DDN
Drink and Drugs News

16 July 2007
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OPEN GOAL
Sport in treatment, a missed opportunity?

SLOTTING INTO PLACE
Finding the right pieces for reintegration

KNOWLEDGE EXCHANGE
Open forum on workforce development

GENERATION GAP

Urgent support needed for grandparent carers

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University of Kent

Alcohol - Back on the Agenda!

MONDAY 10 SEPT – FRIDAY 14 SEPT 2007

The Addictive Behaviours Group at the University of Kent and Mt Zeehan Community Alcohol Services, supported by the Alcohol Education & Research Council and Alcohol Concern, present a

5-DAY NATIONAL SUMMER SCHOOL

For all those interested in working more effectively with people who have alcohol problems, including

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Key Speakers include

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Key Topics include

UK alcohol policy and drinking patterns, measuring treatment outcomes, alcohol and mental health, self-help approaches, understanding behaviour change, ambivalence, how to engage clients, psychosocial and family-based interventions

Location

University of Kent at Canterbury
Residential facilities on campus: Sunday evening 9 Sept to lunch time Friday 14 Sept.

Fees

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non-residential fee: £390; residential fee £690
Standard bookings [received after 6 July]
non-residential fee: £420; residential fee £710

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the alcohol education and research council

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Editor's letter

The heavy burden on carers hits home in our cover story, but the terrible edge to this grandmother's story is that through all the hardship and worry of looking after her grandchildren, she has not even had chance to grieve for her own daughter. At a stage in her life when she should be spoiling the kids with treats, she has been shocked back into the role of enforcer, counsellor and provider and left to cope entirely on her own. The Mind the Gap project is campaigning for raised awareness and a commitment to financial support in line with foster payments, and there can be fewer more deserving causes.

The results of a much-needed helping hand were very visible at The Quay Project in Plymouth (page 10) where Broadreach House have pulled off an amazing refurbishment, with help from Futurebuilders, to totally revamp their aftercare. The building was amazingly well equipped, but what really impressed me was the positive and industrious vibe that hit me as soon as I went through the front door. Service users told me they were making the experience work for them, and were anchoring themselves in training and work experience. Their addiction was not their sole preoccupation anymore and their achievements stood alongside their ambition in justifying the staff's faith in them. Alongside, Chrissy Richman's enterprise scheme is helping entrepreneurial service users get started in business – an enormous stride towards rediscovering skills and talents that had become submerged for years by an 'addict' identity.

Equally impressive was the commitment to those who are not yet as far along their journey. 'If anybody has the temerity to relapse and stop coming we actually go and find them!' Chrissy Richman told me. It seems to be working: she added that 94 per cent of those who tried to drop out have re-engaged. Even if they only start by coming for lunch, they are beginning to tune into a culture of acceptance and support that lets them take one day at a time.

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

Cover: SuperStock / Alamy

In this issue

'Flying in the face of evidence': agencies attack Tory drug proposals

Proposals to discontinue programmes such as needle exchanges and methadone prescriptions in favour of an increased emphasis on abstinence initiatives contained in the Conservatives' Breakthrough Britain report have been attacked by drugs agencies as out of touch and flying in the face of evidence, *writes David Gilliver*.

The report acknowledges that spending levels on tackling addiction may have to more than double, but says that government spending is 'often wasteful, unwise and misdirected'. The government has failed to properly address drug and alcohol problems, it says, and claims that a 'medical management' approach to treatment has simply entrenched addiction, while the 'preferred harm reduction approach to drugs education in schools could be doing as much harm as good'.

Among the report's proposals are an integrated addiction policy to replace separate drug and alcohol treatment, and an expansion of third sector provision of abstinence-based treatment, including 'personal abstinence treatment vouchers'.

'Out of political cowardice, the Conservatives have failed to grasp the nettle and it is the public that will pick up the £16bn a year crime bill,' said Transform director Danny Kushlick.

The proposals form part of a wide-ranging report from Iain Duncan Smith's Social Justice Policy Group. While Turning Point and Addaction praised the report's call for more funding for integrated treatment, and recognition of the problem's place at the centre of the social exclusion agenda, the agencies were unanimous in their condemnation of the report's proposed return to an abstinence agenda as the centre of drug policy.

'It would be disappointing and damaging if drug education were to return to the days of 'just say no', a failed approach to protecting our children from the harms that drugs do,' said chair of the Drug Education Forum, Eric Carlin. 'We know that those strategies didn't have any credibility with children and young people.'

All of the agencies stressed the need for a wide range of measures to tackle a complex problem. 'Abstinence-based rehabilitation has its place, but harm reduction can also play a part, preventing the spread of infections and helping to stabilise people's lives,' said Turning Point chief executive Lord Victor Adebowale. 'Different solutions work for different people, in response to their complex needs.'

The UK Drug Policy Commission warned against the Tory Party adopting a 'flawed policy' on the recommendations of the report. Chief executive Roger Howard urged them to 'look carefully again at the scientific evidence' before accepting the proposals.

Work and boredom help reduce occasional heroin use

The desire to hold down a job and growing boredom with the routine of getting hold of drugs were two of the main reasons why occasional heroin users had either stopped using or reduced their use, according to a report from the Joseph Rowntree Foundation.

Exploring user perceptions of occasional and controlled heroin use followed on from a previous study that found many users were able to regulate and manage their heroin use so that it caused them relatively few problems. Of the original 32 interviewees, most had either reduced their use or stopped using altogether.

Reasons included the need to focus professionally and boredom with the routines of use and withdrawal, particularly around acquiring the drug. Many had deliberately made it as difficult as possible to get hold of, such as by deleting the numbers of nearby drug dealers, forcing them to travel long distances.

Very few were involved in crime and many felt that their heroin use was less problematic than their use of alcohol or cannabis, and most were sceptical about the benefits of treatment services.

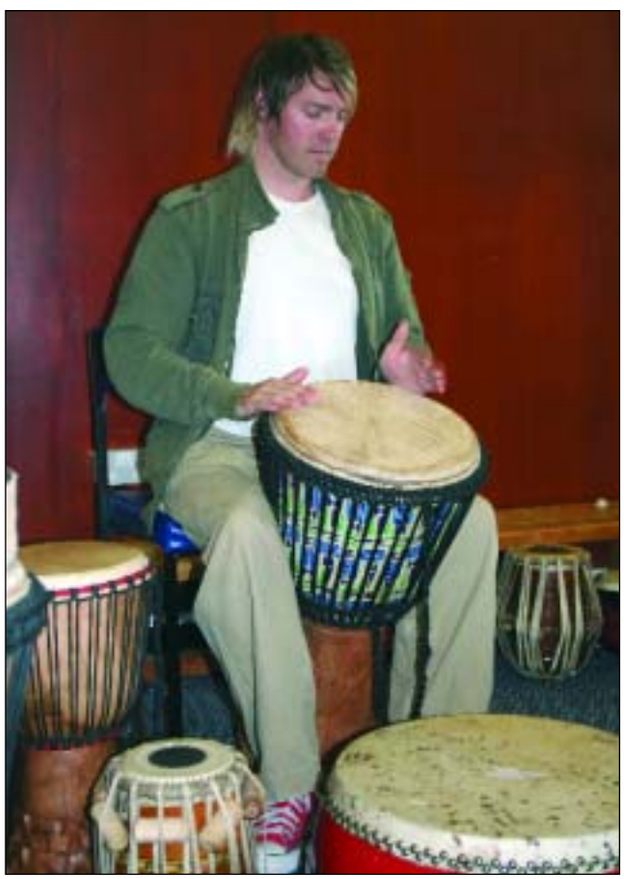
Available at: www.jrf.org.uk/bookshop/eBooks/2079-heroin-controlled-drugs.

Unemployed youngsters 'more likely' to self harm

Unemployment is the most likely reason for young people to self harm, more so than either gender or parents' social class, according to a report by the Medical Research Council, published in the British Journal of Psychiatry. One in 14 people will self harm at some point in their lives.

Unemployed young people were three times more likely to have self harmed at some stage and six to seven times more likely to be self harming currently, it says, with young women more likely to self harm than boys and to start at a younger age. While they tended to use methods such as cutting themselves or taking tablets, young boys were more likely to use more violent methods. Relief of anger was the most commonly reported reason for self harm.

'More effective interventions for unemployed young people who are self harming are urgently required,' says Dr Robert Young of the Medical Research Council's Social and Public Health Sciences Unit. 'This will require training and additional support for GPs.'



