DDN
Drink and Drugs News
23 March 2009
www.drinkanddrugsnews.com

SPECIAL ISSUE

News and views from the second national service user conference

VOICES FOR CHOICES

Service users across the country speak out for change

Your fortnightly magazine | jobs | news | views | research

NHS

National Treatment Agency
for Substance Misuse

SUPPORTING YOU, SUPPORTING YOUR CHOICES

The NTA is committed to working with service users and to promoting a balanced treatment system – helping you on your route to recovery. We are proud to support the Voices for Choices conference.

EFFECTIVE TREATMENT
CHANGING LIVES

www.nta.nhs.uk

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.drinkanddrugsnews.com
Website maintained by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover: JellyPics

Editorial - Claire Brown

Voicing choices

One day in Birmingham – and we were all ears

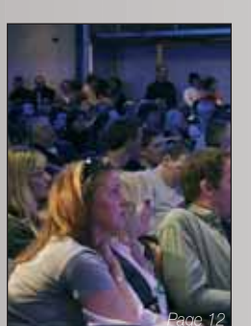
There's a lot in this issue and it's been hard work to put together – but that's an accurate reflection of our DDN/Alliance service user involvement conference in Birmingham. The hard work at the event extended to the delegates, who contributed their views and participated willingly – in the conference hall, during their breaks when they answered questions from our superb band of volunteers, and through going to the video room to give their views on camera.

We've pored over the results of this research since coming away from the event. We realised from the outset that we were not looking to collect scientific data, but capturing a snapshot of service user experience. What struck me most was the conviction of the commentators – there's not much sitting on the fence, but a clear view of what worked or didn't work, and why.

What also stood out was the difference a worker's personality and commitment can make to the treatment experience and its chances of success. We're so used to hearing how the system fails through lack of investment and public prejudice, but success or failure in so many cases depends on a clued-up keyworker who respects the person's preferences and circumstances, listens to them, and opens up a new world of realistic and viable choices. As with anything in life, if the subject is fully involved in making that choice there is a much greater chance of it leading to the desired goal, so it was surprising to come across many other examples of decisions being enforced on service users, particularly where prescribing is concerned.

The other major concern was the level of ignorance exposed, particularly on the effects of polydrug use, the signs of alcohol dependency, and detecting mental health problems. By talking and listening we can at least try to get to the root of what's not working – so lets take debate way beyond one day in Birmingham.

This issue


Page 12


Page 18

News in Brief

It's good to talk

A new guide to help drug workers make more use of talking therapies has been launched by the NTA, in partnership with the British Psychological Society. *Psychosocial interventions in drug misuse* explains how to best deliver interventions that tackle the behaviour and underlying causes associated with drug misuse. 'Providing effective talking therapies alongside other standard treatments for substance misuse can improve the likelihood that drug misusers will overcome dependency and lead stable lives,' said NTA clinical psychologist Dr Luke Mitcheson. 'This guide provides a practical framework for equipping drugs workers with the core skills to support users through treatment and towards recovery.' *www.nta.nhs.uk*

Street knowledge

A new campaign urging parents to take the time to discuss drugs with their children has been launched as part of the Scottish Government's *Know the score* initiative. The campaign, which will run until the end of next month on radio, television and the internet, features adverts showing children being given the wrong information on drugs in various settings such as in the park or on the bus, while the website features an information resource on a range of substances. 'As this new *Know the score* campaign makes clear, if parents don't discuss drugs with their children, someone else will and very often they'll be getting the wrong advice,' said community safety minister Fergus Ewing. *www.knowthescore.info/kts/451.html*

Grim alert

The Department of Health has issued an alert to drug treatment services, GPs and other health professionals following five cases of wound botulism among injecting drug users, all of whom have been hospitalised. Wound botulism is a rare condition that occurs when a wound becomes infected with botulism spores or tissue is damaged – the source of the current cases is thought to be contaminated street heroin. Another injecting drug user has contracted the rare Clostridium novyi wound infection, and has since died. Health professionals are being urged to promote vigilance and provide expert advice.

Overwhelming public support for investment in treatment

More than three quarters of the general public think drug treatment is a good use of government money and almost 90 per cent believe it should be available to anyone who needs it, according the findings of a poll commissioned by DrugScope.

Despite the often negative portrayal of drug treatment in the media, 76 per cent of more than 1,000 people questioned by ICM agreed that 'investment in drug treatment is a sensible use of government money, so long as it benefits individuals, families and communities' while 88 per cent agreed that 'drug treatment should be available to anyone with an addiction to drugs who is prepared to address it.'

The charity published the findings to coincide with the launch of its new report *Drug treatment at the crossroads*, which calls for drug treatment to remain a priority for public investment. The report also wants to see promotion of choice in drug treatment, with support for both harm reduction and abstinence based approaches, more research into alternatives to substitute prescribing, more recognition – backed by appropriate financial support – for the role of families and carers in recovery, and a requirement for abstinence based services to have policies in place to manage relapse and the risks of post detox overdose.

The report also calls for politicians from all parties to publicly commit to an evidence based approach to drug policy – an early day motion (EDM) was tabled in the House of Commons earlier this month by Brian Iddon MP urging 'members of the House to commit to continued public investment in drug treatment, informed by the best available research.'

DrugScope's chief executive Martin Barnes said the poll's findings were 'extremely encouraging' and that the report aimed to reinvigorate the debate around treatment in a positive way. 'Drug treatment has been subject to intense scrutiny and, at times, uninformed and unwarranted criticism over the past 18 months,' he said. 'While there should be space for informed and constructive criticism of the drug treatment system, drug treatment is worthy of public investment and should be delivered in the most effective way possible, to help drug users get their lives back on track. It is the time to evaluate where we are now and how we can make drug treatment even better.'

The report has been welcomed by the NTA. 'The poll shows that the public supports investment in drug treatment as long as it benefits individuals, families and communities,' said chief executive Paul Hayes. 'It is the NTA's job to ensure that it does. The NTA is committed to leading the improvement of the quality of a balanced treatment system, and in the coming year will ensure that local drug action teams continue to focus their efforts on moving the record numbers of clients safely through treatment.'

See the next DDN for an in-depth feature on the report's recommendations. *Report available at www.drugscope.org.uk/ourwork/Policy-and-public-affairs/topics-and-campaigns/key-topics/drug-treatment.htm*

Services failing gay men, says Terrence Higgins

Alcohol and drugs services are ill-equipped to help gay men, according to a new report by the Terrence Higgins Trust (THT).

One in six gay men is concerned about substance misuse issues, with alcohol seen as by the far the biggest problem, according to *Wasted opportunities – problematic alcohol and drug use among gay men and bisexual men*.

Many of those interviewed for the report attributed their use of alcohol and drugs to conflicted feelings about their sexuality or the pressures of the gay social, bar and club scene – described as a 'socially mediated dependency' – issues they felt they needed to be sure that service providers understood. As a result, the majority said they would prefer services that were either gay run or gay friendly. 'The majority had developed a dependency on substances that was heavily mediated by their gay social and sexual networks and norms,' says the report. 'Substance use was bound up with gay identity in many ways. This has a profound influence both on tactics for control or abstinence, patterns of help seeking and indeed the way any services could best be configured.'

Countering these norms of substance use in an often hedonistic culture would be a 'tall order', acknowledges the report, but it wants to see the Home Office acknowledge gay men as a specific population vulnerable to drug-related harm, and delivery of national drug and alcohol strategies to take account of sexuality through local DAATs and community-based health promotion initiatives.

'It's clear from these findings that a lot of gay men who have a problem with drugs or alcohol could benefit from more dedicated support services,' said THT's deputy head of health promotion Marc Thompson. 'This could involve training service providers to deal with issues that affect gay men's lives, or running special sessions for gay men within existing organisations. We hope that by introducing services that are more tailored to gay men, we would see an increase in the number of gay men getting the help they need.'

Report available at www.sigmaresearch.org.uk/go.php/reports/report2009c

CMO calls for minimum price for alcohol

Chief medical officer Sir Liam Donaldson has called for the introduction of a minimum price of 50p per unit of alcohol, one of a range of recommendations in his annual report. It is also time to recognise the effects of 'passive drinking' on society as a whole, according to *On the state of public health*.

The report wants to see a shift in public opinion along the lines of the move to smoke-free public places, with drunkenness no longer socially acceptable – passive drinking is a 'concept whose time has come', it says. Other recommendations include making public health considerations a central part of the licensing process, making passive drinking the basis of national awareness campaigns, and for a government-prompted 'national consensus' that the country as a whole should substantially reduce its alcohol consumption.

The recommendations aim to tackle the 'collateral damage' that alcohol causes for family members, society, the NHS and the economy. The average adult in the UK drinks the equivalent of 120 bottles a wine per year, says the report, and, while other European countries have seen a fall in alcohol consumption since 1970, England's consumption has grown by 40 per cent.

The 50p minimum price, designed to target heavy drinkers, would mean that a 750ml bottle of 12 per cent wine could not be sold for less than £4.50, a 2 litre bottle of 5.5 per cent cider for less than £5.50 or a six-pack of 500ml 4 per cent cans of beer for less than £6. The report claims it would lead to more than 3,000 fewer deaths and nearly 98,000 fewer hospital admissions per year.

However, the recommendation was leaked ahead of the report's publication and the government appeared keen to distance itself from the proposal – widely assumed to be a result of the economic climate and forthcoming election – alcohol industry body The Portman Group said minimum pricing would 'not deter binge drinkers or those addicted to alcohol'. The Scottish Government, however, is planning to introduce minimum pricing – along with a ban on bulk discount promotions and local flexibility to ban off sales to under-21s – as part of its forthcoming Criminal Justice and Licensing Bill, although a specific price has yet to be set (*DDN*, 9 March, page 4).

