DDN
Drink and Drugs News

17 November 2008
www.drinkanddrugs.net

SHARING THE STAGE
Putting clients on the stage and screen in Liverpool

HITTING THE BOTTLE
Health, criminal justice and industry sectors debate alcohol

FREE TO RECOVER
Prisons need a culture change to escape low expectations

SOMEONE ELSE'S SHOES
Service users take feedback one step further

Your fortnightly magazine | jobs | news | views | research

VOICES FOR CHOICES

The second national service user conference

One day, one place, one voice

Policymakers, DAATs, treatment providers and service users working together to bring about meaningful service user involvement.

FULL PROGRAMME

now available online

Book online at www.drinkanddrugs.net
Email ian@cjwellings.com Telephone 020 7463 2081

DDN Drink and Drug News

29 January 2009

Holiday Inn, Birmingham

The Alliance

DDN
Drink and Drugs News

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

Editor: Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Advertising Sales:
Faye Liddle
t: 020 7463 2205
e: faye@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
Charlotte Middleton
t: 020 7463 2085
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover : Apartment

DDN is an independent publication, entirely funded by advertising.

PUBLISHERS:

CJ Wellings

PARTNER ORGANISATIONS:

fdap
Federation of Drug and Alcohol Professionals

wired in

SUPPORTING ORGANISATIONS:

Adfam
Alcohol Concern
The Alliance
ANSA
drugs and alcohol today
EATA
European Association for the Treatment of Addiction
THE FEDERATION
UDCN
Mentor
RELEASE
SMMGP

Editorial - Claire Brown

Learning to listen

An active user group can be the sounding board you need

The phone rings just as you're rushing out the door to see a client. You hesitate to answer it because you don't want to be late – you're already having to scoff your sandwich as you run. But you're supposed to answer calls within four rings, so you pick up the phone and resolve to get rid of the caller as soon as possible.

On the other end of the phone, John has finally decided today's the day – after almost dialling the number every day for weeks, he's decided to go for it. He's been feeling worse every day, he feels he's got nothing left to live for, he might as well see if anyone can help him out of this mess. His call's put through: he gets you. You sound cross, you try to hurry him up a bit... why is he taking so long to spit it out? He starts to ramble. You tell him you're in a bit of a rush – can he explain a bit faster or call back another time?

John puts the phone down and decides he's never going to call back. You rush off and don't give it another thought, apart from a moment's aggravation at being delayed. In your attempt to do the right thing – answer the phone, keep your appointment, fit everything in – you've completely forgotten there's a vulnerable person at the centre of this; someone who only contacted you because they really needed you. It's not particularly your fault is it? You've been doing this job for years, you have targets that you haven't time to meet and too much paperwork...

Greenwich service users carried out a mystery shopper exercise, an initiative suggested by their commissioner and backed by their DAAT (see page 6). They unearthed experiences that made them realise some of their services needed a wake-up call – so that's what they gave them. It speaks volumes for effective service user involvement that the service givers can also take it, when the need arises.

This issue


Page 8


Page 14

News in Brief

Inherited addiction?

People addicted to cocaine are 25 per cent more likely to carry a specific gene variant than the general population, according to research led by professor of psychopharmacology at the Central Institute of Mental Health in Mannheim, Germany, Rainer Spanagel. His research team linked a version of the CAMK4 gene with cocaine addiction following experiments with mice.

Education, education, education

The Drug Education Practitioners Forum (DEPF), the membership body for professionals involved in drug education, is to meet this week to discuss the findings of the government's review of drug education and its decision to make Personal, Social and Health Education (PSHE) compulsory in schools (*DDN*, 3 November, page 4). The Department for Children, Schools and Families (DCSF) has also agreed to fund the forum for three years, meaning membership is now free. 'This is an exciting time in the development of drug education,' said DEPF chair Jenny McWhirter. 'We're determined that the DEPF will grow and continue to provide drug education practitioners, many of whom work in isolation, with an opportunity to discuss their work with young people and have a collective voice at national policy level.' For information on joining contact *depf@drugscope.org.uk*

Voice your opinions

Members of the public are invited to the Advisory Council on the Misuse of Drugs' (ACMD) third open meeting, to be held on 25 November in London. Those attending will be able to have their say and take part in a question and answer session. Attendance is free but by registration only, with places allocated on a first come, first served basis. Form available at *drugs.homeoffice.gov.uk/drugs-laws/acmd/*

HK's 'K hole'

Ketamine is now the most widely misused drug in Hong Kong, and is gaining popularity across southern China, according The United Nations Office on Drugs and Crime (UNODC). The drug is also being widely used in developing countries, says UNODC, but the fact that it is not a controlled substance made gauging the true extent of use difficult.

'Fast track' help for 20 worst problem alcohol areas

The Department of Health is to target 20 areas in an attempt to 'fast track' help to those places worst affected by alcohol misuse, public health minister Dawn Primarolo has announced.

The £6m Alcohol Improvement Programme will include increased access to specialist treatment as well as establishing regional alcohol managers who will co-ordinate action and pull together local information on hospital admissions and medical conditions to help with commissioning.

There will also be a new Alcohol Learning Centre and support activities, backed by a further £1m, and extensive sharing of best practice so that 'other local services can learn from the programme,' says the government. The 20 targeted PCT areas include Middlesbrough, Warrington, Leigh and Wigan, Newham, Bolton, Blackpool, Oldham and North Tyneside.

'More than a quarter of adults in England drink above government guidelines and around 15,000 people die because of alcohol every year,' said Dawn Primarolo. 'We clearly have a serious problem that needs urgent attention. Starting with the most deprived areas in inequality hotspots we are going to roll out a new programme which will identify and help drinkers who are at risk.'

The announcement has been welcomed by Alcohol Concern who say that problem drinkers have up to now faced a 'postcode lottery' for access to services. 'This new injection of cash is most welcome for the areas worst affected by alcohol misuse and all areas will benefit from improved information and guidance,' said chief executive Don Shenker. 'Slowly but surely local areas are now being provided with the tools they need to invest in alcohol treatment – the challenge will be for them to convert this into services on the ground for those who need it most.'

Meanwhile a committee of MPs led by Leicester East MP Keith Vaz has called for a ban on both happy hour promotions and supermarkets selling alcohol below cost price as a 'loss leader', adding to growing pressure to make voluntary codes of conduct for the drinks industry legally enforceable.

See feature on Alcohol – the debate, this issue page 12.

Aberdeen clubbers 'itemised' for drugs

More than 750 people were tested by a portable drug detection machine when entering clubs and bars in Aberdeen earlier this month.

Called the 'Itemiser', the device allows police or door staff to swab someone's hands and instantly check for traces of illegal drugs – the machine can detect traces of cocaine, cannabis, ecstasy and heroin, among others.

The equipment was used at nine premises – both pubs and clubs – over the course of one weekend, with 13 people searched 'in relation to suspected misuse of drugs offences' and two arrested. No one refused to co-operate, say Grampian Police, who claim the device 'provides reassurance to regular pub and club goers.' All the licensed premises taking part in the pilot did so voluntarily, say the police.

The project was the last part of the force's weekend anti-social behaviour initiative, Operation Oak, and also involved Aberdeen Alcohol and Drug Action Team, the Scottish Crime and Drug Enforcement Agency (SCDEA), NHS Grampian and the city council's licensing board.

'The feedback from the public and licensees during the weekend has been consistently positive, supported by the fact that nobody refused to co-operate,' said the operation's co-ordinator Inspector George Macdonald. 'We will undoubtedly repeat this initiative, working in tandem with the Scottish Crime and Drug Enforcement Agency, and indeed other partners, in the future to target the minority whose behaviour causes problems.'

Home Office extends arrest referral schemes

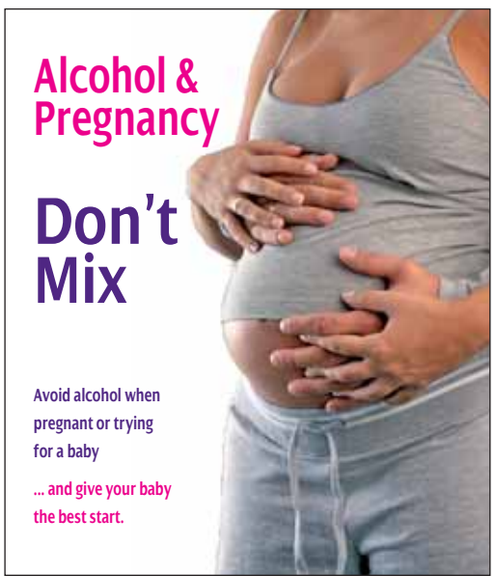
Nine new pilot arrest referral schemes for alcohol-related offences have been announced by the Home Office.

Under the project, people arrested for alcohol-related offences will be referred to alcohol specialists for assessment of their drinking behaviour and risks to their health, and given advice on cutting their consumption. An extra £1m is to be made available to police and DATs to implement the schemes.

The pilots in Stoke on Trent, Cumbria, Islington, Northamptonshire, Bristol, Cleveland, Swindon, Rutland and north-east Lincolnshire follow existing referral projects in Liverpool, Manchester, Ealing and Cheshire. If police feel alcohol played a part in the offence committed, the offender will be referred for either one or two assessment sessions. When complex alcohol problems are identified and the offender is given a conditional caution they can be then referred to more in-depth alcohol advice sessions – failure to attend could result in prosecution for the original offence, says the Home Office.

