or disorderly behaviour' says the Home Office, and breaching one could result in a fine of up to £2,500. The orders were 'an example of our targeted and focused approach to ensure people can enjoy drinking sensibly and socially,' said Home Office minister Alan Campbell.

The move follows a government announcement last month that it will make a further £4.5m available to tackle alcohol-related crime and disorder – £3m to crime and disorder reduction partnerships, plus an extra £1.5m to help tackle underage sales and confiscate alcohol from underage drinkers in priority areas.

'Drink fuelled anti-social behaviour is a major concern for many councils and this power is a necessary step in helping them deal with it,' said chair of the Local Government Association's safer communities board Hazel Harding. 'However it's important to recognise that drinking banning orders should only be used as a last resort, when all other efforts to tackle the problem have been exhausted. Also, it remains to be seen how they will be enforced.'

Alcohol Concern chief executive Don Shenker said while the orders could 'make a real difference' to community safety if used as part of a wider package of measures, 'policing of alcohol-related crime must go hand in hand with more robust measures to curb irresponsible and illegal sales and improve treatment pathways for dependent drinkers.'

UK's hep C 'legacy' of past behaviour

Many of the UK's hepatitis C infections are the result of injecting drug use dating back as far as the 1960s, according to a report from the Health Protection Agency.

Many people may have been infected years ago and be completely unaware of the infection, says the agency, which describes deaths from hepatitis C related liver disease as 'a legacy of our past behaviour'.

It is estimated that around 250,000 people in the UK are infected with the virus and that half have never been tested and are unaware of the infection. Hepatitis C can be silent for many years and have led to serious and potentially fatal liver disease by the time it becomes apparent. The agency estimates that the number of people becoming infected in England increased dramatically after 1960, reaching nearly 2,000 new infections in 1988 and now reflected in liver disease deaths more than two decades later. The HPA is urging anyone who feels they may have put themselves at risk to get tested.

'Hepatitis C is a disease many people associate with current drug use but we should not forget people who could have been infected many years ago and are unaware of their infection,' said HPA hepatitis C expert Helen Harris. 'For example, people may have been infected by sharing needles once or twice when they were younger and are now living stable everyday lives.'

Hepatitis C in the UK available at www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1228810569993

NTA hits back at Conservative critics

The NTA has responded to Conservative Party criticism of drug treatment, stating that it was 'not surprising' that there had been an increase in methadone prescribing as the number of people in drug treatment had more than doubled in recent years.

The comments followed shadow health spokesperson Mike Penning's statement that there had been an 'explosion in methadone prescription' and that his party would pursue an abstinence-based approach.

The goal of all drug treatment was abstinence, stated the agency, although 'it may take time for individuals to achieve it,' adding that of the estimated 332,000 problem drug users in England dependent on heroin or crack cocaine, approximately half were already in treatment programmes.

Substitute prescribing was the best way of stabilising problem drug users while their dependency was treated, said the agency, reducing health risks and the likelihood of committing crime to feed their dependency. The key issue was how quickly people could move through the treatment system to become drug free, as people with entrenched heroin problems could spend between five and seven years in and out of treatment before becoming free of their dependency, requiring a 'series of treatment exposures of varying length.' Most drug users could make adequate changes to their behaviour in the community, the agency said – residential rehab was one option for delivering abstinence, 'but not the only one'.

'Methadone is the first-line treatment for opiate dependency because that is what NICE guidance and expert clinical guidelines recommend,' said chief executive Paul Hayes. 'The NTA supports a balanced treatment system in which individuals can access the treatment most likely to work for them. The increase in the numbers of heroin and crack users benefiting from substitute prescribing is a reflection of the massive expansion of drug treatment services in recent years, and evidence that we are tackling the problem of drug addiction.'

DrugScope's director of communications Harry Shapiro said what was needed was a flexible drug treatment system to reflect the many routes out of addiction. 'DrugScope supports the availability of the widest possible range of interventions, including the prescribing of methadone and the provision of rehab. While we do need more investment in rehab services, we must be careful not to treat them as a "silver bullet" for addiction recovery, ignoring the demonstrable benefits of methadone treatment in the process.'

Comprehensive drugs death database launched

A database of national drug deaths has been established by the Scottish Government in an attempt to reduce future fatalities.

From this month, the details of the medical and social history of everyone who dies from drug related causes will be recorded and centrally collected in order to 'help inform service providers and policy makers.'

The database is the first of its kind in the UK and follows local pilots. It will include information collected by local DATs or other nominated individuals on things such as drug taking history, involvement with the criminal justice system, whether the person was taking methadone or other drugs and whether they were prescribed, where the person was living and with whom – including children – and whether they were known to services or on a waiting list.

'Sadly a great number of people die every year in Scotland through taking drugs – over 450 in 2007,' said community safety minister Fergus Ewing. 'It's far too high and we believe many are preventable. Comprehensive information about every life lost to drugs in Scotland will be gathered on the national drug-deaths database – allowing us to look much closer at the circumstances surrounding each one rather than simply counting numbers. The detailed information will be studied to look at emerging patterns or trends and to put in place interventions to seek to prevent future fatalities.'

The database has been launched alongside an overdose bereavement booklet aimed at the families and friends of those who die from a suspected drugs overdose. The booklet, developed by service users in the National Forum on Drug-related Deaths and the Scottish Network for Families Affected by Drugs (SNFAD) will be distributed to GPs, community centres and libraries among others and includes practical information on procedures as well as advice on coping with grief.

'There can be no more devastating circumstances for a family than the loss of a loved one to drugs,' said SNFAD chair Eleanor Robertson. 'Any support that can be given in these circumstances is vital.'

FRANK advice for foster carers

A new drugs resource pack for foster carers and young people has been launched by FRANK in collaboration with the Fostering Network.

The pack is in response to research by FRANK that revealed foster carers and those in their care often have difficulties talking about issues like drugs.

The fragmented nature of their home lives can mean that children in foster care frequently have no one they can trust to talk to about sensitive issues, and many young people in care have been placed there because of problems around parental drug use, meaning they have been exposed to drugs from an early age. Foster carers also have a legal obligation to report anyone in their care they suspect of drug use, making it difficult for young people to feel they can be open about the subject.

The pack includes information on why children in care are especially vulnerable and how to talk to young people about drugs, as well as details of FRANK information resources. 'This new resource should be a useful tool for foster carers, particularly those who are new to looking after young people,' said Fosterline manager Malcolm Phillips.

Download copies of the pack at http://drugs.homeoffice.gov.uk/ or phone 0870 241 4680 for a hard copy.

News in Brief

Mandatory moves

A mandatory code of practice for the drinks industry moved a step closer with measures announced in last month's Queen's Speech. Following an independent review that found many retailers are failing to adhere to voluntary codes, the government announced it intends to introduce a mandatory code with compulsory conditions for all alcohol retailers. It will consult on the measures that may be included, among them a ban on 'all you can drink' promotions, a requirement that customers are able to see the unit content of all alcohol they buy, a requirement for bars and pubs to always have minimum sized glasses available and an end to bulk 'multi-pack' discounts in supermarkets. British Beer and Pub Association chief executive Rob Hayward said his members would welcome a ban on irresponsible promotions but that other mandatory code proposals would impose 'an unnecessary, disproportionate and costly red tape burden on well-run community pubs.' Last month however also saw pub chain JD Weatherspoon introduce 'indefinite' reductions on many drinks, including a 99p pint.

Get it checked

EATA has launched a new online service for its members, POVA First (Protection of Vulnerable Adults) – a preliminary check carried out by the Criminal Records Bureau that allows workers, in exceptional circumstances, to begin working while waiting for a full CRB check. Contact EATA on 020 7553 9580 or ghada@eata.org.uk

Action honour

Action on Addiction chief executive Nicholas Barton has been awarded an honorary doctorate of health from the University of Bath for his contribution to addiction treatment. Formerly chief executive of Clouds, which merged with Action on Addiction to form the current organisation, he was the 'inspirational force who developed Clouds into the highly professional, creative and multidisciplinary organisation which Action on Addiction has now become,' said the university's professor Bas Verplaken. The award 'honours all those who have contributed to realising the charity's goals,' said Mr Barton.

Despite successfully completing treatment many clients can be left with an overwhelming feeling of 'what now'? **David Gilliver** hears about a new programme designed to get them through this tricky time and firmly on the right path

New horizons

The New Year will start with an innovative new approach to aftercare for Rugby House clients in west London. The organisation is joining forces with independent therapist and trainer Catherine Dixon to pilot the eight-week *Empower your life* programme at its Alcohol Resource Centre in Ladbroke Grove.

The programme combines elements of cognitive behavioural therapy (CBT), positive psychology, neuro-linguistic programming (NLP), hypnotherapy and the energy principles of holistic therapies like acupuncture and Chi Kung (also known as Qigong). 'It's cherry picked the best,' she says. 'And all of these are very positive and life affirming. It's about hope and inspiration, and something exciting that clients can do for themselves. Motivation comes from within and for that they need powerful goals.'

The eclectic mix of ingredients mirrors her background – starting in shiatsu and acupuncture, she went on to train in cognitive hypnotherapy. 'When I talk about the mind body link it comes from 11 years training and practice, combining the bits that I think belong together,' she says.

An alternative to maintenance based treatment, *Empower your life* is aimed at clients who have attained stability and are looking at the next step, based on the premise that relapse tends to come from low self-esteem and unresolved emotional issues, as well as a sense of futility from an inability to see a different kind of future.

The programme works to challenge clients' beliefs about their own capabilities by fostering self-esteem, personal responsibility and building strengths. It also addresses the lack of guidance and supervision after treatment that can also make relapse more likely. 'It's about breaking free of "this is how life is, and it has to be like this",' she says.

Dixon has been working with Rugby House on aftercare for around three years, and the programme is the result of extensive client feedback – her hope now is that *Empower your life* becomes incorporated into mainstream aftercare practice in the sector. 'The first thing when working with clients who've gone through treatment is to maintain, obviously, but my work is focused on taking stock and looking at the future – the what next, rather than the why. That doesn't mean I ignore the why, but it's not what I'm concentrating on.'

Crucially – and unusually for this kind of work – the programme will be measured and assessed by the NTA, with clients filling in Treatment Outcomes Profile (TOP) forms at the beginning, middle and end. It has been created with the input of alcohol clients throughout its development but is equally applicable to any addiction, and comes from years of listening to what clients find helpful. 'It's based on what I know makes a change in my private practice – what I know people will pay for,' she says.

The work is in a group context which, as well as being more economical, also means clients can share ideas and be spurred on by their peers. 'It focuses on evaluating where you are and who you think you are from the point of view of strengths, attributes and skills, and also what drains those strengths. The act of doing this in a group – acknowledging and verbalising those ideas – can be very useful,' she says.

It is also careful not to impose pre-existing fixed concepts of recovery, revolving instead around continuous healthy lifestyle choices. So how does it work? 'It's looking at the whole concept of the mind body connection, what actually happens,' she says. 'That's something that's bandied around but what does it actually mean? How much does the mind lead in the struggle for health? It's all very well going through a detox programme, stopping drinking and starting to eat again, but it's the correlation between mind and body that is explained in this programme.'

Part of this is based on the concept of 'magnetic thinking', a

hybrid of aspects of cognitive behavioural therapy (CBT) and neuro-linguistic programming (NLP) among others, as well as drawing heavily on her work with phobias and smoking. 'It's about what actually happens to the mind, the way we talk to ourselves,' she says. 'The idea is that the mind is like a magnet – we magnetise our thoughts. By obsessing, for example, on having a drink you create the situation – the thought becomes reality. The mind is creating the idea – 'I want something' – then it's 'how do I get it' and then it ends up in an action. It's about awareness of how powerful your thoughts are, and taking control and responsibility. It's a challenging programme.'