'England has a drink problem and the whole of society bears the burden,' said the CMO. 'The passive effects of heavy drinking on innocent parties are easily underestimated and frequently ignored. The concept of passive drinking and the devastating collateral effect that alcohol can have on others must be addressed on a national scale. Cheap alcohol is killing us as never before. The quality of life of families and in cities and towns up and down the country is being eroded by the effects of excessive drinking.'

Full report available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206

UN sticks to prohibition

The world's drug problem had been 'contained but not solved' said executive director of the United Nations Office on Drugs and Crime (UNODC), Antonio Maria Costa, as the United Nations Commission on Narcotic Drugs (CND) met in Vienna to review the effectiveness of drug control and what had been achieved since the UN General Assembly's special session on drugs in 1998.

The meeting took place against a backdrop of growing dissatisfaction with the effectiveness of the prohibitionist approach. While acknowledging that drug control had unintentionally led to a vast criminal black market, Antonio Maria Costa said 'drugs are not harmful because they are controlled, they are controlled because they are harmful.'

However, writing in *The Guardian* newspaper, chair of the International Drug Policy Consortium Mike Trace said 'evidence of the failure of policy is overwhelming' and accused UNODC of having 'no recognition of a decade's evidence, no new ideas or initiatives', while Transform called for a year-long moratorium on 'strategic drug policy commitments at the global level' to allow for meaningful evaluation. 'This is a watershed moment for the UN, member states and the NGO world,' said head of policy Danny Kushlick. 'World leaders need to take a stand for the principles upon which the UN was created.'

More than 1,400 delegates from 130 countries attended the commission, which concluded with the adoption of a draft political declaration and plan of action on the future of drug control, stressing 'health as the basis for international drug policy'. The commission also saw UNODC and the World Health Organisation (WHO) launch a joint programme on drug treatment and care, with the aim of sending 'a strong message to policy makers regarding the need to develop services that address drug use disorders in a pragmatic, science-based and humanitarian way, replacing stigma and discrimination with knowledge, care recovery opportunities and reintegration.'

A series of fact sheets on human rights and drug policy have been launched by the International Harm Reduction Agency (IHRA), Human Rights Watch and the Open Society Institute to coincide with the commission. *Available at www.ihra.net*

Hostels to prescribe naloxone

Homeless charity St Mungo's is to prescribe naloxone – the drug that can reverse the effects of a heroin overdose – on a trial basis to clients living in its hostels.

The trial will cover two hostels, with a view to expanding to other sites, and is being carried out in partnership with South London and Maudsley Trust and Southwark DAAT and PCT. It will initially only be available to clients who have entered treatment.

The initiative follows a successful pilot project at the charity's Southwark hostel, which saw the drug successfully administered six times, on each occasion by another client – although staff at the hostel were also trained to administer the drug. Despite naloxone having a proven track record of reversing overdose, its distribution remains inconsistent (*DDN*, 1 December 2008, page12). Delegates at *Voices for choices* heard Wiltshire DAAT harm reduction lead Mick Webb describe how a successful pilot to distribute the drug on an outreach basis saved lives and call for it to be made more widely available (this issue, page 11).

'The success of the naloxone pilot speaks for itself,' said substance use regional manager for St Mungo's, Gayle Jones. 'Six lives have been saved since naloxone was introduced and our clients are happy with the project. Naloxone is a life-saving and virtually side effect free drug. An ambulance is always called when naloxone is administered to provide vital follow-up medical support but having naloxone on site saves precious time. We are working to expand the use of naloxone within our hostels and to widen the availability to clients who are not engaged with treatment services but who may be at high risk of overdosing.'

A trial to provide prisoners with 'take home' packs of naloxone on release, to be funded by the Medical Research Council, will also begin next month.

Bespoke services get best results

Young people respond far more positively to treatment when it is tailored to their needs and when families are included, according to a new report from Addaction.

Closing the gaps sets out the results of a three-year lottery-funded pilot study of young people aged between 10 and 19 with complex drug and alcohol problems whose needs could not be met in mainstream services.

Among the findings were that 82 per cent of young people involved in the Young Addaction Plus pilot reduced or stabilised their drug use, while 91 per cent made positive changes to their lives. Addaction wants to see treatment for young people tailored to take account of specific needs, dedicated family support integrated into services, and for services to be able to respond quickly to young people in vulnerable situations.

'Young people sometimes have major problems with their misuse of drink and drugs, but it is possible with commitment and an informed approach to change things for the better,' said the charity's chair Adrian Auer. Addaction has produced another new report, *Trouble and love*, examining the impact of drugs on family life. *www.addaction.org.uk*

It's all about you

Treatment must be person centred was the message that came out of the three different presentations that opened the National Drug Treatment Conference this week. DDN **reports**

The conference began with Stefan Janikiewicz, clinical director of drug and alcohol services at Cheshire and Wirral Partnership Trust discussing how much of drug treatment was art and how much was science. Acknowledging the role of science and that 'evidence-based medicine is now accepted as the norm' he went on to warn against treating all medical studies as being completely without bias'.

'I would like to see more companies publish negative data – you could print it in a magazine called *Clangers*,' he said, adding that 'almost every drug trial shows the drug is only slightly better than the placebo'. There were also external factors that impact on trials, he stated. 'If buprenorphine cost the same as methadone, the studies and general practice would probably be different.' The art came with treating the patient as a person: 'Qualifications don't mean a thing – if you don't have a good bedside manner, forget it.'

Virginal Berridge, professor of history at the London School of Hygiene and Tropical Medicine, looked at historical changes in drug treatment and the relative position of healthcare professionals, the state and the patient. In the late 19th century, when treatment first started becoming institutionalised, British physicians looked to new American state funded treatments for drunkenness and their efforts to take 'inebriates' out of the criminal justice system and into public health by recognising the condition as a disease. The 1902 Licensing Act allowed magistrates to send inebriates to reformatories – there was already a worry about the hereditary nature of addiction, she said.

The meeting of the Rolleston Committee in 1924 – the departmental meeting on cocaine and morphine named after its chair Sir Humphrey Rolleston – saw a conflict between those wanting to pursue the American policy of prohibition and the many doctors who still followed the 'disease model' and wanted to treat their patients on an individual basis. The doctors won the day, with the report from the committee allowing autonomy on how they treated their patients, and with the option to use prescriptions as part of this.

After World War II, a shift occurred with addiction being seen as an infectious disease, one that could infect society. More state intervention occurred with the rise of specialist treatment services such as psychiatry, and the 1970s saw the start of methadone prescribing. HIV and Aids in the 1980s saw a move towards harm reduction services and there was also a swing back towards seeing addiction as part of the criminal justice system.

The recent rise of patient power was stressed by Dr Chris Ford, speaking from the floor, who highlighted the 'quiet revolution' – more than 30 per cent of GPs treat patients with drug and alcohol problems, as opposed to less than 1 per cent 25 years ago. This, she said, was because GPs treat the person not the problem.

Dr Phil Barker, honourary professor at the University of Dundee, told delegates that addiction was not a disease, just what some people choose to do with their lives.

'Despite all my years at university, when someone sits down in front of me I know sweet FA about their lives,' he said. 'People are storytellers – their life is just their story and you have to listen to them. You have to talk to the person and if you don't have enough time to sit and talk, you need to make time.'

'Even after we gained our certificates, many drug organisations that work with addicted people are very unwilling to let us loose on their clients.'

Hanging on the telephone

I wanted to say a few words that for some time have played on my mind.

Recently my users' group had advocacy training and I must say this was superb – it was done by the very capable Mr Bill Nelles. All of us who did the training felt as if our eyes had been opened to what we could do to help others. Many who are in the grip of addiction and could have benefited from our wonderful training are not being reached – all of us who did the training did part one and part two, which are both recognised training certificates.

The point I would like to make is this – even after we gained our certificates, many drug organisations that work with addicted people are very unwilling to let us loose on their clients. I myself have over 30 years of addiction experience, many of those years spent in extreme hardship, and would have given my right arm for an advocate. I nearly did give my right arm trying to get the help I needed in harm minimisation all those years ago.

I could get alongside most drug users who came to me with a problem even without that training, so what is this training all about? All that money spent on training 'good to go' people who want to help people who are still immersed in addiction.

For crying out loud, what is going on here? Why do we sit here, trained and willing to get alongside people who I am sure need an advocate, and no one ever calls?

Bri Edwards, Cumbria

Back to school

The Independent reports that 15 per cent of residential rehabilitation clinics have closed their doors during 2008 and that many more will likely go the same way this year. While some of this is due to bank policies, it is clear that government spending on methadone and Subutex prescribing instead of on 12-step and other residential rehabilitation is a major cause.

The majority of 12-step systems deliver results in long duration abstinence terms seven times better than methadone, but as methadone only has a 3 per cent success rate over a three-year period, this means that 12-step is still only succeeding in 21 per cent of cases.

As a result, for many health authorities, civil servants and MPs this means that residential rehabilitation is merely six weeks of expensive bed and board for 79 per cent of those who are referred. And because such substitute pharmaceutical drugs have been advertised, promoted, lobbied and sold to government as 'the answer' for over half a century, it looks like good value to any chancellor to spread costs over eight years, especially as at least half those costs could thus be left to be paid by the next government – which might well be the opposition. Although the psycho-pharm fraternity has for over half a century been trying to convince government that drug addiction is basically incurable, one has only to talk to a few senior MPs to discover that a majority do actually know it can be cured, 'if only we could afford it'. Well,

the truth is – we can! An addict on methadone is, in the majority of cases, unemployed and receiving job seekers' allowance or unemployment benefit. He is also likely to be receiving housing support and children's allowance, as well as costing the community more in policing, court time and health.