Drumming it in: Senior occupational therapy technician at Runwell Hospital, Chris Barton has become the first person in the world to receive a Diploma in Therapeutic Drumming, an award recognised by the British Complementary Medicine Association. 'When I joined my current team I was given the opportunity to extend my skills and undertake further training so I asked if I could take the course leading to the Diploma,' said Mr Barton, who's employed by South Essex Partnership NHS Foundation Trust. 'Drumming is one of the oldest healing activities known to mankind,' he said. 'Therapeutic drumming is a holistic activity that has a positive effect on mental, emotional, physical and spiritual health.'

Enforcement a 'high risk strategy' warns JRF

Enforcement to deal with the 'problematic street culture' associated with rough sleeping, such as street drinking, is a high risk strategy and should only be used as a last resort, according to a new report from the Joseph Rowntree Foundation. It should never be used with very vulnerable street users, such as those with mental health problems,

The impact of enforcement on street users in England concludes that while 'softer' forms of enforcement like controlled drinking zones were effective in reducing the visibility of the problem, they had little discernable benefits for the users themselves, and 'harder' measures such as ASBOs , while potentially beneficial if combined with intensive supportive interventions, could lead to 'displacement of activity', such as switch from begging to street crime.

The report found that it was almost always local rather than national pressure that led to the use of enforcement measures, and that the local community's concerns were usually based on fear of a threat rather than any personal experience of danger or abuse. It calls for gaps within local service networks to be addressed, since while access to drug treatment has improved in many areas, provision of alcohol treatment services remains inadequate. Harder enforcement measures like ASBOs should 'never be used with extremely vulnerable street users such as those with serious mental health problems who are unable to comprehend or respond constructively to enforcement action,' it says.

Online at: www.jrf.org.uk/knowledge/findings/housing/2074.asp

Home Office offers cash prizes for service excellence

Rewards of £10,000 are up for grabs in the Home Office's Tackling Drugs Changing Lives awards, designed to recognise the 'unsung heroes' at the front line of efforts to tackle problem drug use.

One individual and one team will be awarded the prize for their local project, with winners announced in November. Anyone can choose to nominate for either category, whether it's a rehabilitation or drug treatment facility team or someone contributing to reducing drug related crime or supporting the friends and families of drug users.

The awards are designed to celebrate and recognise those 'going the extra mile to help change lives,' said Home Office minister Vernon Coaker.

The winner of last year's individual award was Dave Gordon, who runs a mobile needle exchange in Southampton, working with more than 400 people (featured alongside other winners in *DDN*, 5 June 2006, page 12). 'The award has been used to acquire equipment for the advancement of wound care,' he said. 'This will have a big impact on clients who would previously have used local accident and emergency facilities, so this is also a saving for the general public. It has gone a long way in helping substance users in my area to gain a better quality of life and a better understanding of their drug use.'

The deadline for nominations is 17 August 2007. More information at www.drugs.gov.uk/awards2007

Dual diagnosis prisoners receiving poor quality care

The quality of mental health care in prisons is 'frequently poor' and is failing those with a 'dual diagnosis' of both mental health and substance misuse problems, according to a new report from the Sainsbury Centre for Mental Health.

England and Wales together have the highest prison population of anywhere in Western Europe, at more than 80,000. Around 70 per cent of those have two or more mental health problems, and a large proportion have both mental health and substance misuse problems, says *Mental health care in prisons*.

According to the report, there is a lack of skills and knowledge among dual diagnosis workers and poor communication with agencies on the outside. While Counselling, Assessment, Referral, Advice and Throughcare services (CARAT) provided support for those with substance misuse problems in all prisons, substance misuse and mental health teams in prisons often simply referred prisoners to each other rather than working together.

Detoxification usually lay outside the prison healthcare remit, and prisoners interviewed for the briefing paper claimed that lack of suitable dual diagnosis care in prison and on release had led them to re-offend.

The report calls for support and training for staff to develop specialist skills, along with policy guidelines and national standards for inreach teams. It also wants to see better team working within agencies in prison and improved co-ordination between prison agencies and the NHS on the outside. 'Prison inreach teams have been described as under-resourced, overwhelmed by referrals and limited in the range of interventions they can offer,' it says.

Online at: www.scmh.org.uk/80256FBD004F6342/vWeb/pcKHAL74HHC6

News in brief

Durham and Darlington double up

County Durham and Darlington DAATs have teamed up to produce a joint harm reduction strategy, supported by County Durham and Darlington PCTs. Among the services are a wider range of needle exchanges, including pharmacy exchange, and offering immunisation programmes for hepatitis B and C, along with hep C and HIV tests, to all drug users. 'This is an important opportunity for public services across Darlington to work together to minimise the harm to injecting drug users and the wider public,' said executive director of public health, Dr Tricia Cresswell. 'In particular the risks of blood borne viruses such as hepatitis B can be reduced by immunisation and local services such as needle exchange programmes.'

Snap out of it

More than 1,000 pregnant women are being recruited for the largest ever trial to establish the effects of using nicotine patches when pregnant. Funded by the National Institute for Health Research's Health Technology Assessment Programme, the £1.3m Smoking, Nicotine and Pregnancy (SNAP) trial is being led by Dr Tim Coleman from the University of Nottingham's primary care division. 'If the SNAP trial establishes that NRT is effective and safe when used for smoking cessation by pregnant women, then greater use of NRT by pregnant smokers could have a substantial impact on their health and also on the health of their babies,' he said. Smoking during pregnancy is the cause of around 4,000 fetal deaths a year and can lead to cot death, premature birth and low birth weight.

Parent power

Seven parents successfully completed Tower Hamlets' Parent Peer Education Programme last month, designed to give parents a better understanding of drug and alcohol misuse by young people. The six-week programme looks at different types of illegal drugs and their effects, and includes visits to local drug treatment centres. 'Parents play a crucial role in preventing drug and alcohol misuse,' said the programme's co-ordinator Fiona Millar. 'The training programme gives parents a real opportunity to make a difference and improves their awareness around substance misuse.' Four parents have now taken up part time jobs in advisory roles as drug and alcohol educators since completing the course, which is delivered by the DAAT and funded through the Neighbourhood Renewal Fund.

Preston praise

A Preston-based safer drinking initiative has been awarded funding and support from the Queen's Nursing Institute in London. The Ribbleton Alcohol Brief Intervention Project Initiative aims to raise awareness of safe drinking levels among the clients of district nurses and health visitors. Clients will be asked to fill in a questionnaire about their drinking habits, supported to reduce the amount they drink and visited again after eight months to see if their drinking habits have changed. 'We are certain that the project will have a real, positive and lasting impact on the lives and health of the people of Ribbleton,' said QNI director Rosemary Cook. 'The institute wishes them well in following through the project and will be on hand to help with a year-long programme of support.'

Generation GAP

No one knows how many grandparents are bringing up their grandchildren because of their children's problems with drugs or alcohol, but it could run into hundreds of thousands, according to the Mind the Gap project. One woman's harrowing story illustrates their urgent need for practical support backed by legislation, as **David Gilliver** reports.

'I didn't even have time to grieve for my daughter,' says Pam Carnegie. 'She died from drug and alcohol-related illness, and I inherited my four grandchildren – the baby was six months old and she had three others, eight, twelve and fourteen. I'd be sitting on a bus and burst out crying. People would move away because they thought I was mad.'

Pam is now in the fourth year of bringing up her grandchildren and is one of the people who have contributed to Mind the Gap, a joint project between Mentor UK, Adfam and Grandparents Plus, with funding from the Department of Health. Aimed at both grandparents bringing up grandchildren because of their children's drug or alcohol problems, and the people who work with them, it includes a resource pack, staff training tools and a series of policy recommendations.

The project's impetus, says Mentor UK's chief executive Eric Carlin, came from *Hidden Harm*, the Advisory Council on the Misuse of Drugs report on the impact of problem drug use on families. 'It came about through not knowing enough on how to make sure children don't go on to repeat the same patterns that their parents did,' he says. 'What can you put in place to support these families to break that cycle?'

So how big a problem is it? 'It's impossible to tell,' says policy and communications manager at Adfam, Nicolay Sorensen. 'According to Grandparents Plus there are around 500,000 grandparents raising their grandchildren and we estimated – based on the information we had available – that 10 per cent of those will be because of parental substance abuse. But it could be ten times that for all we know.'