Re-offending rates in the areas will be studied closely, says the government, and if successful the schemes will be extended until 2010. Perhaps mindful of media reaction, the Home Office has been at pains to point out that the referral sessions are not an 'easy option'. 'They aim to cut re-offending and so make our towns and city centres more pleasant places by making offenders realise their mistakes,' said Home Office minister Alan Campbell.

'The importance of early intervention to break persistent offenders out of the cycle of drink-fuelled offending cannot be overstated,' said the Association of Chief Police Officers' (ACPO) lead chief constable for alcohol licensing, Mike Craik. 'This trial will be an important step in terms of crime prevention and the compulsory attendance of offenders will, I am sure, maximise our chances of making a real difference.'



Pregnant cause: a new campaign to encourage women to avoid all alcohol while pregnant has been launched by Alcohol Focus Scotland. A series of posters and leaflets will target pregnant women and those trying for a baby, as well as people who might encourage them to have a drink. 'We are concerned that women have been given conflicting advice about whether or not drinking alcohol during pregnancy will cause harm to their developing baby,' says the charity. 'No alcohol is the best and safest choice.' A new study by researchers at University College London a fortnight ago suggested that a pregnant woman's occasional light drinking did not pose risk of behavioural problems in the baby, but these findings have not changed government advice to expectant mothers to avoid alcohol altogether.

Drug seizures up

The number of drug seizures by police and customs officers rose by 15 per cent to just over 186,000 in 2006/07, compared with 2005, according to the Home Office.

Seizures of Class A drugs were up by 10 per cent since 2005 to more than 42,000, while seizures of Class B and C drugs were up by 15 and 20 per cent respectively.

Of the Class A seizures, more than 16,000 were of cocaine – an increase of 35 per cent since 2005 – while heroin seizures were down by 1 per cent to just over 13,200. Overall, seizures have gone up by 73 per cent since 2004, although this is largely accounted for by an increase in the number of cannabis seizures, thought to coincide with the introduction of cannabis warnings. In 2006/07, there were more than 80,000 formal cannabis warnings – which can be completed on the street – compared to just over 23,000 cautions, which have to be processed at a police station.

The statistics cover seizures made by police, including British Transport Police, and HM Revenue and Customs, but not those made by the Serious and Organised Crime Agency (SOCA). A single seizure is counted as one drug quantity of a single type – a seizure of more than one type of drug is counted as a single seizure in the total number of seizures, but separately against each drug type or class.

The Home Office has also published a summary of research into the national and regional prevalence of opiate and crack cocaine use. The number of problem drug users had remained roughly stable for the last three years, it says, while prevalence of injecting had decreased. London, followed by the north west, was the region with the highest estimated prevalence for problem drug use, while the north west had the highest estimated opiate use.

Seizure statistics available at *www.homeoffice.gov.uk/rds/pdfs08/hosb1208.pdf*.

Drug prevalence report available at *www.homeoffice.gov.uk/rds/pdfs08/horr09.pdf*

Heroin situation 'not improving' says EMCDDA

Opioids remain 'at the heart of Europe's drug phenomenon' according to the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) 2008 annual report.

There are up to 1.7m problem opioid users in the EU and Norway, and heroin is responsible for the majority of drug-related health and social costs, it says. The agency has called into question its previous assessments that the situation might be improving (*DDN*, December 2007, page 4), based on new data and the record Afghan opium harvest.

While cannabis is still Europe's most commonly consumed illicit drug, the report says there are 'strong signals' of its waning popularity, with national survey data on cannabis use within the last year among the 15-34 age group showing a stabilisation or decline in most countries. Stimulants remain Europe's second most commonly consumed drugs after cannabis – use of amphetamines and ecstasy show a 'stabilising or even declining' trend, it says, while cocaine use continues to rise in a number of countries including the UK, Spain, Italy, Ireland and Denmark.

The EMCDDA estimates that around a quarter of the cocaine trafficked into Europe now comes from west Africa, and that the increase in trafficking via this route has contributed to the growth of the Iberian Peninsula as a key entry point – 41 per cent of the cocaine seized entering Europe in 2006 was intercepted in Spain and 28 per cent in Portugal. Amphetamines, however, 'retain a strong foothold as the prevailing stimulant' in central, eastern and northern member states, particularly those joining the EU since 2004, says the agency.

'Although drug use levels remain historically high, we appear to be entering a more stable phase,' said EMCDDA director Wolfgang Götz. 'Overall, for most forms of consumption, we are not seeing major increases and, in some areas, trends appear to be downwards. While it is important to acknowledge these positive developments, we must also remember that the dynamic nature of the drug problem presents us with ongoing concerns and future challenges.'

Regarding heroin, evidence did not point to the 'epidemic growth' seen in much of Europe in the 1990s, he said. 'Nonetheless, we cannot ignore the threat posed by the glut of heroin on the world market.' In most EU countries, opioids accounted for between 50 and 80 per cent of all treatment demands, and drug overdoses were one of the leading causes of death for young Europeans. 'Reducing drug related deaths is an explicit goal of most national drug strategies but our actions are yet to match our words,' he said. 'We must prioritise overdose prevention measures and target high risk groups, such as those leaving prison or relapsing after treatment.'

Report available at *www.emcdda.europa.eu/events/2008/annual-report*

News in Brief

Common cause

Charities DrugScope, Mind, Homeless Link and Clinks have joined together to promote the needs of service users with complex needs who don't easily fit into conventional treatment patterns. The partnership of organisations will stage an event, *Making Every Adult Matter*, to try and drive forward positive developments in policy and practice. The event will look at the main barriers clients face when accessing services, what is working and what isn't and the relationship between national policy initiatives and what happens on the ground, and marks the beginning of the charities' work to promote a common language between their sectors. Speakers will include BBC home affairs editor Mark Easton. To attend visit *www.homeless.org.uk* or call 020 7960 3032.

Green shoots

The Department of Work and Pensions (DWP) has published a summary of responses to its *Helping people achieve their full potential: improving specialist disability employment services* consultation, the 'strong support' for which, it says, led to the welfare reform Green Paper *No one written off*. A number of the Green Paper's proposals relating to service users and benefits were seen by many in the drugs field as unworkable and discriminatory (*DDN*, 3 November, page 4). Available at *www.dwp.gov.uk/resourcecentre/des-consultation-paper.asp*

Popular vote

New facilities for Open Road's drug and alcohol treatment centre in Clacton have been formally opened by shadow energy secretary Greg Clark – who formerly held the brief for charities and volunteering – and local MP Douglas Carswell, following the charity securing grants from the Big Lottery Fund and ITV Anglia's People's Millions, where it received more than 2,300 votes. 'We are absolutely delighted that so many local people supported our appeal to provide extra facilities and develop our work at the Clacton centre,' said chief executive Sarah Chambers. 'We will be able to get more people into treatment, and combat their drug and alcohol addictions. We now have a vastly improved environment for all our clients, staff, volunteers and visiting professional staff.'

In the shoes of a service user

Greenwich service users have taken their feedback to services a step further – by encouraging them to swap experiences. DDN reports

When his commissioner suggested a mystery shopper exercise to evaluate drug and alcohol services, Manjit Singh Johal took the idea back to his panel of expertise: the service user group. Since he came to Greenwich DAAT as user and carer involvement coordinator last year, Greenwich Local Addiction Support Service – otherwise known as GLASS – has gone from strength to strength, according to Terrie, Ashley and David, who have each drawn considerable strength from being involved with the group.

From peer support and friendship to practical training sponsored by their DAAT, the group has helped them put their substance using past into perspective, and helped them cope with repercussions that have affected their families' lives as well as their own. It was, they say, natural that they would want to be involved in the latest initiative to improve local services.

Tackling the mystery shopper exercise meant calling on help from six service users from another borough who weren't recognised in local services, explains Manjit. He developed a role play template with his commissioner, 'which broke down into six or seven scenarios, such as female, single parent, injecting crack and heroin and speedballing'. The neighbouring service users made calls with a check list of prompts; they made sure they found out who they were talking to, what interventions they were being offered, whether they were being referred, and any information being sent out to them.

Collating the information from this exercise brought GLASS members together to scrutinise the experience someone might have if they were trying to access services in Greenwich for the first time. 'There was a pattern of not being referred to other services,' explains Manjit. 'The provider often did not have the knowledge to pass on, and wouldn't be giving information that was relevant to that person's needs. We also found one of the services was not referring to a

carers' group, so we knew there was a communications gap.'

GLASS members were not only disturbed to learn of the results; they were determined to change the situation and suggested developing a training package for local service providers. With the support of the commissioner, Manjit was given the go-ahead to bring in a consultant to give the service user group a 'train the trainers' course. It felt like a big step, participants say now: they were preparing to train frontline staff including team leaders and admin staff and needed the confidence to impart their knowledge with authority. They emerged from their training and developed their own training package, calling it 'In the shoes of a service user'.

All they needed now was for services to participate, and that's where the commissioner came in again, says Manjit, by sending an email to services saying they were required to send a staff member. As an unexpected and 'really powerful' bonus, they also had two GPs and two psychologists turn up as well. For a month, the 36 participants came for four three-hour sessions, every Friday, with only four frontline professionals not turning up. 'We delivered it and evaluated it, and the feedback was very positive,' says Manjit.

Terrie, Ashley and David were part of GLASS's core team of service user trainers on the day, and are the first to admit that the exercise was initially nerve-wracking. 'The three of us sat down to work out the programme,' explains Terrie. 'We had to plan three hours, which needed to include check-ins and breaks so people wouldn't get bored. It was difficult because we hadn't done this before.'