Addicts cost society billions, not only because they cause the most accidents at work and mug and rob old people, but because addicts and drunks cause the most road accidents, sell drugs to children, increase the numbers of prostitutes in our towns, disrupt our schools, the education of our children and the life of our communities, because addicts bankrupt businesses and destroy jobs, burgle people's homes, spread HIV, Aids and hepatitis and waste our tax money and other resources. Addicts and drunks also commit the most crimes, and are undoubtedly the real current threat to our lives and to everybody's future, and this not only includes addicts on illegal and licensed drugs but also those on prescribed drugs.

With effective residential recovery training at £97 a day for a 22-week programme, we not only have them off the street for five months, but thereafter we also save billions per year in taxpayer funded benefits.

When you add in the costs across all government departments, you find that less than three years' worth of methadone supplies and benefits will pay for 18 to 26 weeks of effective recovery training and a lifelong abstinence result in over two-thirds of cases.

In addition, a cured drug addict is a productive citizen who is again able to contribute to society and his family. So I know where I'd like to see my tax being spent – even though we know that some addicts are bankers.

Kenneth Eckersley, CEO, Addiction Recovery Training Services.

Dr Pharm-assist

As Dr Joss Bray is proposing to spend even more of my taxes on supplying provenly failed methadone to prisoners (*DDN*, 9 March, page 9), I feel I should remind him that when pharmacists some 50 plus years ago persuaded government to substitute methadone for heroin, their main argument was that methadone was a drug which enabled a dose reduction programme to be comfortably implemented in order to bring those on a methadone script to eventual, if not early, abstinence. In all those years I have personally never met a methadone addict who achieved abstinence – not surprising now that we know from Professor Neil McKeganey and the NTA that less than 3 per cent of such users ever stop. As a result we should all rejoice that prisoners are on a maximum dose of 40mg (and hopefully supervised reduction) rather than on the higher dosages proposed by this self-styled substance misuse specialist. Or should he adopt the more appropriate title of: 'tax misuse specialist', or even just straightforwardly: 'drug-pusher'?

Elisabeth Reichert, school head.

Give peace a chance

I can't help thinking that Derek Wilson is being a little harsh on Geoffrey McMullan and his nature awareness therapy (*DDN*, 9 March, page 9). It's fair enough if he thinks there's nothing to nature awareness therapy – Geoffrey McMullan is open about the fact most people are cynical about it. But to call the article 'frankly insulting to those of us who have spent many years offering service users robust evidence-based programmes' seems somewhat over the top.

It was clear that Geoffrey McMullan was saying that nature awareness could be used as a useful add-on for some clients, to help them engage more effectively in treatment. At no point does he call it an alternative to mainstream treatment, nor is he asking for NTA money, as Derek Wilson appears to be implying.

He's helped some clients and wanted to share his findings – where's the harm in that? And, as he's the only practitioner in the country carrying out these interventions with this client group, I don't think he really poses too much of a threat. I'd say the robust evidence based programmes were safe from being discarded in favour of people pretending to be wolves for quite a while yet.

Molly Cochrane, by email.

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.

Post-its from Practice

Playing safe

Don't forget contraception when starting treatment, says **Dr Chris Ford**

Elizabeth walked into my room with a broad grin on her face and said 'I thought I would help you this time!' She went on to explain that she had decided to try for her second child. We laughed, remembering the story of her first pregnancy.

Almost seven years ago, Elizabeth had arrived at the surgery in a terrible mess. She was thin and drawn, had multiple new and old track marks and a large abscess on her left arm. She was 'Miss Angry', and in a broad Dublin accent that I struggled to understand, Elizabeth said that we had better help her or she would be done for. She went on to say she was injecting two grams of heroin daily and her source, her partner, had just been arrested, leaving her without money or drugs. We treated the abscess and started her on methadone titration. Within six weeks she described herself as a new woman. Elizabeth had put on about three-quarters of a stone in weight, had stopped injecting and had settled well on 90mg of methadone.

Around this time, her partner Owen was released and also came to register, being so impressed by the visible improvement in Elizabeth's health. He likewise settled into treatment and things progressed well. About three months later, one of the receptionists casually asked me when Elizabeth's baby was due.

I was dumbfounded – I hadn't noticed and neither had Elizabeth! On arrival she had been so unwell and underweight she hadn't had a period for many years. Then, on starting treatment, I had forgotten to offer contraception, which is a must.

At her next attendance the pregnancy was confirmed and Elizabeth and Owen were shocked but pleased. Charlotte was born six months later with mild withdrawals for about ten days, but has not looked back since and is doing well at the local school. Charlotte was meant to be and her parents are happy that she came into their lives.

However this is not always the case. In order that women can make a choice, they need to be advised about the return of, or increase in, their fertility and be offered contraception at the same time as beginning treatment.

Any method of contraception is open to drug using women and over the years women have used pills, injections, IUD and IUSs, implants and condoms. It's good practice for all women at the beginning of a relationship or change of partner to use the method of their choice and condoms to help prevent sexually transmitted infections. After the birth of Charlotte, Elizabeth had settled on an IUD, which she now wanted removed.

I smiled as I sat and remembered the slogan from my favourite birthday card from last year, which is still on my mantelpiece. It says 'I've learnt so much from my mistakes, I'm thinking of making a few more'!

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

VOICES for choices

A vital part of this year's conference was the service user consultation exercise that ran throughout the day. Our volunteers, armed with their clipboards, asked delegates about their personal experiences of drug and alcohol treatment. One of the main points of this was to find out if they had been offered choices – and if those choices had worked well for them. **DDN** reports on the results

'After lots of relapses it's finally worked with a good script and a good key worker, but mainly because I wanted to stop. I've been three years heroin free.' For many service users this statement sums up the difference between success and failure – having the choices available and the right support at hand to help them use those choices and set 'small, achievable goals'.

The importance of a 'brilliant' key worker was obvious to respondents. When the chemistry here was right, service users saw a world of possibilities opening up. They were put in touch with the appropriate health services, given advice about their prescribing choices and options for achieving abstinence, and pointed in the right direction of support to find training, work and help with family life. The key worker also offered vital continuity of care: 'Having the option of changing from methadone to Subutex with good support from my keyworker was essential,' said one service user, who added that the support he received following some traumatic events in his family saved him 'from complete breakdown'.

With a disinterested or poorly trained key worker, choices – and a tailored care plan to follow them up – became more remote. A service user who commented that 'relations with service users could be improved' explained how, when their drug use became chaotic, they had to attend clinic twice weekly, where 'they only did drug tests – I had no therapeutic interventions. There was no consideration of the costs of transport and other commitments, and no choice, only methadone. I did a detox twice, and they caused a setback in my treatment' – a clear case of the jointly agreed care plan not happening.

'Excellent peer support and having key workers who were ex service users

Cheers...

'My own choice when free from alcohol was to look forward to gaining employment, but I had to set small achievable goals and now I am attending college doing HNC social care... so yes, my own choice has worked well.'

'I have seen the services change so much as I have been using methadone for 30 years and was on a heroin script before that. In the 70s there was just methadone or nothing, so to see the full range we get today is how treatment should be. I wish I had had the choice then – things might have been different for me in treatment terms.'

'I have been given a lot of choices by the services I use and this has helped me no end.'

'I think it worked because I was given the choice of medicine, psychosocial intervention etc.'

'Aftercare is good, I have felt benefits, it has cut old behaviour patterns... users run drop-ins and do tasks. It builds confidence.'

'I'm very happy with my treatment, I was given lots of service user involvement opportunities... Help people keep busy, volunteering, training, education.'

who I could relate to' took one respondent through the treatment system and into good aftercare. His experience had encouraged him to follow the route to helping others in treatment, and he had rewritten a manual for the expert patients programme and created an abstinence peer group.

Others had been coerced into treatment and felt they had been offered no choices. 'I was rushed into treatment via CJIP, with a poor explanation,' said one. 'I was put straight onto methadone within 24 hours without any real assessment. They like methadone in CJIP... now I have two habits instead of one.' Another client of the criminal justice system commented: 'The DTTO was garbage – I was not treated equally.' By contrast, the same person experiencing a structured day programme said 'it was 'brilliant – it works'.

Many respondents felt they would have benefited from a different, more 'person-centred' approach from both agencies and key workers, who should be 'looking at a person's whole situation'. 'The choices were limited and owned by the agency,' commented one of many service users who had hoped for 'a more tailored care plan'. 'There is no flexibility, no manoeuvrability, it's service-centred treatment: "if you can fit your treatment around us it will be OK".' Another added: 'More individualism is needed. I feel as though I am in a cattle market or on a conveyor belt.'

There were many worries about inadequate or inappropriate treatment relating to specific drugs. The loudest complaints were about the lack of alcohol treatment, which they blamed on ignorance about clients' needs or lack of local funding. For many services users, an alcohol problem became far more significant during the course of their drug treatment, and in many cases was overlooked from their initial assessment onwards.

'After reducing my script I found my alcohol intake increased dramatically,' said one respondent, who explained that he had to 'play down the alcohol side and play up the class A side' to be accepted by a project that was not funded for primary alcohol treatment. 'I fully realise this is a funding issue, but I feel that the correlation between drink and drugs should be better addressed,' he added.

