14 July 2008
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DDN
Drink and Drugs News

BREAKING THE CIRCLE
How death can affect the dynamic of recovery groups

SMOOTH LANDINGS
Easing the way from criminal justice system to treatment

TAKE THE INITIATIVE
Checking for activity on hepatitis C

REACHING NEW HEIGHTS
How do you motivate your service user group?

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Release

Drugs, The Law & Human Rights

Summer 2008

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Thursday 18 September 2008

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8:30 Coffee & registration

9:30 Keynote address
Chris Huhne MP
Liberal Democrat Shadow Home Secretary

10am Access to health - unlocking the truth
Dr Ben Goldacre
'Bad Science' columnist - The Guardian
"How moral values get dressed up as 'science'"

Dr Gordon Morse
Clinical Lead, Turning Point, Somerset
"Treatment dogma - the road to discrimination"

Mandie Wilkinson
BBV Team Manager, East London NHS Trust
"Treatment for all with Hep C - including current users"

11:20 Coffee break

11:45 Caught in the middle - where is the child in drug policy?
Professor Rod Morgan
Former Chair of UK Youth Justice Board
"Youth, drugs and discrimination"

Damon Barrett
Human Right Analyst, IHRA
"Drugs, children and human rights"

Panel discussion and Q&A

1pm Lunch

2pm Drugs and discrimination - a transatlantic race?
Deborah Peterson Small
Executive Director, Breaking the Chains
"Racism in the war on drugs"

Alex Stevens PhD
University of Kent
"The racial impact of UK drug law enforcement"

Tiggey May, Senior Research Fellow
Institute for Criminal Policy Research
"Disproportionate cannabis policing in the UK?"

King Downing
National Coordinator Racial Profiling
American Civil Liberties Union
"Drug policy and racial profiling"

Panel discussion and Q&A

4pm Champagne reception

DDN Drink and Drugs News

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Editorial – Claire Brown

Harness the energy

User groups are rightly passionate about what they do

By the time I got in touch with Dave Stork to interview him about the progress Gloucester's Service User's Support Team (SUST) had been making, he was quite wound up. Why hadn't I got in touch sooner, while they were doing their outdoor challenge course? Why hadn't I been down there for their service user conference last month? To me, in a busier than usual fog of activity here, the reasons were obvious. To Dave down in Gloucester, it was a sign that we weren't interested and that initiatives that had taken so much time, energy, planning and effort were insignificant to us. I hadn't communicated what what was going on to delay me from arranging the story earlier; Dave naturally thought I wasn't bothered.

I mention this only to demonstrate how easily different perspectives play their part in influencing the dynamic of user involvement. Dave's first experience of trying to contact me convinced him that DDN isn't interested in service user involvement; I hope I managed to convince him that quite the opposite is true. But it made me think how easily the relationship between a hard working service user group rep and those who hold the local purse strings for service user involvement could fail to gel through simple misunderstanding. Service user groups have to be passionate about what they do – after all they're in the business of campaigning for better treatment and standards while trying to support their members, whatever stage they're at. With different pressures on those who are answerable to budgets it would be easy to disconnect because of differing priorities – but it could be a wasted opportunity not to appreciate hard work in different guises on each side, and harness the positive energy.

I'm glad Dave persisted with his suggestion for an article. Not only was it enjoyable talking to him, but it gave me a fresh burst of energy in thinking about the second service user conference we're organising with the Alliance for next January. I hope energetic groups like SUST will want to take part.

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Special Brew 'not encouraging' irresponsibility

Cans of nine per cent strength lager do not encourage irresponsible drinking, according to a ruling by the Portman Group's independent complaints panel. The ruling followed a complaint by homelessness charity Thames Reach about cans of Carlsberg Special Brew, Kestrel Super, Skol Super and Tennent's Super, all of which contain 4.5 units of alcohol in a single 500ml can and are used by clients in the charity's hostels. The government's guidelines recommend that men do not regularly exceed 3-4 units a day and women 2-3 units.

The Portman Group's code of practice forbids 'encouragement of binge drinking, irresponsible or immoderate consumption'. The panel rejected the charity's complaint that the lagers were in breach of the code, however, on the grounds that the government advice is a guideline rather than a strict limit. It also said it could not make a 'reasonable and objective' distinction between cans of strong lager and bottles of wine which also contain high numbers of units and are 'not easily re-sealable'.

The panel did however rule that Kestrel Super was in breach of the code as the lager's strength was the dominant theme in its marketing. InBev, the brewers of Tennent's Super, have also voluntarily opted to reduce can size to 440 ml so that it no longer contains more than four units per can.

'In an ideal world we would like to see this harmful product banned,' said Thames Reach chief executive Jeremy Swain. 'But InBev UK has to be applauded for putting people before profit, by taking the lead and reducing the can size. I would urge Carlsberg, so far depressingly impervious to our campaign, to respond to this brave step by reducing the can size of Special Brew and Skol Super at the earliest opportunity.'

The decisions 'completely discredited' the panel, he said. 'The panel's conclusions that drinking a can of lager is comparable to drinking a bottle of wine, in that neither vessel is meant to be re-sealable, flies in the face of common sense. The public are well aware that a bottle of wine can be re-corked and saved, while a can of lager is always consumed in one bout of drinking.'

Government goes hi-tech to tackle prison drug problem

Technology like hand-held mobile phone blockers and body orifice security scanners (BOSS chairs) – currently the preserve of high security (Category A) establishments – is to be introduced to all prisons from next year in an attempt to stem the flow of illegal drugs into jails.

The measures are among those contained in the review *Disrupting the supply of illegal drugs into prisons*, commissioned from former HM inspector of constabulary David Blakey by justice secretary Jack Straw. The Ministry of Justice has committed itself to meeting all of the report's ten recommendations, which also include reviewing the distribution of search dogs, a nominated senior governor to lead the drug strategy for each prison and monitoring use of the Offender Management Act – which makes it a specific offence to convey contraband into prison, with a maximum ten-year penalty.

BOSS chairs signal the presence of metallic objects that a person has secreted internally. However mobile phone technology is advancing so rapidly that 'regular reinvestment' will be required to upgrade the phone blocking equipment, the government acknowledges. The National Offender Management Service (NOMS), however, will work with suppliers to get the best deal for taxpayers, says the ministry. The programme will be rolled out next March.

'Illegal drugs are a disruptive influence in society today,' said Jack Straw. 'They play a significant role in the causes of crime and act as a barrier to the rehabilitation of offenders once in custody. The prison service takes this issue very seriously – keeping drugs out of prisons helps them to run more smoothly and allows prisoners to engage more effectively with rehabilitation programmes.'

The Centre for Policy Studies' new Prisons and Addictions Forum (PandA) recently called for the government to completely overhaul its approach to drug use in prisons (*DDN*, 16 June, page 4).

London borough launches cocaine club crackdown

The London Borough of Kensington and Chelsea is visiting every bar, pub and club in its area over the next six months in an attempt to reduce cocaine use. Licensing officers – accompanied by Safer Neighbourhoods police – are warning managers that they need to do more to address drug use and offering advice when premises test positive for cocaine. All but two of more than 40 premises visited so far have tested positive.

Venues are tested using moist tissues that turn blue when they come into contact with the drug, even in amounts invisible to the naked eye. Those premises testing positive are warned that if they still test positive when re-visited – and have not made efforts to prevent drug use in the meantime – the police may apply for a review of their licence. Bar staff are being advised to put up warning signs, smear petroleum jelly on smooth surfaces and regularly check toilets for drug use.

'It is extremely worrying that almost all of the premises we tested had traces of cocaine in their lavatory cubicles,' said cabinet member for environmental management Nicholas Paget-Brown. 'In the vast majority of cases licencees do not want drug takers in their establishment. We will support those licencees who are tackling the problem, but those who have made absolutely no effort to reduce cocaine use may find their licence under review. Cocaine use is illegal, dangerous and far from glamourous. In fact, the most common place where our officers found traces of the drug was the porcelain rim of the lavatory bowl, which goes to show just how sordid drug use can be.'

The government launched a major awareness campaign on the health and social effects of cocaine earlier this year, specifically targeting younger people (*DDN*, 2 June, page 5).

Global figures point to less than one per cent 'problem users'

Less than 1 per cent (0.6) of the world's population are 'problem drug users' – defined as people with 'severe drug dependence' – according to the United Nations Office on Drugs and Crime's (UNODC) 2008 report. However this still adds up to 26 million people, but the report points out that the death toll from legal drugs continues to far outweigh that of illegal substances – around 200,000 deaths a year worldwide are thought to be caused by illicit drug use compared with 5m by tobacco.

Fewer than one in ten people aged 15-64 have tried drugs in the last year, says *The World Drug Report 2008*. Drug control has helped stabilise the world drugs situation, the report maintains, but acknowledges that this could be undermined by increasing drug use in developing countries. Stabilisation is also threatened by dramatic increases in opium and coca cultivation in rebel-controlled regions of Afghanistan and Colombia, it states (*DDN*, 5 May page 4 and 16 June page 4).

Afghanistan's record opium harvest in 2007 has led to levels of supply that are double the level of demand, the report says, leading to falling prices in Europe. The cannabis market meanwhile remains relatively stable, with Afghanistan overtaking Morocco as a producer of cannabis resin.

UNODC executive director Antonio Maria Costa called for a stronger public health focus, which was the 'first principle' of drug control, he said. 'Drug statistics show that the drug problem was dramatically reduced over the past century, and has stabilised over the past ten years. Drug dependence is an illness that should be prevented and treated like any other.'

Full report available at www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf

Get in touch: A new poster campaign has been launched by Drugsline to encourage people to contact their helplines. Aimed at drug and alcohol users along with their families and young people in general, the posters were developed following consultation with service providers and users as well as families and friends affected by substance misuse. They will be distributed to pharmacies, GP practices, libraries, schools and community groups among others. The launch was timed to coincide with United Nations International Day Against Drugs (26 June) and National Misuse and Addictions Week (23-30 June). Posters are available by calling 020 8554 3220.

Home Office wants your *Tackling drugs* nominations

This year's Tackling drugs changing lives awards have been launched by Home Office minister Vernon Coaker. Anyone can nominate an individual or team for an award – practitioners from both the public and voluntary sectors are eligible, but all nominees must work for a recognised organisation.

Ten finalists from different regions of England and Wales will be chosen by an expert panel, before the overall winner for each category is selected – winners will receive £10,000 to spend on expanding or improving their work, at a ceremony later in the year. Last year's winners were Turning Point outreach worker Vicky Ward in the individual category and Essex Young People's Drug and Alcohol Service Team in the team category (*DDN*, 14 January, page 15).