It also provides clients with exercises to break those cycles, before going on to focus on the creation of goals and their manifestation. 'Clients make very specific goals in any area they choose – and remember they're doing this in a group so they're accountable – looking to the future and how it will be different. The mind needs a future focus to lead it – the unconscious will play out anything you want it to, so it's about re-programming that. Clients learn a suite of tools where they use visualisation and see their goals.'

According to the programme, there are set steps to achieving any goal, addiction-related or not. 'Understanding what you want is the first thing,' she says. 'Most of the people I deal with tell me what they don't want, so the first thing is to identify exactly what it is they do want and not to be apologetic about it. That's a process in itself – when you identify what you want, you step out of victimhood. It's the first step of empowerment.'

The second is for clients to believe they can have it, she says, looking at 'limiting beliefs'. 'I have a range of tools to slice through those – the language of "I can't", "that's not for me". It's standing up for yourself and stepping out of the "poor me, I can't do anything" mentality, and you absolutely have to step out of that if you're going to get through addiction. The third is feeling you can have it, the fourth is taking inspired action, getting on with it, while the fifth is an acceptance that it's going to take time.'

Does she feel some clients could be too self-conscious to fully open up to these concepts in a group setting? 'I think that depends on the group itself, but there is an assessment process before to explain what it's about and encourage them to have an open mind – that's critical. A group of people that's highly motivated has its own energy – eight people in a room all wanting to improve their lives and helping each other. The therapist doesn't have all the answers.'

Dixon will facilitate the groups to begin with, and is also interested in establishing a buddying scheme to progress beyond the eight weeks. The aim is that there will be monthly follow-up sessions to provide a level of supervision as well as evaluate impact, and clients will also get a resource pack covering everything from healthy eating to meditation. 'When people start to see themselves in a much more positive light they start to want to do things for themselves, and then it's about getting them the right information. It's certainly not about following certain steps – there's no philosophy here,' she says.

The strategies at the core of *Empower your life* have also proved very popular with women, largely, she believes, because of the focus on self-esteem. 'Alcohol can completely obliterate self-esteem and sense of self in a woman. This is getting them to look at themselves in a completely different way.'

Coming from outside of the field has given her an ideal vantage point on what's missing and what would make a difference, she believes. 'It's about imagination and doing things differently, especially in the current climate. Group therapy is nothing new but I wouldn't call this therapy, it's group coaching. It's a structure and a process but not imposing things.'

'Most of the people I deal with tell me what they don't want, so the first thing is to identify exactly what it is they do want and not to be apologetic about it... when you identify what you want, you step out of victimhood.'

The eight-week duration is designed to keep energy and inspiration levels high, with the ideal group size anywhere between eight and 12. Several can be run at once to help build up an evidence base for its effectiveness and, of course, group work is more economical. 'A one-to-one therapy session is not only a great cost but it's also slow and I'm not sure it's always the right way of going about things. This is a much softer approach – it's not keying in on individual problems.'

Future plans are for an online community for the programme, to keep the momentum going and provide a place for people share stories and experiences. 'Communities are where people share goals and get a lot of support – you start to create something that has momentum and it's a great way of keeping people on track,' she says.

The programme is also designed as a transferable package that others can use. 'They don't even have to be therapists, she says. 'They just have to be good with people, be a good facilitator – it's transportable. And it will also be developed constantly as it runs, based on user feedback – it's definitely not something static.'

So does she think NTA accreditation will help break down some of the suspicion that can greet anything seen as different? 'It's not different, really,' she says. 'It's bringing together the best of what's out there at the moment – what people are paying independent therapists for. All the clients I've spoken to want to do to it – there's user involvement every step of the way. The feedback is that it's something new and fresh, and I think that's what the NTA is looking at. Given the amount of money spent on treatment, there's a need for other solutions.'

A message from DDN

Why we want to hear your voice

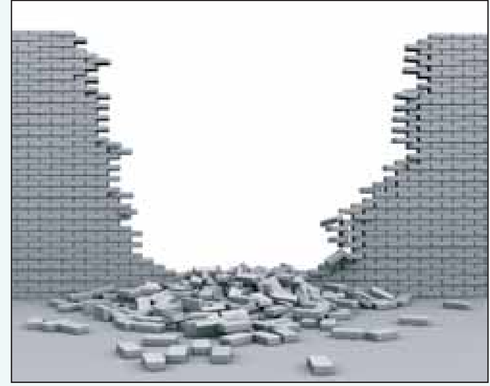
This year's service user conference depends on your involvement.

As well as the informative presentations from service users and policymakers, there will be a consultation exercise running right through the day, where we will be seeking your views and wanting to hear your experiences. Whether you answer a few questions on our questionnaire or share more in-depth views and experiences for us to report back on or film, we will be ready to hear your take on the local service user experience.

Our aim is to build up a picture of how service user involvement is working throughout the country. We have the listening ear of the Department of Health, the National Treatment Agency and drug and alcohol treatment services from all over the UK. Delegates are travelling from the far corners of the country and we want to hear what's working and what's not – and help those whose needs aren't being listened to, to find a stronger voice. Delegates' personal accounts and feedback will be crucial.

We've drafted key issues for our questionnaire, with the input of the conference steering group, but we want to make sure that we're covering your burning concerns though the topics to be discussed. Please visit the forum section of our website, www.drinkanddrugsnews.com/forum and let us have your thoughts ahead of the big day. It's fast approaching – hope to see you in Birmingham!

More information on Voices for Choices, the second DDN/Alliance national service user involvement conference on 29 January, is at www.drinkanddrugsnews.com



'The NTA remains committed to the provision of evidence-based measures to reduce drug-related harm, which includes naloxone. The challenge is for local areas to work out how best to make it available given the barriers...'

Definitely not on the fence

David Best and colleagues usefully highlight some of the practical barriers to the widespread provision of naloxone and the efforts being made locally to overcome them (*DDN*, 1 December, page 12). However, it is misleading to suggest the NTA is agnostic on this issue.

There is clear UK national guidance on naloxone as part of the package of overdose prevention measures set out in *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (DH and devolved administrations, 2007). This endorses the use of naloxone both in appropriate services and in the home, subject to suitable training.

The NTA has asked all providers and commissioning partnerships to audit their services against these guidelines, and take steps to ensure local practice is in line with them and the NTA has produced audit guidance to enable this. It is not within the NTA's gift to set national targets about naloxone and it may be more effective to encourage implementation of the 2007 Clinical Guidelines through the existing treatment planning process.

The recent *Good Practice in Harm Reduction Guide* was produced in response to the specific harm reduction findings of the 2007/8 NTA/Healthcare Commission Service Review. This review found that the majority of areas had trained paramedics in the use of naloxone, but it did not raise wider naloxone issues.

The current national harm reduction action plan for England (*Reducing Drug-related Harm: An Action Plan* [DH, 2007]), has a clear objective to reduce the incidence of drug-related deaths. Under this plan – and following the NTA-funded research into the use of naloxone to which the author refers – the NTA will shortly call for expressions of interest for demonstration projects on the use of naloxone by service users and family members.

In addition, the Medical Research Council is funding a randomised controlled trial of the use of naloxone on release to prisoners with a history of injecting heroin use.

The NTA remains committed to the provision of evidence-based measures to reduce drug-related harm, which includes naloxone. The challenge is for local areas to work out how best to make it available given the barriers highlighted in the article.
Annette Dale-Perera, NTA Director of Quality

Don't shoot the messenger

I must say I am a little concerned at the reporting of the device called the 'Itemiser' which tested people in both pubs and clubs in Aberdeen which you reported in your recent edition (*DDN*, 17 November, page 4).

While I appreciate that you are merely reporting the press release from the SCDEA and Grampian Police, this gives the impression that violating the civil liberties and freedoms of otherwise law abiding people is normal, and to be encouraged.

You quote one of the inspectors from Grampian Police as suggesting that this device called the 'Itemiser' will allow them to screen out the minority who cause problems. The quote is as follows:

'We will undoubtedly repeat this initiative, working in tandem with the Scottish Crime and Drug Enforcement Agency, and indeed other partners, in the future to target the minority whose behaviour causes problems.'

While I am not in any way indicating that the use of illegal drugs is to be encouraged, is it not the case that the drug problems in which the police are asked to intervene are mostly alcohol related – and that this is an empirical fact verifiable not only with data from the police, but also from the NHS and the Scottish Government? The problems that the police inspector is referring to are surely about the possession of drugs, or the possession with intent to supply illicit drugs. Of course this is an offence, however what freedoms are we as a society willing to give up, what levels of surveillance will we tolerate in order that we live in a 'safe' society, free from the use of illicit drugs?

Are we to infer from this 'puff piece' from the Police that this device should routinely and randomly test everyone, as is the case now in some states in the USA? The fact is that this device can indeed produce false positives. Should you not also in fairness, have at least someone in your editorial team produce a challenge to these police perspective press releases, and attempt

balance and some measure of objectivity as you inform and educate your readers?
Iain McPhee, lecturer in postgraduate alcohol and drugs studies, University of the West of Scotland

IDTS is an asset to prison nursing

Drug treatment has been available in prisons for many years, but has not always been successful.

In 2006, the prison Integrated Drug Treatment System (IDTS) was introduced to provide evidence-based drug treatment for offenders and since has been rolled out in many prisons across the country.

The IDTS offers the clinical and psychosocial support, bringing agencies to work closely as a team to provide a seamless pathway of treatment for offenders from, and back into, the community.

In my view as a prison nurse, prisons have a captive and vulnerable audience, and so it is an excellent place for the offenders to address their substance misuse issues; they are easy to reach and to engage in treatment.

The IDTS provides a range of benefits for individuals, the establishment and the community. Clients are now offered an opiate substitute treatment programme which can be continued in the community on release, and which reduces the re-offending rate.

Working in a prison healthcare cluster for a number of years, I had the opportunity to work with the team to implement the service. I followed offenders' care from a closed environment prison to an open prison and noticed the change in the clients' behaviour and perspective on life when they engaged with treatment.

'It is one of the best things that happened to me,' stated one of my clients, a problem drug user (PDU) who had been coming to prison for many years because of a drug habit.

The IDTS have given many of the PDUs the opportunity to change their way of thinking on release from custody, knowing that they will access treatment to reduce the pressure and risk of overdose.

It's not always been easy to implement the service. There have been obstacles, the most difficult of which was staff attitude. But as a substance misuse nurse, I personally welcome the IDTS in prison as I feel that now I can really help my clients.
Paul Ramsamy, substance misuse nurse specialist, HMP Maidstone

Please email letters for publication (up to 350 words) to the editor, claire@cjwellings.com or post them to the address on page 3.
Letters may be edited for space or clarity.
Our discussion forum is now open at DDN's new website – visit www.drinkanddrugsnews.com

Notes from the Alliance

Your conference needs you!

Don't let the second service user involvement event go by without having your say, says Daren Garratt

On Thursday 29 January 2009, the Alliance and *DDN* will be co-hosting our second National Service-User Involvement Conference at the Holiday Inn in Birmingham. We've called it Voices For Choices, and for very good reason.

Although the government and NTA have unarguably taken great strides in the last ten years to make the wide-ranging individual needs of users central to effective, dignified care-planning, we now seem to be moving steadily into a new age where these basic rights could be gradually stripped away if we fail to take advantage of any opportunities we may have to let policymakers know how their decisions are impacting on the reality of people's daily lives.

Last year saw the publication of two key strategic documents that will shape the future of drug treatment over the next ten years, and both of them contain elements that, if left unchecked and unchallenged, could result in pretty bleak futures for a considerable amount of users.

Take the contradiction inherent in the aims of *Drugs: Protecting Families and Communities, the 2008 Drug Strategy* for instance.

On one level, it contains the welcome and relatively progressive goal that seeks to 'ensure treatment is personalised and outcome-focused, making full use of new treatment approaches that are shown to be effective' (and our conference aims to add weight to this evidence by presenting feedback from participants in the Randomised Injecting Opioid Treatment Trial).