Crack was another frequently misunderstood drug, particularly when combined with alcohol. 'It's all targeted on heroin or alcohol use as individual addictions,' said a service user who has been drug free for five years and alcohol free for a year. 'I was determined to stop crack and stimulant use, but carried on drinking for four years because the link between crack and alcohol was not catered for or acknowledged,' he explained.

One service user described how she had to visit a number of treatment agencies because she was using more than one drug. 'Agencies should be able to work across all substances,' she commented.

Many others complained of regional variations in treatment and called for services to be consistent across the country. 'If I move I should know what to expect,' said a respondent who complained that 'wherever one goes in the country treatment is different.' Another commented that he experienced the best choice when he was homeless and on the street for eight years. After many previous attempts at getting into treatment, it took the homeless outreach team to make it a reality.

Ignorance of mental health problems was another serious barrier to treatment.

'There can only be true choice when the service user has comprehensive information about the options available.'

One service user said they were refused antabuse in treatment for their alcohol problem 'on the grounds of a mental health problem', and 'felt brushed under the carpet'.

Others were hampered by services' lack of knowledge around dual diagnosis: 'My partner had a mental health assessment (he was violent and paranoid) and was sent home as "just having a drug problem".'

Real choice boiled down to individually tailored treatment time and time again – and a constant fight with resources. Being part of the RIOTT (Randomised Injecting Opioid Treatment Trial) had 'worked brilliant' for one service user – 'the first time I have been stable in over 20 years'. For many others, a menu of choices that did not resort to just methadone, but which included holistic and alternative treatments, had formed a vital part of treatment and aftercare. Others had found the service user network a vital lead into life after drugs. In cases relating to all of these situations, there was high praise for inspirational and committed workers and peers who had looked beyond budgets and processes to empathise with them and spur them on – and equally, condemnation of workers and services who were ill equipped to deal with vulnerable people.

'Please employ the right people for the right job – people who care,' said one, who complained that 'people in higher management make a decision about treatment without it having a positive affect on the service user'.

'Being at the centre of my care plan, being allowed to decide my treatment route, and that decision being supported and respected,' was the ideal vision of one single mum. It's a far cry from one disenchanted service user, whose verdict was: 'I never really felt I had a choice, just shuffled through the system. Even five years clean I think "the bastards made me do it".'

Service users throughout the day gave plenty of clues on the choices that would help them, and some gave an entirely positive reflection: 'I have been given a lot of choices by the services I use and this has helped me no end.' For others, there was a long way to go: 'Nowadays there's all talk about choices, but little action. Staff are so stretched they haven't got time to sort things and would prefer the easy choices.'

One respondent summed up: 'For most first time service users, as I was, the treatment journey is a chaotic lottery,' and added: 'There can only be true choice when the service user has comprehensive information about the options available.'

And tears

'The choices are limited and owned by the agency. There is no flexibility, no manoeuvrability.'

'I had alcohol dependency but I was thrown out of treatment. The biggest mistake I made was asking for help. It was why I got involved with service users.'

'At one point I had a bad keyworker. I felt that I could not ask to change the keyworker for fear of retribution.'

'I have been in treatment for the best part of 20 years. As yet my choice has not been taken into account. So far, in my experience, it's been the drug team's way or the highway.'

'There were no options, none signposted, no pharmacological interventions and very poor psychosocial interventions.'

'Peer support has never been suggested by providers. There was limited harm reduction and no aftercare – just "keep busy".'

'The service went in trends, eg methadone or detox, then rehab. There's no abstinence-based approach.'

'When I wanted a detox there was no help given, they just said don't stop the methadone maintenance due to a risk of relapse. My goal was not a consideration.'

‘The other side of choice is responsibility,’ says NTA chief executive, Paul Hayes

THE OTHER SIDE OF CHOICE

‘Choice is a good thing. Responsibility is a bit scary,’ said Paul Hayes, referring to the theme of the conference.

The responsibility of service users was to help shape services and make their treatment successful, alongside the responsibilities to earn a living and look after their children, he said. Service users needed to concentrate on organising themselves to influence policy. ‘Focus on action’, he stressed. ‘It’s a message that many people are ready to hear.’

Service user input into services was having more and more influence, he said, and gave everyone an opportunity to make the whole process more transparent – a ‘reality check’ that operated in two directions. ‘It means services can’t manipulate the figures and get away with it.’ There had been a sea change that meant service users were able to exercise much more control, but the capacity for some to advocate on behalf of others had to remain.

In terms of income, it was important to look at the benefits system and work together, he said. ‘Society gives people benefits because they’re not able to work and care for their dependents. Very few people say to me “I want to be on benefits for the rest of my life”.’ The proposed reforms of the welfare system were a ‘two-way street’, he said – the system needed to be changed to enable people to work, and the government was determined to build routes into work. ‘Grasp that opportunity,’ he urged delegates. The ‘political script’ was that people did not want to work, and that if they refused to access treatment they would be subject to the same sanctions as everyone else, he said. However, it was not as simple as that, with a complex world of people moving in and out of dependency and treatment. ‘It’s about meaningful engagement – enabling people to move out of treatment into work, and to access treatment while in work’. This represented a ‘huge opportunity,’ he said. ‘And the opportunity is real – it’s not a smokescreen.’

Drug treatment had been largely crime-driven, he acknowledged, but equal billing was now given to the needs of children, particularly vulnerable children. Being a parent with the additional challenges of problem drug use was challenging, he said, but most parents rose to that challenge. ‘Drug treatment services tend to look at people in silos – they forget that people live in families.’ Services needed to think about the people dependent on their clients, he said, but it was also important not to fall into media stereotypes. ‘The objective we have is parents supported and children protected, and that should be integral.’

In terms of people’s treatment, they could expect there to be a care plan, they could expect the TOP to check on progress and they could expect checks on their aspirations and recovery orientation. Systems and services would be expected to focus on achieving recovery and therefore needed to work together with self help groups and mutual aid – commissioners would be expected to make that a more central focus. The more non-using social networks people accessed the better, he said. ‘Nevertheless, we need to build in that there will be lapse, relapse, success.’

Many people achieved recovery outside the treatment system, he said, relying instead on family and friends. ‘All of this is a shared responsibility, expecting you to take more control over treatment and goals.’ It was difficult to sustain improvement without a job, a house, a partner or a stake in society, he said. ‘We can give you opportunities to improve your lives, but you need to take those responsibilities.’ There were real opportunities for service users to turn their lives around and make them as constructive and beneficial to society as possible, he stated. ‘But the bulk of the responsibility will always be with you.’

Andy Stonard tells delegates of a systemic, vested interest in failure

DRUGS FIELD ‘SETTING UP PEOPLE TO FAIL’

There was a ‘massive’ income for the government from alcohol, former chief executive of Rugby House, Andy Stonard, told delegates. The Treasury ‘had an investment in everyone’s misery’, he said.

He had heard ‘a history of apologies’ from the government over his 25 years in the sector, he said. ‘Individuals have the capacity to change when they’re ready, and the important thing is for services to be there when they’ve made that decision.’ On average it took around seven years for someone to turn their life around, which meant that motivational interviewing was a key factor in a person’s experience of treatment, and determining whether they came back. A US study, Project Match, had found significantly different outcomes in treatment at the same places, he said – ‘it all depends on the staff.’

‘The drugs field does not take alcohol seriously,’ he stated, with an NTORS study finding that, for between 30 and 40 per cent of people who had successfully completed drug treatment, their drinking increased – the reason why it was essential that motivational interviewing be given the right weight. ‘You’re seeing someone who doesn’t want to give up a lifestyle – they’re confused. Motivational interviewing is key to whether they take action, but instead in the drugs field the first contact is about filling out a form.’ The QuADS standards stated that assessment should be a two way process, he said. ‘It is in alcohol. I don’t think it is any more with drugs.’

The field also needed to build the necessary partnerships and make the links to help provide clients with practical skills, he said, which was ‘more important than therapy.’ There was also widespread confusion that needed to be addressed. ‘I’ve been teaching alcohol units for 25 years and I still don’t understand them,’ he said. ‘It’s a nonsense. The models we work to are a real blanket coverage.’

The units applied to people regardless of their age, weight and whether they were on medication or not, rendering them effectively meaningless, he said. ‘It’s a model that treats us all as equals, and it’s not very helpful.’ The reality of the situation was that 80 per cent of alcohol-related ill health was in the poorest 10 per cent of the population.

Issues like responsibility, learning and skills were central, he stressed. People needed practical advice, but the drugs field set people up to fail, as they were forced into treatment before they were ready. ‘They feel demeaned, they lose confidence and it sets them back six months. How you skill your workforce up to be worthwhile for the people that come through the door is key.’

In the drugs field there were lots of people who were well meaning but who lacked the necessary skills, he said, and the situation was being worsened by the increasing overlap between the drugs and criminal justice agendas. ‘What about health? What about poverty? If we looked at it from these angles, we’d have much more effective strategies.’

Templates for success

The day's second session focused on some shining examples of best practice, ranging from supplying naloxone on an outreach basis to the benefits of employing service users for both client and organisation. The thing they all had in common, however, was the central role of service users in shaping the agenda.

The session began with a look at alcohol detoxification using monitored drinking. Caroline Thompson of Nottingham-based Framework Housing, which specialises in housing and support for homeless people, described how her organisation was commissioned to provide a 'sensible drinking service', after a service user consultation found that many clients did not want complete abstinence. The service even provided the alcohol.

Clients were breathalysed on arrival, before being given four units of alcohol at set intervals until reaching a breath alcohol reading close to negative. There were a maximum of five nights when alcohol could be consumed, and one of the abstinent days had to be the day clients received their benefits. The service would never be offered where there could be potential physical or mental health consequences, she said, and exclusion criteria included use of benzodiazepines.