'I know that drug workers and drug teams across the country are working tirelessly every day to tackle drugs and save lives,' said Vernon Coaker. 'In fact I have met many people and teams who deserve to be nominated for these awards. In recent years we have introduced tough legislation to tackle drug supply and remain committed to informing young people of drug dangers through information campaigns like FRANK. I want to do more, but I know we cannot achieve our goals without professionals and volunteers going that extra mile. These awards recognise their inspirational examples, which will help us to realise our ambition of fewer people starting to use drugs and for our society to be free from the problems caused by illegal substances.'

To make a nomination visit drugs.homeoffice.gov.uk/communications-and-campaigns/tackling-drugs/awards/

Licensing shake-up: no positive impact on drink-related violence

Levels of drink-fuelled violence, disorder and anti-social behaviour have not been reduced by the 2003 Licensing Act, according to a survey of police, NHS and councils carried out by the Local Government Association (LGA). Half of police authorities report that the changes to the licensing regime have simply meant incidents now occur later at night, according to Licensing Act 2003 and the effects of alcohol.

The LGA surveyed 20 police authorities, 49 PCTs and 51 local authorities for the report. Around 70 per cent of PCTs, councils and police authorities reported either an increase or no change in alcohol-related incidents, while 94 per cent of councils and 86 per cent of health authorities said there was now more pressure on resources, the latter primarily through A&E admissions. The council tax bill for implementing the change in licensing laws adds up to £100m, it says.

The report however does acknowledge that the changes in legislation have been effective in streamlining and simplifying the regulations and have led to better joint working, with three quarters of PCTs and police authorities now saying they work more closely together on licensing issues.

'The new drinks laws have made no impact whatsoever on reducing the alcohol-related violence that blights town centres and turns them into no-go areas on Friday and Saturday nights,' said LGA chair Sir Simon Milton. 'The government was always going to fall short on its promises to curb excessive drinking, because new licensing laws alone were never going to be enough to change this endemic culture of alcohol and violence. The new system was burdened with exaggerated expectations, as it was never a single solution to alcohol-related disorder.

'There needs to be a wide-ranging national debate about how freely available alcohol is,' he continued, 'how the nation views social drinking and how we can go about reducing consumption. It seems that we have a deep rooted social and cultural problem in this country in the way we view alcohol that cannot be addressed by one simple piece of legislation – it will take years, possibly decades of concerted action across the board.'

Full report available at www.lgar.local.gov.uk/lgv/aio/73541

News in Brief

Ley lines up new chief

Wendy Dawson will take over from Paul Goodman as chief executive of rehab organisation the Ley Community in September. Beginning her career as a drugs worker in the early 1980s, she went on to become director of services for the YWCA and chief executive of Connections North London. 'I look forward to building on the reputation of the Ley Community,' she said. 'The big challenge is around sustainability and continuous funding to support people through the programme. It will be my task to ensure that the quality of the current service is protected and built upon.'

Sudden impact

The final 'impact report' for the Blueprint project – designed to test the delivery of an evidence-based drug education programme – will be produced by the end of October according to the Home Office. 'Home Office policy and research officials will use the summer months working intensively with colleagues at DCSF and the research contractor team at the University of Stirling to ensure that the programme findings are robust,' it says. 'It is our aim that the final impact report will be a good quality and credible addition to the worldwide evidence base as were the Blueprint delivery and practitioner reports released in November 2007.'

Quitting time

There has been a 22 per cent increase in the number of people giving up smoking through local NHS stop smoking services since the introduction of smoke free legislation, according to Smokefree England: one year on. The report also found that 76 per cent of the public – including 55 per cent of smokers – supported the law. 'Measures such as the introduction of picture pack warnings this autumn and the current consultation on the future of tobacco control are essential to keep up the momentum to create a truly smokefree future,' said chief medical officer Sir Liam Donaldson. Available at www.dh.gov.uk/tobacco

With plenty to tackle on local treatment, Dave Stork needed to find a way of taking his service user group to a higher level of involvement. He talks to DDN about meeting the challenge

'We put a lot onto service users at a difficult point in their life. We say, "Come to this meeting, come to that meeting, it's about these integrated care pathways." And they're like, "You what..?".' Dave Stork is a service user co-ordinator based in Gloucester – but the scenario he describes could apply to service user involvement anywhere in the country.

There may be an acknowledgement of service user involvement – a willing DAT, a supportive commissioner, an energetic service user rep. But Stork's point is that the road to help and support is paved with 'Models of Care' jargon that can obscure the purpose.

In early 2004, Dave Stork was a founder member of SUST – Gloucester's Service User Support Team. After a year away volunteering he can back with a new NHS-funded post as the service user co-ordinator – and a determination to translate the NTA tick boxes into meaningful dialogue between local services and those who needed them.

It was all very well saying 'you've got a voice and a right to be involved in this, we want your input', he says. The problem was not just a lack of common purpose in making service user involvement work; there were more basic stumbling blocks, such as a lack of trust that cancelled out any hope of proactive involvement.

'There's a fear element that if people put their heads above the parapet they're going to get penalised for it. There's still a belief that the drug treatment system is punitive,' explains Stork. For those on a methadone script, this translates as saying 'no way' to involvement. They were not willing to risk 'the one thing they totally rely on.

With SUST meetings taking place at a day programme in Gloucester, as well as at local residential rehab The Nelson Trust, dialogue was taking place among service users – even if it had to weather the usual setbacks of people moving on for whatever reason. But Stork wanted to galvanise the process to make sure service users participated actively in decisions that affected treatment. They needed to bond as a group so they could then be confident in negotiating with other partners across the healthcare landscape.

There was a particular issue hampering dialogue. 'Something that's common with people with substance misuse problems is low self-esteem, low self-confidence and a lack of trust,' he explains. He wanted group members to be more resilient, charged with purpose and able to negotiate on their own terms.

He decided to turn for inspiration to the nearby Christian Adventure Centre at Viney Hill – a centre whose motto is 'Inspiring growth through adventure'. Briefing them that all participants would be 'in some stage of recovery from substance misuse', he asked them to come up with a programme of activities that would develop team-building skills – as well as service users' personal confidence.

Supported by qualified instructors, the onus would be on SUST members from the outset to make sure they were working well with each other and not taking on more than they could handle at each stage. While instructors were sympathetic to vulnerable levels of fitness, group members knew they would have to push themselves to new limits and learn to depend on each other for support. There would be six service users taking part – three men and three women; three of whom were abstinent and three who were on scripts.

After the first meeting, an 'ice breaker' session to plan the weeks ahead, the course moved into full-on activity mode. Over the next seven weeks, participants would attend a full day a week of activities, building up to a three-day hike into the mountains of Snowdonia.

Activities were challenging from the start, and incorporated essential survival skills like bush craft, wild cooking, and travelling over the roughest terrain. By the third week the group members were learning to canoe down the River Wye – which was as much 'about choosing good rest stops, co-operating with the group, and learning not to bash into each other', Stork explains. Week five's mountain day in the Brecon Beacons built on the previous week's orienteering exercises in the forest, by introducing load-carrying – 'tents and sleeping bags that we didn't need… it was a test to see how well we could do'.

The three day trek into the mountains was the big one. The group was to head to Cader Idris, a 893 metre mountain in Snowdonia National Park. The route would be away from the tourist hordes and would include camping by a lake at around 450 metres – a cold prospect in April, which explained the 6am start: 'It was too cold to stay in bed'. Led by their instructor, 'the mountain man', they stashed tents and sleeping bags under some rocks and took basic equipment for an emergency shelter. 'The instructor and his assistant were brilliant,' says Stork. 'As he led the way he explained why we were going a particular route. He explained everything as we were going along,' which perfectly fitted the culture of the trip.

For one reason or another there had been a couple of changes within the group, as 'a few people had dropped out along the way because of things that were going on in their lives'. Another member was still part of the group but didn't join the three-day trip because of a chest infection.

For those that hung in there, the team dynamic became stronger: 'One girl was finding it quite difficult, but one guy was carrying her pack for her and somebody else was encouraging her to keep going.' Furthermore, as they kept going up the mountain, Stork says they realised the significance of being out in the wild. 'We were completely out of civilisation, away from the streets, away from drugs. All that stuff just didn't come into it.

'It was steep and it was hard work going up there. We kept saying come on, come on, keep going. But it was just fabulous. We got up to the top and it felt very high – but what an achievement.'

Coming back down the mountain, he says 'the weather was awful, there was wind, it was snowing. It was sheer and steep… but they loved it, absolutely loved it. I can't put it into words – it was awesome.'

Most importantly, from the 'rather daunted' group at the outset, Stork says the change was remarkable: 'Coming down that mountain they were absolutely a team, working together and helping each other. And they bonded you know.'

Back home for week seven, the group reviewed their progress while taking part in a day's archery. All agreed they wanted to keep the group together, and they have kept up weekly meetings since the course began in March. Two new volunteers have joined, says Stork, and are not only keen to keep activities going, but have brought the added benefit of their own areas of expertise – Sharon with her interest in dual diagnosis and Jason with his understanding of how the drug treatment system works. The group has attracted outside speakers, including a counsellor and ex drug users that had found employment or gone into fulltime education.

A 'next steps' programme followed, funded by Gloucester County Council adult education. It helped the group identify individual skills and areas of personal development, says Stork, and was 'about helping them to find a way forward and personal direction, whether they want to go into further education, volunteering, employment, or extended aftercare'.

Last month SUST took the further step of inviting representatives from services, the DAT and NTA to join service users at a one-day conference in Gloucester. Through a series of presentations, service users explained their journey through the drug treatment system. 'It was not just about service users talking, but about feeling safe to ask questions – and to say to services "that's not what my experience was" and to challenge them,' says Stork.

Service users came from all environments to have their say – ranging from representatives of the tiny self-sufficient rehab community at Inishfree, to the four patients that broke off from a detox to travel over from their ward in a minibus.

The work leading on from that day is in full swing, says Stork, and involves pages of notes being turned into action – some of it to resolve personal issues, and some of it major work to improve service users experiences and choice of treatment.

Stork acknowledges that he has the backing of a good commissioner 'who says he commissions a treatment system' and is 'very pro service user involvement'. He also benefits from the DAT's clear allocation for service user involvement from the pooled treatment budget. But there is plenty of scope for putting the service user team's new skills to the test. He recalls how a delegate at the conference – 'somebody involved in service user involvement' – asked him 'what the hell' the outdoor course had to do with strategic planning.