However, in the same section, it makes explicit the government's position that: 'The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency.'

So 'User A' sees the Drug Strategy as a means to support them in getting the injectable diamorphine maintenance script they've needed for years, while 'Treatment Provider B' reconfigures their service in line with the government's clearly stated 'goal' to get all drug users abstinent.

Who wins?

Then in December we saw the publication of the Department of Work and Pension's White Paper, *Raising expectations and increasing support: reforming welfare for the future*, which sets out, in what I consider a rather worrying choice of words a 'new *regime* for problem drug users on benefit' (my own italics!) in which more than 80 per cent of the public 'strongly agreed' that there should be 'a requirement for unemployed drug users to tackle their problems or face a stronger sanctions regime'.

Now, 'get drug-free or get a job' might be acceptable in *Daily Mail* world, but in the real world, the loss of benefits simply means the cycle of deprivation, and therefore the reliance on street drugs continues.

These are the issues that need discussing and thankfully, our good friends from the Department of Health will be there in Birmingham on the 29th to hear these realities, because they want to ensure that the programmes of work they commission are effective, and that the Strategy is helping people, not making their lives worse. And if it's not, then what can we do? We have a direct line to government here, let's not waste it.

Lest we forget, we're not only talking about the use of millions of pounds of taxpayers' money here, we're also looking at programmes of health and benefit reform that may shape the outcome of the next General Election.

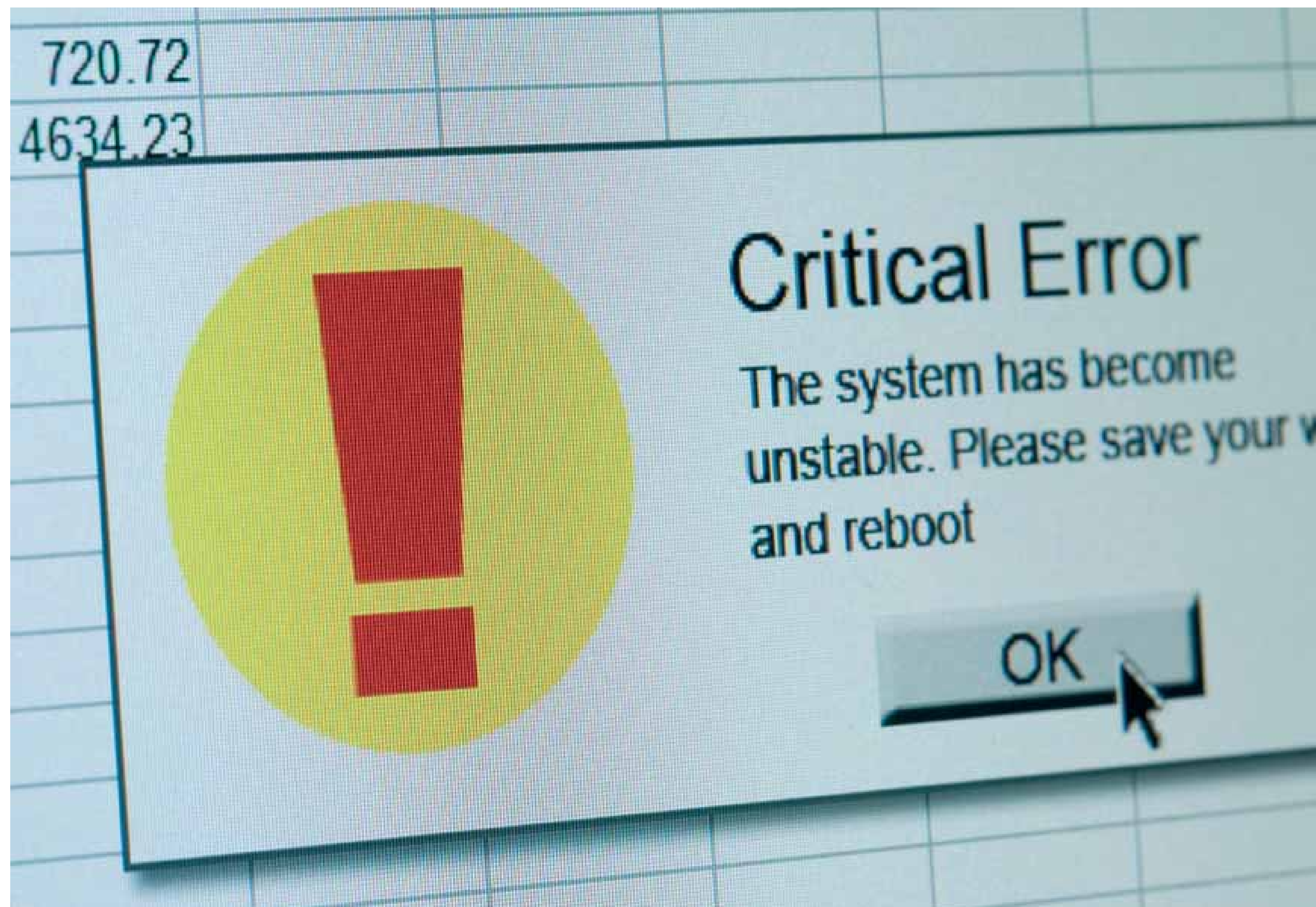
Admittedly, the unemployed drug users, unskilled, long-term Job Centre Plus claimants, disabled people, individuals experiencing ill health and partners of those claiming benefits with kids over seven that the DWP's new regime aims to sanction, have never been the key demographic that successful election campaigns have sought to target. Vilify maybe, but never target.

But I was fortunate enough to be staying in a black area of Brooklyn on the morning that America went to the polls, and was humbled and quite overawed by the sight of hundreds of predominantly black voters queuing from 6am in a line that snaked for blocks and blocks in a determined act of getting their voices heard.

Poor black communities never win elections either, do they? It's amazing what a bit of dignity and hope can do for mobilising people, and for the subsequent effect it can have on governments.

Daren Garratt is executive director of the Alliance

Be part of it!
Voice for Choices, the second national service user involvement conference will be held in Birmingham on 29 January. For details and a registration form go to our website, www.drinkanddrugsnews.com



System error ?

The NTA has pledged commitment to both increasing the numbers of drug users in treatment and helping more addicts to become drug free. But are the two aims compatible within our treatment system?, asks Professor Neil McKeganey

One of the most memorable phrases of the conservative government of the nineteen nineties was provided by Michael Howard who, as Home Secretary, made the statement that 'prison works'. If there is a New Labour equivalent to the prison works statement it must surely be that 'treatment works'.

So persuaded were the incoming New Labour government that drug abuse treatment did indeed work that it set up the National Treatment Agency with a multi-million pound budget in 2001 to 'double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008' and 'increase the percentage of those successfully completing or appropriately continuing treatment, year on year'.

To realise those aims, funding for drug treatment in England and Wales was increased from around £390m in 2002/03 to £800m in 2007/08. That expansion in funding resulted in an increase in the number of addicts in treatment from around 118,500 in 2001 to 202,000 in 2007. As well as being characterised by an unrivalled expansion in drug abuse treatment, the period from 2003 to 2007 was also a time when the focus of attention shifted from the numbers of drug users coming into treatment to the number leaving treatment drug free.

In 2002 the question of how many drug users were leaving treatment drug free was not so much a side issue as a non-issue. The 2002 annual report of the National Treatment Agency, for example, made no mention at all of the numbers leaving treatment drug free. By 2007/08, following the BBC revelation that only 3 per cent of drug users were leaving treatment drug free, the picture could hardly have been more different. Paul Hayes opened the 2007 NTA annual report with the statement that: 'In the year ahead all of us in the field face this challenge to focus our efforts on the outcomes of treatment, to enable more addicts to become drug free.'

But to what extent is the historical focus on increasing the numbers of drug users in treatment compatible with the current commitment to ensure that services are working towards addicts becoming drug free? In one sense these aims are fundamentally incompatible.

In research that James McIntosh and I carried out for our book *Beating the Dragon: The Recovery from Dependent Drug Use* we showed how addicts who had managed to overcome their addiction to illegal drugs had built up a new, non-addict identity for themselves. They had come to see their drug use in a new light – not as something they did for pleasure or as a way of enabling them, in their eyes, to function normally, but as something that was causing massive harm to themselves and those around them.

They needed to build up a new set of relationships with individuals that were not involved in using or dealing drugs. On occasion this could involve moving to a new area where they were not known as someone who had a drug problem. They needed to fill the time they had previously devoted to tracking down and using drugs. They needed to build up a sense of the person they could become rather than the person they had been throughout the years of their involvement with illegal drugs. They often needed to reflect back, with support, on the things they had done to the people they loved most over the years of their addiction and they needed, on occasion, to recapture a sense of the person they might have been had they not gone down the road of protracted and chaotic drug use.

Creating a new non addict identify was not a process of fast turnaround and large numbers but of intensive, faltering work, of two steps forward and one step back, of limitless counselling, appropriate medication, and real practical help delivered sometimes over many years. As drug treatment services are enjoined to develop a recovery perspective that enables more drug users to leave treatment drug free, they will increasingly face the question of how to do that with the large number of drug users they are currently in contact with.

> **'As drug treatment services are enjoined to develop a recovery perspective that enables more drug users to leave treatment drug free, they will increasingly face the question of how to do that with the large number of drug users they are currently in contact with.'**

One potential solution to that problem is to begin to segment the addict population. In the simplest terms this could mean differentiating between those addicts who stand a reasonable chance of being able to come off drugs, and for whom a recovery or abstinence focus might be appropriate, and those who are in the midst of their drug use and for whom a maintenance orientation may be more appropriate.

Stated in this way the segmenting strategy may sound like a workable method for dealing with the large number of drug users currently in treatment while at the same time delivering a recovery focused agenda within services. As a solution to the problem of large numbers, however, the segmenting approach is based on the assumption that the population of drug users for whom abstinence based services would be appropriate is relatively small compared to the much larger population of drug users for whom a maintenance approach would be more appropriate.

At the present time, however, we know relatively little about the characteristics of those drug users for whom abstinence and recovery may be an achievable goal. Within the UK we have simply not undertaken the long-term research studies on the natural history of addiction to identify those drug users who may benefit most from a recovery focus. We know from US research that some addicts mature out of their addiction after a period of ten to 15 years of chaotic drug use. Based on that work, one might be inclined to target the recovery services on those drug users who are nearing the end of their 15-year career.

The maturing out of addiction research, however, is over 40 years old, and was based on a different continent with addicts who had a very different drug using profile. In addition one may wonder at the wisdom of targeting recovery services on those individuals whose drug use has become an entrenched part of their lifestyle in preference to focusing on those individuals at an earlier stage of their drug using career, and for whom recovery may be a more achievable and less demanding goal.