'The aim is to comfortably achieve a negative breath alcohol reading in the absence of physical withdrawal symptoms, and to try and engage people in the positive aspects of their treatment' she said. It was a good way to suppress withdrawal symptoms and increase self-efficacy regarding future alcohol consumption, she said, and worked better with younger service users, particularly in conjunction with the organisation's meaningful occupation programmes.

'For many people, this is a massive change,' she said. 'The process is about people being in charge.' The detox was extremely safe and constantly monitored, as well as cost effective, she said, and staff turnover was extremely low. The service was also very popular with partner agencies, including Nottingham DAT. 'It's service user led. We want service users to be happy, and we offer choice. We also run an abstinence programme side by side in the same environment, and it works very well.'

Also service user driven was the Wiltshire naloxone pilot, which saw the overdose-reversing drug supplied on an outreach basis in 2007 (*DDN*, 12 January, page 12). A multi-agency project, the aim was to not only to reduce drug-related deaths but also to raise awareness of blood-borne viruses.

A show of hands revealed that most people in the audience knew someone who had died of an overdose, and would have done something to help had they had access to naloxone. Despite being safe and effective, however, naloxone distribution remains patchy (*DDN*, 1 December 2008, page12). The drug should be freely available at needle exchanges, Wiltshire DAAT harm reduction lead Mick Webb told delegates. 'Why do we need to provide evidence that naloxone works?' he said. 'It's so frustrating. The stuff's been used by A&E departments and ambulance services for years to save lives – it's proven that it works.'

Meanwhile service user Cristina Lora told the conference about the Random Injectable Opioid Treatment Trial (RIOTT), where a third of those involved were provided with injectable diamorphine, with access to doses of oral methadone. The emphasis was on self-reporting, she said, with meetings held every four weeks. 'As a service user you always have to be economical with the truth, but in the trial they really did believe us. They would increase the dose instead of penalising people.'

The trial began in 2005, with a survey carried out in 2007. Of the 26 people in treatment at the time, 12 were not using at all after the trial, whereas before more than half had been using seven days a week. Crack use had also reduced, because service users were not being exposed to dealers and their 'clever marketing and two for one deals,' she said, and over the three-year trail period there had been no drug-related deaths or criminal justice incidents. 'The way forward is for service users to ask joint commissioners to start trials in their areas,' she said. 'It makes sense – it works, it saves lives.'

Counted4 is a tier 3 prescribing service in the north east that routinely employs drug users, and it was often asked why, said drug worker and ex-service user Sharyn Smiles. 'Drug users have invaluable experience of accessing services, customers relate to them well, and they're good "interpreters" for GPs,' she said. 'Drug users are willing to learn. They're good, honest, reliable people and very employable – they go that extra mile. I don't want a job because I used to stick a needle in my arm. I want a job because I want to make a better life for my family.'

Being able to provide for dependants and the sense of achievement that goes with it was one of the recurrent themes in feedback from service users, said Counted4's Lisa Mallen, along with feeling part of society, doing something worthwhile and being trusted and taken seriously. Negative aspects included the attitudes of some other employees, Criminal Records Bureau checks and fitting work around accessing treatment.

For the employer, however, it also helped promote an attitude of equality as well as improving retention rates, providing a wealth of learning opportunities and offering a new perspective. 'Customers can engage and relate, and it also inspires colleagues,' said Lisa Mallen. It also helped challenge attitudes – among GPs, for example – and the perceptions of some partner agencies around working with service users.

'What I would say to employers is this,' said Sharyn Smiles. 'Try it – you might like it.'

From the top: Caroline Thompson, Mick Webb, Cristina Lora, Sharyn Smiles and Lisa Mallen.

As part of our service user consultation at *Voices for Choices*, delegates were asked what impact they thought the proposed measures in the welfare reform bill might have on them and others. **DDN** reports

WELFARE TO WORK?

'We need to consider how society views drug users... They want them back in employment, as long as it's not them employing.'

'I don't think it's worth the paper it's written on,' said one service user of the Department for Work and Pensions' (DWP) welfare reform bill. 'It's all stick and no carrot,' said another. Under the bill's proposals, claimants with problematic drug use issues who do not enter treatment could see their benefits withheld, as well as face benefit fraud investigations for failure to declare heroin and crack use (*DDN*, 28 July 2008, page 4). Benefits could also be withheld for failure to attend special employment support sessions, and the proposals allow for extensive information sharing between the criminal justice system and the DWP.

However the bill does include the creation of a 'treatment allowance' for drug users who are stabilising their condition, and also aims to encourage employers to take on people with a history of problematic drug use. Many in the sector are sceptical about how effective this would be, given the likely attitudes of employers and the many barriers towards re-entering employment. Despite the DWP characterising the proposals as 'more support in return for greater responsibility' they were widely criticised in the field for being discriminatory, ill thought out, likely to increase stigmatisation and an attack on the civil liberties of service users. According to Release, they display a 'failure to understand the fundamental nature of addiction.'

Delegates were asked for their own experiences of the welfare system and how it has affected their drug treatment goals, as well as how the reforms might support – or conflict with – those goals.

In terms of their experience of the system, respondents described how being in receipt of incapacity benefit had helped them from a financial point of view – as it meant more money than Job Seeker's Allowance – but that it could potentially hinder their return to work. One described people 'using just before the reviews' in order to continue receiving benefits, and a corresponding fear of abstinence because 'suddenly you're well, and there's no concept of recovery time and all the anxiety that goes with it.'

People felt that in the system as it stood there was no incentive to earn money on a part time basis – as benefits would be reduced accordingly and prescriptions would also have to be paid for – and that the system also needed to be flexible enough to adapt to claimants doing brief periods of work, as at the moment it was 'easier not to let them know.'

More than one service user said they – or people they knew – had kept their drug use a secret when dealing with benefits agencies for fear of having their children taken away by social services, and that the proposed requirement to declare problematic drug use could mean

more and more women not accessing the treatment they need.

Many respondents thought the reforms would lead to service users being more stigmatised and marginalised, foster resentment towards services and that the requirement to declare drug use would 'promote fear and mistrust at job centres'. 'The focus seems to be on penalising people, not helping them,' said one. Others were worried about the impact of the reforms during a recession. 'It's sending the wrong message at the wrong time,' said another. 'Where's the jobs?'

People spoke of how having to be 'actively seeking work' added to the pressures they faced in trying to address the problems of their addiction, especially if they lived in an area where there were few employment opportunities, and how agencies failed to understand the psychological impact of re-entering the job market after a long period. 'Stepping out of the comfort zone' was very unnerving, said one respondent, and there were fears expressed that the added pressures could lead to more relapses, as well as around the training and competencies of the government's new JobCentre Plus co-ordinators (*DDN*, 26 January, page 4) and how well they would be able to understand the problems facing drug users.

One service user representative expressed doubts that services would be able to cope with the influx of people required to enter treatment, and another respondent thought it would lead to 'unmotivated staff herding dissatisfied punters.'

Many respondents were unaware of the proposed changes – they'd either heard nothing, or were confused by what they had heard. But, although a minority, a number of service users thought the proposed new regime a good idea, provided it was implemented thoughtfully and effectively. 'With a clean head I sort of agree' with the proposals, said one. 'The sooner it comes in the better,' commented another. 'This will get everyone off their arses,' said a third.

The majority of criticism, however, was reserved for the potential impact on crime levels, with many service users feeling that withdrawal of benefits would inevitably lead to an increase in acquisitive crime, as people unable to stop using would fund their use through illegal means. 'By taking people off sickness benefit they will have no other choice but to commit crimes,' said one. 'If someone isn't ready for treatment, they shouldn't be forced into it,' commented another. 'It could send the crime rate sky high if people lose their benefits.'

And many saw the proposals as symptomatic of attitudes to drug users as a whole. 'We need to consider how society views drug users,' one delegate commented. 'They want them back in employment, as long as it's not them employing.'

Notes from the Alliance

Don't stop now

We're in a unique position now to galvanise consultation – let's keep pushing forward, says Daren Garratt

Firstly, can I thank all of you who attended and contributed to this year's *DDN*/Alliance *Voices For Choices* national service user conference in Birmingham. It was fantastic to see the event filled to capacity (again), and the overall energy and levels of discussion, debate and general engagement were truly inspiring.

I felt extremely proud and privileged to be associated with such a positive advertisement for effective, targeted, proactive user involvement, and I know our friends and masters at the NTA, Department of Health and Home Office were equally impressed with both the turnout and highly articulated willingness of so many people to reflect on the real impact that drug treatment is having on their lives.

We all have a collective duty to ensure that national drug strategy moves beyond being a just a daunting set of increased (and often contradictory) targets and demands that restrict creativity in an already over-burdened workforce, but instead effectively supports an individual's recovery and reintegration by providing 'more personalised approaches to treatment services which have the flexibility to respond to individual circumstances'. And one way to do this is to directly inform the relevant government departments of the positive and negative effects that local drug treatment provision is having on the lives of the people it is intended to serve – namely, users and carers.

We hope we managed to start this process in January by using the conference as a means to gather the views and experiences of service users (and again, thank you all for your time and contribution), but this needs to be an ongoing process, and we intend to make this a key part of the Alliance's role over the coming years.

We're in a unique position in that we have a conference, internet forum, local peer-led projects, and continually expanding training courses that specifically target and engage with service users, and we need to galvanise these opportunities for consultation and establish a true picture of drug treatment in the UK, and make it our duty to keep government informed of what is – and perhaps more importantly, isn't – working.