The programme would involve group exercises to give service providers insight to service users' experiences, they decided. But first things first, they wanted to connect with their audience. After their introduction, they did a 'check-in' to find out how people felt about attending the training. 'We thought people might have felt they'd been forced to come – and some did!,' says Terrie.

Then came Ashley's 'ice-breakers', where she passed M&M sweets around the room and asked everyone to pick a colour, 'or two or three colours if they wanted. When we got to the end we asked, "what does that colour mean to you, what does it represent about yourself?

'People came out with some really deep thoughts,' she says. 'I wasn't sure how it was going to work out, and whether they'd say yellow was the sun. But a lot of them talked about themselves.'

For each of the three, the exercise went beyond an ice-breaker for the training. It was vital reassurance that service providers were willing to participate in the training in the spirit it was intended. Manjit was on hand as DAAT representative to intervene if anyone reacted badly to the training, but he relaxed as the ice-breakers did their trick. 'It made us become one, not "us and them",' according to Terrie. David adds: 'I felt I was going to be judged in some way, as a service user. But it never ended up that way – we actually used the service providers as clients.'

With the traditional boundaries dismantled, the GLASS trainers got on with their main business of the day, and introduced a role playing exercise based on the mystery shopping. Service providers became service users, and the service user trainers took the role of providers, to give them a taste of the varied reception they might experience during their first phone call.

'Within the role play I might have an attitude, or be nice, I could have information, or I could just be really arrogant,' explains Ashley. 'And they really saw how some service users felt.' The experience was just as intense for them as trainers, she adds: 'When I phoned first wanting to get into treatment I was lucky. People were really nice on the end of the phone and I got into treatment quite quickly.' But doing the mystery shopper gave her a taste of unlucky experience. If she'd had an experience like those she found herself role-playing, she'd have put the phone down, she says.

Being in the service user's shoes for a day also meant the providers having to think about how they would be feeling before that vital first phone call, how they would react to being spoken to in certain ways during the call, and how would they feel afterwards, depending on how they'd been spoken to and the information they'd been given. They fed back words to Ashley, who scrawled them on a board. Out came the feedback, 'nervous, scared' beforehand, then 'ashamed, judged, belittled, nervous' during the call, then 'thankful, angry or disappointed' afterwards.

It was enough feedback to prompt the team to give out some tips. The mystery shopper exercise had shown the need to highlight some fundamental basics, particularly where phone etiquette was concerned. 'Think before you answer your phone and be aware of your responsibilities to prospective clients', the team advised. 'And try to get the person inside your service – talk face to face and make it real.'

'If you're due to be with a client in two minutes, don't answer the phone, as it's going to give the person on the other end of the line a big disappointment,' says David. 'Let them phone back when you can give your full attention.' Terrie adds: 'We realised that that first phonecall, that first contact, can determine if that person goes into treatment or not. With a lot of services we spoke to on the mystery shopper exercise, we found all they were interested in was your name, your phone number, your address, children… just one question after another. We know these questions have to be answered, but talk to the person, get them in first.'

'Find out how the person on the phone is feeling,' she adds. 'Give them some information. You might not be able to see them for a week, but you can say here are some numbers, here are some drop-ins you can go to. If someone comes off the phone and you haven't given them this information they're going to say "you know what, f' this, I'm gonna use". It does take so much for someone to pick up the phone and talk to a stranger.'

'A lot of people were quite complacent, answering the phone the way they had for years,' says David. The team suggested ways of revitalising the necessary procedures; services could make more use of volunteers, asking them to go through the initial forms with new service users to encourage them to connect at the early stages.

Buoyed by the positive response from the service providers, the GLASS team now wants to extend its reach to other professionals that have vital contact with drug and alcohol users. They want to reach staff working in housing, the DSS, doctors' receptionists and social services – those who are a first contact point – to help them step back before reacting negatively; 'not to take abuse, but to just step back and think how much it took for them to step in the door and ask for help'.

Ashley, in particular, says she is 'very passionate about social services, and really believe[s] they need to come in on this training', particularly to help them support carers. Her own mother struggled to care for Ashley's children while Ashley sought help, and because she had her own house, did not get support of any kind. 'There was some naivety within social services that needs to be updated,' Ashley believes.

'I've been around people who've been to court, lost their children and that's it, there's no other contact' adds Terrie. 'If your child's adopted you're not given information on where your child is, or what you have to do to get a letter from them. There's nothing, you're just left in the dark.'

Being left in the dark will no longer be an option if the Greenwich service users have their way. Terrie is bringing her experience from Kensington and Chelsea to open a Saturday Project, 'getting people off the streets and offering washing facilities, food and hot drinks, tv and internet connections… and knowledge on where they can be referred.'

Ashley and David have been getting feedback from service users on their transition from a decommissioned service to its replacement – a situation that traditionally poses a high risk of drop out – to make sure their concerns are taken notice of.

Manjit highlights a publicity campaign to reach carers, which leads them to a support group facilitated by Adfam. There's also a new harm reduction campaign, where 12 service users have been trained to give overdose and harm reduction information to service users in the community, including how to use naloxone injections for overdose. Five thousand 'survival keyrings' are to be distributed, giving clear and concise information on local services, such as needle exchanges, as well as harm reduction advice.

Alongside the new initiatives they are so keen about, each member of the GLASS team is keen to stress how much DAAT and commissioner support has galvanised their own personal development. Terrie says the group has given her 'strength, confidence, values and trust'. It has opened doors for David, giving him training and knowledge and leading him to do voluntary work in an alcohol detox ward. Ashley has just secured her placement as an independent advocate with an aftercare service.

Each member is using the training they been offered to the full. Their motivating ambition is to now be able to give others the same chance – however many barriers they have to break down along the way. **DDN**

Sharing the stage

Liverpool's Park View Project not only aims to set up its clients for life back in the community – it's also putting them on stage and screen.

David Gilliver reports

'I was in recovery from the early 90s. At that time there were three NA meetings and no rehab in the whole of Liverpool,' says director of Liverpool-based Park View Project, Carl Edwards. 'There was no genuinely drug and alcohol free environment at all – there were around 850 hostel beds available, but nothing drug and alcohol free with a programme running.' The city now has 18 NA meetings, many of which are serviced by ex-Park View residents. 'Liverpool now has an indigenous recovery community,' he says.

Park View is a residential 12 step abstinence-based project launched in 2003, where all the key workers and frontline staff are in recovery themselves. 'The admin staff, the cook and handyman aren't,' says Carl. 'All the rest are.'

It's this shared experience that means that, for many clients, Park View has succeeded where other services have failed. 'It makes a big difference that the staff have had the same experiences,' says Robbie, now into his twelfth week at the project. 'I've had 24 years of active addiction and came here straight from prison. It's like a big family – a safe environment to find out who you are, because in addiction you don't know who you are.'

The first phase of treatment lasts 12-18 weeks and is split into in two parts, followed by a second phase nearby and then aftercare. Park View provides a range of activities to offset the intensity of the therapeutic work including football tournaments, complementary therapies, yoga, swimming and running, but has now gone a very significant step further than most in setting up its own film, theatre and media production company, Genie in the Gutter.

Park View had already been providing drama classes for its residents and had good contacts with Liverpool's Everyman Theatre through taking clients to see its productions, and this eventually led to the theatre's actors visiting Park View to do workshops with clients. 'The Everyman has a remit to reach hard to reach groups, but this hasn't just been a box ticker,' says Carl. 'The workshops have created a real bond with the actors and are such a buzz for the clients – it's given them an insight into the fact that people who seem to have it all together have got their own problems and vulnerabilities. That's important for our clients to know – they see that these people on the stage are just ordinary people who've worked really hard and developed skills.'

Genie in the Gutter will formally launch at the end of this month at the Everyman, but has already been commissioned by Liverpool DAAT to produce an advocacy film that has been distributed to agencies and prisons across the North West, and has also produced a show for online channel Inexcess TV.

A registered charity with the aim of offering media opportunities to substance misusers, the company will be doing active outreach work with those still in addiction, not just abstinent Park View clients, and is actively bidding for funding from bodies like Northwest Vision and Media, the Arts Council and Virgin Media Shorts. 'We've got funding for the next three years but it doesn't stretch a long way so we're definitely looking at other funding streams,' says project manager Carolyn Edwards. Neither does it intend to limit itself to work about drugs or alcohol. 'We don't want it to all be about drugs – if someone wants us to do their wedding video that's fine,' she says. 'As long as service users in recovery are helping in front of the camera or behind it.'

Along with the Everyman, the company already has strong links with the Playhouse Theatre and the Liverpool Actors Studio, with acting workshops with service users taking place around every six weeks, and is a member of the Everyman and Playhouse Community Forum. Actress Pauline Daniels, from the stage show 'Shirley Valentine' has had a long-standing involvement in the workshops and will be acting alongside service users at the launch. 'I just approached her and told her about Genie in the Gutter and she was really keen to get on board, which was a real boost for us,' says Carolyn.

Genie has also arranged for clients to exhibit their artwork at local galleries and theatres and will be launching a magazine, *The Word*, to raise awareness of recovery issues as well as covering more general cultural and lifestyle issues. 'All the projects will be service user-led,' says Carolyn. 'Service users were involved in the making of the film, they did all the interviews for the magazine as well as the art and the photography. We've also sent clients on accredited production training, and a group of them have just completed a stage and set design course.'

'It's definitely the place to be... It teaches you something else. It's not just about putting the drugs down – it teaches you who you are. You get to know other recovering addicts and you have a network of non-using friends. And you're not rushed here – you can take longer.'