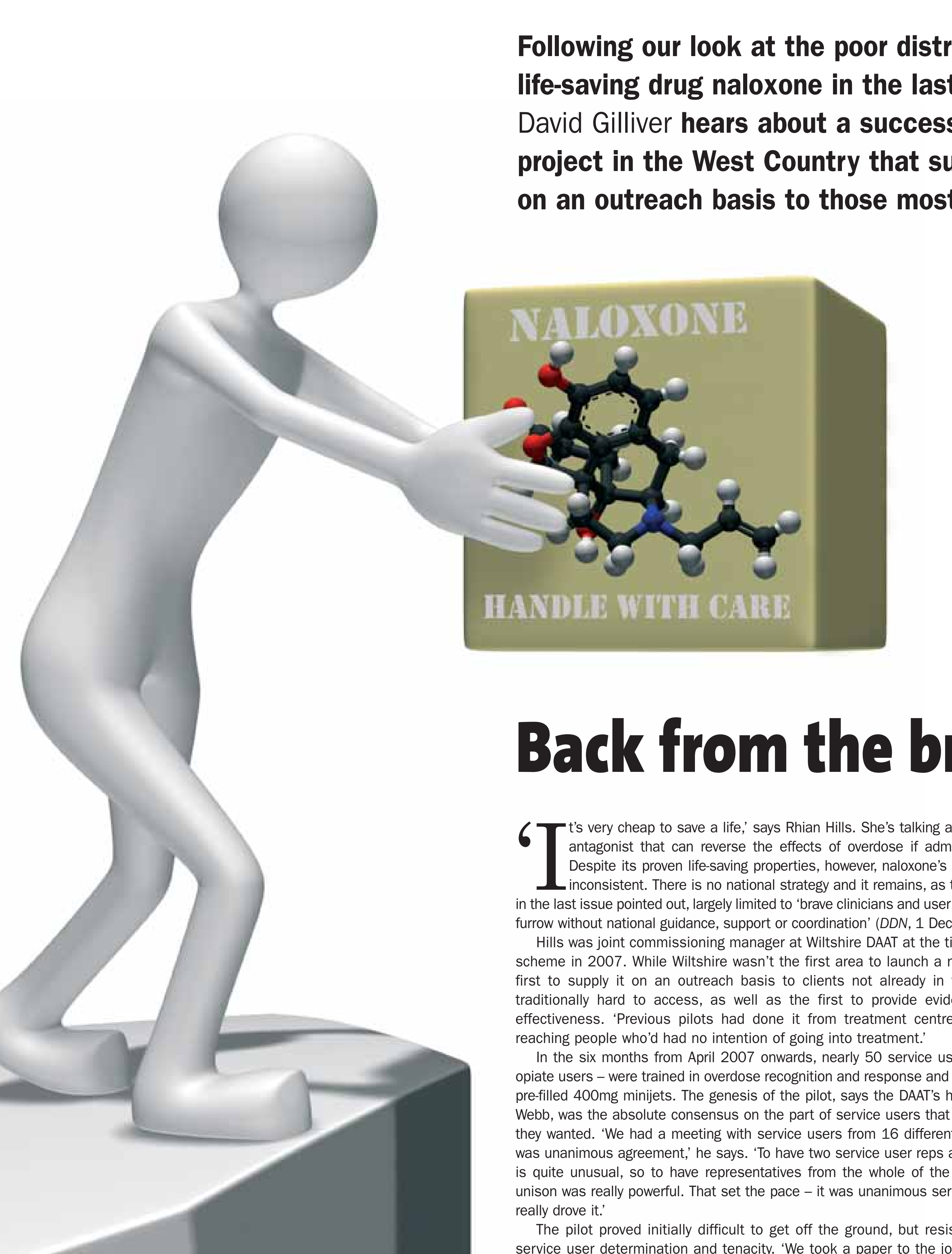
There is though a radical alternative to the segmenting strategy, which is to ensure that all drug treatment services working with drug users are able to deliver a recovery focus, and to combine that orientation on the part of services with a much clearer articulation of the responsibilities placed upon the clients of services. Within these terms, the aim of drug treatment services would not be to hoover up larger and larger numbers of drug users, but instead to work intensively with a smaller number of individuals committed to their recovery. Under such a regime the number of drug users in treatment would go down, but the proportion leaving treatment drug free and able to build a sustained drug free life for themselves would increase.

Wholly aside from the issue of how drug treatment services identify which drug users would be suitable for the more costly intensive recovery oriented treatment, there is also the question of where the experience and expertise in recovery is to be found. On the basis that drug treatment services are presently enabling only a tiny minority of drug users to leave treatment drug free, one would have to conclude that the answer to that question would not take one to many of the mainstream services currently available. By contrast, the self-help, abstinence oriented 12-step projects have a wealth of experience in working with drug users to enable them to become drug free.

Irrespective of whether the solution to the problem of developing a recovery focused agenda on the part of drug treatment services is to segment the addict population or to work with smaller numbers of drug users in a more intensive way, there may still be a need for drug treatment services to draw upon the expertise of the self-help groups and to integrate the expertise of those groups into their own work with clients.

Neil McKeganey is Professor of Drug Misuse Research at the University of Glasgow

Following our look at the poor distribution of life-saving drug naloxone in the last issue, David Gilliver **hears about a successful pilot project in the West Country that supplied it on an outreach basis to those most in need**



Back from the brink

'It's very cheap to save a life,' says Rhian Hills. She's talking about naloxone, the opioid antagonist that can reverse the effects of overdose if administered quickly enough. Despite its proven life-saving properties, however, naloxone's distribution is patchy and inconsistent. There is no national strategy and it remains, as the authors of our feature in the last issue pointed out, largely limited to 'brave clinicians and user groups who plough a lone furrow without national guidance, support or coordination' (*DDN*, 1 December 2008, page 12).

Hills was joint commissioning manager at Wiltshire DAAT at the time of an innovative pilot scheme in 2007. While Wiltshire wasn't the first area to launch a naloxone pilot, it was the first to supply it on an outreach basis to clients not already in treatment and therefore traditionally hard to access, as well as the first to provide evidence to the NTA on its effectiveness. 'Previous pilots had done it from treatment centres,' she says. 'We were reaching people who'd had no intention of going into treatment.'

In the six months from April 2007 onwards, nearly 50 service users – including 25 heavy opiate users – were trained in overdose recognition and response and supplied with naloxone in pre-filled 400mg minijets. The genesis of the pilot, says the DAAT's harm reduction lead, Mick Webb, was the absolute consensus on the part of service users that naloxone was something they wanted. 'We had a meeting with service users from 16 different DAAT regions and there was unanimous agreement,' he says. 'To have two service user reps agreeing on any one thing is quite unusual, so to have representatives from the whole of the South West speaking in unison was really powerful. That set the pace – it was unanimous service user consensus that really drove it.'

The pilot proved initially difficult to get off the ground, but resistance was overcome by service user determination and tenacity. 'We took a paper to the joint commissioning group with service user reps – if it wasn't for user involvement the project wouldn't have worked,'

says Hills. 'The sheer commitment and determination of service users helped not only to put the project in place, but more importantly saved lives.'

It quickly became a multi-agency project, with the Wiltshire ambulance service and police on board alongside the Wiltshire users forum and a number of professionals who gave their time free of charge. 'That was very much capturing the spirit of harm reduction,' says Mick Webb. 'We had this raft of well-paid professionals saying "let's get this off the ground" – it was all above and beyond their roles.'

The aim was not only to reduce drug-related deaths but also to use the project as a platform for other harm reduction work, particularly increasing awareness of blood-borne viruses and encouraging testing, as well as helping to map the main areas where overdoses were taking place. 'It was a fantastic way to get people engaged,' says Hills. 'They wanted to be tested for hep C, vaccinated for hep B – it was an overall harm reduction initiative, not just about saving lives.'

Two lives, however, were saved during the course of the pilot, as verified by the ambulance service. 'It was important that we had the ambulance service validate that,' says Mick Webb. 'We were emotionally involved in the project so it was nice to have an objective viewpoint.'

The simple act of entrusting service users to administer naloxone made them much more open to the range of other harm reduction messages, Webb believes. 'It created a platform for information to be received as well as delivered – the empowering effect of the training and supplying someone with naloxone, and the boost in confidence and self belief that brings about, meant people became much more receptive to other information. If your self-esteem's been around your ankles and suddenly you're in a position to save a life then clearly you're going to feel quite different.'

The project used word of mouth and traditional street networks to engage with clients, boiling down research findings into easily understood messages. 'The most remarkable thing about the pilot was its outreach basis,' says Gordon Morse, the prescribing GP and one of several professionals to provide services free of charge. 'Doing this on an outreach basis hits the target audience – people already in established treatment, as in other pilots, should be more stable and less likely to overdose anyway. But it also therefore introduced the difficulties of getting people to prescribe for them, because they're very risky people and very often you have to go out to them. We had to be quite creative about that.'

Some of those trained were on DRRs or street homeless, but carers were also involved in the scheme, including a man who had watched his brother overdose time and again. 'He knew it was only a matter of time, but he'd realised there was a project that gave a damn,' says Mick Webb. 'Even with quite hardened drug workers, moments like that do take the rug out from under you a little.'

As the law stands, naloxone is a prescription-only drug but is permitted by law to be administered by anyone with appropriate training – the problem is getting hold of it to administer in the first place. Feedback from service users and all the other partners involved was overwhelmingly positive, so why is naloxone use so patchy – where does the resistance come from? 'The people throwing up the barriers and arguing against it were other professional drug workers who didn't like the idea of drug users being given a drug to inject,' says Mick Webb. 'Even a simple process of putting a minijet together and giving an inter muscular injection to save a life – they thought it was irresponsible.'

There was also a good deal of concern around the potential legal consequences, he says. 'It was frustrating hearing "what happens if something goes wrong?" over and over again. What's going wrong is that people are dying of drug overdoses. Then there were the professionals who said "I don't care – I'd rather be in court having saved someone's life than at an inquest". Negative stereotypes about service users and their capabilities also played a part, he believes. 'People were saying service user involvement was a really good idea but when it came down to it there was no trust there. People are skilful at saying the right things but when it comes to action, and validating service user involvement, it falls short.'

'The irritating thing is that this drug is completely safe,' says Gordon Morse. 'You can squirt it in someone's eye and it's not even going to sting. It's completely harmless, so why it's a prescription only medication is an anachronism. And, because it's off patent, there's no financial will from big pharma to change its product registration, because that's very costly. But if people are upset about dishing out needles or injectable drugs then you can also give the stuff nasally.'

'Everyone carries their nose around but not everyone has good quality veins,' says operations manager at Great Western Ambulance Service, Steve Blackmore, whose service uses pre-filled MADs (mucosal atomisation device) to spray naloxone in the noses of overdose patients – best used when patients can be observed in hospital afterwards as it tends to wear off faster than when administered by minijet. 'It's a quick hit, whereas if you're trying to get a vein it can be ten, 20 minutes before it takes effect. If you've got a patient in severe respiratory distress or even respiratory arrest it's an ideal route.'

'To have two service user reps agreeing on any one thing is quite unusual, so to have representatives from the whole of the South West speaking in unison was really powerful. That set the pace – it was unanimous service user consensus that really drove it.'

So, from an ambulance service point of view, would rolling out naloxone use across the country save lives? 'It would definitely make a difference to the number of fatal overdoses,' he says. 'If we could persuade someone to finance it we could be saving lives on a regular basis. The pilot was a really important initiative – allowing our paramedics and technicians to safely give an antidote has got to be good news.'

The company that manufactures the minijet, UCB, is also now redesigning the device into an all-in-one unit with a fixed pin, removing the need to give out needles with naloxone and the associated fears that they could become diverted. In that case why is it taking so long to get naloxone to all the people who need it? 'I think partly it's about getting the clinical governance in place,' says Rhian Hills. 'It's new, and that's frightening for people – it takes time to get a joint commissioning group on board. And it's about fear, partly of the public response.'

So are there any indications that attitudes are starting to change? 'I think a lot are probably quite ingrained,' says Mick Webb. 'One of the most common questions was "if someone's got naloxone won't that encourage them to have bigger hits?" We've tried to find evidence of that and we can't – we haven't found any evidence of irresponsible use of naloxone at all. There's a lot of political correctness around service user involvement but the reality is there's also a lot of hidden dissent, and I think that's through all tiers of drug treatment. Naloxone is a life-saving intervention. It clearly works, and it's a treatment specific drug – it doesn't do anything else except reverse an overdose, so why has it been such a stuttering start? I think the system needs to look within itself, shine a light over this dissent and get it addressed.'

But surely something with such life-saving potential will become universally available sooner or later? 'I think ultimately it will, but we need to drive that – I don't think it will happen by osmosis or simply because it's a good idea,' he says. 'People need to become proactive – there's more evidence emerging that it saves lives, and no evidence emerging that people are using it irresponsibly.'