This is why it was so important to use the conference to give a platform to exciting new initiatives that support controlled drinking, the prescribing of injectables and user and carer administered naloxone pilots, as these are exactly the types of 'new approaches to treatment' that the new drug strategy proclaims to support. Although given the apparent contempt and disregard the current government appears to have for the Advisory Council of the Misuse of Drugs' guidance and recommendations (cannabis and ecstasy reclassification anyone?), I do understand if there's a collective snort of reader cynicism out there.

But we have to keep pushing forward, and with the third National Service User Conference already being planned, and a series of nine Alliance/*DDN* regional roadshows awaiting confirmation from the Department of Health, we can really cement the user and carer voice in effective strategic consultation.

Thanks again folks. We couldn't do it without you.

Daren Garratt is executive director of the Alliance

TALKING THERAPIES

The afternoon saw a panel discussion on key issues around service user involvement, featuring Andy Stonard of the Conference Consortium, Hugo Luck of the NTA, GP and *DDN* columnist Dr Chris Ford, and editor of service user magazine Black Poppy, Erin O'Mara.

At your service:

'There was so much networking going on – I think that was the most important thing,' says *DDN*'s service user volunteer co-ordinator Marcus Wilson about the service user exhibition he organised at Voices for Choices. 'The aim was to bring together as many service user groups as possible to share good practice and see other groups at different stages of development.

'I was really pleased with it – in the run up to the conference I wasn't sure how many people would turn up but it went really well,' he continues. 'It gave the service user groups a chance to show off what they'd achieved and helped people realise that being part of the service user movement is worthwhile, and that the NTA is listening. With that many people coming together the NTA has no choice but to listen, because it's such a viable force.

We had really, really positive feedback. People were telling me that they'd really learned a lot and it was important to meet other service users, so they don't feel they're just plugging away in isolation.

A couple of people said how much it had re-energised them – they were getting a bit disillusioned and this gave them the boost they needed. Next year I'd like to really build on what we've done and make it even more successful.'

'Service user involvement has a large part to play in drug treatment and days like this demonstrate that to the NTA. It was great to meet other service user groups at varying levels of development.'
Dave Rankine, Lancashire User Forum.

'I took along two new service user reps and we all found it a really informative, useful day, especially the Wiltshire Naloxone Pilot presentation, which we're now looking into.'
Jill Dunnington, service user involvement worker, Turning Point, Wakefield.

'No one ever said user involvement was easy.'

The opening question was on an emerging tension in the wider drugs strategy – what did the rights of the individual, and person-centred treatment, mean now that the stated goal of treatment was abstinence? 'The only conflict is the one we allow the field – and critics of the field – to have,' said Hugo Luck. Seventy per cent of users wanted to get out of their lifestyle and needed support, he said. 'There's no dichotomy – only the one that critics exploit. We need to move on from abstinence versus harm reduction towards concentrating on effective treatment.'

People should have a choice and not be pushed into abstinence, said Chris Ford. 'A diabetic on insulin doesn't get excluded from a job. Why should someone on a script? Drug users should be employed everywhere if they have the confidence and abilities to do the job.'

On the question of the NTA's definition of effective treatment, Andy Stonard said that there was a criminal justice driven agenda that meant drug users were seen as a criminal class, while on the subject of needle exchanges, Erin O'Mara said it was essential that services moved with the times. There was also a significant issue around outreach workers not reaching a range of people who were 'below the radar', she said.

Many delegates felt strongly about use of the word 'choice' when it came to treatment. 'How can you give a service user a choice and say 'this is your choice?' asked one. 'The key term is 'evidence base',' replied Hugo Luck, urging delegates to 'get informed'. 'Knowledge is power,' he said. 'Effective treatment is evidence-based, humane and individual.'

Another question was on the potential reluctance of providers to put forward individuals to be part of a service user group. 'They often get rid of the most vocal individuals and keep the ones who don't give much trouble,' said Erin O'Mara, while Chris Ford stressed that 'services should not be deciding who is in a service user group'. On the issue of how to start a user group, meanwhile, Hugo Luck said everyone's experience was different. 'Funding is important,' he said. 'No one ever said user involvement was easy. But service user groups don't need the NTA.'

On the question of whether there existed a clear policy on needle exchange provision for the under-18s, Hugo Luck said that NICE had 'not gone down the young people's line' in its guidance. 'There's a clear absence there that needs to be addressed,' he acknowledged. There was also the highly charged issue of needle exchanges in prisons. 'They definitely should be in prisons,' stressed Chris Ford. 'Needles are already in prisons, and they're the contaminated ones,' commented one delegate.

When it came to provision of specific services for stimulant users, Andy Stonard said that there was undoubtedly a lack of both services and recognition. 'Services don't look at harm reduction issues around stimulants, like the sharing of straws and pipes,' he said. 'They always end up looking at needles.' Most services were opioid based and had been for 40 years, said Chris Ford, but services needed to respond to people as individuals, with individual issues and problems. Some delegates felt that those in recovery for stimulant use only were not given consistent medication and treatment, it being done instead on an ad hoc basis. 'A lot of people with stimulant issues are in jail or mental health facilities,' said one.

On the controversial issue of the welfare reform white paper and the increasing overlap of drug treatment with the criminal justice agenda, Erin O'Mara thought that treatment services were only now emerging from '20 years of the dark ages'. 'There are a lot of snappy phrases in the document,' she commented. Referring to the new JobCentre Plus coordinator posts (*DDN*, 26 January, page 4) she said there was '£9m of training for staff, but what kind of training will they have? There's nothing in the document about the psychological impact of returning to work. It's terrifying for people.'

It was also felt that the NTA's stated aim of keeping families together could be a hollow promise when the funding was not available. Hugo Luck acknowledged that for the last two or three decades services had been geared towards white male opioid users in their 20s and 30s, but commissioners would now need to meet their targets around childcare. 'There's nothing that stops funding for childcare,' he said. 'It's down to the local DAT, so it's up to service user groups to lobby for this.'

'It was good to see what is possible and it has inspired me to carry on with service user involvement.'
Tim Archbold, Heads Together, Luton.

'It was a very interesting and informative day... there was so much going on.'
Nigel Calvert, SUST, Gloucester.

'I really got a lot out of it. It made the training I've been doing make sense and seem worthwhile, and energised me to carry on in service user involvement.'
Jean Ayers, PAST, Barking.

'Great to catch up with colleagues and friends and meet new people involved in the user involvement movement... same old rhetoric from the NTA.'
Dave Stork, service user coordinator, Gloucester.

'The event was great for networking with other service user groups and even though we're an established group we still learned a lot.'
Tracey Gibbs, Hi's & Lows, Walsall.

'This year's event was as real as last year's. Everyone loved the alcohol presentations and Mick Webb's naloxone slot seems to have re-energised the subject. We brought 12 service user reps from Bristol and two felt really heard when they grabbed Paul Hayes – though his lecture on responsibility and benefit reform met with disappointment, especially since, down our way, DWP are already telling people in structured treatment to "get back to work".'
Alex Boyt, service user coordinator, Bristol Drug Strategy Team

Throughout the day the **DDN** film crew was on hand to hear people's experience of treatment, their views on choice and whatever else was on their mind. Here is a selection of highlights. You can view them in full at *www.drinkanddrugsnews.com*

VIDEO VIEWS

Rachel Clements,
service user involvement co-ordinator
'Paperwork is actually an impediment to creating a rapport with someone. If somebody comes in in distress, they've got loads of stuff going on, they might be feeling paranoid about having contact with the system in the first place. The last thing they want to do is complete a massive mountain of paperwork. It's not helpful – who's it for? The clients don't want it, they'd prefer to just be able to chat to you. As a worker it's just a nightmare and a source of stress that stops you from being able to think properly about your client. So who wants it? It's the NTA that wants it so they can audit what's going on and it's all to do with performance management and ticks in boxes and it's nothing really to do with people's welfare – the welfare of the people it's supposed to be about.'

Kevin Knott,
Bradford service users representatives forum
'I'd like to say how glad I am to be here this year after being here last year, seeing improvements that have been made. And I'd like to say "big up to the Bradford SURF" and I'm happy to be involved. I've come a long way since coming out of prison in August 2007 after a long time in for drug addiction. I'm clean at the moment, touch wood – hope it stays that way – and I'm just happy to be here.'

Toni Meshko and Sammy Manzarolli,
Artheads, West Suffolk
TM: 'Artheads is a brilliant project that has been running for a few years, involving music, dance, drama, art exhibitions, and it's basically been to raise awareness of addictions to the general public.'
SM: 'No one said to me it was possible to stop using drugs and I worry that that still hangs around – that that doesn't get tabled as an option quite as often as it might.'

Sean Murphy, Nottingham
'It's not so much the services, but the structure the services fit in. They're the ones that ask for the targets to be met. The services try and meet the targets, and somewhere along the way the people get left and kind of forgotten.'

Phil Craig, Addaction
'They say they can't have needles in prisons because it's a political thing and they're afraid of what the media might put out to the public about it – the fact is, needles in prisons are already there and I think the authorities should begin to get more real.'

Paul Simmons, Suffolk DAAT
'The people that do go for abstinence services and remain free from drugs and alcohol do seem to lead more productive lives… when I was using, I just wanted to be normal. To me, what normal meant was going out, getting a job, having a family, children, all that kind of stuff. And what abstinence-based treatment has led to eventually for me, with a lot of hard work, is exactly that.

'It's about time the NTA went Alan Sugar on the rogue commissioners who are not interested. At the end of the day it is proven that involving people in their experiences of treatment does contribute to more effective treatment. We need to listen to what people want and we need to give them that.'