The key policy implication of the project is the sheer financial hardship faced by the grandparents – having to raise a family at a time when incomes are severely reduced. 'They've got to find money to pay for food, clothing and to get these kids to school,' says Sorensen. 'We've had stories about grandparents who had to take second jobs or come out of retirement to pay for school uniforms and all the rest of it.

'This is not something that's necessarily part of a social services structure,' he continues, 'and we often found that – unless they were willing to go down the formal adoption or fostering route – there was very little the grandparents were entitled to in terms of state benefits. A lot of them don't want to do that, because it might cause conflict with their other children or grandchildren.'

'It's been tremendously hard – harder than I ever thought it would be,' says Pam, 'simply because the system had nothing in place that catered for the needs of grandparents bringing up grandchildren – certainly not four of them. I had three and a half years of struggling to raise them in a two bedroom flat – at one stage there were seven of us. I separated them into a room for girls and a room for boys and I slept in the living room with the baby. It was horrendous – trying to cope on a day-to-day basis with the children and battle with the local authority to get suitable housing. It's a lottery, depending on where you live – you may get something, or you may not.'

'They feel out on a limb,' says

'It's been tremendously hard – harder than I ever thought it would be... simply because the system had nothing in place that catered for the needs of grandparents bringing up grandchildren – certainly not four of them. I had three and a half years of struggling to raise them in a two-bedroom flat.'

Nicolay Sorensen. 'There's a lack of both financial and emotional support. How do they cope with being a parent all over again? How do they deal with having a daughter or son who's a drug and alcohol user? There's a whole range of problems.'

Unsurprisingly, the project found that financial hardship and social isolation go hand in hand. Most have little idea of where to turn for information and advice and very few have any contact with anyone in a similar situation. 'You can't talk to your friends about it because they're not in the same boat,' says Pam. 'You can't keep moaning to people about it because after a while they see you coming and they run! I'm doing this by myself, without a partner or anything – what man in his right mind is going to want someone in my situation? I can't go back to work and I have no social life – it's almost as if I've lost my identity. I just manage one day at a time.'

In Pam's experience, that sense of isolation has been compounded by what she sees as a wall of local authority bureaucracy and lack of help from official agencies. 'I'm already hurting from the loss of my child, and I've got my grandchildren to raise. If these children went into foster care the council would be paying £400 per child per week. As a grandparent, you'd be lucky to get £50 per child. I have been really low, to the extent that I thought of putting them in care. I really was at the end of my tether.'

Pam is classed as a kinship carer and has taken out a residency order, which grants parental responsibilities. 'Some boroughs, although there's a residency order in place, will not financially support the grandparent at all,' she says. 'There needs to be legislation to ensure that an appropriate payment is attached to grandparent carers, and it should be the same wherever you are. It's a genuine unwillingness to value the work we're doing in caring for these children with the minimum of support.'

'There has to be greater discretion on the part of social services to provide payments to grandparent carers,' says Nicolay Sorensen. 'Family carers do not fit into their current model of working in a way that accommodates their quite specific needs.'

Mind the Gap wants to see payments to kinship carers standardised and on a comparable level with payments to foster carers in recognition of the ongoing support they provide.' That would be a really good start,' he says. 'It's that immediate financial stuff that's the biggest issue.'

Another policy recommendation is for grandparents to have access to appropriate respite care and childcare arrangements. 'If I become a foster carer then I'll get respite,' says Pam, 'so I think I'm going to have to go through that process. I've had no break since my daughter died. Foster carers get respite, three weeks paid holiday and the support of the social services. Kinship carers get nothing.'

As well as managing her own grief, Pam has been dealing with that of her children, along with their growing sense of resentment against what they see as an unsympathetic system. 'After a while I got them to do a little bit of counselling,' she says, 'but they say "how can we go and talk to people who don't care about us, because if they cared we wouldn't be living in a two bedroom flat for three and a half years?"'

There is a real need for training social workers, drugs workers, teachers and others to be aware of the practical and emotional implications of becoming a kinship carer, says the report. 'My grandchildren came with baggage because of my daughter's addiction, and when they came to me I changed,' says Pam. 'They lost their nan and got this person who was now setting boundaries and bedtimes. We've had to develop a new relationship, and it's hard.'

'It crosses over so many different policy areas,' says Nicolay Sorensen. 'Grandparents are often left not knowing where to turn. There are some excellent projects working with the children of substance misusers but they're few and far between. You have drug and alcohol treatment services like the local DAATs, but they don't always link up very well with children's services and often don't have the capacity to deal with family issues. There really is a communications gap.'

'We all get sick of saying there should be more joined-up working,' he says, 'but that really is the case. I find it hard to find models we can recommend, other than where there's a local champion who has some input into the commissioning process of the local DAAT, or someone from social services who's passionate about the subject and drives that policy through at a local level. But relying on local champions obviously means that it doesn't happen in most places.'

'A lot of the grandparents feel that they've failed,' says Eric Carlin. 'They feel they've taken over caring for their grandchildren because they have to, but also because they've failed as parents, so quite often they're ashamed to go and ask for help. With BME communities especially, we found that problems were more hidden and there was much more of a sense that the family ought to pick up the care of the children, and more of a stigma about approaching social services. We need to sensitise people like social services departments about the shame and all the complicated issues around this.'

'When it gets hard for me I get down and cry,' says Pam. 'Not in front of them, because I'm always doing something, going somewhere, picking one of them up, cooking, washing, ironing. All the children's needs are different, and then there's my own children who feel they've lost their mum – they've got to share me now. I don't know what the long term effects on these kids will be, but I know things would improve with better financial help and support.

'When I took them on what got me was that no one wanted to know what the needs of the family were,' she says. 'Everything was me banging on doors. To me it seems it's this way by design, because if they recognise it they have to do something about it. I don't believe there's really a willingness to address it because everything's down to budget. I don't think that anyone's really thinking about what the long-term social implications of situations like mine are going to be.' **DDN**

Copies of Mind the Gap are available from admin@mentoruk.org

What's the picture on **workforce development?**

Many people have had workforce development dumped on them and are feeling unsupported and under-resourced. There is a lack of management buy-in to the workforce targets, accompanied by feelings of isolation, and inconsistent efforts around the country to make the best of a difficult agenda. These were some of the issues to emerge from the first National Workforce Seminar, run by FDAP and the Competence Group for those responsible for workforce development within DAATs and within national service providers. Here are some of the comments from a lively day of discussion.

I was given workforce and told it was my baby, but workforce became the child I wanted to place in care. I thought 'this is awful'. Providers were looking to me for direction and I didn't have a clue. When DANOS came into the picture I got completely confused. I had nowhere to bounce ideas off. I began by carrying out an audit and made recommendations to my DAT.
Taiwo Dayo-Payne, Croydon DAT

Many DATs have come saying workforce has been thrown at them, and that they're feeling very isolated and unsupported. We need much more consistency from DATs' point of view.
Fiona Hackland, Outcome Consulting (and CoG Group)

When I took on my workforce role I was trying to make sense of NTA targets. I thought, 'what's it all mean, what do I do to take it forward?' A year on we've cracked it a certain part of the way and done a strategy, audits and training. Providers need to be willing to take the journey with us if it's going to work. People need to feel they can move around jobs.
Rob Spencer, Poole DAT

There's a feeling at the centre that there's only so much that you can do. But all of us know that workforce development is where it's at.
Carole Sharma, independent consultant (and CoG Group)

We need buy-in from line managers. We're developing aspirational training for line managers as well as looking at our induction programme to make sure it's competency based. Role profiling when advertising is a useful way to recruit.
Kirstie Smith, Westminster Drug Project

You need to make performance management a key part of the job and map each job description against DANOS units. It's the framework that keeps your client safe.
Tim Morrison, Alcohol-Drugs.co.uk (and CoG Group)

Managers need to be trained to assess – assessing against DANOS units shows where practitioners didn't meet the standards. We've put a lot of focus on people's induction. I needed to make sure it was working, so at first I sat in on every staff member's six-week assessment. You can't assume anything at all.
Satya McBirnie, Rugby House

The competence revolution is here, whether you like it or not. It's about training, practice and supervision. It would be nice if one part of the government had a strategic focus on the drug and alcohol sector, but it won't happen because we're too small. We've fought with that situation for years – we just have to find a better way of making it work. We started CoG because the central workforce agenda's been thrown out. Let's seize the opportunity.
Trevor Boutall, MSC (and CoG Group)

We're looking to bring workforce into the mainstream DAT agenda – it should be at the top, and part of the furniture. Workforce targets are just until 2008. So instead of just renewing them, we're trying to inculcate in commissioners that workforce is part of core business. We're not saying that previous work doesn't matter, but that workforce will be taken into other parts of work. Competency isn't some idiosyncrasy. The spending review is due to be published in October, so we will have greater clarity then.
Colin Bradbury, NTA

The Home Office don't give out a pot of money separately for workforce development. It needs to come out of money for services, so you need to prioritise within your own DATs. There's been a massive increase in resources to the drug and alcohol field – it's just not earmarked. Money for service provision includes workforce development, so I'm not comfortable with the comment that there are 'no resources'. It's a balancing act on how much you want the government to tell you to do. There's a consultation for the new drug strategy on 20 July – so say there should

be ring-fenced money for workforce development.
Pamela Spalding, Home Office

There's a limit to what government can do from the centre. We need to engage not just with the centre, but regionally.
Iain Armstrong, independent consultant (and CoG Group)

Developing competence is not always about training. Every job should have a specific description for each role, with interim and long-term targets. I've grown to love targets over time. They concentrate the mind.
Simon Shepherd, FDAP (and CoG Group)

Are you involved in workforce development?