'It's a completely safe drug that can only be given out by a licensed prescriber, which is potty,' says Gordon Morse. 'It's a real problem, all for want of a change in regulations. I'm not being a maverick here – I'm not saying we should be legalising crack cocaine or anything – but this is a complete no brainer, which is what's so infuriating. Doctors shouldn't even be involved, nurses shouldn't be involved – this stuff should be freely available at needle exchanges.'

Hear more from Mick Webb at 'Voices for Choices' on 29 January. Visit www.drinkanddrugsnews.com for details.

Is the treatment field so distracted by the symptoms of addiction that it's in danger of overlooking the cause? In the first of a series of articles by practitioners concerned by the lack of research into the aetiology of addiction – and excited by the emerging findings of the neuro-psychology movement – **Fran Miller** sets out a self regulatory theory of addiction.

The big bang

In all my years as a therapist and clinical nurse specialist working in the addiction field I've always felt as though there was something missing. I've been a woman on a mission, launched off the starting blocks by the things I've seen and heard and the patterns in client stories that we're all familiar with – the full speed ahead followed by the dead stop. And then there are clients who somehow seem to find the peace associated with deeper levels of recovery.

I've looked at addiction from just about every angle you could imagine, and it's a trip that's taken me down the road of trauma work. Now I'm really excited because I'm managing to make sense of what I've been seeing and hearing over the years. I never thought I'd formulate a theory of addiction – I'm no academic – but I feel I just have to write something about what I've been uncovering. It's too important not to.

I was really pleased to be invited to do a presentation for the NTA about my ideas earlier this year – excited and nervous in equal measure. You know how it goes – all geared up, knowing what you want to say and trying to calm the racing heart and shaking hands as you shuffle the papers before you begin. Then in you go, the dry mouth kicks in, there's a squeak where your voice used to be and, just as you're becoming aware that your head's begun shaking as well, you've forgotten everything you ever knew about anything.

Or maybe you're one of the lucky ones – given the right circumstances, somehow you seem to order up just the right amount of adrenaline you need to perform well. It can be a fine line between the 'buzz' of a finely tuned autonomic nervous system (ANS) delivering a peak performance and the total unmitigated disasters associated with nature's cocaine.

On a good day our neuro-physiology pans out something like this: the stimulus hits the amygdala, it's checked out in the cerebral cortex and the sympathetic mode kicks in via the basal ganglia, ensuring optimum levels of hormones are released and peak performance relevant to the situation follows via the cerebellum. After the event the parasympathetic mode restores the balance and we're back in 'neutral'.

Put another way, life for all of us is a series of ups and downs. Because I've had previous positive experiences of doing presentations, during the uncomfortable 'hyper arousal' I experienced I could trust the physical discomfort would pass and my system would return to a balanced state. We like to think of ourselves as a pretty together intellectual society, but deep in the brain, lurking just underneath our calm cool intellectualised exterior, is the limbic system, the storehouse – or hard drive, if you like – that contains all our previous sensory experience, the survival 'fight, flight and freeze' centre originally designed to save us from the tigers and other threatening species from millennia ago.

If there's danger, bang – on it goes, but in an intellectualised society there's a down side. It quite literally causes us to act on impulse in ways that we and other people can't always make sense of after the event. What I've become far more aware of through my training in eye movement desensitisation and re-processing (EMDR) is that we all have individualised neurological set points, and for some individuals being left unsupported in unpredictable distressing circumstances can result in a more elevated set point.

Deprived of the opportunity and support to learn how to regulate distressing hyper arousal, some people live on 'permanent standby' – less able to relax, think in a logical way and check their experience against previous positive outcomes in highly charged situations.

Whether it's a bomb blast or the repeated explosions in young people's lives of bullying or domestic violence, fear can become encoded on the amygdala, deep within the limbic system. This associated, often unconscious, sensory information can leave individuals – as very often their parents before them – in persistent states of stress and hyper vigilance.

Easily re-triggered into hyper arousal, the internal dialogue necessary to take considered action for effective social interaction becomes increasingly problematic and in some situations breaks down completely. Under pressure, 'considered action' can become 'impulsive reaction'.

Given sufficiently highly charged situations, the stimulus hits an already elevated set point in the amygdala. The cerebral cortex is taken out of the sequence, the past distressing sensory material is re experienced as though in the present, survival levels of hormones are released and impulsive re-action follows. As the adrenaline is spent impulsively, the stimulus settles down and the already hyper vigilant amygdala returns to 'permanent standby' until the next time.

Encouraged by the initial positive 'normalising' and 'relaxing' effects, some

'Whether inherited, acquired or invited by regular excessive use of substances and processes, autonomic nervous system imbalances undermine cognitive ability, learning, motivation and behaviour, and leave some people condemned to a life determined by avoidance rather than choice.'

people become increasingly dependent on highly complex attempts to regulate long-standing, hyper-arousal with the use of substances – alcohol and benzodiazepines being particularly effective.

Ever heard the first use of alcohol described in terms like 'I felt normal, like I could think straight, relax, fit in, like I belonged'? I have – many, many times. Statements like these might lead trauma therapists to suspect dissociative experience prior to the use of alcohol and substances, and, suspecting this, I've done some screening with recognised dissociative scales. The results have been a real eye opener.

The self-regulatory theory of addiction is evolving from greater understanding of the neuro-physiology that may be responsible for some of the unconscious sensory triggers, extremes of affective and cognitive splitting off associated with impulsive reaction. I believe I can now make sense of those clients who continually present at A&E departments with overdose and self harm – often referred to as poorly motivated and attention seeking or, worse still, diagnosed as having a 'borderline personality', 'obsessive compulsive' or 'phobic' disorders.

I appreciate the physiology behind the bodily-held tension and breathing patterns, the lowered emotional tolerance some clients experience and the power of overwhelming triggers. I can hear and make better sense of the stories – 'I was doing so well, then I could feel it building up, like I couldn't breathe/think straight, and all I knew was I just had to get out of there'. I can identify the looping patterns of thought and fear before the bang, and better understand the unconscious neuro-physiological drivers that may have led to the 'unmitigated disaster'.

I believe I can also empathise more fully with the self-loathing and frustration of a significant number of chronically lapsing clients who may well be unrecognised, untreated adult children of trauma attempting to self regulate debilitating hyper arousal. Although we may become desensitised to the horrific stories we hear over time, the limbic system won't. Whether inherited, acquired or invited by regular excessive use of substances and processes, autonomic nervous system imbalances undermine cognitive ability, learning, motivation and behaviour, and leave some people condemned to a life determined by avoidance rather than choice.

Cognitive behavioural therapy (CBT) and cognitive mapping have their place, but for clients whose triggers are sensory and affective in origin during hyper arousal the 'c' (cognitive) – can become unavailable, and the 'b' (behaviour) may be determined in a nanosecond by the limbic system. And if alcohol and other things work when you're feeling confused, fearful or angry, is it a problem or perhaps a shot at a solution?

We've been spending a fortune on treatment – what if we've become so distracted by the symptoms that we've been overlooking the condition? These are exciting times. The means of researching the aetiology and moving towards a new understanding of addiction are at our fingertips now. There are a growing number of us who believe we need to be researching the emerging integrated treatment approaches that enable people to integrate their unique sensory cognitive and affective experiencing. There's a goldmine of screening and treatment approaches that we believe we should be developing and incorporating in our work.

Understandably, funding is made available for evidence-based treatment, but we're in a double bind. Innovation and research are being seriously inhibited by current commissioning practices and we're falling behind the times amid the emerging and exciting findings of the neuro-psychology movement.

There are some of us who believe ANS imbalances are the real 'hidden harm' affecting many of the young people who are becoming marginalised in society. We believe we need to be more proactive in giving young people opportunities to avoid being the next casualties of what is fast becoming a traumatising society, by offering them places of therapeutic respite away from others people's chaos.

During my training in EMDR I bumped into Dr Art O'Malley, a consultant infant child and adolescent psychiatrist, and consultant in EMDR. He uses (NICE guidelines approved) EMDR very successfully with children, many of them affected by hyper arousal where alcohol and drugs have been a feature, and he's writing the next in this series of articles.

Thanks to the NTA North West and Lancashire DAAT for supporting us in raising these important issues. But where's the money for research? Because if we keep doing the same thing in the same way, we're going to keep showing the same outcomes.

Fran Miller is an EMDR therapist and clinical nurse specialist. Her website is at www.homedetox.co.uk

THE GHOST OF DRUG TREATMENT YET TO COME

Andy Horwood imagines how the experience of drug treatment might be different

Your local chemist. January, sometime soon...

Chemist: Hey Mr. Thompson

Client: Hey Jo. You know to call me Tim.

Chemist: Sure but we need to keep professional! Usual pack? How are your sites going? You still remembering to alternate, like we talked about?

Client: Yeah, but New Year always sucks. The whole thing gets in the way of stuff. Even my dealer takes time off and he's nowhere near Christian.

Chemist: Well. As they say, 'when you're ready'.

Client: Maybe I'm getting there. So tell me again about this new system they're doing?

Chemist: Orange pack, yeah? Any returns? Any extras?

Client: Nah, thanks, just the usual supplies. That's what is feels like – keeping stocked up, keeping safe, keeping myself in gear. It's a full-time job!

Chemist: Yeah, but what they say now is 'it's not about Hep C and HIV' and 'it's not about the crime', but it's about 'what works for you'.

Client: I remember them going on about 'treatment works' when all it meant was a methadone script and a probation order! Yeah – that worked didn't it!

Chemist: For some it did. But it's much more tailored now – much more about what works for the individual. Drug users aren't seen as the big boogey man, but as people who can change.

Client: Yeah yeah, same-o same-o. We are still seen as the scum to be done to, co-operate or else, admit to your sins and pay the penance, you know.

Chemist: I know, but things are different. Health is health, crime is crime, and treatment is treatment. Everyone now does what they're good at – like I talk to you about your sites, techniques, keeping yourself safe, these care assessors are your main contact to get what works for you. As I said last time, talk to these guys and check out your options.

Client: Like? And have you any water?

Chemist: We've only the 2mls – still waiting on the legislation to kick in.

Client: No, that's good. And Jimmy asked me to get some 5ml barrels – is that okay?

Chemist: Of course, but you'll need a bigger sharps box – tell him to come in himself next time.

Client: I will. So these care assessor people, what can they offer?

Chemist: Much more than before. Whatever is going to do it for you. That may be a script...

Client: Methadone sucks...

Chemist: ...but it may be other pharmaceutical options to deal with that side. Things change all the time and the evidence has to catch up, you know! Methadone has been around forever but it doesn't mean it's the only game in town! How you getting on with those filters?

Client: Right, but cheap, innit? They're great if I'm smoking roll-ups made from dust.

Chemist: I know, but we talked about the fibre thing.

Client: Yeah, okay, they do. So what else on these options?

Chemist: Well, all the evidence says a script on its own is pointless, so now they look at the whole 'stabilisation and rehabilitation' thing. Could be day programme, residential, one-to-one, coaching, mentoring – could be bits and pieces of each, depending on where you're at – whatever you and your care assessor agree on.

Client: Yeah, but who wants to get known to social services?

Chemist: And who wants to get known to the police and probation? It's all about the public safety thing, – they all share information on that basis. If you were a bad parent I think you'd know!

Client: Okay, okay. But I wouldn't want social services busting in Donna's door just 'cos I was trying to do something.

Chemist: What you worried about? Donna's a good mum – you and her need to sort yourselves out, not be worried about what might or might not happen. And if she weren't a good mum I'd let them know what I thought.

Client: Would you?

Chemist: Of course. It's kids – and you know you'd do the same.

Client: So?

Chemist: So – give them guys at the substance misuse team a ring – here's the number, again. I could make a referral if you like, give them the background and say that I've known you for 18 months, here at the pharmacy needle exchange.

Client: Would you? I wouldn't want to go through all that whole life story, what did your dad do, assessment shite.

Chemist: I told you, it's different now. And you know people who've got out – some of the people doing it when you started.