He replied that it has nothing directly to do with it, but it was 'inspirational'. What would have taken longer to explain was how the group had talked about the drug treatment system while they were battling the elements. 'They spoke to me about their personal experiences and that has contributed to what I take into the planning groups', says Stork.

It's a gradual team-building exercise that's extending from the service user team to those they come in contact with – whether it's the staff at planning meetings, or the police officer who oversees Gloucestershire's PPO [Prolific and other Priority Offender] scheme, 'who's interested in getting a couple of his guys onto the next mountain trip'.

It's led to 'some real partnership work', says Dave Stork. 'And we've got a good network now. Our advocacy worker is in regular attendance at clinics, down at the homeless day centre and at the Tier 2 agencies, looking out for people that need us.'

There's lots to be done, and plenty of ideas from service users on how their experience of services can be improved. But encouragingly for Gloucestershire, not only is the dialogue now becoming more audible, but there's a distinct feeling of 'onwards and upwards'.

'As someone with a personal interest in antiquarian books charting the history of the addictions field, I can tell you that we have been discussing and exploring the meaning and the methods of recovery for at least 140 years... I would be surprised and disappointed if we stopped now.'

No final word

I have read with interest the comments in response to the UKDPC consensus group's statement on recovery (*DDN*, 30 June, page 10-13).

The suggestions for changes to the wording serve to illustrate both that reaching a consensus among the 16 participants was quite an achievement and that, as the group recognised, no statement could ever hope to be the 'final word' on the matter. Indeed, as someone with a personal interest in antiquarian books charting the history of the addictions field, I can tell you that we have been discussing and exploring the meaning and the methods of recovery for at least 140 years (*The Opium Habit*, 1868, Harpers), and I would be surprised and disappointed if we stopped now.

I would, however, like to make a few points of clarification.

The statement does not use the term 'controlled substance use', as misquoted in the header on page 12; rather, it refers to 'control over substance use'. This is an important distinction because, in the former, some forms of abstinence would be excluded from the definition. However, by referring to 'control over substance use' we definitely wished the phrase to include abstinence – indeed, for many people abstinence may be the only way to achieve control over their substance use – but it is also inclusive of people like Christopher Hallam who find 'being maintained works'.

The consensus group did not represent any organisation (either those of the individual members or the UKDPC) or 'movement' as suggested by one of your commentators. Individuals were selected to ensure that the group represented as many perspectives as possible (including that commentator himself, had it not been for personal problems that prevented him attending on the day) and it had strong representation from people involved in abstinence-based programmes.

Nor was it our intention to defend the legacy of a 'harm reduction approach' from the dangers of 'a rejuvenated abstinence movement'. Rather, one of the great strengths of the consensus statement is that it shows it is neither necessary nor desirable to refer to treatment modalities when considering what recovery means. And far from defending the status quo, our intention was to encourage the change needed to improve the support drug users receive from all types of service so that we can deliver the improved outcomes that most people in the field believe are needed.

We do, however, need to consider how we measure progress throughout the recovery process, an issue that needs to be addressed no matter what definition of recovery you adopt. (For example, even a definition including being drug free needs clarification: would it mean abstaining from all drugs including alcohol, tobacco and caffeine; is it being drug free for one day or one month or one year; is it acceptable to use acamprosate or naltrexone to assist abstinence?) Therefore I hope the field will rapidly move toward the next steps and consider the practical implications of a recovery focus. As well as considering measurement, we need to ask: 'What does being recovery-orientated mean for users, services, commissioners, the NTA, funding, workforce development…?'

Finally, I was pleased to see Nick Barton's constructive comments and I suggest that we heed his warning that if we are not careful we are in danger of 'driving each other around the semantic twist', since a debate on 'what recovery means', while valuable, will only get us so far.

The statement is intended as a call for change and I am confident the field will rise to the challenge.

Professor John Strang,
UKDPC Commissioner and member of the consensus panel

NTA stands for balance

I welcome the remarks by Andy Horwood and Kathy Gyngell acknowledging the value of both methadone and harm minimisation in the spectrum of drug treatment services, alongside abstinence-based recovery ('Comment', *DDN*, 30 June, page 13). They are also entitled to their view that the Social Justice Policy Review Group was not responsible for polarising the current debate.

However I must protest at their false suggestion that the NTA is somehow guilty instead. This assertion was based on a complete misunderstanding of what I said to the NTA conference last month, coupled with a misquotation.

As the transcript of my address on the NTA website makes clear, I was urging delegates to have the confidence to espouse a middle way that reflected both the benefits of being in treatment, and the benefit of overcoming dependency and leaving treatment. The siren voices to which I referred were those advocating that the only way forward was either abstinence-based or solely maintenance.

My exhortation to 'carry on doing what we've been doing' was explicitly about delivering an effective drug treatment system that both holds people in treatment long enough for them to benefit, and enables those who can leave treatment having overcome dependency to do so.

At no stage did I suggest that abstinence should not be included in the substance-misuse menu. It represents a substantial part of the menu of services that are currently commissioned.

The NTA has always promoted a balanced range of treatment. The Social Justice Policy Review is also in favour of a balance. If we can agree on this, what exactly is the 'great debate' about?

Paul Hayes, Chief Executive,
National Treatment Agency (NTA)

Abstinence and hope

When I participated in the UKDPC consensus group which produced the recovery statement, what I was looking for was a description of recovery that would indeed encompass the kind described by Christopher Hallam (*DDN*, 30 June, page 10) as well as recoveries

based on or enhanced by completely drug-free living.

I am not against abstinence. In fact I am very much in favour of it, not on moral grounds, but because I believe it to be attainable by far more people than some seem to imagine, and that it usually (not always) facilitates many benefits to health and personal relationships. I am however very much opposed to enforced abstinence, and I accept that some attempts to become abstinent may be premature. Abstinence should be an informed personal choice based on hope for a better life, and it often needs and deserves help and support to achieve and maintain it.

In my experience it is not frequently achieved by threatening people with the removal or restriction of prescribed medication; in fact in my 35 years experience of the drug scene, including many years working in abstinence-based treatment, I can't recall anyone citing this as the precipitating event that led to their abstinent recovery. I have met quite a few who decided to come off methadone of their own free will and many of these have succeeded.

I would be horrified if Christopher Hallam or anyone in a similar position was threatened in this way, and I would stand up and protest loudly against it. We have got the argument the wrong way round in my view: we need to define wellbeing first and then measure personal recovery against it. This is why abstinence *per se* cannot be the defining characteristic of recovery – that would be a classic case of begging the question. This is a very different thing from claiming that abstinence is irrelevant, or that it is not central to many recoveries: it clearly is.

Obviously recovery is multi-dimensional, as is wellbeing, and indeed many people would agree that it does consist generally of the kinds of things mentioned by Neil McKeganey. His list is not that long and as he says, it could be extended. There has been some interesting recent research into the concept of 'wellbeing' in developing countries, and the methodological problems involved in its definition and measurement. This suggests to me that the definition is variable depending on the cultural context, that it needs to depend on what those whose 'wellbeing' is being defined have to say about it, and there needs to be at least a local consensus about it for it to be meaningful.

My own non-exhaustive list for the 'wellbeing and social participation' aspect of addiction recovery would consist of improved physical and mental health, improved parenting and relationships with family and friends, earning opportunities, educational opportunities, a more satisfying identity or social role, and the elimination of substance use-related harm to others.

I would like to say a few words about the phrase 'sustained control over substance use'. This phrase can be interpreted (and clearly has been) in different ways. I did object to this phrase in the UKDPC meetings on the grounds that it would likely be a serious stumbling block, but I do not believe my objection was understood by the group. I did attempt to gloss the phrase in a draft paper with the following paragraph:

'Control is intended to mean a comfortable and sustained freedom from compulsion, a mastery of the problematic substance use, which may (perhaps most advisedly in some cases) be achieved through maintained abstinence. It does not mean the effortful struggle to restrict use, sometimes described as "white-knuckle" abstinence.'

According to this view (which I find problematic), abstinence represents one form of 'control' over substance use. I personally did not intend the phrase to mean excessive or inappropriate drug or alcohol use that happens to be more or less under the user's control either.

I did not press my objections because my understanding was that in this context 'consensus' did not and could not mean 'complete agreement', but that it meant general or broad agreement, and would inevitably require compromise with different points of view. I have not quite decided whether the 'control' issue prevents the consensus statement from meeting this definition from the British Standards Group: 'consensus means general agreement, characterised by the absence of sustained opposition to substantial issues by any important part of the concerned interest.'

I am not sure whom Professor McKeganey means by the 'key players in the UKDPC movement' (not me I know for sure, but perhaps the commissioners listed on the website?), but speaking personally again, I couldn't give a damn about preserving the 'legacy' of the last 20 years. To the extent it has succeeded in helping making people's lives better I am for it; to the extent it has failed to do this I am against it. I feel similarly about the consensus statement: to the extent it serves to reduce polarisation (which was the original idea of the consensus group) I am for it; to the extent it fails to do this, I am against it.

Tim Leighton,
director, Centre for Addiction Treatment Studies, Warminster

From the horse's mouth

I have been following the debate regarding methadone *v* abstinence, from the 'Different Roads' article (*DDN*, 19 May, page 6) through to the letters in *DDN,* 30 June (page 8) and I would like to give a service user's point of view on this issue.

I'm not too good at explaining myself, so would like to use my own experiences.

I have been a drug user for over 33 years now and in the past have used drug treatment services. Back then all that was on offer (when you eventually got to see the doctor) was either a reduction programme or abstinence focus programmes and I failed every one of them, to the point that I swore I would never use services again as the blame was always on me for failing.

Then in 2003, I ended up in hospital after spending eight years on the streets of London. This was the most chaotic time of my life as I neither wanted help, nor wanted to sort it out. In my own little world I was OK with life and thought that this was it until I died. While in St Thomas' and Guy's Hospital, an outreach worker came to see me and explained that treatment had changed since my last episode, and that there was no expectation to either reduce fast or be free from drugs to enter the programme on leaving the hospital.

I kept my appointment with the treatment service and was put on methadone. Since then I have managed to deal with many of my other issues, my chaoticness, homelessness, health and mental health, and have had counselling to help deal with guilt and anger. I've been put back in touch with my family after 16 years, and confronted so many other issues.