The company has started work on a play written by Carl Edwards, and rehearsals are being staged with Park View clients as a work in progress. A recent performance was put on in front of an audience of 90, made up of clients, staff, family members and probation officers among others. 'It was people who've never been on the stage before, some of them just out of prison,' she says. 'I couldn't believe it – they really raised the bar. They got a standing ovation.'

The aim is to stage the play at the Everyman next May, using a mixture of clients and paid professionals, before taking it on a tour of hostels. 'I'm really keen to get a production where the people in it are professionals as well as people in recovery and the audience won't be able to tell – it's quite an ambitious project,' says Carolyn. 'The hope is that the actors' skills will rub off and people won't know the difference.'

'You'd be surprised what you can achieve when you're not using,' says cast member Ellen, who is 11 weeks into the primary stage at Park View. 'I love doing the play. I'd been using for 26 years – I'd never had a period of abstinence before, never knew anything about it, but they just understood me here. I've used all the other services, but here they taught me how to get clean. It's all about the support.'

But it's obviously not all about working in the arts. Many of Park View's residents have gone on to work in the treatment sector, with 19 ex-clients now working in the field in and around Liverpool. 'We've had some real stars,' says Carolyn. 'One guy is managing probably one of the most difficult services on Merseyside, and we actually employ five of our very first residents here now. It's tangible evidence that there's a life after drugs and offers that kinship and bond that a probation officer or drugs worker who's not in recovery doesn't have. But they obviously need the right training and support and length of time being clean – it's not just a case of they're clean so they can do the job.'

Liverpool is estimated to have around 8,000 heroin and crack cocaine users, with half of the city's injecting drug users thought to be infected with hepatitis C. 'There was no provision of its kind in the whole of Liverpool before we launched – a structured regime with a completely drug and alcohol-free environment,' says Carolyn. 'If you wanted rehab, you had to go out of Liverpool. That suited some people but for others it was a real disincentive to taking the first step.'

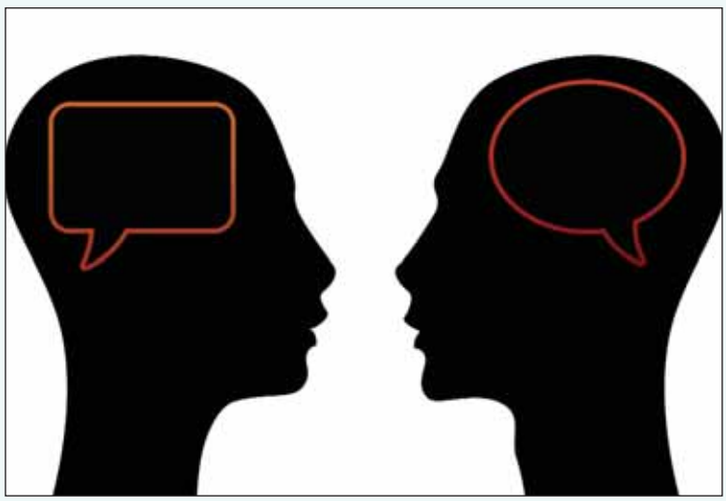
The project now has 16 staff, including nine key workers, and handles a substantial amount of criminal justice referrals, working closely with CARAT teams from across the North West. Places are paid for by Liverpool DAAT and Supporting People on a block contract, which helps speed up rates of admittance. 'We can take a call or referral, book an assessment, and admit someone in the same day,' says Carolyn. 'With someone who's chaotic or scripted there usually isn't a great incentive for them because they know it could take months – that's if there's a bed available and funding.'

The project's resettlement officer helps set up clients to live independently in the community at the end of treatment, placing them in suitable council or registered social landlord accommodation as long as they complete the programme and remain clean, and the project also works closely with Jobcentre Plus to find employment and training. 'Once you're out you're not forgotten about,' says Paul, another client who came straight from prison. 'There's help with housing, financing, budgeting, bills and a lot of aftercare.'

'It's definitely the place to be,' says Ellen. 'It teaches you something else. It's not just about putting the drugs down – it teaches you who you are. You get to know other recovering addicts and you have a network of non-using friends. And you're not rushed here – you can take longer.' Ellen had already had one go at recovery at Park View but eventually relapsed. 'It wasn't my time,' she says.

'I didn't know there was any way out – I was introduced to NA in prison but I didn't think I'd be strong enough to do it in the community,' says Paul. 'I'm 46 – I've had enough of that life. It's great to see people getting their lives back, seeing the progression of people as they come in – people who have only detoxed just before coming in, people who are withdrawing and really unsure of themselves. The thing is, we've been suppressing things for so long we don't know what we're feeling, so it's about discovering ourselves.'

Some names have been changed.



'The main issue for most drug and alcohol professionals is working within the framework that they operate – even if many of them would like to open up the ''great debate'' on prohibition and drug legislation.'

Credit where credit's due

It was with great interest that I read Danny Kushlick's article, 'In pursuit of truth' (*DDN*, 6 October, page 12).

While I agree with much Mr Kushlick says, I am concerned with the implications in his piece regarding the perceived apathy of the drug field. During my time working in substance misuse I have been privileged to witness a hotbed of debate on international drug and alcohol policy by some very educated and informed people.

While I applaud Mr Kushlick's argument that one of the most informed groups of individuals dealing with this issue should stand up and be counted, I do not understand how he wishes this to be achieved. I am sure Mr Kushlick does not wish to imply that this is through some complicit desire of the drug and alcohol field to continue the industry in which they work, but I am worried this could be the way it is construed.

The main issue for most drug and alcohol professionals is working within the framework that they operate – even if many of them would like to open up the 'great debate' on prohibition and drug legislation. While this discussion may be something that many clients are willing to engage in, the job regards dealing with their immediate and practical health.

In practice, this treatment may concern harm reduction measures to the local community, and I realise that 'safe injecting rooms and heroin prescribing will not help the plight of Afghan and Colombian opium and coca growers'. However I do not understand how Mr Kushlick suggests we turn this profession from one with the aim of helping people in immediate need, to a campaigning and lobbying group for worldwide drug policy change.

While I support Mr Kushlick's work against the war on drugs, and to end the culture of prohibition, I hope he is not placing undue and unfair expectations on the drug treatment field by expecting them to openly campaign for this. His very well thought out article was food for thought for every reader; however I do not wish for any more pressure on this already overworked and caring field.

Simon, by email

Hearts for Life!

I was am extremely touched and impressed to read 'Catching them young' by Dr Chris Ford (*DDN*, 3 November, page 10).

General practice is the place to work with young people and Dr Ford once again showed her understanding and total commitment to supporting us addicts. There were young people of 15 and 16 years of age seeking support and help to overcome their addiction, and that amazed me. As the years go on the age that people are seeking support seems to become lower and lower.

I am 48 years of age and came into recovery way back in 2001. I am now just over three years clean from my drugs of choice, yet over the past seven years I have seen the age decrease for those seeking support, whether this is with AA, NA, drop-in centres and counselling, or rehabs. 'Catching them young' gives so much more chance of supporting individuals before their lives are unmanageable. My ex-counsellor recently had funding to go to a general practice surgery in the week, and had a room where the GPs referred adults aged from 30 to 50 to her, who had drink and drug issues they wished to address. This was highly successful and popular and in most cases the individuals could safely address their addiction before their lives became unmanageable, they had break downs with marriages and relationships, lost jobs and homes and ended up with the DAT or CMHTs or in the courts. The practice was, to put it mildly, very upset to see the funding run dry.

Yet for Dr Chris Ford to catch individuals even at a younger age is to my way of thinking totally logical – nip it in the bud before the illness escalates. I have noticed over the years since 2001 there is more awareness for the country as a whole, whether in the private or public sector, about the ever-increasing level of addiction to the younger generation.

Yet with magazines like *DDN* and sites like Daily Dose and Wired In, and many others in the country, maybe both sectors together with GP surgeries can look at the logic of supporting the younger age group far more than is currently available.

Well done Dr Chris Ford, you are a true asset to your practice.

Sean Rendell,
volunteer recovery advocate
www.wiredin.org.uk

Get yourself connected

I enjoyed reading your article 'Bear Necessities' (DDN, 3 November, page 11) about the Coventry and Warwickshire newsletter. It is great they have such an active and vibrant sounding way of communicating between service users and services across their region and I'd like to do something similar with our (somewhat stagnant) group. I would be very interested to find out more about other service user groups and their publications – is it possible to access a directory of the different groups around the country and the work they are doing?

Sarah, by email

DDN's Ian Ralph replies:

As you may know we take an active interest in working with service user groups (we are of course joint hosting the National Service User Involvement conference on 29 January 2009!) and our service user group fact files (published in DDN and available at www.drinkanddrugs.net) give a snapshot of the different groups and their activities.

We are currently compiling a comprehensive Service User Group directory that will be a free resource available on our website and which will include contact details for the groups, and information about them.

To help with this I would be very grateful if service user groups could contact me as soon as possible to ensure that I have an accurate entry for them.

Please email me at ian@cjwellings.com or call 020 7463 2081.

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity.

Comment

Pride in prejudice?

Looking at his local drug treatment options brings David Wright to just one conclusion – that the system is modelled around prejudice

TREATMENT FOR DRUG USERS IN WALES is in a mess. In England they have got their waiting lists down to NTA targets of around four weeks, but in South Wales where I live it is a different story. In Cardiff, the capital of Wales, we have an 18-month waiting list – and OK, it can be argued it is the major city so it attracts outsiders, which again in turn creates more people. But this cannot be said in other areas of South Wales.