Client: Mikie was one – you're right. Last time I seen him he'd been seeing someone from that voluntary group eight hours a week. I said to him 'where do you find the time? That's a whole day out of my week!'

Chemist: Yeah, but that's got to be better than 15 minutes with a nurse every fortnight when you pick up your script. I spend more time with you than that! You get your own allocated budget to spend on the services you need. And if they're not doing it then you can buy something else! They see it much more as an investment in you for the future, not just the cheapest option to keep you quiet. I read that at one time the average spend was two grand a year for what they used to call 'treatment'. Now they're ready to spend it 'cos they know it pays back over and over – you know, you're earning, you're skilled, you're contributing. That's the big change that happened. Go for it, what you got to lose?

Client: Only this. Thanks Jo. See ya in the week.

Andy Horwood is a social worker and contributor to the Prisons and Addictions Forum (PandA)

Concateno plc

global drug testing services

Concateno

Concateno is a global provider of drug, alcohol and blood borne virus testing and represents the combined expertise and product portfolios of Altrix Healthcare, Cozart, Euromed, Medscreen and TrichoTech.

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www.concateno.com

Altrix Healthcare

The largest provider of oral fluid lab-based drugs testing to the UK healthcare market. Complemented with the fast growing offering of a blood borne virus screening service and range of support services focused on client treatment needs.

Cozart

Long established experts in oral fluid rapid testing and the manufacture of laboratory products, Cozart have supplied the Home Office with the drug testing equipment used in the Drugs Intervention Programme since its initial pilot in 2001.

Euromed

Supplies a comprehensive range of point of collection testing devices with a proven track record in quality assurance and technical support, underscored by its longstanding contract with HM Prison Service.

Medscreen

Europe's most experienced workplace testing company providing legally defensible urine testing to employees for 20 years, including Governments, worldwide shipping and petro-chemical industries.

TrichoTech

Europe's largest hair testing laboratory with unrivalled knowledge and expertise, performing over 50,000 tests on hair samples annually.

Concateno plc
Garrett House, Garrett Field,
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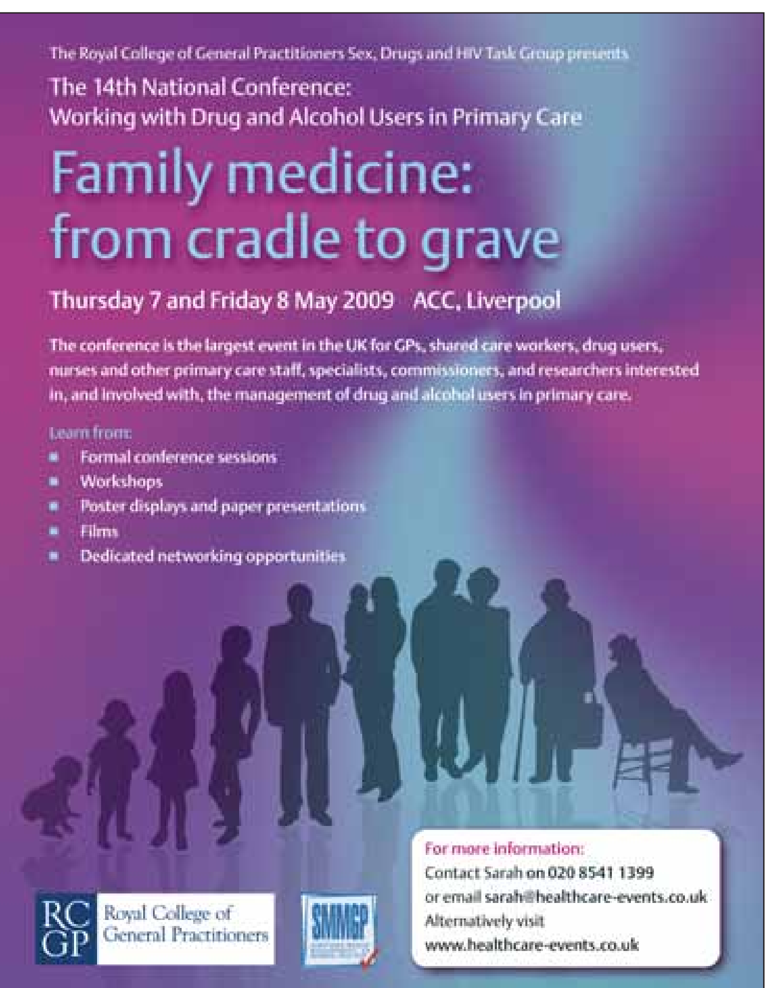
The Royal College of General Practitioners Sex, Drugs and HIV Task Group presents
The 14th National Conference:
Working with Drug and Alcohol Users in Primary Care
Family medicine:
from cradle to grave
Thursday 7 and Friday 8 May 2009 ACC, Liverpool
The conference is the largest event in the UK for GPs, shared care workers, drug users, nurses and other primary care staff, specialists, commissioners, and researchers interested in, and involved with, the management of drug and alcohol users in primary care.
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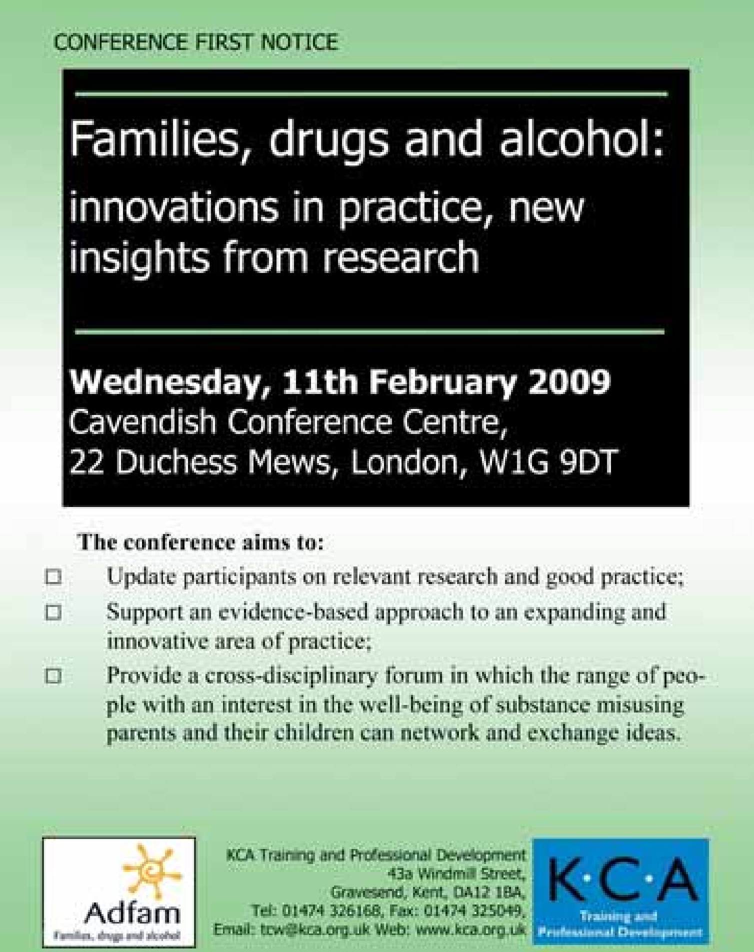
CONFERENCE FIRST NOTICE
Families, drugs and alcohol:
innovations in practice, new insights from research
Wednesday, 11th February 2009
Cavendish Conference Centre,
22 Duchess Mews, London, W1G 9DT
The conference aims to:
Update participants on relevant research and good practice;
Support an evidence-based approach to an expanding and innovative area of practice;
Provide a cross-disciplinary forum in which the range of people with an interest in the well-being of substance misusing parents and their children can network and exchange ideas.
Adfam
KCA Training and Professional Development
43a Windmill Street,
Gravesend, Kent, DA12 1BA,
Tel: 01474 326168, Fax: 01474 325049,
Email: tcw@kca.org.uk Web: www.kca.org.uk
K·C·A
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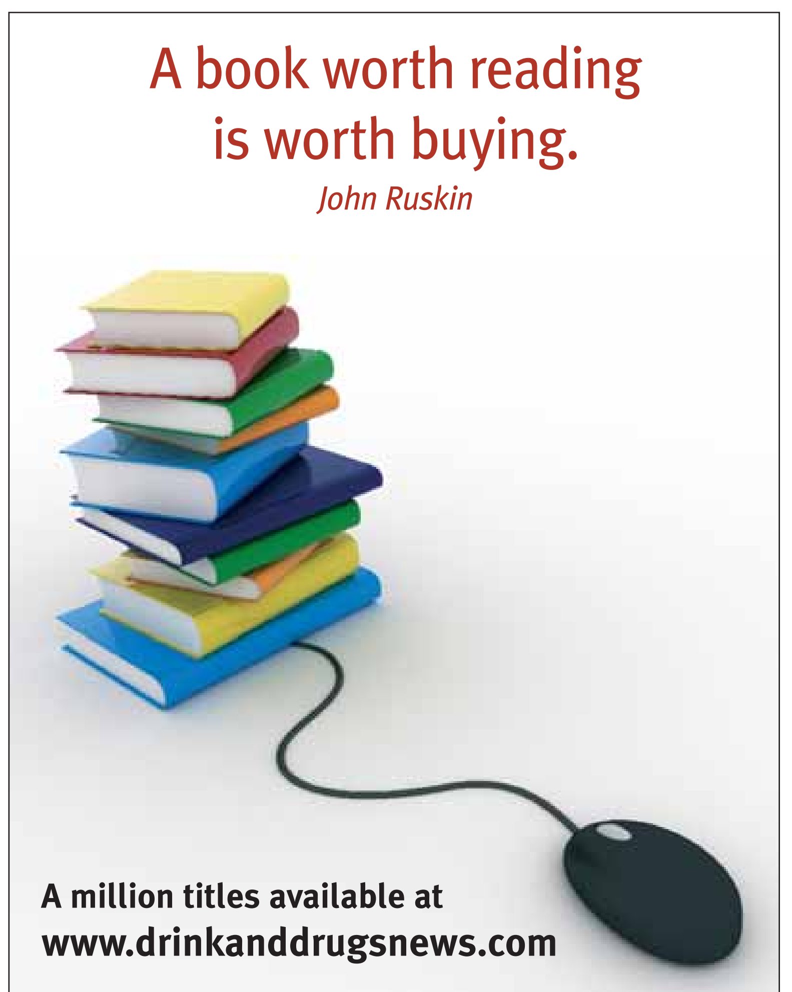
CONFERENCE CONSORTIUM
Presents...
Drugs Alcohol & Criminal Justice
Drugs, Alcohol and Criminal Justice
Interventions – how do we make a difference?
The Conference Consortium in partnership with DDN, CNWL Health Trust and Coventry and Warwickshire Partnership Trust announces the above conference on:
Thursday 25th June 2009 (10.30 to 4.30)
Venue: Friends House, Euston Road. London
The aim of the conference
The Conference will focus attention on Criminal Justice interventions from arrest, arrest referral, assessment and pre-court work, health stabilisation, looking at both 'what is working' and the 'pinch points' in the delivery of services.
Who should attend
The conference will be aimed primarily at DIP and Service Managers, Practitioners and Staff from arrest referral, courts teams, Probation Officers who manage the DRR's and those who run the programmes. Health Workers and Doctors who deliver rapid prescribing and triage interventions, Police Officers and Magistrates.
The cost – £145 inclusive of VAT
info@conferenceconsortium.org
www.conferenceconsortium.org


A book worth reading is worth buying.
John Ruskin
A million titles available at
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Do you, or your organisation want a website but don't know how to get one?

The Your Space pages on www.drinkanddrugsnews.com provide a quick easy way to have your own webpage.

Simply register on the site and request a page, then add text, upload photos and even add video.