Being allowed to do this at my own pace with a few lapses on the way while being maintained on methadone has, without doubt, saved my life. My ultimate goal has always been abstinence – but giving me the time and the choice to do it at my own pace and with all the information to make informed choices has really worked for me.

So I say to you all – yes, offering abstinence as a single option or offering methadone as a single option does have drawbacks; but they can and do work well together, and from this service user's point of view save many, many lives.

What about having a system where service users are offered all of the choices for recovery and are supported in making an informed choice? The debate has been an interesting one, but I now think it's time to move on.

Let's not detract anymore from the real issue of improving services and more treatment options for clients – now there is a debate well worth having. I'm sure there are excellent examples of innovative thinking out there on how best to use the limited resources you have, and how best you can use peer support or peer mentoring, and self-help groups.

Tony Lee, Lancashire User Team

Drugsline fills the gap

David Gilliver writes about the gaping hole in current service offerings that leaves family members and carers of people with substance misuse issues 'woefully neglected' ('Family matters', *DDN*, 30 June, page 6)

Gilliver's moving report highlights a crucial issue, but while many services alienate family members by the lack of appropriate support, there are others that actively fill this gap.

As Gilliver suggests, the critical role that family members can play in recovery is hugely under valued and under resourced. Recommended solutions include educating GPs and widening services to include support for alcohol as well as drug addiction.

Drugsline, founded in 1991, set out to provide addicts – together with their families and affected others – with the means to face recovery, through crisis intervention and counselling. A subsequent 17 years experience has brought about a natural evolution and Drugsline now offers face-to-face, telephone and email counselling to anyone affected by drug and alcohol abuse and addiction. Next steps include setting up briefing meetings with local GPs to educate them about the need, and guide them towards

Continued on page 10 →

making effective, speedy referrals.

Such specialist service offering for families must not exclude members of BME groups. Drugsline spearheaded a unique collaboration between local community groups that resulted in an interfaith partnership, 'Joining the Loop', launching the first UK crisis line run by volunteers trained to cater for the specific needs and cultural sensitivities of the Jewish and Muslim communities simultaneously, where the taboo of drug and alcohol use and addiction remains prominent. Family support is now available in Urdu, Bengali, Gujarati, Hebrew and Yiddish, and Drugsline is determined to extend this service in the future.

Following calls to the freephone crisis line, families have arranged to visit the Drugsline centre to take part in sessions with specialist counsellors. When possible, referrals to appropriate services have been made – but relevant programmes are rare and places are limited.

The NTA research and guidance is an important step towards ensuring every borough has a service that caters for families and carers and it is encouraging to read of the effort being put into understanding the need. I hope the government will make provision for such essential services.

Christina Ball, Operations Director, Drugsline, www.drugsline.org
Freephone crisisline: 0808 1 606 606

Only if the price is right

Louise Olson is right to look at the economic arguments for offering methadone maintenance treatment (*DDN*, 30 June, page 15), and as her figures of £8 per methadone dose and £32+ per day for heroin appear okay, then she is right to champion MMT.

Unfortunately, like many other such champions, she neglects a huge load of additional costs tied to MMT, and is also making the wrong comparison.

She is comparing the costs of two addictions. But the only meaningful comparison which will improve our society is that between any form of addiction and the relaxed abstinence of the drug-free citizen.

For each MMT addict, the government spends not just the cost of the methadone, but also in the majority of cases, there must be added doctors' prescribing commissions, pharmacists' dispensing fees, unemployment benefit, income support, housing allowance, child benefit, excessive usage of NHS facilities and police, court and probationary officer time, and a continuation of acquisitive crime, as most methadone users also use illicit drugs – for which they have to 'find' payment.

Therefore the average annual cost for each MMT addict is between £6,000 and £8,000, so that in three years they cost taxpayers between £18,000 and £24,000, plus further such amounts for every year they continue on methadone. According to the *Big Issue* report, this period is likely to be 12 or more years, during which time they cost at least £72,000 to £96,000 and are still unlikely to be drug or crime free, so these figures must also be added any crime costs.

On the other hand, while many rehabs only achieve a minor long-term abstinence rate, the most effective residential addiction recovery training services are delivering 69 to 84 per cent success on a worldwide basis with a programme lasting 16 to 28 weeks, providing a permanent abstinence result and costing less than £17,000 to £19,000.

Economic, humane and societal considerations therefore signify sane government policy to be in support of those services with an acceptable record of delivering comfortable lifelong abstinence which, Glasgow University indicates, also slashes crime figures by 85 per cent.

E. Kenneth Eckersley,
CEO Addiction Recovery Training Services (ARTS), Former Magistrate and Retired Justice of the Peace

We welcome your letters

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

Comment

Discrimination – another harm for reduction

Understanding how discrimination has made its mark on drug policy is the first step to challenging it, says Claudia Waller

MANY DRUG USERS will have first-hand knowledge of what it is like to be discriminated against because of the fact that they consume illegal substances. Some groups already marginalised by their gender, sexuality or race, will be subject to further discrimination because of their drug use. Many will have been treated unfairly, for others it will be the direct impact this discrimination has on fundamental rights – the right to health care; the right to a family; the right to life.

Discrimination is all too evident when we look at women affected by drug use. A third of women in UK prisons are there for drug offences, many of them foreign nationals – drug mules from the poorest countries in the world. These women face long custodial sentences, which fail to act as an effective deterrent where actions are driven by poverty, deprivation and violence. Many women are single mothers whose children are left abandoned in their home countries without any state support.

Mothers who use illegal drugs in the UK are often subject to an unreasonable amount of interference from social services. There is no doubt that if a child is at risk of harm, intervention is necessary. However, many women face investigation and potential legal proceedings in respect of their ability to care for their children simply on the grounds of their drug use. The rights of the child, protected by UN conventions, are regularly disregarded when drug policy is developed and implemented.

Access to healthcare is an issue faced by many drug users. Anecdotal evidence shows that active drug users who have been diagnosed with hepatitis C are refused treatment solely on the grounds of their continuing drug use. Contrary to NICE guidelines and potentially open to a legal challenge, many consultants are refusing to treat active drug users despite evidence to show that treatment is effective for this group. From a public health point of view, treating sharing injectors first is the only logical step.

Perhaps most sinister is the way in which drug policy is used as a method to discriminate against people of a particular race. Clearly, this issue has had predominance in the United States where, for example, disproportionate sentencing guidelines in relationship to crack and powder cocaine have resulted in huge numbers of black and Hispanic people facing long custodial sentences. There is no doubt that in the US young men of black and Hispanic origin are regularly treated much more harshly than their white counterparts. Sadly, it appears as though the UK experience may not be that dissimilar. Stop-and-search figures for last year, published this week, show that black people were more than twice as likely to have been stopped than whites.

Discrimination can be experienced in many ways and for many different reasons. The complex, pervasive and profound effect that stereotyping and racial profiling has on drug policy is one of the defining features of this field in the modern era. Understanding the challenges it poses is crucial for any successful drug strategy.

Claudia Waller, is head of policy and communications at Release.

The Release Conference on 18 September 2008 at Hampstead Theatre will examine the relationship between drugs, race and discrimination.

Relapse or death within a recovery group can alter the dynamic of the group – not just for members, but also for the therapists who lead it. **Jan Lynch**, **Lynda Winn** and **Dr Marian De Ruiter** share their observations.

Breaking the circle

WITH THE RATIONALE that recovery is a lifetime programme, the Windmill NHS Drug and Alcohol Team provide a psychotherapy group in the community. Our aim is to support clients in maintaining long-term abstinence after they have completed primary treatment.

To people that may have become used to instant gratification in their relationship with substances, the group can represent a very different culture. For many, it can be the first time they have space to explore underlying issues that may have contributed towards their addiction, and they also have a chance to benefit from longer relationships with others in the group.

In starting up the group, we felt that a 'closed' environment was the best way of providing a safe place for 'intensive therapy'. It is suggested that to achieve long-term therapy with substance misusers this can be best achieved through an inpatient or prisoner setting, but as Windmill clients are outpatients, we offered them a six-week group programme to address various issues around addiction. The client's GP, together with the community key worker, are kept informed of their progress on a regular basis.

Two psychotherapists co-facilitate the group for its duration, and any breaks in therapy are agreed with the group's supervisor and its members. Its membership is made up of eight clients (both genders) in varying stages of recovery from alcohol and drug dependence. Before their assessment and introduction to the group, their treatment includes inpatient detoxification and a six-week primary rehabilitation programme at the Windmill Drug and Alcohol Team's Inpatient Unit, Windmill House. They will have been offered community interventions in the form of relapse prevention groups, auricular acupuncture and one-to-one keyworking sessions.

During the early months of group therapy, there is a tendency for clients to overlook aspects of 'otherness' and use linguistic jargon to reinforce understanding between them, relating to their experiences of substance misuse. It seems that this process requires a 'pivotal' point whereby clients cease relating to each other objectively and begin a more subjective relationship, and relapse or death may provide this pivot.

A group member's relapse may have occurred several weeks previously, so they can be attending the group without showing signs of their return to drinking or using drugs.

The response to this relapse within the group is predominantly one of anger and disillusionment. Anger comes from the perception that it is an act of betrayal; the group member is seen as relinquishing the collective ethos of honesty, negating the feeling of trust within the group.

The group members then 'deconstruct' what has happened, to relate to when they had personally experienced relapse. There is an oscillation between blaming others and their shame and identification with the predicament.

As facilitators of the group, we become the omnipotent figures of authority. The dichotomy for us it that as employees of the NHS, we are supposed to hold the answers and thereby the cure, while not understanding how they feel. At this point the other members do not consider us as part of the group, mainly because of their belief that the phenomenon of relapse is unique to them.

The subsequent process involves working through feelings of vulnerability and fragility. Group facilitation continues to provide a safe boundaried environment for members to focus on, explore and describe the impact a lapse or relapse has had on them.

Death of one of its members can also have a significant impact on the group's dynamic. Although the death may not be directly related to substance misuse, the other members can go through a process of questioning their own mortality, both in relation to dependence and as individuals.

Both therapists emerge as 'bad mothers' who failed to look after their children. We are unable to prevent the clients' demise and have therefore been 'negligent' in our roles.

Group members may retreat to a 'familiar place' to cope with what has happened. Recalling how their parents had been unwilling or unable to tolerate emotional distress, clients may prevent themselves from attaching any significance to it. As a coping mechanism they might resort to a 'false self' – another persona, to deal with what is happening.

Another comfortable environ emerges when members create a place that is behavioural and structured. This is reflected by members relating how physically unwell they had all been at some stage of their dependence and recovery and how fortunate they feel to be alive.