What are your experiences, successes and problems?

If you have issues you would like us to investigate, or would like workforce-related questions answered in DDN by members of the CoG Group, email the editor, claire@cjwellings.com.

The Competence Group (CoG) is a group of consultants and trainers brought together by the Federation of Drug & Alcohol Professionals (FDAP) to support workforce development in the substance misuse sector. The group's aim is to help ensure a fully competent workforce in line with the joint NTA/Home Office workforce development plan, and they provide guidance, training and support on workforce development issues, for workers, managers and commissioners, as well as an online helpdesk and FAQs facility. The CoG website is at www.thecompetencegroup.net or email queries to cog@fdap.org.uk

A lifeline back to treatment

A targeted outreach service is proving an effective way of re-engaging alcohol clients who have dropped out of local treatment. Mike Blank shares early successes of SADAS' pilot project.

Leafy Surrey is not necessarily the first place you think of when it comes to treating those with drug and alcohol issues. Yet in the first three months of a six-month pilot project the Surrey Alcohol and Drug Advisory Service (SADAS) exceeded its target for assertive outreach services designed to help those with alcohol problems in region.

Targeting high-risk individuals who have been referred but have failed to attend or dropped out of the appropriate treatment, the service focuses on the root cause of disengagement. Many are referred by the Community Drug and Action Team, probation, arrest referral, housing services, GPs or non-statutory service providers. Our staff help track down these vulnerable individuals – who are often homeless or the victims or perpetrators of domestic violence – find the most appropriate treatment and support them through their programme.

Interestingly, we expected around 50 per cent of cases to be successful. However, during the pilot project our staff were able to re-engage with more than 80 per cent of people to get them the help they needed. A total of 40 people are already back into treatment following the pilot and significantly, two of those have now even been able to go back into full-time employment.

We believe this is because clients are all fresh out of some sort of treatment. We believe many are disappointed with themselves for dropping out, and that the outreach service offers a lifeline. It also provides the chance to re-engage individuals with more appropriate treatment. Someone who is just coming to terms with alcohol addiction, for example, may find that being asked to write down his or her life story is just too much and a gentler approach like AA may be more helpful.

The team also work to help overcome social issues that might be preventing access to treatment. This may mean assisting those who find it psychologically difficult to leave home to attend appointments for example, or liaising with refuges or treatment centres. Whatever the issue, our staff's intervention is already helping many people get their lives back on track. The project, which is commissioned by Surrey PCT and match funded by the Guildford and Waverley Grants Panel, has just received additional funding to allow it to continue for a further year.

SADAS' intervention is already on the way to saving the community many thousands of pounds in missed NHS and alcohol counselling appointments. In addition – and an unexpected benefit of the programme – clients have reduced calls to the emergency services. Previously, individuals wasted police and other emergency services' time with non-urgent calls. Often drunk and lonely they would call 999, sometimes hundreds of times a month. Our staff become involved the number of calls drops dramatically, reducing wasted emergency services' time.

The statistics and success – even at this early stage – clearly demonstrate how much the service is needed in the Surrey region and how many more people could benefit if it was replicated throughout the UK. The NHS spends a significant amount of money each year funding missed appointments and this type of service could go a significant way to counteracting the wasted spend.

Mike Blank is executive director of Surrey Alcohol and Drug Advisory Service (SADAS).

Q&A next issue

We're repeating last issue's Q&A question. Please email your suggested answers to the editor by Tuesday 24 July for inclusion in the 30 July issue – the last before our summer break.
Please send letters, comments and feedback on DDN to the editor: claire@cjwellings.com or post them to the address on page 3.

Reader's question: A drug and alcohol worker in my team has come to me wanting support because she has just relapsed after several years. She is a valued member of staff and we want to help her over this episode and keep her in her post. Can anyone suggest practical support we can give her? ***Lizzie, by email***

Fitting into life

'It's like everything's coming together like a jigsaw', says a service user at The Quay Project, Broadreach House's innovative day support centre in Plymouth. **DDN** met staff and users at the project.

'It's counterproductive to spend a lot of money on someone's rehab programme and then plonk them back where they started from, in the same community, with the same housing, training, and employment issues they had before,' says Rick Weeks, manager of Broadreach House, which has three residential Plymouth treatment centres (Broadreach, Longreach and Closereach).

'Over the years we've started seeing people with huge social issues as well as drug and alcohol problems,' says chief executive Chrissy Richman. 'Through talking to service users, we realised we needed a much broader kind of care than in our traditional aftercare groups.'

With funding and advice from Futurebuilders, the business plan for Ocean Quay evolved. Support from the European Social Fund accelerated development: they had to have the building ready in six months' time. With 'a lot of screaming at the builders', the former warehouse was transformed into a state-of-the-art centre that includes a gym, acupuncture studio, internet café, recording studio and crèche.

A modest enterprise scheme has opened new doors. With money from a bank trust, they have created a 'miniature Futurebuilders scheme', helping entrepreneurial clients with a business plan and small loan to begin trading.

'We believe it's our job to provide the motivation, rather than waiting for people to find it,' says Chrissy Richman.

'When I came here my life was at an end. I'd hit rock bottom,' says Jackie. 'I had a drug habit and an alcohol habit, and I was being battered – literally, my face was bruised. I lost my daughter when she was three and a half – she's now 16.

'When I came to Broadreach I had a safe place to stay. I was in a group of other women who were in similar circumstances. I still see two of them, and both have gone on to get careers. I still haven't, and that's why I now attend this project. I've been able to fit in quite well.

'I also suffer from depression. When I started the 12-week course, I came to stay for four weeks then my tablets were changed over and I crashed down again with depression. The project allowed me to come back and start from where I'd left off. That was really great for me because if I don't have some kind of goal to pull me back out, I could stay in depressive mode for six months or a year.

'Because of the Quay Project I've been able to come back and get on with it. I've completed my course, done voluntary work in the nursery and am starting a course for carers that will give me a certificate. This has been just the safety net I've needed.'

'We were involved in Ocean Quay from the beginning, as we are based in public health and have a 'whole systems' and evidence-based approach,' says Plymouth DAAT manager, Gary Wallace.

Funding half the running costs, the DAAT works with Broadreach House 'to try and mainstream as much of the funding as we can' – not easy in the face of this year's budget cuts. But the DAAT is committed to 'looking at things in the round, and trying to have a realistic and achievable approach'.

'We try not to see services in isolation, because as a treatment community we see substance problems as complex, requiring complex solutions,' he explains. To reach these solutions, the DAAT meets regularly with the chief executives of local services at the Dave Group ('It doesn't stand for anything – we were just fed up with acronyms') to share targets and priorities.

'The way to get the best for the service user is to have an inclusive approach and listen to other people's views, says Gary Wallace. 'A lot of DAATs lock themselves in a cycle of re-tendering and that's not very good for the service user, so we try to keep as much stability as possible. Ocean Quay is like the lynchpin of the "whole system" approach.'

'For a long time I realised that we provided an incredible service in terms of residential treatment, but at the end of that people were clearly not ready to move into the wider community,' says team manager Derek Buchanan.

'I felt we were not really doing what we ought to be doing to help people make that final transition – that integrated part of the process.

From working as a rehab counsellor, he realised that by the end of their treatment, clients would regard the place as their home and could feel excluded in aftercare.