As a humble service user of South Wales I cannot understand why the Welsh capital has one controlling prescribing organisation, the Cardiff Addictions Unit (CAU). Apart from that, there are just little offshoots like DIP (Drug Intervention Programmes) which is one of these crime based initiatives where if you commit a crime and you have a heroin habit, instead of prison you are fast tracked onto methadone or Subutex.

I first heard of these schemes when, following England's lead, drug addiction was taken out of health and put into crime. In other words drug users were no longer looked at as people with a medical problem, but people who where doing wrong by taking drugs had to be punished.

I said at the time, after a small amount of thought, that surely fast-tracking people to methadone/Subutex if they commit crime would have the paradoxical effect of creating more crime. But I was just a humble service user in a meeting of bigwigs who, from where I am standing, get paid a lot of money with very little positive results in the care and treatment of drug users.

So now we have all these service providers in South Wales with growing waiting lists wondering what can be done to shorten the waiting time. The answer? Kick people out who are testing positive for illegal street drugs and replace them with new people off the waiting list. Brilliant! Well thought out – let's create a revolving door so we spend money on some service users and they do not stop taking illegal drugs, so we throw them back on the streets where they came from. Then they reapply and the waiting list stays the same. Oh what brilliant minds we have here in South Wales.

Is it me, or is the whole focus being lost here, with people becoming numbers instead of human beings?

Also, the powers that be here in South Wales are ignoring the medical definition of drug addiction – 'a chronic medical condition characterised by relapse'. If people did not lapse they would not be suffering from drug addiction, which means service providers here in South Wales are stopping drug users' medication for showing the symptoms of their illness. How many other medical conditions can you think of where you have your medication stopped for showing the symptoms of your condition?

I here a cry, 'It's their own fault for taking drugs in the first place.' Well let's apply that argument to other medical conditions. Diabetes type 2 due to overeating – let's stop their medication. Lung cancer for smokers – let's empty the beds and get someone more worthwhile in. In fact if you take a walk round a hospital you will be surprised to see just how many illnesses are caused by lifestyles, but that's OK because they are not drug addicts/users.

The prejudice against drug users is allowed to continue because we are seen as misfits; lying thieving scumbags. But why do we lie? Because we know if we tell the truth they will stop our medication! Why do we steal? Because of being fast-tracked into this world of criminalising the drug user – and also because street heroin is illegal.

What substitute injectables we did once have are nowadays very few and far between, and that's a massive understatement. So it is no wonder people are using on top of their oral medication which has no euphoric effects.

Until doctors start to prescribe to drug addicts/users/self-medicators what they are addicted to, I think the whole point of treatment is being missed. That's if we can even call it treatment.

Notes from the Alliance

Another game of jargon bingo?

Actions speak louder than words when we're defining recovery, says Peter McDermott

ACCORDING TO THE ALLIANCE'S TEAM OF GUERRILLA SEMIOTICIANS, the term 'recovery' has finally edged out 'tipping point' in the top slot of for most popular piece of jargon for state drugs apparatchiks.

The idea is not a new concept. I first encountered it in 1986 or so, when the Self Help section of every American bookshop was full of recovery workbooks on everything under the sun, from an enthusiasm for pornography to your 'recovered memories' of 'satanic ritual abuse' – something we refer to here in the UK as 'bad dreams'.

I was working at an early needle exchange, and we'd get a lot of visits from Americans. In an attempt to cultivate empathy relations, many would confess, 'I'm in recovery for nearly ten years now.' My colleague, the recovering sociopath AP, would respond, 'So when are they letting you out?' Twenty years on, recovery is gaining some purchase in UK drug treatment circles. We resisted as long as we did because it's an idea derived from AA and other 12 step fellowships.

Don't get me wrong, I like the fellowships. If I was seeking total abstinence from all drug use and couldn't achieve it on my own, I'd be 'in like Flynn'. Or rather, given that Errol died an early death due to alcoholism and drug abuse, and was buried with six bottles of whisky, perhaps that should be 'in like Flynn should have been', but you get my drift?

The original title of the Big Book tends to be somewhat elided these days, but the full title is: *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. At some point, the number of relapses made it pretty clear that many of these people weren't 'recovered', so perhaps needed to start thinking of recovery as a process rather than an outcome?

Recently, I've met a number of fellowship members who consider themselves recovered rather than recovering, but that's something of a heresy within the fellowships. And this is part of my problem with the concept of recovery.

While US treatment providers have the ideology of the 12-step movement thoroughly embedded within its philosophy, here in the UK, we've tended to draw our concepts from science rather than from quasi-religious ideology. And so we talk about dependence rather than addiction. About multi-factorial causes rather than a 'spiritual malady'.

And so I wonder what the purpose of defining 'recovery' is at this stage of our development as a field? Is it to assist clients with the identification of treatment goals? My experience is that they're generally able to do that without any assistance, and where they aren't, a spot of motivational interviewing works wonders.

Or is it an attempt to come up with a new Treatment Outcome Measure? A measure that will allow us to compare different treatment services and show which is more successful? If that's the case, then it really doesn't strike me as any more helpful than the measures identified in the Treatment Outcome Profile.

The most likely explanation that I can come up with, is that this is a definition that's aimed at raising the aspirations and expectations of the workforce – something that's long overdue. It's a very small step, and I don't know whether it's a step in the right direction, but I am glad to see movement on that front.

My favourite definition of recovery comes from Dan Bigg and his Chicago Recovery Alliance. Their definition is a very simple one. It also acts as the agency's strap line.

ANY positive step...

Peter McDermott, is press and policy office at The Alliance

The second DDN/Alliance service user involvement conference will be held in Birmingham on 29 January 2009. For more information, email ian@cjwellings.com

Hitting the bottle

HIT's *Alcohol – the debate* in Liverpool saw lively interaction between the health, criminal justice and alcohol industry sectors on how best to tackle Britain's relationship with the bottle. **David Gilliver** reports

'We talk about all these big numbers and they make very little sense,' said Alcohol Concern's director of policy and communications, Nicolay Sorensen, of the estimated £17bn to £26bn annual cost of alcohol misuse in England and Wales. 'But the cost to the UK economy is greater than the GDP or Slovenia or Belarus and nearly twice that of Uruguay. The drain on resources is phenomenal.'

Sorensen was addressing HIT's conference, Alcohol – the debate in Liverpool earlier this month, which brought together representatives of the treatment field, NHS, police and alcohol industry to discuss the best way forward in tackling the country's damaging relationship with alcohol.

The industry had an important role to play in reducing alcohol-related harm, and the government had a duty to drive that, Sorensen told delegates, but acknowledged that money all too often played a significant role in decisions. 'The industry is an employer – it provides taxation and is a leader in business and we recognise that,' he said. 'But the human cost is often forgotten about.'

Regional secretary of the Beer and Pub Association Lee Le Clerc told the conference that the industry was a responsible one, however. 'There are people in the industry who are reckless and silly but the vast majority are not. We have our rogue elements, but the proportion is no higher than any other sphere of industry.'

The vast majority of young people who drank were actually getting their alcohol from older friends or from home, he maintained. 'Sixteen and 17-year-olds are drinking in pubs, of course they are,' he said. 'Sixteen and 17-year-olds have always tried it on. But gangs of intoxicated eight to 12-year-olds in parks are a relatively

new phenomenon and represent a far more worrying and damaging aspect of under age use. Fining a wicked licensee for serving a pint beer to a 17-year-old is easy pickings, but we should ask ourselves if we've really got our priorities right.' The 'draconian proposals seeping from the Home Office' did not differentiate between an honest mistake and wilful sales to those underage, he said.

It was essential to work as closely with the industry as possible, said Ernst Buning of the Amsterdam-based Urban Nights project, which provides information for policy makers, planners, and the drinks industry on safe, well organised night-time economies. 'As someone who used to work in the drugs field, we're very fortunate with alcohol in that – unlike illicit drugs – we know everyone at every level from production through to distribution. To get anywhere, you have to include all the stakeholders. The industry is a very diverse group – there are very responsible people and some real money makers, so you can't generalise.'

Genuine partnership working was vital to genuinely addressing the problem, he said. 'No one can do it alone. Mutual respect and a clear division of labour and responsibilities are essential – we all need to find common ground, because harm reduction is the first priority.'

Le Clerc claimed his members' willingness to act responsibly was being actively held back by the government, however. 'Three months ago our association received a formal letter from the Department of Business, Enterprise and Regulatory Reform telling us that our promotions code could be illegal under competition legislation. To advise licensees they couldn't run happy hours or two for one deals could distort the market, and we should desist. If departments in the same government can't get their act together, what hope is there for any of us?'

Local residents now had a freedom of expression to complain about problem premises that they never enjoyed before the 2003 Licensing Act was implemented, he maintained, and neither had the Act brought in '24-hour drinking', with bars increasing their opening hours by just 21 minutes on average. 'Of course, as public sector agencies squabble for more funding the truth can slip, as long as the headlines push the right buttons,' he said. 'Britain's so-called drinking culture has been around for centuries. Alcohol fuels bad behaviour, yes – but it most certainly is not the cause.'

'It could be argued that misuse of alcohol by young people is a failure by police or local authorities, but I disagree,' chief constable of Merseyside Police, Bernard Hogan-Howe, told delegates. His force had closed down problem premises, which involved a huge amount of work, as well as carrying out test purchases with young people in partnership with Trading Standards officers and dispersing groups of young people drinking, he said. But the real argument was for having more control over the sale of alcohol through price or number of locations.