This fragility may continue for some weeks and emerges in their discourse, including narratives based on physical ailments such as colds and infections, and their increased visits to the GP.

Fragility is not confined to the group members that are clients. Both therapists have found themselves exploring the impact of the death in supervision. The deceased client had been a member of the group with whom they worked; the abrupt, unforeseen and emotive ending changes both the group dynamics and the therapists as individuals.

The therapists' own feelings of impotence about what has occurred and the inability to reassure the rest of the members that it could not happen again gives them insight into everyone's dependence upon each other to complete this journey.

For the rest of the group, coming through this experience reflects their own personal journey through substance dependence and the continuation of a long and periodically difficult progression to the next stage in their life.

Jan Lynch is a substance misuse specialist/psychotherapist, Lynda Winn is clinical nurse specialist/psychotherapist, and Dr Marian De Ruiter is a consultant psychiatrist. All work at the Windmill Drug and Alcohol Team in Chertsey, Surrey.

Smooth landing

Many people's first taste of drug treatment comes via the criminal justice system, and so can be a disorientating, alien experience. David Gilliver **hears how a new group programme in Portsmouth is helping to smooth the path into treatment for those in the early stages of Drug Rehabilitation Requirement Orders**

For a sizeable proportion of the service user population, their first experience of drug treatment comes when it's imposed by the courts, and for all too many their attempts to negotiate their way through this bewildering, unfamiliar world will end in relapse or dropping out.

Set up late last year, Portsmouth Drug Intervention Programme (DIP) 's 12-week structured group sessions for those in the early stages of Drug Rehabilitation Requirement Orders (DRRs) aim to make it a much easier process. Designed to get people used to structured group work before they move on to the next stage of treatment, the initiative began with an extensive consultation with service users about a year ago.

'A lot of people can be cynical when you try to do a consultation with chaotic users, saying "you'll never get any sense out of them" and that kind of thing,' says DIP manager Simon Walton. 'But we did it in a different way – things like getting people to look at made up case studies and asking them what kind of treatment plans they'd put in place and what they'd do to help the people, which really engaged them.'

The sessions began in December and run on a 12-week, 24-session module. Every client who begins an order attends for those 12 weeks before moving on to Cranstoun Drug Services in Portsmouth for their treatment. 'A lot of places operate some form of day programme or group work for people on DRRs, but I think ours is different in that it's really getting them used to treatment and ready to move on to something more structured,' he says. 'What we didn't want was a huge drop-out rate when they went on to the new group, but rather something that keeps up the good work they've been doing.'

'The idea is that we get them a bit more grounded,' says group facilitator Jo Horton-Taylor. 'They tend to be quite chaotic when we first get them so it's about getting them more stable, introducing them to the group process and giving them a basic education in how to engage in treatment.'

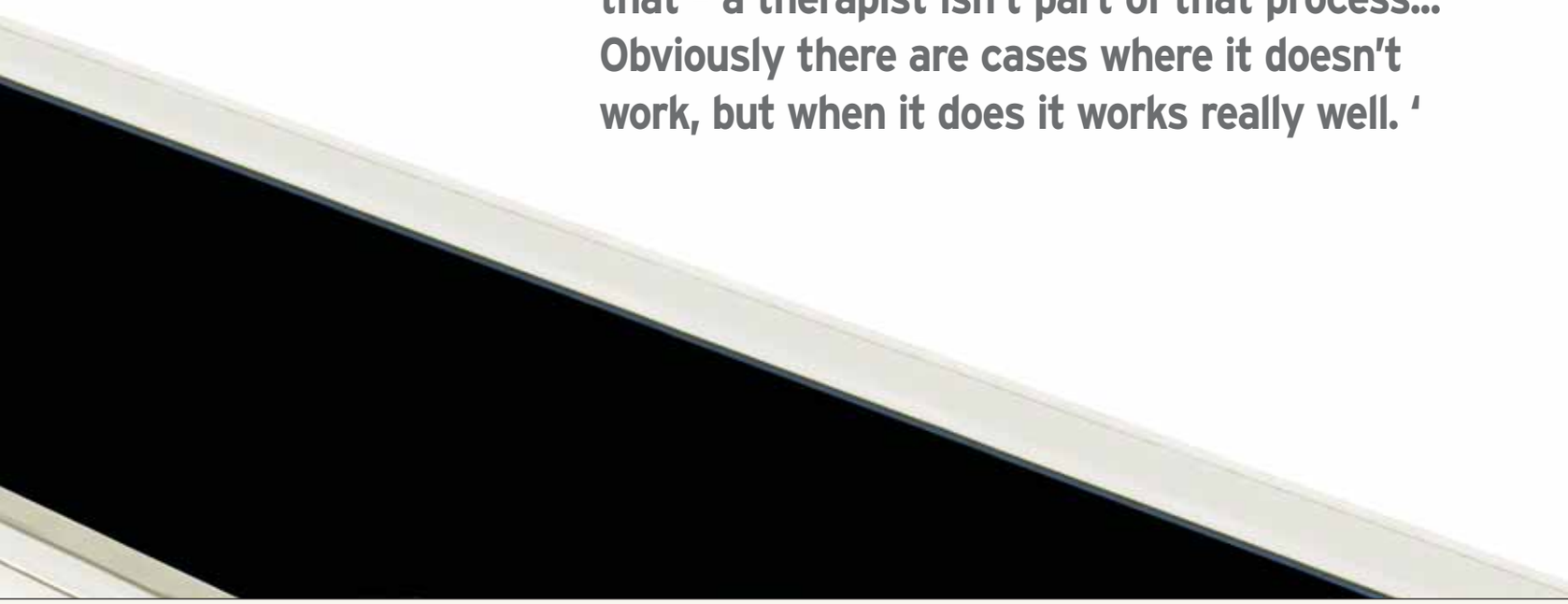
The DIP is part of a national programme that started five years ago, bringing together different agencies to try and steer offenders with substance misuse issues into treatment and out of crime. The aim is to break the cycle of offending behaviour by intervening at each stage of the criminal justice system – arrest, detention, sentencing and release – to bring people into treatment.

So how significant a substance misuse problem is there in Portsmouth? 'I think it's typical of a city this size,' says Simon Walton. 'We're a fairly standard southern city with quite high levels of deprivation. There are more problems with alcohol admissions than with drugs, and it's also quite an enclosed community. There are three or four different treatment centres discharging into the area – if people are discharged it means they've used or done something at odds with the centre, so you tend to get people from out of the area staying around after that who need treatment and support. But there are quite a lot of services in Portsmouth and they all work really well together.'

Around 15 clients are involved in the group at the moment and are encouraged to attend every week, although not all do – numbers attending range from five at the lowest up to around 12. 'There's a nucleus of people who've done really well and in the next few weeks will be in the process of moving on to the Cranstoun programme,' says facilitator John McCarthy. 'It will make it easier for Cranstoun because they'll already be prepared for group work, whereas before this was set up it would be really daunting for them and they'd turn up with no experience.'

And what kind of feedback has there been from clients so far? 'It's been absolutely excellent,' says Jo Horton-Taylor. 'At the end of the first 12 weeks we did a group review asking them if they were happy with the content, if they felt the groups were beneficial and whether they had any more ideas around how they'd like it to run. It's been very client-led, right from the consultation before we set up to find out what service users wanted from it. At the end of the 12 weeks they didn't want to go to Cranstoun! They wanted to stay here, which was nice to hear because we felt we were delivering something that was beneficial to them.'

Wednesdays are structured groups based around specific topics like self-esteem, change or relapse prevention while Fridays are support groups, but clients often ask for the Friday sessions to be structured as well. 'They have to do a little



‘ It’s about the common experience – sharing that experience and getting support from other people in the process. If you’re dealing with someone on a one-to-one basis you don’t get that – a therapist isn’t part of that process... Obviously there are cases where it doesn’t work, but when it does it works really well. ‘

less work if we deliver the topic,’ says Jo Horton-Taylor. ‘A lot of clients can feel uncomfortable when they have to talk about themselves, but it’s a process that they need to go through to begin their recovery journey.’

‘You really see a lot of progress,’ says Simon Walton. ‘People who are quite fearful of expressing themselves in group work really open up and look at what the possibilities of treatment are. We’re not looking to make dramatic changes in those first 12 weeks – it’s about trying to get people into the idea of treatment and on to the next stage and they’re really buying into that, getting some ownership over the group and supporting their peers as well.’

This peer support has turned out to be one of the most beneficial aspects of the groups. ‘Over the last couple of months there have been a couple of deaths from overdose,’ says Simon Walton. ‘Not among the guys in the group but people they know and it’s been a significant time for them. To be able to come in and talk about that, how it affects them and what it makes them think about their lifestyle is important. Before they probably wouldn’t have had that opportunity – they may have had it with their key worker, but to be able to discuss it with a group of their peers is something they’ve really valued.’

It’s not just the clients who have benefited, however. ‘We’ve held clients better and I think they’ve stabilised much quicker in that first 12 week period,’ says Jo Horton-Taylor. ‘A lot have engaged much better in treatment because it’s been more focused, but it’s still early days to assess that. We’re going to do a major review to see how beneficial it’s been.’

The DIP is part of the Surrey and Borders Partnership NHS Trust and funding comes from the Home Office and the local pooled treatment budget, but provision is not statutory. So is the intention to keep it going and expand? ‘Absolutely,’ says Simon Walton. ‘Obviously there are issues around commissioning. The commissioners have put in place a structured group programme for the city so we have to refer on to that – we’ve got to be careful about not duplicating provision. But as long as the funding continues we’re keen to keep it going, introduce new aspects and keep up the reviews and consultations to make sure it’s doing the right things.’

One of the things that’s been introduced is jointly delivered sessions with local service user groups, who were approached by the DIP and very keen to get on board. They talk to the groups about everything from treatment to self-help and the value of getting involved in service user participation.

‘People from local groups who have done DRRs themselves come in and talk about what it was like for them when they first started, and where you can get to,’ says Simon Walton. ‘It’s really quite inspirational to people – they’ve just started and they’re still not sure what the order’s about or what treatment’s about so when you get someone coming in a couple of years after doing their DRR saying “this is where you can get to if you want to” it’s really inspiring them to stay involved in treatment.’