Christopher Campbell,
substance misuse users group, South Wales
'We're pushing a social enterprise. Groups in South Wales are looking to amalgamate. England, we can't deny you're doing a good job and you would be sorely missed if you weren't there. But come on, there's more than just England in the nation.'

The Voices for Choices consultation

Articles on pages 8-9 and 12-13 of this issue are based on the responses to our consultation, carried out throughout the day of the conference. For the 101 questionnaires completed, 58 of the interviews were with men and 43 with women.

The regional breakdown was:

East Midlands – 8	East – 3
London – 22	North East – 6
North West – 9	South East – 21
South West – 5	West Midlands – 17
Yorkshire – 6	Wales – 3
Scotland – 1	

Ethnic mix:

White – 92	Black – 2
Asian – 3	Chinese – 1
Mixed race – 3	

Living arrangements:

84 were in their own home or rented accommodation;

4 were in hostels	1 was in rehab
3 were rough sleeping	9 others

Employment:

21 in paid employment	22 unemployed
33 unable to work	7 students

Members of service user groups – 86

Treatment paths:

drugs – 25	alcohol – 12
both – 64	

Currently in treatment – 55

41 had been in the past and 5 had never been.

Age:

under 25yrs – 6	25-35yrs – 31
35-45yrs – 40	over 45yrs – 24

Grateful thanks to our team of volunteers who did an excellent job interviewing delegates and helping throughout the day: Jean Ayers, Tony Birt, Caroline Blackburn, Jim Briggs, Abi Butters, Duncan Cairns, John Downes, Bri Edwards, Tidjane Gbane, Carlos Harmankoya, Peter Hawley, Julie Hunt, Mandy Kewley, Linda Lee, Peter McDermott, Si Parry, Dave Pennington, Beryl Poole, Claire Robbins, Carole Sharma, Roz Smith, Sue Tutton, and Maddy Wilson. Thanks also to Neil Hunt and Danny Morris for conducting training.

Partners in criminal justice

In the second of our series, senior practitioner at Addaction, Surrey, **Nick Walter**, describes the workings of the enhanced arrest referral service

Addaction provides an enhanced arrest referral service across Surrey and has workers in the four main police stations at Reigate, Staines, Woking and Guildford.

Each worker also has responsibility to cover the adjoining magistrates court, and in Guildford the Crown Court as well. The workers are co-located within the prolific and priority offender (PPO) teams at each police station, enabling them to give a premium service to those PPOs who have been identified as having substance misuse issues.

Although a small team in terms of numbers we are at the forefront of delivering the Drug Intervention Programme (DIP), alongside Surrey Alcohol Drug Advisory Service (SADAS), who provide the aftercare, and Access, who provide rapid prescribing – Access is able to provide an appointment within seven working days for those clients with prescribing needs. Unfortunately the DIP team is not co-located at the moment but hopefully this will happen within the next few months.

Arrest referral workers offer a service to everyone at the point of arrest, obviously targeting DIP clients but signposting any non-DIP clients to alternative community agencies as well. The worker will case manage any DIP client on bail up until the point of sentence.

There are five prisons within Surrey and we maintain good links with the CARAT teams in all of them, especially HMP Bronzehurst and HMP Highdown, which are remand and shorter sentence prisons. Problems still occur, however, with those prisoners who are released early on license or given very short sentences. Presentations are made to local magistrates to replace very short sentences with three month deferred sentences – so the client can engage in treatment and a report be prepared for the sentencing court – and this option has now been taken up on several occasions.

Surrey is a non-intensive DIP, but is surrounded by intensive DIP areas – the Home Office originally predicted that the impact on Surrey for required assessment follow-ups and restrictions on bail would be no more than five per year. To date we are, on average, being asked by various DIPs to provide five appointments per week for Surrey clients, and in the course of a year have given well over one hundred appointments.

Arrest referral workers also have strong links with probation and are able to provide up-to-date client information to pre-sentence report (PSR) authors with regards to clients they are case managing.

Surrey is a large area and has its problems with transport links for clients attending clinics, especially in the east of the county – the journey can take well over an hour and involve changing trains up to three times. In the light of service users' concerns, the local PCT and DAAT are reviewing this and it is hoped that a satellite clinic can be made available in this area.

Another concern is that conditional cautioning has not been taken up in the county – it was hoped that as a non-intensive DIP this would be the ideal way to get low-level offenders with drug issues into treatment, and consultation continues with Surrey police.

Understanding what is working and the 'pinch points' in the criminal justice system relating to drugs and alcohol is the aim of the Conference Consortium's forthcoming event, 'Somebody else's shoes', on 25 June in London. Visit www.conferenceconsortium.org for details. In the run-up to the conference DDN will be interviewing a selection of people working within the system, to give insight into different roles and how they relate to each other.

Regain your brain

Addictive substances 'hijack' the brain by depleting, mimicking or interfering with its neurotransmitter-based reward system.

Nutritionist and psychologist Patrick Holford **describes how nutrition strategies can reduce craving and prevent relapse.**

The vast majority of people have some level of desire or craving for, dependency on or addiction to, one or more substances. Some are mildly dependent on substances like caffeine, sugar or alcohol – they get on with life, perhaps experiencing some benefits as well as some downsides. Some have tried to stop taking the substance because they wanted to be healthier, but started using the substance again because of the discomfort this caused. Others have had their lives ruined by addiction, are desperate to quit and may have attempted to many times.

Others still have successfully quit an addictive substance, expecting to feel so much better but only to find, months or even years later, that they still feel lousy. Whichever of these apply, the chances are that they have experienced some level of what we call 'abstinence symptoms' – symptoms that emerge when the addictive substance is removed, but after the immediate withdrawal phase. They include cravings, hypersensitivity to stress, noise or pain, feeling empty, incomplete, anxious or 'shaky', having problems with memory or sleep, fatigue, mood swings, restlessness and impulsiveness or depression – in short, pain and misery.

It is these symptoms that often cause people to return to the addictive substance, whether it's sugar, nicotine, caffeine, alcohol or cocaine – the reason why attempts to give up fail. But what if you didn't experience these abstinence symptoms? What if you had no cravings, no mood swings, no sleep problems and had good energy and motivation?

This should be our normal state – when the brain is working properly it creates a sense of wellbeing and satisfaction. When you are taking in the right nutrients your brain rewards you. Craving, dependency and addiction are what happens when the reward system goes wrong.

Every addictive substance, from caffeine to cocaine, works because it mimics or increases levels of naturally occurring brain chemicals such as the neurotransmitters dopamine, serotonin and endorphins that are all part of the brain's reward system. If you are reward deficient and you find a substance that makes you feel good, your brain gives you a pay-off and you are going to use that substance again.

However, the more a person consumes the more their brain adapts to the presence of these substances, until they must use larger and larger quantities to get the same effect, causing more and more changes in the brain. As neurons in the brain adapt to larger and larger quantities, the brain can become reliant on the mood-altering substance and increasingly shuts down its own production of neurotransmitters. By this stage, attempts to quit soon lead to a whole host of abstinence symptoms that tell the person they must have the substance – life is not worth living without it. The addictive substance has hijacked the brain.

One logical way out of this cycle is to feed your brain the concentrated building blocks – amino acids – of its own natural feel-good chemicals, the ones the addictive substance has replaced. Twenty years ago a series of trials – some placebo-controlled double blind – by Kenneth Blum, who first coined the phrase 'reward deficiency', illustrated the benefits of this approach. More recent research, published last year, gave either placebos or amino acids to cocaine addicts and pathological gamblers. The cocaine users who were given amino acids found their desire for cocaine significantly reduced and 59 per cent of the

'Eating protein is the best way to get essential amino acids for a normal healthy person, but taking amino acid supplements is the best way to guarantee a person in a state of reward deficiency is receiving the optimal amounts to rebalance their neurotransmitters.'

gamblers given amino acids stopped gambling.

The neurotransmitters adrenalin and noradrenalin, for example, are made of amino acids L-phenylalanine and L-tyrosine. They create arousal, energy, stimulation and mental focus, and symptoms of deficiency include depression and poor concentration. The substances used to compensate for this deficiency are caffeine, cocaine, amphetamines, tobacco, marijuana, alcohol and sugar. Dopamine is made of L-phenylalanine and L-tyrosine and creates feelings of satisfaction and comfort. Deficiency symptoms are lack of pleasure, motivation and reward, and fatigue and depression, compensated by use of alcohol, marijuana, cocaine, caffeine, amphetamines, sugar or tobacco.

Endorphins and enkephalins create physical and emotional pain relief, pleasure, euphoria and sense of wellbeing, and are made from the amino acids D-phenylalanine and DL-phenylalanine. Symptoms of deficiency include physical and emotional hyper-sensitivity and inability to feel pleasure, and are compensated by heroin, alcohol, marijuana, sugar or chocolate. Seratonin, meanwhile, is made from L-tryptophan or 5-HTP and creates emotional stability, self-confidence, pain tolerance and quality sleep, while deficiency causes depression, compulsiveness, worry, low self-esteem, insomnia and irritability, compensated by use of alcohol, sugar, chocolate, tobacco and marijuana. So, if you're a habitual coffee drinker during the day, then crave a glass of wine or two in the evening, and would feel tired, depressed and less able to concentrate without them, then the amino acids that are most likely to help you would be L-phenylalanine and L-tyrosine.

Of course, it's not quite as simple as that. Your ability to turn these amino acids into neurotransmitters, and the ability of those neurotransmitters to be 'read' by the brain, also depends on other nutrients such as B vitamins, minerals and essential fats. In our book *How to quit without feeling s**t* we have a specific strategy for each addiction, backed up by a specific supplement regime – you can also find summaries of these strategies on the website www.how2quit.co.uk .