A quarter of the 4,000 licensed premises in Merseyside were now off-licences, he continued, which had been opening at a rate of around 40 per year since the 2003 Act came into force. This increase in points of sale and decrease in price meant young people were now more likely to be able to afford alcohol and less likely to be challenged when buying it, with a four pack of lager as little as 90p in some places. This kind of deep discounting presented a real worry, said Sorensen, as did the high price of soft drinks in pubs. 'Sometimes it's cheaper to drink than not,' he said.

'I don't make the argument that there's a crisis,' said Hogan-Howe. 'But I do make the argument that there's a lot to do.' One crucial element was proper staff training, he said, but at the moment there was no statutory requirement to provide this, and many of those new premises were estate shops staffed by untrained people. 'The shop assistant in an off-licence on an estate, who's likely to be young, alone and poorly paid, will be very unlikely to challenge a group of – often aggressive – young people trying to buy alcohol,' he said. 'That is who controls the point of sale in these shops.'

And the more premises there were, the less likely they were to challenge, as intensifying competition meant those that refused to sell to young people risked going out of business. 'We will continue to make best use of existing legislation, but an attack on the price of alcohol and the number of licences available could make a real impact in the future,' he told the conference. 'Competition is so great and the pressure is so great that we can't see anything other than a mandatory code making a difference,' agreed Sorensen.

'Fining a wicked licensee for serving a pint of beer to a 17-year-old is easy pickings, but we should ask ourselves if we've really got our priorities right.'

This proliferation of licences had the potential to undermine the industry itself, said Le Clerc. 'The more cowboys there are, the harder it is for regulators to keep an eye on them.' But when it came to drink-fuelled violence and anti-social behaviour, it was the density of premises in a given area that could present the real difficulties, said Hogan-Howe. 'When people are leaving bars and competing for space or transport or food, then we see a problem,' he said. However, this density could also help policing, as resources could be targeted on a concentrated area, he acknowledged.

Nightlife was clearly a major boost for local economies, said Buning, but it was essential to organise the night time economy in the right way. 'Setting is crucial. If the setting is inviting aggressive behaviour, then it's more likely to happen. How do the bouncers operate for example – are they rude and aggressive? And what about opening hours and public transport – does transport run later at the weekend so it's easier for people to get home?' Training was vital, he stressed, as 'so many people out there are not properly equipped', as was effective crowd control.

So what about the 'ten pounds for all you can drink' or 'women drink free all night' type promotions that were often responsible for the condition of many of the people spilling onto the streets late at night? These 'had to stop' said Le Clerc, but 'paled into insignificance' when compared to what went on in the supermarket. Only the government could intervene on pricing, which was unlikely in the current economic climate, he stated. Halting the serving of drinks to those already drunk would also be a difficult area to manage without a legal definition of drunk, such as existed for drink driving offences. But the powers existed to take away the licences of persistent offenders, he said.

Initiatives like his organisation's Challenge 21 – where those who looked under 21 could be challenged to produce ID – were being implemented and were having a real effect, he maintained. 'We know this is working because we know that kids are finding their previous routes to alcohol barred. Too many kids are still being served, yes, but I would say to the chief constable "if your officers know of a persistent offender, take away their licence". You have those powers.'

But it was not just about the industry, said Sorensen. It was also about making sure that heavy or problematic drinkers got the help they need, which was going to require more money. 'Alcohol is behind the drugs field in terms of focus, in terms of money and in terms of waiting times,' he said. 'And with heavy and dependent drinkers, time is often of the essence.'

Clearer information about the health impacts of alcohol was essential, he said. Awareness of units was high but understanding remained low, so there was little point having that information displayed on a drink unless it was consistent and properly contextualised. Le Clerc maintained that the pub could not be the centre of public health, however. 'That has to happen outside the pub, so that it's informed people who then come into the pub.'

And that still left one very large obstacle to overcome, stressed Ernst Buning, particularly relevant in the UK. 'The idea that binge drinking equals having a good time will be very difficult to change,' he said. 'Whoever comes up with a solution for that is ready for the Nobel Prize.'

Free to recover

Scotland's prison system is suffering from low expectations, says **Fraser Ross**, who argues for a culture change focused on recovery.

Community safety Minister Fergus Ewing announced that one of the five elements of the new drug strategy would include better service delivery to be more focused on recovery. He also told members of the Scottish Parliament, 'where this government differs from the previous administration is the question of emphasis – less on crisis intervention and enforcement, and more on early intervention and family support'.

The Scottish Advisory Committee on Drug Misuse's (SACDM) report *Essential Care* highlighted the need for a thriving recovery network with the service user at the centre.

This year's Scottish Prison Service (SPS) survey found that 45 per cent of prisoners were drunk when they offended and 70 per cent of prisoners reported having used drugs in the year before coming to prison. Half of prisoners reported being under the influence of drugs when they offended and 70 per cent of prisoners were estimated to have mental health issues, according to the Scottish Prison Commission.

Prisons in Scotland work like an acute care model service. They are effective at reducing problem severity, but compared to community interventions they are expensive for short sentence prisoners with substance misuse and or mental health problems. Prisoners tend to recycle many times back into the prison system.

Recovery management with prisoners could be much more than a period of acute care. Post sentence support and monitoring is essential to build on and maintain change, and early signs of slipping should be identified in time for the ex-prisoner to be referred to a higher step of healthcare or intervention. The result would be re-entry to an external health service before reoffending happens as a consequence of returning to substance misuse. Peers can provide crisis intervention post sentence, and families will play an important role.

Evidence of need for this type of model can be seen from the SPS Survey. Forty-one per cent of prisoners with alcohol problems would take up support on release if offered, and 34 per cent of prisoners with drug problems said they were concerned it was still going to be a problem on release. Statistics from the Prison Commission tell us that three quarters of prisoners who serve sentences of under six months return to prison within two years.

Recovery can occur at different stages of problem progression. There are success stories among those who have not yet suffered severe losses related to their substance use, and equally among those who have experienced severe personal and social disintegration and anguish before achieving stable recovery.

As well as the degree of problem severity, the person's 'recovery capital' – the internal and external resources that a client can draw upon to support them on their recovery journey – influences the prognosis for recovery.

Prisons reduce substance misuse problems because they isolate people from their problem. While in the prison environment 'natural triggers' can be avoided, but returning to the community brings with it the return of personal choice in a high-risk environment. When they complete their sentence some prisoners receive a short period of low frequency aftercare, and if they return to prison it is viewed as a personal failure rather than a 'wrong systems' approach.

What is missing is a link to new community recovery services to keep the returning offender engaged and support post sentence for as long as is required. These services are not available at the moment and should not be confused with traditional aftercare services.

Many prisoners will have had low recovery capital before they went to prison, so failure to work on creating it while they are inside leaves them without

'Studies of recovering ex-offenders have found that relapse rates are highest at times of reduced employment opportunities.'

community resources to maintain their efforts at change. The result is that a prisoner feels better inside rather than out of prison, so they want to go back there – hardly the right goal of the criminal justice system.

In research commissioned by SPS, prisoners emphasised that the magnitude of problems on return to their communities could, and usually did, overwhelm all their good intentions. While prisoners made significant improvements in prison as a result of the range of services, change was difficult to sustain because of the lack of links to continuity of care on their return to the community.

Prison addiction staff also did not always see cessation of drug use as an appropriate objective for a single sentence, particularly where that sentence was short, and often expected to work with prisoners sequentially over a number of sentences. Many staff expected prisoners to just come back to start all over again, demonstrating the need for links to the community and a new range of recovery services.

The existing situation represents a very expensive acute care service when you compare it to the cost of a community rehabilitation model: current figures show that it costs £36,000 per year to the taxpayer to keep someone in prison. This cost does not include capital charges, compensation claims or the Reliance Escort Contract Costs. Helping communities to support their returning members effectively can also be highly beneficial to environments that may be blighted by deprivation and crime.

While the government is moving towards a recovery model, they need to take the lead in making change happen. The prison system can be an excellent initiator of recovery and change but if the community and families are not at the heart, fully engaged and embedded in the system and model, it won't work.

There will always be a need for the public to be protected from dangerous offenders. But the Prison Commission argues that those who serve community sentences re-offend considerably less than those serving a short sentence in prison. Short-term offenders are not in prison long enough for many drug programmes to be started, yet alone completed.

Shifting the sentence to the recovery management model takes its focus out of the institution and into the wider community. This will require a greater emphasis on outreach and services based in the communities where prisoners live and removes many of the barriers associated with a prisoner having to return to his or her community.

Creating these communities of recovery that are embedded within the existing treatment systems will require work to build joint working, joint understanding and mutual respect. Using home detention and tagging with structured appointments supported by local recovery coaches will ease the offender back into the community, spot early danger signs and quickly re-enter the offender into an increased level of care or support as required, to avoid them reoffending or returning to substance misuse.

Technology can help with post prison and recovery monitoring. In Connecticut a telephone support service has been set up and run by volunteers in recovery (CCAR). The service calls at pre-arranged times and goes through a set of questions to monitor and report on the individual's recovery. Brief (15 minutes) but sustained telephone monitoring following primary treatment has been shown in studies to increase abstinence rates, and reduce heavy drinking, emergency department admissions and the need for primary treatment.

The use of the Internet for providing support services to clients in their homes is growing. Self-guided interventions, one-to-one support, group work, recovery support and education can all be delivered using this medium with no one needing to travel.

There is currently a Scottish Government funded pilot using this system with Inverness Prison and SMART Recovery to evidence its potential and effectiveness. It is going to be used to link prisoners up to support outside the prison before their release, using an online face-to-face counselling room over the Internet.