‘It comes back to the group process,’ says John McCarthy. ‘It’s about the common experience – sharing that experience and getting support from other people in the process. If you’re dealing with someone on a one-to-one basis you don’t get that – a therapist isn’t part of that process, but working with peers who are going through these things themselves gives people encouragement and motivation. Obviously there are cases where it doesn’t work, but when it does it works really well. It’s an open group so there are people who’ve been there quite a while and new people coming can see their progress and it pulls them along. You’ve got this nucleus of people who are doing really well and that rubs off.’

Given the client group, however, surely it can’t all have been plain sailing? ‘We’ve had very, very few problems,’ says Simon Walton. ‘Some people assume that because they’re on DRRs they’re going to be disruptive and come in off their face and not be able to concentrate, but we’ve had virtually none of that. We haven’t had to stop any groups or kick anyone out. What we’ve seen is a group of people who historically have been very difficult to engage in structured treatment and they’ve formed an extremely supportive group. It’s their first experience of treatment and very early on in that, and again you find that cynicism around whether you can work effectively with chaotic people at such an early stage. But they’ve really engaged.’

Post-its from Practice

Taking the initiative

Encourage people to check up on whether their hepatitis C is active, says **Dr Chris Ford**

One of the local outreach services had asked us to take over the care of Janet, aged 35 years, as they were worried about her failing health. They were particularly worried about her hepatitis C. Janet had known she was positive for hepatitis C for ten years and she was complaining of increasing tiredness and feeling more unwell. She had been in drug treatment and prison a few times during that period but had not been offered either further investigations or treatment.

We agreed to take over her healthcare and after a full assessment we began counselling for her heroin and crack problems and a methadone titration. She also agreed to have her tiredness, including her hepatitis C further investigated. Full examination revealed little except old and new track-marks, large groin injecting sites and marked skin damage from crack injecting.

Before taking blood for hepatitis A, B and C and HIV antibodies, a PCR HCV test (polymerase chain reaction test for hep C), full blood count and kidney and liver function tests, I undertook a pre-test discussion about hepatitis and HIV. I included that initial HIV and HCV tests are for antibodies only and explained that a positive HCV antibody test, the only test Janet had had, was insufficient to show whether the HCV infection is active or not. For that she needed a HCV PCR (viral load) test. She willingly agreed to all these tests.

In HIV the test always indicates ongoing infection, but does not indicate for how long the infection has been present or the current state of the immune system. HIV has a long natural history and it may be five to ten years or longer before an untreated person develops symptoms or signs.

With HCV, about 75 per cent of people will develop a chronic infection. In time many of these will develop cirrhosis of the liver (over an average 20-40 years) or some long-term symptoms or signs of liver inflammation, and of those who develop cirrhosis, 5 per cent per year will develop liver failure or cancer[1].

Janet's HCV PCR showed that her hepatitis C was inactive, so would not be causing her any symptoms. Her other results were normal, except mild iron deficiency anaemia (from chronic blood loss from her groins, which was rapidly solved by stopping injecting and taking iron supplements). I was excited to be able to give her these results a week after she registered. Janet entered my room looking unwell, then on receiving her results she skipped out the room saying she felt instantly better!

Now two months on, settled on methadone mixture of 120mg daily, with her blood count back up to normal and her skin damage largely healed, she feels well and says she can begin to think about the next steps in her own recovery process.

There are many people like Janet, feeling unwell and thinking they have active hepatitis C and they don't (as well as thousands who don't know they have HCV). I personally feel it is now bad practice to test for HCV antibodies without also testing to see if it is active or not.

In our area you still need two blood tests, which can be taken at the same time, and the laboratory will only do the PCR if HCV antibody positive. In other areas, if requested, they do it on the same sample. So if you don't know what happens in your area, find out the system and don't allow anyone, such as your PCT, to say the PCR is not required (as recounted in a recent email from a GP) because it is!

Last year the Healthcare Commission and the NTA improvement reviews looked at commissioning and harm reduction. The weakest scoring area was that for needle exchange and blood borne virus screening, vaccination and treatment. The national mean percentage for injecting drug users that had been tested for hepatitis C was 21.5 per cent and this was only for the antibody test[2].

If we are going to have any effect on this epidemic we need to test all who consent, find if it is active or not, and refer all people who have active hepatitis C.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP

1. *'Guidance for the prevention, testing, treatment and management of hepatitis C in primary care' is available to download from www.rcgp.org.uk and www.smmgp.org.uk*
2. *www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=75*

Events

21 July – London

International Remembrance Day

Organised by Black Poppy magazine and Lambeth Service User Council, this event will take place in Kennington Park, London, from 2-4pm.

This date, 21 July, is an internationally recognised day of commemoration to remember those who have died as a direct or indirect result of drug and alcohol use, and misguided policies. A special event will be held for the first time in the UK to give drug users, their families, their friends and those who work with them in the drugs field, the chance to come together and remember those who have died. It will be an act of solidarity with others around the world.

Organised and supported by the drug using community, in partnership with a range of supportive organisations from the drug and alcohol field, the event includes speeches from 2pm, music, artworks, and tributes. Speakers include Daren Garratt from the Alliance; Rick Lines from IHRA; Rev Kenneth Leech who has worked with drug users and the homeless in London since the 1960s; Lyndzey Moon, whose brother died in 2007; Claire Robbins, clinical lead at Soho Rapid Access; and author Tony O'Neill who will read a poem written especially for the day.

Black Poppy's editor, Erin O'Mara, is inviting tributes from friends or relatives of those who have died from drug or alcohol-related causes. These will be collected together and read out throughout the event. If you would like to contribute, write 150 words that describe what made your friend or relative special, funny, spirited, unique; why you were friends; their age or the year they died – or any words you choose to remember them by. Email your contribution to: *blackpoppy@btconnect.com*

Numbers are limited, so please email *Black Poppy* as soon as possible if you are interested in attending. For more information on the event visit: *www.blackpoppy.org.uk/remembrance2008_infoaboutday.html*

Other events:

8-10 September – Stockholm

The International Conference, World Forum Against Drugs

Organised by World Forum. This conference aims to exchange ideas and share experiences on how to develop methods and move forward to the visionary goal of a world free from drug abuse. Details at *www.wfad08.org*

27-28 October – London

National Conference on Injecting Drug Use

Organised by Exchange Supplies. The NCIDU conference aims to develop the field, share information and learn by bringing together clinicians, researchers and users. More details – 01305 262244, *www.exchangesupplies.org*

13-14 November – London

Society for the Study of Addiction's 2008 Symposium

Organised by SSA. This year's event focuses on 'Addiction across the lifespan: tracking processes of recovery'. More details from graham.hunt@leedspct.nhs.uk or tel: 0113 295 2787.

Thursday 29 January 2009 – Birmingham

DDN/Alliance 2nd Service User Involvement Conference

Taking forward the challenges thrown up by the 'Nothing About Us Without Us' event last January. Don't miss out – we need your voice! Email *info@cjwellings.com* for details.

A journey into and out of heroin addiction

In this Background Briefing, Lydia continues to tell her story about the depths she went to before realising that things had to change.

'My dream life became a distant memory. My real life became a nightmare. Although I could talk to the other girls, and we would even have a laugh – I felt completely alone.'

When I entered treatment I had thought that things would change for me. But things just got worse. I was still using heroin, and on top of that I was using methadone. I also had to take more risks to fund my drug use.

I felt like I had been failed. I had put everything into treatment and trying to change, but nothing had worked. I couldn't really see any way forward – I felt trapped in a vicious cycle. That was until I met a friend who told me about the amount of money I could make working on the streets.

Initially the thought of working as a prostitute repulsed me. I had been sexually abused as a child, but I had learnt then to switch off, so I thought I would be able to do that again. It was a means to an end. Treatment hadn't worked for so it was time I helped myself. If I managed to make enough money to move away then I could start afresh – leave everything behind.

One night, after a close escape from shoplifting, I bumped into my friend on the streets. She helped me to sell my goods, and then we went to score together. After a long session I went back out with her. That was my first night working.

The next day was horrible. I hated myself. The only consolation was that I had earned a fair amount, so I went out and bought myself a sixteenth, and I still had some money leftover to save for my new flat. I kept on telling myself that it was worth it for the money and how it would change my life. I still believed that it would be temporary – then I could get on with the rest of my life.

After a couple of days working, I was introduced to crack. Everyone else was using it so I thought I would give it a go. That first smoke was amazing. The rush was intense – the best thing in the world – nothing else had ever come close. I wanted that rush again. I needed that rush again.

The next few months were a bit of a blur. My nights were spent working and my days sleeping. My drug use rocketed. I couldn't get enough of crack, and I used heroin to bring me down. Every penny I had went on drugs.

When I did take a look at my life, I was gutted. So I didn't let myself think about it. That was the only way I could cope. Drugs were the only way I could cope. I think I was quite good at pretending that everything was alright. It was easiest when I was with people like me. We were the same. It was normal. The hard times would be when I saw someone from my old life. I could see the pity and fear in their eyes. So I made sure that I kept away from everyone.

I completely lost touch with all my family. I couldn't deal with them. When I saw them I felt like a complete failure. They didn't understand me at all. The easiest thing to do was to avoid them. So that's what I did.

Things carried on for a year or so. My dream life became a distant memory. My real life became a nightmare. Although I could talk to the other girls, and we would even have a laugh – I felt completely alone.

Although I had heard about people overdosing, I had never seen it happened to someone. Until one day after work, having just scored, my friend went over. No one knew what to do. There was some panic and talk about the police. None of us could afford to get the police involved. We left her alone and scarpered.

The next night I found out that my friend had died. I was shocked, hurt, angry and scared. A group of us went to her funeral. Afterwards we went straight to out score. I guess it was our way of coping. But I knew this couldn't go on.

A couple of weeks later, I decided that I wanted help. Continuing to use heroin wasn't an option for me anymore. I was willing to do anything to stop. It was almost a relief to come to this decision – even though I didn't know how I was going to go about it – I knew that things had to change.

I went to the local drop-in centre, where I normally collected my needles from. I spoke to a support worker there and told him what I wanted to do. He tried to explain that there were two local treatment services, but the only thing I really understood was that there would be a long waiting list. I was so angry. And frustrated. I was desperate for help now. I couldn't do it by myself and now I was being told I would have to wait months for help. I didn't know if I would survive for much longer...

Written by Lucie James and Kevin Manley of Wired In.