'They were outsiders, they had lost their place. And that was a very negative experience for them.

'The greatest advantage of this place is helping people with their personal development, making them ready to leave here and go on to more community-based settings, such as a college of further education and Working Links.'

Vocational training is high on the agenda. The 'introduction to care' course is a six-month programme, three days a week, which includes a professional placement in an outside organisation and an NVQ at the end.

'It's not sending people to work in charity shops – that's what we don't want to do,' he emphasises. 'It's not occupational therapy, we're not just keeping them busy – they're learning transferable skills.'

'I came from prison to the treatment centre at Longreach, which was very good. But I came out, relapsed, went into Broadreach, came out and relapsed again,' says Traci.

'When this project opened, I'd just moved into supported housing. It gave me the break I needed. I committed myself to the 12 weeks and it was hard – I can't say it wasn't. That was last June, and I've stuck with it.

'I've got most out of the voluntary places I've done – in the community, here on reception, and doing induction, mentoring all the new people that come in.

'It's been really good for me because I've never had a job or qualifications. I'm in college now, doing my English and maths GCSEs, and I'm starting an access course in psychology in September. It's like everything's coming together like a jigsaw.

'I struggled and relapsed when I came out of treatment, but maybe I wasn't ready to change anything. But this place is for people who want to make a go of it and not mess about – it's a fantastic opportunity.

'They believe in you here and will give you the utmost backing. I've done voluntary work for nine months, and now I'll get a reference. Going into the workplace as a receptionist fills my self-confidence up.'

'I was very scared that if I stopped taking heroin I would die,' says Paolo. 'Coming to Broadreach was the first time I've done treatment in my life, and I feel so fortunate that I actually engaged with it.

'But when I came out, that's when reality really hit me in the face, and although I was still having support from Broadreach, I felt uncomfortable with myself. I found it difficult to live clean.

'The organisation helped me out of that by giving me a structure. I went to groups and also started going to NA [Narcotics Anonymous] meetings, and decided to do the 12 steps.

'When they set up this place, my brother was out of treatment as well, and they asked both of us if we were willing to facilitate the furniture-making workshop. So he does the woodwork and I do the upholstery side.

'The worst thing that can happen to someone like us is to feel we're on our own. I'm my own worst enemy and if I stay at home with my own thoughts, I'll go backwards big time.

'It's been so beneficial for me is to talk with other people here and see their perspectives around things that are worrying me – worries lose their power.' **DDN**

Sports activities can play an active part in galvanising drug treatment programmes, says Chris Bruce. **He explains how.**

A sporting chance of recovery

Despite currently working within the Drug Intervention Programme Team here in Lytham St Annes in Lancashire, my background is sport. I still play anything that involves either kicking or hitting a ball and professionally over the last 14 years I have either been involved in specialist sports projects, or have spent time creating activities for clients wherever I've worked.

My sports degree was modular, which meant that I could combine sport with American studies. I was able to visit the States for my thesis on drug treatment in the US, and while visiting a treatment centre out there, I saw for the first time sports being used within a treatment programme. The centre I visited had a fully operational gym as well as offering sports and various outdoor activities to clients.

Back in the UK, I worked for a pioneering project, managed by John Wheeler, an entrepreneurial ex-athlete. He believed wholeheartedly that sport can work in a positive way to divert criminal behaviour as well as drug and alcohol misuse problems, and set up a project in 1993 known as the West Yorkshire Sports Counselling Association (WYSCA).

I was employed as one of four sports leaders, and we worked specifically with clients referred by the West Yorkshire Probation Service. We would work with an individual for a period of 12 weeks, during which time we would try to motivate them to take part in sports as well as introducing the possibility of taking courses and developing hobbies.

So what is the evidence that this kind of work helps to divert drug misuse and criminal behaviour? In St Annes we run a weekly football group and a weekly badminton group, and clients summed up what taking part meant to them. After attending a football session involving coaching from the YMCA football development staff, one client remarked: 'I think it makes you feel part of something and gets you involved in teamwork, and helps you let go of your inhibitions. You also feel good about yourself afterwards.' After a badminton session, another said: 'I had nothing to do – this is something I can do. Boredom is a big thing for me. This group helps me solve that.' Another added: 'I feel it gives me motivation and energy. After, I feel alive and focused on the remainder of the day.'

Personal testimonies abound from other projects, such as the North East Drug Interventions Programme Sports Initiative. But what hard evidence is there that sports can positively affect behaviour? It is widely acknowledged that statistics supporting sports initiatives are difficult to find. WYSCA however did have a final evaluation report, drawn up in 1997 by Geoff Nichols and Peter Taylor from Sheffield University. A brief summary of their findings concluded that taking part in activities reduces the ability to take part in crime – based simply on the fact that an individual cannot be in two places at once, so they are using their spare time positively.

But sport can offer far more than this, the report concluded. Individuals taking part showed an increase in cognitive skills. Those participating in team games developed a sense of belonging, their self-esteem improved and taking part fulfilled a need in many for excitement. Nichols and Taylor also concluded that reconviction rates were affected, based on comparisons over a two-year period. Twenty-three participants who had completed at least eight weeks of the 12-week programme were found to be significantly less likely to have been reconvicted than members of the control group.

The North East DIP Sports Initiative concluded in their report last November that crime reduction did take place, based on research related to 22 drug users who attended the programme. It found that those who attended every session of the coaching course reduced their offending behaviour by 42 per cent in the 11 months following their first training session, while those who attended only some of the sessions reduced their offending by only 17 per cent. So in both cases continued attendance was crucial to positive outcomes. In the report they also pointed out that other factors, as well as sports, helped to bring about this change in behaviour, indicating the benefit of a holistic approach. The coaching course was seen as particularly useful in helping individuals achieve change.

This concurs directly with the evidence produced by Okruhlica, Kaco and

"I think it makes you feel part of something and gets you involved in teamwork, and helps you let go of your inhibitions. You also feel good about yourself afterwards."

Klempova in their article 'Sports activities in the prevention of heroin dependency' (in *European Addiction Research*, July 2001) who cited examples of sportspeople at both ends of a behavioural spectrum – positive role models such as Pele or Gary Linekar on the one hand; and on the other the flawed genius of Diego Maradona or the late George Best, who themselves developed problems with substance misuse. However they did also conclude: 'Great importance should be placed on sport as a therapeutic experience, especially in the process of the treatment and recovery in individuals from substance misuse.'

Of course there are many isolated groups and individuals operating around the country that, like me, believe that sport can make a difference and are motivated to bring this kind of service to our respective client groups – but using sport as a therapeutic tool is not part of mainstream treatment philosophy. My experience is often that once a motivated individual leaves a project, the initiative can flounder.

Recently a project near me put together a holistic treatment programme offering clients a range of services from art classes to positive parenting groups. 'Gym' was included on a list of more than 20 different groups, but there was no mention of sports or outdoor activities. If you go to an agency for help and support, it is a matter of luck whether they have a worker motivated to champion initiatives. I would like to see sports development integrated into every holistic treatment programme. Area coordinators could develop links within their communities and with local treatment agencies as part of a national programme, which could bring benefits to both individuals and society as a whole.

Here's a rallying call to all of us who have sport as part of our agenda: let's get together to swap ideas and get motivated!

Chris Bruce is based in the DIP team at Lytham St Annes and is employed by Addaction. If you are interested in responding to his suggestions, call him on 07825 403357 or email chriscbruce@tiscali.co.uk

Notes from the Alliance

Never mind the buzzwords

What's all this about wraparound services? asks Daren Garratt. Surely we're not thinking about making service users truly independent?

I was listening to that good old song called 'New Puritan' by The Fall, and when Mark E. Smith croons, 'the experimental is now conventional, the conventional is now experimental', I was struck by how it reflects a creeping ideology underpinning drug treatment... I'll explain.

Every new year seems to herald a new approach for drug treatment in the UK; we get the new buzzword that we have to use at every possible instance, heralding a unique and innovative way of working that ultimately leaves most workers and users confused as to what's actually required, and how it differs from what the majority of evidence-based practitioners have known to work for decades; namely, a client-centred approach to care that addresses the individual's immediate health requirements alongside any other psycho-social needs that they may have identified.

So after the mind-boggling 'Models Of Care' we got the elusive 'Throughcare and Aftercare', which gave way to seemingly-obvious 'Treatment Effectiveness' and the new era of 'Wraparound Services', which all seemed to be saying the exact same things but with increasing vagueness.