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Training for alcohol and drug workers

Short courses, all mapped to DANOS now run in Birmingham

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2 days intermediate level
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1 day
September 16th 2009

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2 days
July 16th and 17th 2009

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29 January 2009
Holiday Inn, Birmingham

Argyll & Bute Community Health Partnership

NHS Highland

Argyll & Bute Alcohol & Drug Action Team Co-ordinator - Band 7

£29,091 - £38,352 pro rata **Ref: 08ab/248**

35 hours per week (Permanent)

Helensburgh or Lochgilhead

Argyll and Bute Alcohol and Drug Action Team (ABADAT) is a newly established Action Team, offering the opportunity to an exceptional individual to work in an exciting, multi-agency environment, in a very beautiful, but complex part of the world. Argyll and Bute covers 2,600 square miles, with long sea lochs and 26 inhabited islands. There is a population of 91,000, including 16,000 island dwellers. There is great diversity of geography, culture and patterns of addictive behaviours across the area. This background is part of the genuine challenge to making a difference in the lives of the people of Argyll and Bute.

The ABADAT has seven Locality Groups on the Mainland, Bute and Islay/Jura, with two sub-groups on Mull and Tiree. Both ABADAT and its Locality Groups are interagency bodies, with representation from the NHS, Local Authority, Police, the Voluntary sector and the Communities. They are collectively accountable to the Scottish Government; and are responsible to the appropriate Accounting Officer of the bodies through which monies are channelled.

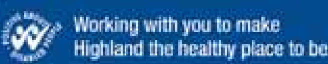
Crucial to the future success of ABADAT will be your skills in inter-agency working and networking abilities. More specifically, you will be involved in developing national strategies in ways appropriate to circumstances in Argyll & Bute. Integral to this will be managing change, developing the Team and tackling complex social, health, criminal justice and employment issues, integrating and deploying the resources available to best effect to reduce the damage done by addiction to individuals, their families and society.

The ABADAT requires a self-starter, experienced in the addiction field, with the ability to manage the complex of autonomous agency bodies involved in the Team, and our Voluntary sector partners, and, through the locality groups, liaise effectively with and support the communities.

Informal enquiries are welcomed by Dr. David Bell 07702059289 or Cath Cakebread on 01546 605 602.

Application packs are available from HR Department, NHS Highland, Argyll & Bute CHP, Aros, Lochgilphead, Argyll PA31 8LB, call 01546 606788 (24 hour answering service) or email: recruitment.ab@nhs.net

Closing date for receipt of applications: 26th January 2009.



www.nhshighland.scot.nhs.uk

EDP is well recognised as the leading non-statutory service provider for drugs work within Devon. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

SDP Preparation for Rehabilitation Worker (2 posts)

Based: **Shrublands House, Torbay**
Hours: **35 hours per week**
Contract: **Permanent**
Salary: **£21,412 to £25,320 pa**

This is an exiting opportunity for two experienced and creative individuals to work in close partnership with local agencies to deliver preparation group work to individuals who have expressed an interest in attending residential rehabilitation to address substance misuse.

The successful applicants will be experienced practitioners and have extensive knowledge and experience of drug treatment in Tiers 2,3 and 4 . You will be required to deliver group work interventions aimed at those preparing to enter residential rehabilitation; effectively implement specific elements of care plans coordinated by our partner agencies; and structured interventions. The successful applicants will have the necessary skills to carry out assessments, undertake reviews, write reports and be skilled in delivering workshops and therapeutic groups. You will also have experience of multi-agency partnership working as this is key to the post. You will also be able to demonstrate your ability to support the planning, development and evaluation of the programme. A professional qualification in a relevant field is desirable.

For an informal discussion *after receipt of application pack* please contact: Michele Rowan, Service Manager of South Devon Services on: 01626 351144.

EDP is committed to equality of opportunity, aiming for the widest possible diversity in its workforce drawing recruits from every part of the community. In accordance with the Police Act 1997 this post is subject to disclosure through the CRB. A criminal record is not necessarily a bar to employment in these posts.

Closing date for completed applications: Noon on Monday 26th January 2009.

For an application pack, please contact Wendy Murkin, Human Resources Administrator, on 01392 666732 or email wendymurkin@edp.org.uk, quoting reference number 01.09
Application packs can be emailed (preferred) or posted to you.

Derbyshire County **NHS**
Primary Care Trust

DERBYSHIRE DRUG AND ALCOHOL ACTION TEAM, CHIEF EXECUTIVES, COUNTY HALL, MATLOCK, DERBYSHIRE

Senior Commissioning Manager Derbyshire Drug and Alcohol Action Team

Band 8a £37,106 - £44,527 per annum

Hours: 37.5 per week substantive

Managing a small substance misuse commissioning team within the DAAT partnership and will hold responsibility for substance misuse commissioning across the County of Derbyshire.

You will need excellent communication, project and budget management skills together with an understanding of drug and alcohol services with a proven ability to work within a partnership arrangement. Previous commissioning experience is essential.

The DAAT is a multi-agency partnership currently located with the Derbyshire County Council with the DAAT team members employed by Derbyshire County Primary Care Trust.

We are looking for an individual who can bring a combination of management and commissioning expertise to the team and who can deliver progress effectively in a demanding environment.

For further information please contact John Stamp, DAAT Co-ordintor, on 01629 580000.

Please quote ref: 585-AJ-COU1308-08

Closing date: Wednesday 28th January 2009

For further details and to apply online visit ***www.jobs.nhs.uk***

Alternatively contact the Recruitment Services Team on 01246 515851 quoting the Job Reference number shown above.

We are committed to equality and improving working lives of all our employees.

www.derbyshirecountypct.nhs.uk

EDP is well recognised as the leading non-statutory service provider for drugs work within Devon. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users.

SDP Community Drugs Worker

Based: **Walnut Lodge, Torbay**
Hours: **35 hours per week**
Contract: **Permanent**
Salary: **£21,412 to £25,320 pa**

This is an exiting opportunity for an experienced, creative individual to work in close partnership with local agencies to deliver a relevant treatment service working with stimulant, cannabis and non-prescribed opiate users.

The successful applicant will be an experienced practitioner and have extensive knowledge and experience of drug treatment. You will be required to deliver tier 3 interventions, manage a caseload and effectively implement care plans and structured interventions. The successful applicant will have the necessary skills to carry out assessments, draw up care plans, undertake reviews and deliver one to one structured interventions such as Motivational Interviewing, Brief Therapy and Relapse Prevention and be skilled in delivering workshops and therapeutic groups. Knowledge and skills in the field of mental health would be extremely desirable as a large proportion of the caseload experience mental health issues. You will also have experience of multi-agency partnership working as this is key to the post. A professional qualification in a relevant field is desirable

For an informal discussion *after receipt of application pack* please contact: Michele Rowan, Service Manager of South Devon Services on: 01626 351144.

EDP is committed to equality of opportunity, aiming for the widest possible diversity in its workforce drawing recruits from every part of the community. In accordance with the Police Act 1997 this post is subject to disclosure through the CRB. A criminal record is not necessarily a bar to employment in these posts.

Closing date for completed applications: Noon on Monday 26th January 2009.

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Application packs can be emailed (preferred) or posted to you.

Enfield NHS
Primary Care Trust

Islington NHS
Primary Care Trust

Expressions of Interest are requested for a Residential Drugs and Alcohol Detoxification and Stabilisation Service (Contract No. 08/097)

Islington PCT invites suitably qualified and experienced providers to express an interest in the delivery of a 17 bed residential adult drugs and alcohol detoxification and stabilisation service. The target service user groups can be generally described as experiencing complex problems with their drug and/or alcohol use, a significant proportion will be poly substance misusers.

The commissioning body for the service is a consortium group comprising the following PCTs: Barnet, Enfield, Haringey, East Hertfordshire, and Islington from whose area referrals to the service will come from.

Consideration will be given to any organisation offering access to accommodation to house the service and any benefits identified will be evaluated within the value for money element of the tender process.

The consortium group has available capital funding to support the development of the residential aspects of the facility. Alternatively, existing accommodation has been identified and may be made available to the successful bidder.

The contract will be for a period of three years, with an option to extend, subject to satisfactory performance.

To express an interest, please use the website address below
https://tenders.islington.gov.uk/systems/islingtonqtplanner.nsf
Category: 85000000 Healthcare

Providers will be asked to complete and return a pre-qualification questionnaire. Once organisations meet mandatory legal and financial requirements, written statements under the following headings will be assessed:

1. *Quality Assurance systems and standards* — *30%*
2. *Experience and track record* — *30%*
3. *Collaborative and partnership working* — *20%*
4. *Management Approach* — *20%*

The top five scoring organisations will be invited to tender for the contract. Once you have been invited to tender, the contract will be awarded to the Most Economically Advantageous Tender (MEAT), based on 60% Quality and 40% price. The breakdown of the 60% quality element will be detailed in the Invitation to Tender documentation. If you are invited to tender you will be assessed by the following methods:

ITT Written statements
Interviews
Site visits
Cost

Please note that this Tender is with the North Central London Substance Misuse Joint Commissioners, however the process is being conducted via London Borough of Islington E-procurement system. Providers of Health Care Services who would like assistance to use the system please contact: *janene.miller@islington.gov.uk* or telephone *020 7527 8140*

The last day for submissions of the pre-qualification questionnaires will be **5pm Friday, 15th February 2009.**

Community. Make it yours... Buckinghamshire County Council

BUCKINGHAMSHIRE DRUG AND ALCOHOL ACTION TEAM

The Buckinghamshire Drug and Alcohol Action Team is hosted by Buckinghamshire County Council and has been in operation since 1995. The team has developed significantly since then. The DAAT brings together the Police, County Council, Health, Local Authorities, Probation, Prisons, Youth Offending Service, Connexions and the Voluntary Sector to co-ordinate planning and commissioning of substance misuse services.

DAAT Communities and Availability Co-ordinator

£34,271 - £38,117 p.a. **Ref: PP044**

Hampden Hall, Aylesbury

Managed by the Safer Bucks Partnership Manager, you will take the lead in supporting local communities to build resistance to drugs. They will work with the Crime and Disorder Partnerships (CDRPs) in Buckinghamshire and other DAAT partners to develop and implement local solutions on behalf of the DAAT.

You will lead on the development and implementation of DAAT Communities and Availability Plans.

You will work closely with DAAT volunteers and lead on the implementation of the User/Carer Involvement Action Plan on behalf of the DAAT.

You will be a good communicator and will drive developments through a variety of media including the DAAT website.

You will maintain the profile of Bucks DAAT at appropriate national and local fora.

Please visit our website at www.buckscc.gov.uk/vacancies
Alternatively call 01296 383366 or email: recruitment@buckscc.gov.uk for an application pack.
Please quote appropriate reference number.
Closing date: 5pm, 30 January 2009.
Interview date: To be held in Aylesbury on 10th February 2009.

Positively welcoming applications from all parts of the community.

www.buckscc.gov.uk/jobs

SURREY DRUG & ALCOHOL ACTION TEAM

Provision of Surrey Drug Interventions Programme

The Surrey Drug & Alcohol Action Team (DAAT) invite expressions of interest from organisations to deliver a Drug Interventions Programme (DIP) comprising of Arrest Referral, Throughcare and Single Point of Contact.

The primary aim of the DIP is to reduce drug related crime and get problematic Class A drug users into treatment.

The contract will be for 2 years with the possibility of a further extension of 12 months. It is anticipated that the Service will commence on the 1st July 2009. The value of the contract per annum will be in the region of £400,000 - £430,000.

Process for application:
Organisations are requested to confirm their interest in this procurement by emailing Heidi.Francis@surreydat.nhs.uk

The Pre Qualification Questionnaire will be available on the Surrey PCT website www.surreyhealth.nhs.uk and should be returned by 12 noon on 28th January 2009.