Family environment exerts a great influence as a source of support or sabotage of addiction recovery, and family members can also play a significant role in encouraging those involved with substance misuse to seek treatment. But families will need support and coaching to increase the probability of a prisoner maintaining a recovery effort if the significant other also uses substances.

In the latest SPS survey, 91 per cent of prisoners said that they maintained contact with a family member, but 58 per cent of family members reported difficulties in making visits because of the distance to travel and the cost. Family members feel that they are punished as much as their loved ones by an imprisonment and the impact on children not having a father or mother around also needs to be considered.

Peer support is also becoming an integral component in the management of all chronic diseases, and self-help meetings are acknowledged as an important recovery resource. Groups like AA, NA and SMART Recovery can play a big part in maintaining behaviour change post release, but the links between them and the Prison Service need to be strengthened and formalised.

Training prisoners during their sentence to become peer group leaders and recovery coaches would enhance the individual's recovery capital. They would also provide an effective recovery monitoring and early re-intervention service within the prison. Alcohol Concern runs a Home Office pilot in prisons in London that teaches prisoners to be mentors and SMART Recovery Facilitators. This evaluated very well and is being considered for expansion to other prisons.

Prison should be used as a last resort. Allowing short-term prisoners to complete their sentences in the community would allow the court to hand out sentences with longer compliance conditions. Social enquiry and pre-sentence reports should include a strengths-based assessment to identify a pathway for change post sentence, which would also allow for longer community sentencing linked to recovery plans.

Studies of recovering ex-offenders have found that relapse rates are highest at times of reduced employment opportunities. Meaningful employment is an important component of recovery capital, whether it is voluntary or paid work, and using a strength-based assessment would identify skills that could be matched to employment in the community. Training prisoners to be recovery coaches and peer group leaders in prison would add to a community's recovery capital on their return.

Prison officers have the potential to be initiators of recovery, but lack of training and awareness in working with people with substance misuse problems prevents it. Core training at the moment is more about prevention than cure, *eg* riot control and suicide prevention, but joint training with those in recovery would be beneficial for prison officers, particularly if it linked with those working within addiction and health services within prisons. Training in a recovery management model would reduce repeat offending and the revolving door experience of offenders.

The need to think differently is essential; our prison system is at breaking point, with numbers forecast to increase. A significant amount of offenders' crimes are associated with substance misuse, and by addressing this there is an opportunity to tip scales of justice towards positive outcomes rather than negative outputs. This model provides a radical alternative to the traditional approach, which is at best a short-term solution and at worst colludes to bring people back to prison.

Fraser Ross is from Smart Recovery (www.smartrecovery.co.uk). This article is based on his personal submission to the Scottish Prison Commission.

Stockton-on-Tees
BOROUGH COUNCIL

INVITATION TO TENDER

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

Chaotic Drug User Service

Stimulant Drug User Service

Structured Day Programme Service

Family & Carer Support Service

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

Applicants will, in the first instance, be required to complete a pre-qualification questionnaire, (with the exception of the Family & Carer Support Service) the PQQ will detail financial status, resources, experience, policies and management systems.

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

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

Tender for a Young People's Substance Misuse Specialist Treatment Service

Hampshire County Council's Drug and Alcohol Team invites expressions of interest from suitably experienced providers who wish to be considered for selection to tender for the provision of a Young People's Substance Misuse Specialist Treatment Service to those aged under 19.

The main aim of the service is to provide a young people's substance misuse specialist treatment service offering comprehensive assessment, individualised packages of care, intervention and treatment based on the needs of children and young people.

The contract will initially be for a period of two years with the option to extend for a further one, two or three years (subject to satisfactory performance). The indicative value will be £550,000.00 per annum.

Tenders are welcome from single agencies or consortia bids.

Organisations interested in being considered will be required to complete a pre-tender business questionnaire. Please contact, preferably by email: Alison Wilding, Contracts Support Officer, Supporting People Team, Hampshire County Council, Capitol House, 12-13 Bridge Street, Winchester SO23 0HL.Email: alison.wilding@hants.gov.uk

Closing date for expressions of interest is 5pm on 4th December 2008.

A presentation for prospective providers is to be held on Thursday 18th December 2008.

Wessex Youth Offending Team

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Hampshire County Council

worthing churches homeless projects

Mental Health Community Link Worker

Salary: £22,106 to £27,080. Full time (37.5 hrs per wk).

You will be an F/H Grade Mental Health Nurse looking for an opportunity to gain more experience in the community or a qualified Social Worker or O/T with significant experience working with individuals with mental health issues.

This post focuses on homeless and/or insecurely housed adults with mental illness and is based at our drop in service in Worthing. It is a key post within WCHP's Community Link Team and incorporates a 9 hour weekly secondment to the Health Central Surgery.

Key tasks will include assessment and inter-agency working in order to obtain timely services from appropriate health, housing and support agencies, offering support to individuals awaiting treatment and other services as part of a co-ordinating role. You will have a key liaison and development role with WCHP and local Voluntary Sector groups. Professional supervision will be provided through the local Mental Health Team.

Closing date for applications is 1st December 2008
Interviews will be held on 12th December 2008

Project Worker: Direct Access Hostel

Salary £15,474 to £21,000. Full time (37.5 hrs per wk).
Rolling rota – to include sleep-in shifts

We are looking for a Project Worker to join our team at our Direct Access Hostel. The project provides emergency supported accommodation, enabling clients to seek and obtain employment and develop skills for independent living. If you have experience of project work or have transferable life skills then we would like to hear from you.

Closing date for applications: 1st December 2008
Interviews will be held on: 15th December 2008

Bank Staff

£5.79 to £8.95 per hour (depending on skills).

Our Bank Staff are critical to the smooth running of all our projects. If you would like to gain experience in this field of work and/or would like to work across all projects, then we would be interested in you applying for these vacancies.

Closing date for applications: 1st December 2008
Interviews will be held on: 15th December 2008

Job descriptions and application forms are available from: Denise Robinson or Alison Malcolmson, Finance and HR Department 16 Selden Road, Worthing. West Sussex BN11 2LL. Telephone: 01903 227826 or, online (to download only), at

www.wchp.org.uk

Registered Charity No: 1027832

Management training course & qualification

fdap ASET

Certificate in Supervisory Management & Leadership Techniques

This **three-day** training course, designed specifically for managers in the drugs & alcohol field, leads to a **level 3 qualification** from the awarding body **ASET**.

The course is based around DANOS and other relevant occupational standards, and is in line with the guidance on management training set out in the NTA workforce targets and "DANOS 2012" .

The next "open" courses, for individuals and small groups, will be held on **3-4-5 March 2009**, in Ladbroke Grove, **London**. [The course is also available on demand.] For more details, or to book, please contact Jim Turner at **The Performance Group** - 0845 880 2255, www.tpgl.co.uk.

Next "open courses": 3-4-5 March, London

(also available "on demand" for groups of 8 or more)

DANOS 2012

More about training & qualifications from FDAP - www.fdap.org.uk

Substance Misuse Volunteering and Training Organisation

NewLink Wales is a key provider of training, volunteering opportunities, and Black & Minority Ethnic Community Services, supporting organisations and agencies working with substance misusers. We currently have the following vacancies:

Development Manager for Black & Minority Ethnic Services

37 hours per week (full time).
SCP 33 - 36 (£27,492 - £29,628).
To oversee the work currently done in two projects and to develop NewLink Wales's services to the Black & Minority Ethnic communities in Wales.

Training Officer

18.5 hours per week (part time).
SCP 30 - 33 (£25,146 - £27,492 Pro Rata).
To provide substance misuse training courses and to assess candidates undertaking NVQs.

To apply either e-mail recruitment@newlinkwales.org.uk for a pack to be sent electronically, or call 02920 529002. For more information about these posts and NewLink Wales's services please visit www.newlinkwales.org.uk

Closing date for both posts: Friday 28th November.

NewLink Wales as an employer is committed to equal opportunities.
Registered Charity 1085545 Registered Company Ltd by Guarantee 4142393

Lewisham NHS Primary Care Trust

Lewisham

LEWISHAM DRUG AND ALCOHOL STRATEGY TEAM (DAST)

INVITATION TO TENDER TIER 3 SUBSTANCE MISUSE CRIMINAL JUSTICE DAY PROGRAMME

Lewisham DAST invites expressions of interest to tender for the provision of a Criminal Justice Substance Misuse day programme.

Expressions of interest are sought from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver substance misuse services with a criminal justice focus to meet the needs of a diverse population. Lewisham DAST is seeking expressions of interest to deliver the following in the borough:

1 x Adult Tier 3 Criminal Justice Substance Misuse Day Programme

Prospective providers are invited to tender for this service; consortium tenders will also be considered.

The expected term of the service will be from April 1 2009 initially for three years, with six month 'no-fault' break clauses either side, with an option to extend for a further two years, subject to review.

The contract will be based, in part, on a performance payment in relation to achieving a set of treatment outcome indicators pertaining to planned discharges and ETE provision, which are outlined in the tender documentation.

To request a tender pack, either in writing or by e-mail, contact:
Mike Hurst, Procurement Team, London Borough of Lewisham,
3rd Floor, Lewisham Town Hall, Catford, London SE6 4RU
Email: mike.hurst@lewisham.gov.uk Telephone: 020 8314 6556

Expressions of interest should be made by Wednesday 10th December 2008, and completed tenders must be returned for receipt by no later than 12 noon, Wednesday 17th December 2008.

Safer Middlesbrough Partnership

SAFER MIDDLESBROUGH PARTNERSHIP

HIGH CRIME CAUSING OFFENDER NEEDS ANALYSIS

The Safer Middlesbrough Partnership wishes to continue to improve services and processes that lead to a reduction in offending locally. There are already very effective multi agency services in place as part of the Drugs Intervention Program (DIP) but we now wish to expand this process to include all High Crime Causing Offenders (HCCO).