Qu'est que c'est these new 'Wraparound Services' that everyone's banging on about nowadays? We're surely not floating the revolutionary concept of incorporating services that support and address a user's housing, employment, family, education and welfare issues into their individualised care plans and maximising their potential to adjust and progress through a maintained, stabilised or drug-free life, are we? Well, whoop-di-doo! Eureka! Who'd have thought it, eh?

If we'd only known that all these factors can influence a user's treatment experience we'd have brought the top brass from all these relevant agencies together over ten years ago and developed localised teams to oversee and take statutory responsibility for planning and commissioning management systems that support such integrated networks of care. Rats! That's another opportunity wasted...!

No. 'Wraparound Services' must mean something different mustn't they, or else we'd be in the illogical position of having to keep reinventing a theoretically perfectly-functioning systemic wheel at additional, unnecessary expense to existing budgets and workloads, while finding that it still fails to translate into effective practice at an operational level for far too many users.

In truth, I was inspired to write this article after this whole issue was raised with me by Anna Millington, who's the Alliance's regional advocate in the North East. When she said, 'So, what are wraparound services? Are they intended to literally wrap people up, keep them contained and stop them from getting out?', I thought, 'ah-ha!'.

While we still fail people at the most fundamental level we enable observers with vested interests to spout such 'evidence' contained in the Conservative Party's jaw-droppingly reactionary, one-sided and anecdotally informed *Breakthrough Britain* strategy.

I could write a whole book about how, as UKHRA state, this 'new policy represents a volte-face to the successes of the last 20 years by determinedly ignoring the wealth of international evidence that demonstrates that harm reduction works by saving lives', but ultimately, if mismanaged drug treatment systems are effectively trapping individuals in an endless cycle of methadone dispensing, then this is bound to give some credence in certain quarters to the notion that maintenance doesn't work, and forced participation in unregulated abstinence-based programmes are the new way forward.

It's our collective responsibility to challenge this, or else the experimental handcuffing of junkies to radiators to see out their rattle, might be a conventional performance monitoring target before we know it.

I think I'm going to stop listening to The Fall. Well... maybe after I've had a quick blast of 'Second Dark Age'....

Daren Garratt is executive director of the Alliance

John Bucknall, children and young people's commissioning manager for Warrington DAT, has transformed his own negative experiences into a career protecting others from the extremes of drugs and alcohol.

Where there's life there's hope

In the years 1981-82 brown heroin hits the streets of Merseyside in a big way. Those drug users who had spent most of their time smoking weed, snorting Charlie and taking LSD were all of a sudden chasing a black oil up and down a piece of aluminium foil.

Dirty black faces and black marks on your teeth were all the fashion along with going to sleep every two to three minutes then waking up to find the cigarette you had been smoking had burnt a hole in your tracksuit bottoms or your quilt cover.

As the years went by, more and more people started to walk about with sunken cheekbones and pupils so pinned you could hardly see them. It became the fashion to steal off each other or travel around the country stealing from shops or people, in the pursuit of the warm feeling heroin can give you. People started to go to jail on a regular basis, where they would spend weeks climbing walls as they went through the process of cold turkey. Drug services opened up across the country trying to help people get rid of this monkey on their back, but few were able to do it and continued to spend the vast majority of their time in search of the golden brown powder.

I was one of those drug users from Merseyside whose life became entrenched in the search for that lovely warm feeling inside my stomach. I spent the vast majority of the 80s in and out of jail for shoplifting or for failing to surrender to the courts. I became isolated from my family, my community and most of the time I walked with my head down to avoid people who had previously known me.

Near the end of the eighties I start to get really fed up with my life and very often thought about ending it all. I had been in detox three times but had always gone back to the brown when I returned home. In 1993 I decided I would try rehab and checked into Phoenix House (Wirral). All that challenging group work and structure… I thought my head was going to explode at times, but I managed to get through it.

During my time in Phoenix, I decided that I wanted to help other drug users change their life and in 1995 I started to work as a volunteer for the Lighthouse Project (formerly Merseyside Drugs Council). For the next two years I volunteered in several projects and attended college to gain some formal qualifications. I was offered a full-time job by Lighthouse in 1996 and went on to work there as a keywork and shared care worker for four years.

My next job was service user involvement coordinator for Wirral DAAT, which was a wake-up call for me. I had forgot what it was like to be a service user and all the preconceptions services and people have about you. Anyway, it was an exciting job and the group (Inner Action) was able to influence services and the DAAT to the extent that some services changed the way they allowed access into their services. The group was acknowledged by the NTA and the Healthcare Commission for the work they did to improve services for users, and four of that group have now moved on to become paid advocates in other areas.

In the last three years I have worked as a manager of a multi-agency children and young people's drug and alcohol service, which involved supervising professionals from organisations who had previously supervised me in a different way, such as probation services and social services. I am now a young people's commissioning manager, and I have also acted up as a DIP strategic lead for the last six months. I am currently in the process of starting my own training and consultancy business and have recently achieved two teaching qualifications to go with my Diploma in Psychotherapy and NVQ 4 in Management.

It's now 25 years since brown smokeable heroin hit the streets of England, and as I look around I still see some of the people I used heroin with standing on street corners waiting for dealers to drop off. Of course quite a few are no longer with us and I often think about them and think why. Why did so many young, intelligent, kind people have to lose their lives?

As the current drug strategy comes to an end, I hope we can continue the progress we have made in educating children and young people about drugs and alcohol. I also hope we continue to improve services for drug users – but most of all I hope we can reduce the number of deaths caused by substance misuse.

Heroin overdose (part2)

In the second of three Briefings on heroin overdose, Professor David Clark considers various ways that can be used to reduce the number of heroin overdoses and overdose deaths, and at the responsibility that we all share in trying to do this.

It is easy to hear, particularly in the prejudiced society in which we live, that the responsibility for avoiding an overdose belongs with the heroin user, particularly if we provide him or her with relevant information.

Yes, heroin users do have a responsibility to themselves, and to their families and friends, in avoiding risky behaviours that increase the likelihood of them overdosing and causing their own death or physical complications, and grief to others. They also have a responsibility in helping other users avoid an overdose, and helping ensure it is not fatal if an overdose does occur.

However, the responsibility for reducing the number of heroin overdoses is far more wide-ranging. It also involves both specialist and generalist workers in the field, family members and friends, commissioners and policy makers, and even members of the general public. How can we all contribute?

If users are to be forewarned about the potential of overdose, and the factors that increase its likelihood, then they must be provided with the correct information, rather than incorrect information through hearsay.

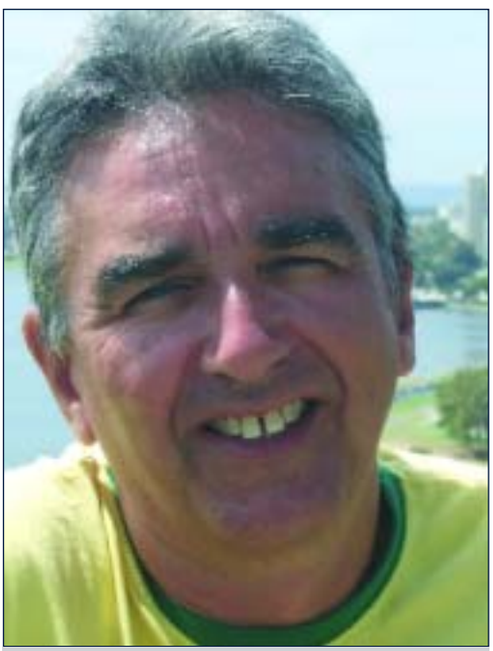
This means that governments have a responsibility to fund research, researchers to conduct and disseminate high quality research, and those involved in disseminating messages to educate themselves, be educated and trained, and get these messages right.

A number of key messages are provided to heroin users to help them avoid an accidental overdose. They are warned that they are much more likely to overdose if they inject, rather than smoke, heroin. If users are injecting, they are encouraged not to inject alone.

They are warned to monitor their tolerance to the drug, since stopping or reducing use of heroin can result in a reduced tolerance and increased likelihood of overdose. Leaving prison and entering abstinence-based treatment are times when users need to be more careful.

Users are often warned to try a small amount of their heroin first, so that they can test their own tolerance and the strength of the drug. (However, in my last Briefing, I pointed out that drug purity plays a relatively small role in heroin overdose deaths.)

Users are also warned not to use heroin and drink alcohol or take 'downers' such as valium and temazepam at the same time, since these combinations of respiratory-depressant drugs are associated with many overdose deaths.