For further information please contact: Heidi Francis, Surrey DAAT, Ramsay house, West Park Hospital, West Park Road, Epsom, Surrey, KT19 8PH. Tel: 01372 205790 Email: Heidi.Francis@surreydat.nhs.uk

Also advertised on www.supply2health.nhs.uk

Sessional Workers

Sheffield, Brighton, Hampshire and Wirral

For details of these and all

vacancies see
drinkanddrugsnews.com

The Addiction Recovery Agency provides abstinence-based and harm reduction services to people with drug and alcohol misuse problems in Bristol.

Counsellor

£21,420 - £23,970 pa + £400 pa on-call allowance (one week in eight)

Attached to the Residential Service with additional opportunities for working with Lapse, 3rd Stage Housing and Aftercare. You will therefore need experience of Abstinence based treatment systems, plus a recognised qualification in Counselling to Diploma level. **Job ref: 0102**

Closing date: 12 noon, Monday, 26th January 2009.

To apply, please visit www.addictionrecovery.org.uk or call 0117 934 0844.

In return, we offer 25 days leave pa plus Bank Holidays, plus one day per year thereafter up to 30 days, 35 hour working week (full-time) and pension.

ARA is working towards equal opportunities. Registered Charity No 1002224

Business Development Manager

(2-year contract – £38,000 pa plus bonus)

Alcohol Concern is seeking a new Business Development Manager to oversee the development and delivery of Alcohol Concern's fast growing Business Development Unit. The Unit provides training and consultancy services to local councils and Primary Care Trusts through established freelance consultants and trainers.

Deadline for applications: 30 January 2009

For an informal telephone discussion about this post, please contact Don Shenker on 020 7264 0518

Embrace – Children Families and Domestic Abuse Project Officer

£29,199 to £31,530 inc LW (according to experience)

Alcohol Concern has set up an exciting new project – Embrace – to enable alcohol services nationally to work more effectively with families affected by alcohol misuse and alcohol-related domestic abuse. With three years funding from the Big Lottery (to 2011), the project will use research with pilot sites in England to drive forward policy that will make a real difference to those affected by alcohol misuse. The Project Officer will have joint responsibility for developing the project and be responsible for training, research and evaluation of the project outcomes. They will provide information, training and support to the Embrace pilot sites in building capacity to work with domestic abuse and children and family issues. The Policy Officer must have experience of working in the field of domestic abuse. Experience of working in with alcohol misuse and children and families issues is also highly desirable.

Embrace – Project Administrator

17.5 hrs, £21,477 to £22,629 pro rata inc LW (£10,738.50 to £11,314.50)

The Project Administrator will provide support to the project and combine administrative work (such as assisting in the organisation of meetings and training events and the production of newsletters) with project activities such as carrying out basic research.

Closing date for applications for both posts: 26 January 2009 (12 noon)

Funded by The National Lottery through Big Lottery Fund

For application packs for all posts email: recruitment@alcoholconcern.org.uk, download a pack from our website: www.alcoholconcern.org.uk or call our recruitment line: 020 7264 0511

Mental Health Professionals

- Continuing to provide for all recruitment needs of Drug and Alcohol Services
- Does your service need staff?

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Manager required

For New 12 Bed Detoxification Unit opening June 2009

Are you?

- Excited by a new venture
- Dedicated to staff development
- Interested in marketing
- Passionate to see addicts recover

Salary between £25 – 35K depending on experience

Closing date: 31 January 2009

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

www.calebbradford.org

Peer reviewer in Substance Misuse for Healthcare Inspectorate Wales (HIW)

Healthcare Inspectorate Wales the lead inspectorate for healthcare in Wales is looking for a team of 20 healthcare professionals from the field of Substance Misuse to join its panel of peer reviewers to support our programme of Substance Misuse Service Reviews across Wales over the next 2 – 4 years.

We are looking to appoint Doctors, Nurses, Senior Managers and Key Workers who are currently or have recently been working in substance misuse services.

Individuals should have experience of substance misuse service development, planning and commissioning and be able to hold high level discussions with the Executive Teams of substance misuse commissioning bodies and provider organisations across Wales;

Individuals would need to:

- Integrate quickly and work well as part of a multi-disciplinary team.
- Be able to undertake qualitative and quantitative analysis of service commissioner and provider self assessments, fieldwork evidence and other associated information.
- Draw conclusions and provide written reports based on analysis of the evidence and information gathered.
- Be available and flexible to conduct on-site service visits (fieldwork).
- Be prepared to travel throughout Wales.
- Have excellent communication skills, verbal and written, and have a high level of discretion and understanding the importance of confidentiality in relation to HIW work.

This role would require a commitment of approximately 10 to 30 days over the period of a single year's review. The timing of this commitment will be flexible to meet the needs of the review and the peer reviewer. Remuneration is payable at £250 per day.

It is the policy of the Welsh Assembly Government to promote and integrate equality of opportunity into all aspects of its business including appointments to public bodies. It welcomes and encourages applications from groups currently under-represented including women, minority ethnic communities and disabled people. The principles of fair and open competition will apply and appointments will be made on merit.

If you would like to discuss this position please call Lesley Johnston, Review Manager on 02920 928862 or email Lesley.johnston@wales.gsi.gov.uk

If you are interested in being considered for this position you should send an expression of interest outlining relevant knowledge, experience and qualifications held and/or an up to date CV to:

Lesley Johnston, Review Manager, Healthcare Inspectorate Wales, Bevan House, Caerphilly Business Park, Van Road, Caerphilly CF83 3ED.

The closing date for applications is Friday January 23rd 2009.
Interviews will be held late February 2009.

Appropriate training will be provided prior to any involvement within the review.

HIW's purpose is to undertake inspections of and investigations into the provisions of healthcare commissioned and provided by Welsh NHS bodies. As of 1st April 2006, HIW was also established as the regulator of independent healthcare and has full delegated authority for its regulatory decisions.

Further information about HIW and the Substance Misuse Services Review Programme can be found on our website

www.hiw.org.uk

CRI LONDON

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

Full-time Substance Misuse Nurses x 3

CRI are looking to recruit several substance misuse nurses for projects in the London Boroughs of Southwark and Haringey. The posts involve working within an already established clinical team delivering clinical interventions in conjunction with the Drug Intervention Programme (DIP) and Drug Rehabilitation Requirements (DRR). These innovative and exciting services will also work in partnership with other healthcare and Criminal Justice Services. This will include CARATs, Probation, community drug treatment services, social care providers and the prison service.

1 x Band 6 Nurse (Southwark) *(Ref KC222)*

£29,234 per annum includes Inner London Weighting • 37.5 hours per week

You will work within a team of Substance Misuse Nurses providing a range of clinical treatment interventions to clients involved in the Drug Intervention Programme (DIP) and Drug Rehabilitation Requirements (DRR). The post holder will have care co-ordination responsibilities alongside screening, completing comprehensive assessments, care planning and reviews, titration and prescribing services and other clinical and psychosocial interventions. There will also be a responsibility to provide supervision to a Band 5 Nurse.

Knowledge of substance misuse and detoxification are preferable and will be reflected in the starting salary. It is essential that you possess good communication skills and are able to work in a multidisciplinary team to provide a high standard of care to this marginalised patient group in a non judgmental manner.

To be successful within this role you will possess a recognised nursing qualification and demonstrable experience of providing and facilitating a range of interventions for people affected by substance misuse enabling you to co-ordinate appropriate packages of care. An enthusiastic practitioner, able to work as part of busy team and effectively with other agencies, you will have the proven skills and abilities to help us develop and promote CRI services.

The post will be based in Southwark but there must be flexibility to cover at our other project in Haringey when required.

2 x Band 5 Nurses (1 in Southwark & 1 in Haringey)

(Ref KC223)

£24,547 per annum includes Inner London Weighting • 37.5 hours per week

You will work within a team of Substance Misuse Nurses providing a range of clinical treatment interventions to clients involved in the Drug Intervention Programme (DIP) and Drug Rehabilitation Requirements (DRR).

The post holder will have care co-ordination responsibilities alongside screening, completing comprehensive assessments, care planning and reviews, titration and prescribing services, and other clinical and psychosocial interventions.

Knowledge of substance misuse and detoxification are preferable and will be reflected in the starting salary. It is essential that you possess good communication skills and are able to work in a multidisciplinary team to provide a high standard of care to this marginalised patient group in a non judgmental manner.

To be successful within this role you will possess a recognised nursing qualification and demonstrable experience of providing and facilitating a range of interventions for people affected by substance misuse enabling you to co-ordinate appropriate packages of care.

Although you will spend the majority of your time at one site flexibility must be shown to cover at the other site if required.

Closing Date: 23rd January 2009.

For further information please contact Claire James (CRI Clinical Service Manager) on 07889 067914 or Enda Egan (Project Manager) on 07738 997 223.

For an application pack and further information visit: www.cri.org.uk or call our recruitment line on 020 7833 6720 (24 hour answer phone) quoting the relevant reference number.

Successful candidates will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.
Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

INVESTOR IN PEOPLE

safer communities, healthier lives

Harbour Drug & Alcohol Service provides a range of interventions for people with problematic substance use in the City of Plymouth. Harbour combines the skills and experience of a diverse workforce and welcome applications from candidates who wish to contribute to this valuable service.

The following exciting opportunity has arisen within the Criminal Justice Service. This service provides treatment for people referred from the police, probation or prison services.

Substance Misuse Specialist (SMS) Practice Supervisor

Full Time (37 hours)

Starting Salary: £ 26,464 per annum

The Role of a SMS Practice Supervisor, is to help reduce the harm caused by substance misuse to users themselves, affected others and to the wider community. The SMS Practice Supervisor will ensure that this is achieved through supervising the services provided to clients by their team base. The practice supervisor will support the service manager in ensuring that services are provided in line with models of care and the drug misuse and dependence guidelines. The SMS Practice Supervisor will also provide other workers with a consultancy service in their area of specialism and where appropriate represent the service manager in his/ her absence.

The practice supervisor must be qualified to deliver substance misuse specialist interventions and experience in providing supervision is preferential.

To download a role profile and an application form please visit our website

www.harbour.org.uk

If you require any additional information please telephone Harbour HR Services on (01752) 314254

Closing date for applications: 5pm on 30th January 2009

Benefits include:

- 25 days annual leave per annum (including incremental increases) plus recognised Bank Holidays
- Company Pension Scheme
- Life Assurance Scheme
- Free Occupational Health Services
- Implementation of policies to positively promote a work/life balance
- Commitment to Continued Professional Development

Harbour is an equal opportunity employer and invites applications from all sectors of the community. All post holders will be subject to an enhanced CRB check and satisfactory references.

Stockton-on-Tees
BOROUGH COUNCIL

INVITATION TO TENDER

Stockton Drug Action Team welcome expressions of interest from suitably experienced organisations for the provision of the following drug treatment and support service within the Borough of Stockton On Tees.

Criminal Justice Interventions Team

The contract will initially be for two years, with the option to extend for a further one year. It is likely that TUPE will apply.

Applicants will, in the first instance, be required to complete a pre-qualification questionnaire, the PQQ will detail financial status, resources, experience, policies and management systems.

Please see the Stockton On Tees Borough Council website for further details regarding how to apply for these contracts.

www.stockton.gov.uk/business/howbusi/curcontopp/

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

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Register online **www.SamRecruitment.org.uk**

Criminal Justice Drugs and Alcohol Workers - Nationwide

As an approved supplier to a nationwide criminal justice drugs and alcohol service we require candidates to fill a variety of open posts. Experience dealing with drug and alcohol clients is essential and experience working within a DIP (Drug Intervention Programme) is a benefit; however the successful candidate may have the opportunity to gain this experience.

The roles will involve working within a criminal justice setting performing initial assessments on clients that have been arrested for various trigger offences that are related to alcohol and drug misuse. Experience referring clients to other services is a benefit.

These posts are available on a temporary or permanent basis offering competitive salaries.

For more information please contact:

Paul Wignall 0800 311 20 20
or 01772 889722
paul.wignall@servicecare.org.uk
www.servicecare.org.uk