University of Kent | Kent Institute of Medicine and Health Sciences (KIMHS)

Training for Drug & Alcohol Practitioners

Programmes from 2008/09

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2008 or by negotiation

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

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

18 month programme from September 2008 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2008

BSc in Substance Misuse Management (Stage 3)

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

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

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

Design & Print Centre 105884 02/08

Action on Addiction

INVESTOR IN PEOPLE

The Centre for Addiction Treatment Studies (CATS) is holding a series of one week stand alone courses in 2008 and 2009. These courses offer an opportunity for professional development and are growing in popularity due to an increasing demand within the field for experienced and qualified counsellors. Credits are awarded by the University of Bath.

UNIVERSITY OF BATH

For more information please visit our website on www.actiononaddiction.org.uk (Training and Education) or contact Carol Driver on 01985 843782 or Patsy Ford on 01985 843783.

RELAPSE PREVENTION:	**28 July – 1 August 2008**
MOTIVATIONAL INTERVIEWING:	**21 – 31 October 2008**
COGNITIVE THERAPY AND SUBSTANCE MISUSE:	**8 – 12 December 2008**
RELAPSE PREVENTION:	**2 – 6 March 2009**
12 STEP:	**30 March – 3 April 2009**
DUAL DIAGNOSIS:	**27 April – 1 May 2009**
GROUP THERAPY:	**1 – 5 June 2009**

COURSE COSTS

Cost if you enrol* with the University: £425 half-board (breakfast and lunch) **Cost if you do not wish to enrol: £725** half-board (breakfast and lunch)

The cost of the course includes tuition, course handouts and support, accommodation, breakfast and lunch and full use of the library and IT suite.

Your accommodation is available from Sunday evening at no extra charge.

**Enrolment is a simple process which we facilitate. It involves filling in a form and there is no charge for this process. Enrolment is necessary if you wish to receive transferable credit from the University.*

The Chemical Dependency Centre, Clouds and Action on Addiction have merged. The new organisation is called Action on Addiction. Charity No. 1117988

Training for drug & alcohol services

Open access programme

All courses closely mapped to DANOS
Bristol venues

the TRAINING exchange

One day courses (£125 + VAT)

Addiction, dependency & change	*25 Sept*
Alcohol & poly drug use	*2 Oct*
Engagement & assessment	*7 Oct*
Appraisals	*12 Nov*
Steroids	*13 Nov*
Difficult & aggressive behaviour	*17 Nov*
Service user involvement	*18 Nov*
Lone working	*25 March 2009*

Two day courses (£210 + VAT)

Training for trainers	*30 Sept & 1 Oct*
Supervision skills	*22 & 23 Oct*
Motivational interviewing	*16 & 17 Oct*
Brief solution focused therapy	*5 & 6 Nov*
Relapse prevention	*25 & 26 Nov*
How do I manage?	*2 & 3 Dec (* £250)*
Dual diagnosis	*9 & 10 Dec*
Mental health first aid	*2 & 3 Feb 2009*
Groupwork skills	*26 & 27 Feb 2009*

Change through People

Bring out the best in your organisation. Work in partnership with us to manage and respond to your training and development needs.

The Training Exchange has over 10 years experience in drugs, alcohol, supported housing & criminal justice sectors.

Our courses cover:
- People skills
- Management skills
- Training and Presentation
- Specialist topics – *Drugs, Alcohol and Mental Health*

Book onto our open course programme (see listings opposite), or bring us in to work alongside you to deliver bespoke, tailor-made training.

For an informal discussion contact Jo or Jools on 0117 941 5859 or info@trainingexchange.org.uk

Visit our website

www.trainingexchange.org.uk

Commissioning and Development Officer – Service Improvement Team – Substance Misuse

£33,976- £42,654 inclusive per annum, Hours (37.5)

Wimbledon Bridge House, Wimbledon

Wandsworth Teaching Primary Care Trust is responsible for improving the health of a diverse population of around 300,000 people in south west London. We provide and commission a wide range of health services including an extensive range of drug treatment services across the borough of Wandsworth.

The post holder will be part of the Drug and Alcohol Action team based in the PCT and also working in partnership with DAAT colleagues in the Local Authority. You will work closely with the Joint Commissioning Manager to monitor, commission and develop high quality drug and alcohol treatment services. You will be responsible for leading on workforce strategy, implementation of the harm reduction strategy for substance misuse and assist in developing effective strategies / services to engage and retain hard to reach substance misusing individuals.

Candidates should be educated to degree level or equivalent and have a good understanding of commissioning processes as well as the ability to communicate effectively with professionals at all levels. You will demonstrate a firm knowledge of relevant legislation and have some experience of project management in this field or a related one.

For further information about the post please contact Helen Standen, Joint Commissioning Manager at helen.standen@wpct.nhs.uk. Tel: 0208 812 7768.

To apply for this post, please visit our website at www.jobs.nhs.uk

Advert closing date: 01 August 2008.

Interview date: 15 August 2008.

✔ Flexible working to suit you
✔ Season ticket loan
✔ A final salary pension scheme
✔ Access to day nursery

We are an Equal Opportunities Employer

Wandsworth NHS
Teaching Primary Care Trust
www.wandsworthpct.nhs.uk

Alcohol Worker

We require a part-time (19 hours) worker for a new two year fixed term project. This post includes providing alcohol interventions as part of a multi-agency team to support individuals whom may be experiencing homelessness.

Salary – NJC Scale Point 22- 27 which is currently £18,907 – £22,122 pro rata per annum (under review).

YAAS offers advice, information and support to anyone affected by the misuse of alcohol. For further information about the service please go to www.yaas.info

For further details or an application pack please contact Stacey or Louise on 01904 652104 or e-mail office@yaas.info

Registered Charity 700394

FDAP/Alcohol Concern Assessors and Verifiers

The Open University

Introduction
The Open University VQ Assessment Centre is looking for qualified assessors and verifiers to help them, on a consultancy basis, to deliver a suite of vocational awards based on the DANOS units. These awards, ranging from three to ten units, have been developed in conjunction with the Federation of Drug and Alcohol Professionals and Alcohol Concern. The awards are designed to recognise and demonstrate the competences of managers and practitioners in the drugs and alcohol field - in line with the DANOS-based competence framework.

Job specification
Most assessment relating to these awards is desk based although we may have opportunities for assessors to visit groups of candidates on site to run 'Getting started' and support sessions. As a consultant assessor, you will be required to assess a case-load of candidates, enabling them to achieve their qualification.

It is essential that you already have the D32/D33 or A1 assessor, or the D34 or V1 internal verification qualification. You must also have at least two years of occupational experience within this sector and have evidence of assessment activity within the last 12 months.

The amount of work you will be offered will be dependant on the number of candidate registrations that the centre receives at each of its quarterly registration periods.

Closing date: 30 July 2008

If you are interested in working with us, please email nvq-enquiries@open.ac.uk attaching your most recent CV, an outline of your sector and assessment experience, an indication of the number of candidates you feel you will be able to support and the geographical area within which you may be able to visit candidate's on site.

North Tyneside Council

Tender for North Tyneside Project ANSWER Criminal Justice Intervention Team (CJIT)

As part of Project ANSWER - a multi agency integrated treatment service for people with substance misuse issues in North Tyneside – North Tyneside Council on behalf of the North Tyneside Crime, Disorder Reduction and Misuse of Drugs Partnership wishes to invite tenders from established and experienced providers of services to deliver a Criminal Justice Intervention Team to undertake identification, assessment, triage, engagement and throughcare/aftercare of DIP Service Users.

Service Providers may be required to give a presentation of their proposal and it is envisaged that this would take place between 8th December 2008 – 11th December 2008.

The Partnership anticipates the contract to be awarded on 15th December, 2008 and work to commence on 1st April, 2009 for a period of 1 year with the option to extend for a further two years subject to satisfactory contract performance and continuation of funding through the Home Office. The contract will be let on the basis of quality of service, ability to perform and tendered prices.

It is anticipated that the Transfer of Undertaking (Protection of Employment) Regulations will apply to this contract award. Following award the successful provider will be expected to work closely and co-operatively with other providers in the drug treatment system in North Tyneside to ensure the most effective delivery of drug services

Further information may be obtained by contacting
Oonagh Mallon, Drug Strategy Manager on 0191 643 6434

Applicants wishing to register their interest against this tender should go to the web site located at *www.nepoportal.org/search*. Select North Tyneside Council in the drop down box and enter the *contract ID: QTLE-7GCC85* to arrive no later than 12:00 noon on Wednesday 1st October 2008. Tender documents will be issued by November 2008. Unregistered suppliers will be redirected to a supplier registration form to be completed.

Further information with regard to documentation can be obtained from Derek Russell, Strategic Procurement.
Tel: 0191 643 5654, email: derek.russell@northtyneside.gov.uk
No previous application or expression of interest shall be taken as an application for the purposes of this notice.

North Tyneside Primary Care Trust

Invitation to offer services

As part of Project ANSWER — a multi-agency integrated treatment service for people with substance misuse issues in North Tyneside – North Tyneside Primary Care Trust, on behalf of North Tyneside Crime, Disorder Reduction and Misuse of Drugs Partnership, is seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of the following services:

1. **Structured Day Programme**
2. **Administration Service**
3. **Structured Psychosocial Service.**

In addition to evidencing the ability to deliver the required services, potential service providers must demonstrate innovation, creativity and commitment, together with evidence of integrated working with other partners.

It is anticipated that the Transfer of Undertaking (Protection of Employment) Regulations will apply to these contracts awards.

Following award the successful provider will be expected to work closely and co-operatively with other providers in the drug treatment system in North Tyneside to ensure the most effective delivery of drug services

The Crime, Disorder Reduction and Misuse of Drugs Partnership anticipates the following timetable:

1. **Structured Day Service**

Expressions of interest:	5pm, 29th August 2008
Tender documentation sent:	1st September 2008
Closing date for return of tender:	Midday 22nd September 2008
Contract awarded:	30th September 2008
Service to commence:	1st December 2008
Length of contract:	36 months subject to satisfactory performance and annual review.

2. **Administration Service**

Expressions of interest:	5pm, 27th October 2008
Tender documentation sent:	31st October 2008
Closing date for return of tender:	Midday 21st November 2008
Contract awarded:	28th November 2008
Service to commence:	1st April 2009
Length of contract:	36 months subject to satisfactory performance and annual review

3. **Structured Psychosocial Service**

Expressions of interest:	5pm, 27th October 2008
Tender documentation sent:	31st October 2008
Closing date for return of tender:	Midday 21st November 2008
Contract awarded:	28th November 2008
Service to commence:	1st April 2009
Length of contract:	36 months subject to satisfactory performance and annual review

To register your interest please contact:
Simon Cox, Commissioning Support Officer, North Tyneside Drug Action Team, Town Hall, Wallsend, Tyne & Wear NE28 7RR.
Tel: 0191 643 6440, email: simon.cox@northtyneside.gov.uk

EDP Drug and Alcohol Services are a team of around 160 staff and volunteers who work with adults, young people (ages 11-18) and people in prison who have problems with drugs and alcohol. EDP is well recognised as the leading non-statutory service provider for drugs and alcohol work in the South West.