'We know from considerable research in the health field that telling someone something helpful does not necessarily change attitudes, and changing attitudes does not necessarily change behaviour.'

Users are sometimes warned that people who die from overdose can do so two or three hours, and even longer, after taking the drug. Just because someone survives the initial hit does not mean that they are going to be all right.

Other messages need to be circulated among users (and practitioners and others) more so than they are at present. One important message is that most victims of fatal overdose are aged in their late 20s and early 30s, and have a long history of heroin dependence. It is important to emphasise to people with these characteristics that they may be at greater risk.

It is also important to get the message across that overdoses are often associated with low morphine concentrations in the brain, emphasising the importance of contributory factors other than drug purity and strength.

As discussed in the last Briefing, the physical health of the user may play an important role in accidental overdoses. Research suggests that overdose deaths may be related to systemic disease or damage to parts of the body, sometimes caused by prior overdoses. Problems can arise from pulmonary dysfunction and liver disease. The importance of continued monitoring by health professionals needs to be emphasised.

Of course, while it is important to ensure that these messages are disseminated to users, we must also realise that many users will ignore them. We know from considerable research in the health field that telling someone something helpful does not necessarily change attitudes, and changing attitudes does not necessarily change behaviour.

We are dealing with a population who often lead chaotic lifestyles, and who at times of desperation for their next 'fix' may not stop, remember, and act upon principles of prevention. A user who has unsuccessfully searched for heroin, got drunk instead, and then been offered the drug, is not likely to wait until the alcohol has left his body before taking his next fix.

A user desperate for her next fix is also unlikely to take a small amount of her batch of heroin to test its strength. She will likely inject it all in one go.

Of course, these problems do not mean that we stop providing users with important information. It just means that we need to be understanding of the reality of the situation, and more innovative in the way that we try to improve dissemination and application of preventive messages.

We must better encourage a shared responsibility or 'duty of care' for other heroin users. We must facilitate communication and support within and across drug-using networks, and improve the quality of communication between service providers and users. We must also work in a variety of other ways to reduce heroin overdoses and overdose deaths.

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2007/08

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2007 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 2007 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2007

BSc in Substance Misuse Management (Stage 3)

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

2 year (top-up of Diploma) or 4 year programme from November 2007

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

LT 104505 3/07

EXPRESSIONS OF INTEREST
DRUG REHABILITATION REQUIREMENTS in STRUCTURED DAY CARE

The Safer Wiltshire Executive would like to invite expressions of interest from Providers to tender for Drug Rehabilitation Requirements and Structured Day Care Services (either together or separately).

The Service would extend across the whole of Wiltshire (excluding Swindon) and include the district locality areas of Salisbury, Kennet, West Wiltshire and North Wiltshire. We are open to tenders for the whole of the geographical area or discrete parts.

The primary aim of the Service will be to change the drug taking behaviour of Wiltshire residents and reduce related offending leading to a reduction in the physical, psychological and social harm to individuals and the wider community. These services must be delivered in line with Models of Care (2006).

Expressions of interest must be submitted in writing or by e-mail by 12pm on 30 July 2007 to Maria Keel, Contracts Officer, Wiltshire County Council, County Hall, Trowbridge, Wiltshire BA14 8JE, email: mariakeel@wiltshire.gov.uk

Wiltshire

Improving life in Wiltshire

Borough of Poole

TACKLING DRUGS CHANGING LIVES

Expressions of Interest for the provision of Structured Day Care Services.

Expressions of interest are invited from suitably experienced and competent organisations to tender for a contract to deliver structured day programmes to adult drug and alcohol users in the Poole DAT area.

The aim is to provide structured activities or individual programmes where a combination of health, social and education rehabilitation can be provided together with purposeful social and recreational pursuits.

The budget available is in the region of £12,000 per annum. The demand for the service is reactive and dependent on the needs of the service users. The Authority can give no guarantee as to the volume of work that will be given to the Contractor during the contract period.

The expected term of the contract will be 1st January 2008 to 31st March 2011 with possible extension to 31st March 2013 subject to recurrent funding and satisfactory performance.

Closing date for Expressions of Interest is 10/8/07
PQQs will be issued week commencing 27/8/07
Closing date for PQQs is 21/9/07
Tender packs will be issued week commencing 8/10/07
Closing date for return of tenders is 2/11/07
The anticipated contract start date is 01/01/2008.

Expressions of interest should be made in writing to Sue Knifton, Joint Commissioning Officer, Poole Drug Action Team, Civic Centre, Poole, BH15 2RU or email: s.knifton@poole.gov.uk

Drug and Alcohol Service for London is an innovative agency working across London to provide a range of services to people experiencing problems with alcohol or drugs.

STRUCTURED DAY PROGRAMME CARE CO-ORDINATOR

£31,805 **35 hours per week** **Ref: 07/07**

Your background in managing and operating day programmes is sought to co-ordinate the Day Programme team. Along with raising the profile of the service, you will run 2 to 4 groups weekly, ensuring the programmes meet NTA and National Drug Treatment Monitoring System requirements. A skilled assessor of substance misuse and related problems, you understand the models of working within the substance use field and treatment outcomes.

Benefits include generous annual leave, support and access to training and development, and regular supervision.

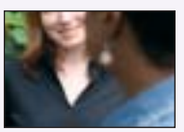
For an application pack visit www.dasl.org.uk, email jobvacancies@dasl.org.uk or call 0208 2573068 quoting reference 07/07. Closing: 5pm 30/07/07.

This post is eligible for Enhanced Disclosure by the Criminal Records Bureau. DASL is committed to the principles of equality of opportunity for all. Registered Charity 299535.

DASL

'From dependence to independence.'

WELLINGTON LODGE



Addiction counsellors and bank staff required

Candidates must be qualified counsellors and have experience in group and individual therapy within the drug and alcohol field. FDAP accreditation or proof of working towards this is essential. The candidate must be flexible to meet the needs of the client group. Salary depends upon experience.

All posts subject to Enhanced CRB and POVA checks.

Applicants that require an application form or further information please contact info@wellingtonlodge.org or telephone 020 8421 2266

Drug and Alcohol Counselling by Distance Learning Course Tutor Ref: E3330/DDN

Downloadable application forms and further particulars are available from www.le.ac.uk/personnel/jobs - Alternatively if you require a hard copy, please contact Personnel Services - tel: 0116 252 2438, fax: 0116 252 5140, email: recruitment3@le.ac.uk

Please note that CVs will only be accepted in support of a fully completed application form.

Closing Date: 31 July 2007.

University of Leicester

the core trust

The Core Trust is an innovative Tier 3 drug and alcohol treatment provider with extensive links to referral agencies throughout London. Our unique abstinent based structured day programme provides treatment for people with addiction problems.

Receptionist - £18,000 per annum - Marylebone

This central post requires an understanding of substance misuse issues and a willingness to work within a multi-disciplinary team. You will have good communication, administrative and organisational skills and be IT literate. **Closing date: 18 July 2007**

If you wish to apply, please email: mviljoen@wdp-drugs.org.uk to receive an application pack, or contact The Core Trust on: 020 7258 3031.

HM PRISON SERVICE

A vacancy has arisen for a **CARATs Manager** at HMP Leicester

£22,742 – £29,771 Pay Award Pending

As CARATs manager you will be responsible for the delivery of the CARATs service including, assessment of prisoners, 1:1 and group work interventions.

You will be responsible for: supporting Offender Rehabilitation, providing supervision to CARATs staff and coordinating their development within the DANOS competency framework, ensuring that the work of the CARATs team follows NDPDU guidelines and delivering key performance targets in relation to both the assessment of prisoners and their commencement on SDP.

You will ensure that all CARATs practises reflect the reduction of harm caused by substance use and must have a proven track record of managing staff. A Social Sciences degree / understanding of research methods or substance misuse related qualification would be advantageous.

Initial contact for application form via Cathie Bruen 0116 2283030
For further information about the post, Emma Stuart 01162283204
Closing Date for the receipt of applications is 27/7/07

The Prison Service is committed to Equal opportunities and welcomes applications regardless of gender, race, disability, sexuality or any other irrelevant factor.

DDN FDAP workshops

fdap DDN Drink and Drug News

Brief Interventions on Alcohol

23 July, London

This one-day interactive workshop will examine screening tools and short motivational interventions. This workshop is mapped to DANOS and provides vital information for all drug and alcohol workers.