We have identified funds to support this process but wish to ascertain the most effective way to utilise these monies via a needs analysis.

It is expected that the analysis will consist of qualitative and quantitative work. The qualitative will be with the HCCOs themselves, exploring their reasons for continuing offending, an assessment of their needs and their own views on what would break their offending cycle. The quantitative will be an analysis of the current crime data, assessing where HCCOs appear in the Criminal Justice System, the crimes they commit and the impact this has on overall crime statistics.

It is expected that there will be a final report produced by the end of February 2009 with recommendations on the most effective interventions/services to address these issues.

Budget: £22000 excluding VAT.

Closing date for applications: 2nd December 2008.

For further details and to receive a full specification please contact David Jackson, d_Jackson@middlesbrough.gov.uk, 01642 354040

Stabilisation Services

LEAD AN EXCITING NEW DEVELOPMENT IN DRUG TREATMENT

Services Manager

Harlow, Essex. c.£35,000

Passmores House is an exciting new development in services to people with drug and alcohol dependency. We are a looking for a talented, resourceful manager to run this new facility and to lead the newly recruited staff team.

The Service:

Passmores House, opening next April, will provide medically supervised residential facilities for detoxification (12 beds) and for rehabilitation leading to recovery (6 beds). The service will be of a high quality, building on the success of Stabilisation Services' Vale House facility, which has a track record of effective treatment over 14 years.

A significant public investment has gone into making Passmores House one of the premier services of its kind in the country. It has excited great interest and is supported by Drug and Alcohol Action Teams across the East of England.

The Manager:

The person we are looking for has significant experience in management of social care services and a sound knowledge of services to people with dependency problems. S/he is qualified, either in nursing or another relevant field. The post will include becoming registered with the Commission for Social Care and Inspection.

S/he will need to show resource, initiative and imagination. Staff motivation and development will also be key skills.

If you think this is the challenge that you have been looking for then e-mail Passmores@puddicombe.net for application details. Closing date for applications is the 3rd December. Interviews are likely to be between the 10th and 17th of December.

Worcestershire NHS
Mental Health Partnership NHS Trust

Worcestershire Substance Misuse Service

DRUG WORKER - Band 5

£20,225 - £26,123 p.a.

Ref: 366-260

SENIOR DRUG WORKER- Band 6

£24,103 - £32,653 p.a.

Ref: 366-259

Worcestershire Substance Misuse Service, operating as part of the Worcestershire Mental Health Partnership (NHS) Trust, is the statutory provider of drug treatment interventions in the Worcestershire area.

We deliver Tier 3 services across three modalities; Secondary care, primary care (shared care) and the Drug Interventions Programme which work in an integrated way to provide a comprehensive and professional substitute prescribing service to problematic drug users in the county.

For more information and to apply please visit www.jobs.nhs.uk quoting the relevant reference number.

Closing date: 1 December 2008.

The NHS aims to employ a workforce which reflects the diversity of the local community.

NHS Working with NHS Professionals

www.worcestershirehealth.nhs.uk

West Sussex Drug & Alcohol Action Team

WEST SUSSEX DRUG & ALCOHOL Action Team

Data & Information Officer
Drug and Alcohol Action Team
PCT Office, Durrington
25 hours a week
£25,940 - £28,270 pro-rata (pay award pending)

Be part of an exciting project to implement our new client information system (HALO) across West Sussex. You will need to work creatively and efficiently to ensure that the collection, processing and analysis of data meet the needs of our diverse client group and agencies. You will deliver training and will need to demonstrate you are self-motivated to produce tangible results.

Closing Date 1st December 2008.
Interviews will be held week commencing 15th December 2008.

For further information please contact Jane Williams, Public Health Specialist on 01903 708683.

For an application pack, please go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 642140 (24 hour). This post is subject to a criminal records bureau check.

For details of all **Phoenix Futures** vacancies see

www.drinkanddrugs.net

Phoenix Futures
Ending dependency, transforming lives

MAKE A TIMELY INTERVENTION

Drug Intervention Programme Regional Manager

£38,463 - £41,083 **Gwent Area**

The Drug Interventions Programme (DIP), a Home Office initiative, helps people in a wide range of circumstances overcome the causes and effects of substance misuse. The programme has been active in Gwent since 2006, significantly reducing both the personal and social costs associated with illicit drugs.

As we gear up for the challenges of meeting the raised expectations of users and key national targets, we're looking to appoint a Regional Manager to lead our small, but highly motivated team.

Based in Newport, your leadership and motivational skills will be put to good use in delivering the programme across Gwent and its five Community Safety Partnership areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen.

Building strong relationships with service users, board members and service providers forms a large part of this role, so your people skills and ability to negotiate and persuade will be first class.

This rewarding role also calls for dynamism and enthusiasm and offers genuine satisfaction and opportunities for personal and career development in return.

Visit www.newport.gov.uk/recruit or call 01633 656656 quoting reference PE088R

For an informal chat only please contact:
Neale Thomas, Interim Regional Manager on 07834 465 488.

Closing date: Monday, 1st December 2008

This post is exempt from the Rehabilitation of Offenders Act and is subject to a CRB check.
We are committed to equality of opportunity. All Council posts are subject to a Pay & Grading review.

Newport City Council Cyngor Dinas Casnewydd

Cambridgeshire County Council

DAAT Alcohol Coordinator

Cambridge

£27,950 - £37,710 per annum
Salary level is dependant on assessed suitability
Fixed term contract until March 2011.

The DAAT is a multi-agency partnership supported by a small vibrant and enthusiastic team, committed to tackling the harm caused by drug and alcohol misuse.

This is a new and exciting role, working to coordinate, develop and implement the new alcohol Harm Reduction Strategy for Cambridgeshire. You will be working across a wide range of agencies including Trading Standards, the Police, Health and local councils to reduce the harms caused by alcohol misuse. The post holder will provide strategic coordination for alcohol for the Drug and Alcohol Action Team.

The role will include enhancing needs assessment and to inform policy and performance targets, develop key multi agency partnerships to address the impact of alcohol misuse upon the communities, and practical problem solving to support local communities in tackling local issues.

You will be a motivated, self-starter with a wealth of experience in partnership working and a sound knowledge of public sector working. You will have excellent interpersonal and negotiation skills as well as a positive, can-do attitude. You will have extensive knowledge of alcohol related issues, be it in health or community safety. Experience of commissioning and/or contracting will be an advantage.

If you are a quick thinking problem solver who can work with a wide range of stakeholders from service users to Chief Executives, to those working on the ground, this could be the job for you. **Ref: JC7077**

For informal enquiries please contact Susie Talbot on 01223 713067.

To apply visit www.jobsincambs.com or call 0845 045 5210 quoting reference number. Alternative formats on request.

Closing date: 3 December 2008.
Interview date: 17 December 2008.

2006-2007 Delivery of Quality Services Through Procurement, Waste and Recycling, 2005-2006 Asset Management, 2004-2005 Better Local Public Transport

Stonewall DIVERSITY CHAMPION

www.cambridgeshire.gov.uk

PROJECT MANAGER FOR SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE (SMMGP)

NHS
National Treatment Agency for Substance Misuse

Salary: AfC Band 6 £28,923.60 – £38,591 inclusive of HCA
Contract: 12 month fixed-term contract
Based: National Treatment Agency - London

This is an exciting opportunity to continue the development of the Substance Misuse Management in General Practice (SMMGP) which is an independent organisation that works in partnership with the Royal College of Practitioners and National Treatment Agency. For over ten years SMMGP has supported GPs and other members of primary health care teams in the provision of community-based treatment and care for substance misusers in England.

We at SMMGP are looking for a highly motivated individual with strong project management skills and a background in substance misuse treatment to maintain and further develop its existing activities.

Often working in a sole capacity, you will have a wide range of responsibilities, including input into and the interpretation of National Health and Home Office drugs policy, management of the project website, publishing the regular newsletter Network, and supporting primary care providers and commissioners to develop and implement existing and innovative approaches to primary care substance misuse treatment. You will therefore have excellent organisational, negotiation and presentation skills with experience in the field of substance misuse treatment, together with the ability to work on your own initiative to tight deadlines.

For logistical reasons the post is based in the head office of the National Treatment Agency, though being based in one of the nine regional offices could be a possibility. The post is funded for one year in the first instance, and a secondment could be considered.

Full details including role profile are available online at www.nta.nhs.uk from where you can download an application form.

Should you require assistance with the application process please call Bianca Di Tullio; HR Administrator on 0207 261 8848 or email your contact details to recruitment@nta-nhs.org.uk quoting the job title.

Closing date for applications: 5th December 2008

Interview date: w/c 15th December 2008

STRICTLY NO AGENCIES!

The NTA welcomes people from all sections of society. We are committed to equal opportunities and diversity in the workplace. Applications are encouraged from minority groups.

NTA better treatment, better outcomes

KINESIS LOCUM LTD

Mental Health Professionals

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

Because Good People are Hard to Find

Call Us **NOW!**
0207 637 1039

www.kinesislocum.com

STILL NO.1 FOR RECRUITMENT AND CONSULTANCY

020 8987 6061

SUBSTANCE MISUSE PERSONNEL

PERMANENT - TEMPORARY - CONSULTANCY

Supplying experienced, trained staff:

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

NOW REGISTERING AND SUPPLYING NURSES

Register online www.SamRecruitment.org.uk