Prison Alcohol Worker

Based: HMP Guys Marsh, Shaftesbury
Hours: 14 hours per week
Contract: Fixed Term Contract until 31.03.09 (subject to review)
Salary: £21,412 rising to £25,320 per annum pro rata

We are seeking to appoint a Prison Alcohol Worker to join the multi-disciplinary teams at HMP Guys Marsh. You will engage and motivate male prisoners to enter alcohol treatment programmes and will provide broad-based services including assessment, care planning and group work. The successful candidates will have experience of working with problematic alcohol users and preferably experience of working in a prison environment. Formal training in a relevant discipline or evidence of experience in substance misuse work is essential. You will have an organized, efficient and solution focused approach to work and will need to be enthusiastic about working in the challenging environment of a local prison.

Closing date for applications: 12 noon on 28th July 2008.
Interviews to be held week commencing 4th August 2008.

Application packs are available from: Wendy Murkin, Human Resources Administrator, 01392 666732 or e-mail recruitment@edp.org.uk – quoting reference number 06.08a.

adapt

HM PRISON SERVICE
Eastern Area

HMP Highpoint

PASRO FACILITATOR

Starting Salary £19,000 to £21,000pa

Working as part of the delivering the PASRO programme, you will facilitate structured accredited groupwork programmes for prisoners who are substance misusers. You will need above average verbal and interpersonal skills, be able to confront prisoners without demeaning them, and have the ability to relate positively and empathetically to them whilst working within professional and Prison Service boundaries. Experience working as a facilitator, or with substance misusers, or offenders would be an advantage, and groupwork experience a bonus.

Appointment is dependent on passing the selection process – an assessment board run in conjunction with the Prison Service and the successful candidate will be on probation whilst undergoing training. Confirmation in post after a six month probationary period is subject to the successful completion of two five-day residential training courses and satisfactory performance.

To request for an application pack please write to: ADAPT, Area Offices, 26 Thorpe Wood, Thorpe Wood Business Park, Peterborough, PE3 6SR or Email suzanne.sutterby@adapt-online.com, quoting reference E-13-08 the closing date for receipt of applications is 25 July.

OPEN ROAD

Reducing the **harmful impact of drugs and alcohol** on users, their families, partners and society

Open Road is the largest charity in Essex providing drug and alcohol treatment services and has been established for over 18 years. We operate centres across Essex including a range of outreach services delivering support, advice and information and structured treatment interventions.

Centre Manager Clacton-on-Sea, Essex

£26,000 - £29,000 per annum

An exciting opportunity has arisen to manage our growing operations in the Tendring area, with the development of a refurbished centre and increased funding streams from both statutory partners and the Big Lottery Fund. With overall responsibility for the smooth running of our services, you will manage our busy Clacton centre and, in addition, outreach services in Harwich and Jaywick.

Project Nurse Clacton-on-Sea, Essex

Salary negotiable - equivalent to Band 5/6

We require a Project Nurse to work as part of a multi-disciplinary team, the role will include keyworking and care planning, co-ordinating the needle exchange and providing information and advice on harm reduction, drugs and alcohol to service users and the general public. A nursing qualification is essential, equivalent to Band 5/6 would be appropriate.

For an application pack please contact Sandra Stockwell on 01206 766096 or email sandra.stockwell@openroad.org.uk - Applications should arrive by Wednesday 30 July

Open Road values and respects the diversity and individual differences of our service users, staff, including contracted consultants who work for us, and our volunteers

www.openroad.org.uk Registered Charity No. 1019915 INVESTOR IN PEOPLE

STRADA on DrugScope

Training Officer (Central Scotland)

Salary £25,500 – £29,318. Full details visit:

www.projectstrada.org

looking for new opportunities?

bdp

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,000 individuals a year.

DETACHED WORKER – (24.5 hours) – ref GU1

(6 months contract with the expectation of continuing beyond this)

To deliver our 'in-reach service' within homeless hostels and support our work with female sex workers, you will need the ability to make effective working relationships quickly and be committed to making every contact count. This job will involve regular out of hours work. For an informal discussion contact Ella Wheatcroft, Senior Practitioner Detached Services, on (0117) 987 6003.

SHARED CARE WORKERS – (35 hours) – ref GU2

Bristol's successful Shared Care scheme provides treatment to over 1,500 drug users. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions and develop and implement a care plan. If you are assertive, diplomatic, with excellent organisational skills and are able to work well within pressurised primary care settings, this is for you. Some early evening work will be required. For an informal discussion contact Jayne Peters, Treatment Services Manager, on (0117) 987 6019.

Salary scale for both posts: £16,617 - £24,980 (pro rata based on 35 hours a week), starting salary for suitably qualified candidates: £22,156. A pay award is pending. For both jobs you will need experience of working with drug users and we welcome past personal experience of problematic drug use.

Funded by Safer Bristol - Bristol Community Safety & Drugs Partnership

Closing date: Tuesday 29th July at noon
Interview date: Wednesday 6th August

Please fax, e-mail or write to Alice Walker, quoting the job reference, for an application pack: BDP, 11 Brunswick Square, Bristol BS2 8PE Fax: (0117) 987 1900, E-mail: recruitment@bdp.org.uk

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation.

No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

Please mention DDN when replying to adverts

IPSWICH

Substance Misuse Development Officer

£27,808 - £31,858 36 hpw

An exciting opportunity has arisen to join the Ipswich Community Safety Team in a key role to deliver the Council's corporate approach to tackling drug and alcohol issues in the community.

A graduate-calibre professional, you will relish being part of a vibrant central team. You will have strong strategic knowledge of national drug and alcohol polices, and proven experience of preparing, writing and delivering reports and information to a range of audiences.

Able to bring innovative new ideas, you will assist in the development of strategies and co-ordinate multi-agency groups with our partners to deliver results. You will lead on the work of the Crime and Disorder Reduction Partnership in tackling drug and alcohol-related crime. We are looking for a strong communicator and negotiator, with proven experience in a relevant area, which includes partnership working and budgetary management.

For an informal discussion please call Jim Manning on (01473) 432702.
An application pack can be downloaded by following the link to jobs@ibc from www.ipswich.gov.uk or by contacting Lynda Morgan, on (01473) 433431 or email: lynda.morgan@ipswich.gov.uk Previous applicants need not apply.
Closing date: 1 August, 2008.
Interview date: w/c 1 September 2008.

Pay award pending applicable to meet posts. ◆ As a thriving multi cultural regional centre, Ipswich offers an excellent quality of life. The Council is committed to promoting equality of opportunity and welcomes applicants from all sections of the community ◆ Any disabled candidate meeting the minimum requirements will be guaranteed an interview ◆ Job sharers welcome. ◆ The above post(s) will be subject to job evaluation. ◆ **www.ipswich.gov.uk/vacancies**

IPSWICH BOROUGH COUNCIL

TRANSFORMING IPSWICH

Federation of Drug and Alcohol Professionals

Chief Executive

£40k

The Federation of Drug & Alcohol Professionals (FDAP) is the professional body for the substance use field and works to help improve standards of practice across the sector. FDAP provides information, training and accreditation to practitioners, has a Code of Practice for its members, and offers advice to government and other agencies on workforce issues.

We are seeking a new Chief Executive. Reporting to our Council of Management, the successful candidate will ideally have experience of the drug and alcohol field, an understanding of workforce development issues, a proven ability to work on his/her own initiative, strong management ability, excellent communication skills and a strong track-record of achievement. The post is currently based in London, but could be moved to accommodate the post holder.

For further details see our website. For an informal discussion about the role please contact the current Chief Executive, Simon Shepherd, on 07940 218073.

To apply send a CV and covering letter to Simon Nicolle (Chair of FDAP), Treatment Director, Mount Carmel, 67 Turle Rd, Norbury SW16 5QW.
[Closing date: 25 July. Interviews: 6 August]

www.fdap.org.uk

FDAP is the "operating name" of naadac, a registered charity (1075222)

want to join a

successful, dynamic, expanding team?

Following a prolonged period of outstanding growth, opportunities have opened for innovative and dynamic individuals to step into these senior managerial roles.

Commercial Director £50,000 – £60,000 (Luton or Warrington)

Company Car, bonus scheme, share option scheme (when available)

A newly created role of Commercial Director has opened within TTP Counselling, a rapidly expanding and successful substance misuse treatment provider offering Tier 2, 3 and 4 treatment. The role of the Commercial Director is to develop profitable, sustainable growth for the business by producing sound financial and commercial proposals; reporting to the Deputy Chief Executive Officer, the Commercial Director will lead a small team and take responsibility for all aspects of the commercial development and governance processes in the team. You must be able to plan strategies to attract new business opportunities and actively work towards expanding existing business services to promote a stronger commercial base. You will be hungry for success and have a strong commitment to getting things done. This role gives an ambitious candidate the ability to work in a fast paced, dynamic environment, and to lead the business development strategy. Most importantly, you will be working in an environment where you can really make a difference, where your ideas will be listened to, challenged and supported. Previous experience of working in the addiction field is essential, as is a very definite sensitivity to the needs of this client group. Those with personal experience of addiction or dependency on drugs/alcohol and who are at least two years drug free/sober are encouraged to apply, but it is not essential.

Operations Manager

£28,000 – £36,000 (Luton)

You will have an instinctive ability to diagnose our current operational position and ideally an appropriate level of training to support your findings.The initial focus of this role will be to revise and implement our HR, Health and safety & Quality and Performance policies. You will help form our financial review team and deliver a programme of performance improvement targets within the business plan, identify and deliver upon opportunities for additional 'stretch' performance and report on their implementation. Ongoing training and support will enable the right applicant to hone their tactical leadership skills and, as our organisation becomes best in class, progress to Director level.

Business Development Manager

£20,000 – £36,000 OTE (South East)

Developing business relationships with both statutory and GP referrers. 2 years+ working within the substance misuse field and familiar with DAT/DIP/ Social Services referral pathways and purchasing of Tier 3 / 4 services.

To apply please email a CV and covering letter to: recruit@ttpcc.org.uk

TTP Counselling Centre Limited is an Equal Opportunities employer.

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