The essential drug and alcohol worker

17-21 September, London

This five-day course provides a full introduction to the elements of effective drugs and alcohol work. This workshop is delivered in association with DDN and DrugScope.

All one day workshops cost: £110 + VAT per head
Five day workshop cost: £635 + VAT per head
(15% reduction for FDAP members/affiliates – rates for groups on application)

Contact Tracy Aphra
e: tracy@cjwellings.com
t: 020 7463 2085

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www.rigpahealth.org.uk

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern is the national voluntary agency on alcohol misuse, working to reduce the harm caused by alcohol and to improve services for people with alcohol problems and their families.

Training Officer – Young People and Alcohol

London, £26,277 (inc LW)

Alcohol Concern is launching a national accredited training programme for practitioners working with young people to develop their knowledge and skills to work with young people around alcohol. The training is rolling out from September 2007 across England, Scotland, Northern Ireland and Wales.

The Training Officer will be responsible for delivering the training to different regions in the UK as part of the national training programme.

You will have a sound understanding of alcohol awareness and working with young people. You will have experience of delivering training to professionals.

Job share also considered.

Closing date for applications: 12 noon Friday 3rd August 2007

For an application pack email: recruitment@alcoholconcern.org.uk
Or download a pack from our website: www.alcoholconcern.org.uk
Or call our recruitment line on: 020 7264 0516.
For an informal chat about the post please contact Hajra Mir on 020 7264 0522.

Alcohol Concern is committed to implementing a comprehensive Equal Opportunities Policy and we welcome applications from all sections of the community.

Bringing service to life

serco

Senior Practitioner

Full time (40 hours per week Mon-Fri)

Salary: £22,000 to 24,000

We are currently looking to recruit a Senior Practitioner to join our expanding CARAT (Counselling, Assessment, Referral, Advice, and Throughcare) team at HMP Lowdham Grange. This is an exciting opportunity for a self motivated, enthusiastic and resourceful individual who has significant experience of working in the substance misuse field. This role will be varied and challenging with lots of prospects and growth.

If you are interested in joining us, you will have experience of case management, have excellent assessment skills, one to one and group work skills. You will be supporting staff to deliver a quality CARAT service by promoting best practice so supervisory experience is essential.
The successful candidate must have a positive attitude towards drug rehabilitation, have high levels of motivation and commitment, excellent problems solving and communication skills. A clear understanding and experience of the CARAT process is desirable. You will be apart of a skilled, committed and multidisciplinary staff team.

If you are interested in this role, please contact us for an application pack by emailing recruitment.lg@premier-serco.com or call our recruitment hotline (24 hour answer phone) on 01159 669 346.

Serco Limited is an Equal Opportunities Employer. Selection for these posts will be on the basis of merit. The company is exempt from the Rehabilitation of Offenders Act 1974 (exceptions) Order 1975. All offers of employment are subject to Home Office Approval.

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HAMPSHIRE DAAT
Drug & Alcohol Action Team

STRUCTURED DAY PROGRAMME SERVICE

The Hampshire Drug & Alcohol Action Team are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of a therapeutic Structured Day Programme Service.

The Service will provide a range of clearly defined group based treatment and intervention programmes and activities addressing the drug misuse, physical and psychological health needs, social functioning and offending behaviour of drug users.

The programmes and activities will be delivered peripatetically across the Hampshire DAAT area in partnership with existing Community Drug Teams and the DIP Team in a planned and structured way with clear output and outcome measures.

The service will be required to commence in December 2007.

A restricted tendering procedure will be followed with the criteria for award of the contract to be:

- Business and financial standing
- Organisation's experiences of the provision of substance misuse treatment services
- Service User Involvement
- Organisational capacity & capability to deliver this Structured Day Programme Service
- Price & Best Value.

Process for application

1. Written Expressions of Interest must be received by the DAAT by **27th July 2007**
2. Upon receipt a Pre-qualification document will be sent to **ALL** interested parties to be completed & returned by **12 noon on 15th August 2007**
3. The Hampshire DAAT invites **ALL** organisations expressing an interest for this tender to attend a consultation meeting **on 1st August 2007**
4. Following assessment of the Pre qualifying document, **FIVE** organisations will be invited to tender for completion and return by **2pm on 13th September 2007.**

To register your interest please contact Richard Curtis, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL.

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working in partnership with service users

NHS

HAVE YOU THE ENERGY?
HAVE YOU THE COMMITMENT?

Inclusion Drug Alcohol Services has a reputation for quality, innovation and commitment to providing excellent drug treatment services to the Prison Service as a provider of CARAT and rehabilitation programme services. **Come and work with us.**

Rehabilitation Programmes

Group facilitator (Based at HMP Gloucester)

Part Time – 18.75 hours per week
NHS Agenda for Change Band 5, £19,166 - £24,803 (pro–rata)

Delivered in partnership with the Prison Service the Short Duration Programme (SDP) is an accredited harm reduction programme that enables adult male prisoners to make informed choices about their drug use and offending.
For an informal discussion please call Kirsten Wright (01452 453 116).

Group facilitator (Based at HM YOI Aylesbury)

37.5 hours per week
NHS Agenda for Change Band 5 £19,166 - £24,803

Prison Addressing Substance Related Offending (PASRO) is an innovative accredited drug rehabilitation programme that is being delivered at HM YOI Aylesbury for young offenders with substance misuse problems. You will have the opportunity of facilitating a drug programme which enables prisoners to make informed choices regarding their drug use and offending.
For an informal discussion please call Jo Edes O'Connor/Lisa Mann (01296 444 024).

If you are committed to harm reduction work have experience within the drugs field and/or a relevant professional qualification we would like to hear from you. Full training will be given to the right candidates

CARAT Services

CARAT Worker (Based at HMP Bronzefield – Ashford, Middx)

NHS Agenda for Change Band 5, £19,166 - £24,803 plus 5% Fringe London Weighting

Based within a private prison setting you will provide a Counselling, Assessment, Referral, Advise, Throughcare (CARAT) service for female remand prisoners or those serving custodial sentences who have drug related problems. You will have proven experience of working in the drug field.
For an informal discussion please call Louise Gallagher (01784 425 690 ext 3793).

CARAT Service Worker (HM YOI Reading)

NHS Agenda for Change Band 4 £16,405 - £19,730

We are building a waiting list for potential vacancies in the near future. *This is a training grade post* but you must be able to demonstrate experience in a closely related field and a commitment with support and training to become an effective drug worker based in a young offender's prison setting. Full training will be provided.
For an informal discussion please call Patrick McElroy (0118 908 5155).

Inclusion, as part of the NHS, offers all staff, personal development programmes; first rate support, supervision and training; final salary pension scheme and occupational health services. We are committed to achieving equality of opportunity in employment.

For an application pack for any of the above posts, please call Jan Smythe on 01785 221488 or email: Janet.Smythe@ssh-tr.nhs.uk
Closing date for return of completed applications: Monday 30th July 2007

want to join a young, dynamic, expanding team?

Due to our unprecedented growth TTP Counselling is looking to recruit the following members to its team:

2 BUSINESS DEVELOPMENT MANAGERS
Luton and North West
Salary £24k basic OTE £36K
Developing business relationships with both statutory and GP referrers. 2 years + working within the substance misuse field and familiar with DAT/DIP referral pathways and purchasing of Tier 4 services. Knowledge of the 12 step programme of recovery is preferred but not essential.

MANAGER, DETOX FACILITY
Surrey
Salary £30k to 35k
Responsible for running the TTP detox facility in Surrey. You will lead the nursing team and ensure that residents receive a high quality service in a safe environment. The following competencies are required:

- Leadership and Management
- Financial management
- Appropriate level nursing qualifications
- Professional nursing expertise working with substance misuse clients
- Able to communicate to various audiences, written and oral
- Facilities management

MANAGER, COUNSELLING SERVICES
North West (Wigan)
Salary £30k to £35k
Experienced Service Manager required for our new 80 bed centre in the North West (opens January 2008). **Must have direct personal experience of the 12 step programme** of recovery and managing a team of counsellors. You must be trained to a minimum of diploma level and have 3 year managerial experience.

10 COUNSELLORS
Luton and North West
Salary £14k to 24k
If you are qualified, in training or wish to train, to a minimum of diploma level and **have personal/professional experience of the 12 step recovery programme**, we want to hear from you.

Please email your CV, with covering letter, to
Gavin Cooper – recruit@ttpcc.org

ttp counselling

alcohol and drug rehab

www.ttpcc.org