Supplementing amino acids

Eating protein is the best way to get essential amino acids for a normal healthy person, but taking amino acid supplements is the best way to guarantee a person in a state of reward deficiency is receiving the optimal amounts to rebalance their neurotransmitters. One of the advantages of taking supplements containing individual amino acids is that they are more easily absorbed this way. Certain amino acids compete for absorption, so if you supplement with tryptophan, for example, you will absorb more into the bloodstream if you take the supplements without eating protein-rich food at the same time. Taking the supplements with a carbohydrate food, such as fruit, may be even better because the presence of carbohydrates is known to help the absorption of amino acids. The minimum effective starting dose for most of these amino acids is 500mg per day and can be increased gradually to 3,000mg per day (except for 5 HTP, which ranges in dosage from 50 to 400mg per day, and L-glutamine, which ranges in dosage from 500 to 15,000mg per day). It's best to start with a lower dose and increase it until you feel the benefits. Most people respond to the daily dose being divided into two or three doses a day.

Brain support nutrients

The process of turning amino acids into neurotransmitters depends on a process called methylation, which is dependent on B vitamins, especially folic acid, B12 and B6. A person's methylation ability is determined by measuring homocysteine in the plasma – substance misusers typically have raised homocysteine levels, indicating a greater need for these B vitamins. The reception of neurotransmitters is also dependent on an adequate supply of essential fats, most notably the omega 3 fats EPA and DHA. Among substance misusers, the higher the plasma EPA the lower the anxiety scores, and the higher the plasma DHA, the lower the anger scores.

IV nutrient therapy

For those with serious addictions, the inclusion of intravenous nutrients given after they have been through detox and delivered via a daily drip, usually for six days – based on a person's specific addiction and neurotransmitter imbalances – greatly speeds up the recovery from abstinence symptoms. This is especially helpful for addictions that mess up the digestive tract, either because the person doesn't eat properly, as in the case of stimulant drugs, or because the nature of the substance and its effects on the gut, as in the case of alcohol or heroin.

The critical question, of course, is does it work? At Bridging The Gaps, a treatment centre in Virginia that has incorporated this approach alongside conventional addiction recovery treatment, we gave a group of clients nutritional therapy, including specific supplements and diet, and compared them with a group also given IV nutrient therapy.

At the end of the month, those given oral nutrient therapy had reduced their abstinence symptoms (based on the scale of abstinence symptom severity) from an average score of 88 to 40 – a 55 per cent drop, while those also given the IV nutrient therapy had a 75 per cent drop – from an average of 114 to 29. Those receiving the IV nutrient therapy had a 69 per cent reduction after the six days of IV treatment. The hypothesis here is that if you feel so much better then you're less likely to relapse. Most treatment centres expect around 80 per cent to relapse.

Bridging The Gaps' Dr James Braly assessed the severity of symptoms commonly experienced in abstinence before the start of nutritional therapy, daily for six days, and again at 30 days. The group receiving intravenous and nutritional therapy had greater reduction in severity of symptoms at the end of six days than the group that had oral nutrients had at 30 days.

The centre also followed up 23 clients who had had serious drug and alcohol addictions and had received IV nutrient therapy, followed by diet and oral supplements, one year after their admission. Of these, 21 – 91 per cent – were still clean or sober after a year or more, and 16 had had continuous sobriety. These results are very encouraging and will, hopefully, inspire more research – the website www.how2quit.co.uk lists treatment centres offering this approach.

Patrick Holford is CEO of the Food for the Brain Foundation
www.foodforthebrain.org

The average crack user spends £500 a week on drugs

Knowing the facts is one thing. Doing something about them is altogether more challenging — and that's where Worcestershire Druglink comes into its own. As the county's main non-statutory provider of drug services, we offer open access for crisis support and needle exchange, care-planned interventions, access to prescribing, structured day programmes as well as outreach work. Ready to join us?

Assistant Service Manager – Substance Misuse c. £31,500

Working closely with the Service Manager, you will be responsible for all aspects of service development, delivery and evaluation. This will involve much more than leading and developing your team. You will define outcomes, build stakeholder relationships, engage service users and ensure robust financial and data management systems. You will also explore ways to enhance efficiency and drive our process of continuous improvement.

This role calls for an experienced operational manager with strong leadership skills and the ability to grow and develop services in a social care or similarly regulated sector. You will certainly know how to involve service users and meet their needs in an increasingly complex commissioning environment. First class database, communication and organisational skills are also required – and you will demonstrate a high level of financial awareness. The willingness to travel across the county is, of course, essential. **Ref: N8710/28.**

To discover more about this influential role – and apply online – please visit **www.jobs-at-turning-point.co.uk**

TURNING POINT
turning lives around

Registered Charity No. 234887

www.commlinks.co.uk

Do you want to become part of an innovative and user-focused mental health organisation?

Alcohol Support Service

Support Worker (2 posts)

£19,370 - £21,244 37 hours per week

Ref: P40 – permanent

Ref: P40A – 1 year fixed-term contract

Based in Batley, covering Kirklees

Experience of alcohol support issues as a worker, service user or carer is essential.

We offer an excellent package, including generous annual leave, excellent training and development, final salary pension scheme and work-life balance policies.

For full application pack, visit our website www.commlinks.co.uk or write to Community Links, Regents Court, 39a Harrogate Road, Leeds LS7 3PD; fax (0113) 262 2294, or e-mail recruitment@commlinks.co.uk

Closing date: 7 April 2009. Interviews will be held shortly afterwards.

We aim for our workforce to reflect the diverse and exciting region we serve. We particularly welcome applications from members of black and minority ethnic communities.

community links

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

You call Kinesis, we do the rest!

www.kinesislocum.com

0207 637 1039

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

Face the challenge of substance misuse

WDP is a leading drug and alcohol treatment provider, delivering a variety of substance misuse services across the South East of England. We recognise the importance of career progression and place great faith in our talented team, resulting in a highly motivated and diverse workforce always eager to seek out and take on new experiences and challenges.

DIP Practitioners • Westminster, Newham & Harrow • £23,088 - £28,933

An experienced generic DIP practitioner with a flexible, empathetic and open minded approach, you'll cover all aspects of DIP, working in police stations to assess the needs of drugs users and refer them into the most appropriate treatment, providing one to one support and covering throughcare and aftercare responsibilities. High security Met clearance is essential.

Women's CJIT Practitioner • Hackney • £23,088 - £26,075

You'll be involved in all aspects of criminal justice work within a women's only service, supporting female drug users within the Criminal Justice System to maximise their uptake of treatment services. Met clearance is essential. This post has been deemed to carry with it a Genuine Occupational Requirement for the post to be carried out by a female worker in line with Section 7 (2) of the Sex Discrimination Act 1975.

Mobile Arrest Referral Practitioner

• 1x East London and 1x South/Central London • £23,088 - £28,933
+ £2,000 enhanced allowance

You'll join a busy team working in a variety of DIP settings including police stations, courts and prisons, assessing the needs of drug users and referring them to the most appropriate treatment. Highly motivated, and with strong experience of working within the substance misuse field, you should also have a sound knowledge of the Criminal Justice System. Met clearance is essential.

GP Shared Care Liaison Nurse

• Harrow • £24,103 - £32,653

Leading on all aspects of GP shared care within the Harrow team, you'll be a qualified nurse with demonstrable experience in the substance misuse field. You'll develop specialised programmes of care and provide highly specialised advice to GPs and other staff on the clinical management of substance misusing clients.

GP Shared Care Coordinator

• Harrow • £25,219 – £30,000

You'll provide care co-ordination, comprehensive assessments, care planning and reviews, titration and prescribing services and other clinical and psychosocial interventions.

DIP Practitioner (RoB) • Enfield • £23,088 - £28,933

As Restrictions on Bail Practitioner, you'll contact, assess and support drug users in the Criminal Justice System and maximise their uptake of treatment services within the WDP premises and in different criminal justice environments.

Closing date for all above posts: 09/04/09. Interviews: w/c 13/04/09.

Parenting Support Worker

• 2 dpw • 1 day in Hertfordshire and 1 day in Wandsworth
• £25,219 - £31,724 pro rata • Fixed term until 31st March 2011

Working within our CoreKids team, a holistic therapeutic service for children, parents and families, you'll support parents who are accessing community based treatment services due to substance misuse problems, delivering parenting support 1:1 and group sessions.

Closing date: 15/04/09. Interviews: 28/04/09.

To apply, please visit: www.wdp-drugs.org.uk

WDP is an equal opportunities employer and welcomes applications from members of BME communities.

THE OASIS PARTNERSHIP

Harm Reduction Co-ordinator

Based: Buckinghamshire (countywide)
Salary: £21,408 – £26,616
Application deadline: 6th April 2009

You will be responsible, in conjunction with the Service Manager, for the co-ordination and continued development of our harm reduction services across the county. This will include facilitation of the static and community based county wide needle exchanges, liaising with pharmacists, the local authority and directly with clients and members of the public.

You will be required to provide training to our clients, staff, key stake holders and community groups. The role also involves the establishment and ongoing development of our Open Access/Drop In service and our outreach provision.

As you will be working with a wide range of people you must be able to demonstrate strong communication skills.

Interviews to be held on Friday 17th April 2009.

Project Worker (Alcohol)

Based: Buckinghamshire (High Wycombe)
Salary: £21,408 – £23,724
Application deadline: 6th April 2009

Working as part of a team, you will primarily provide services to people experiencing alcohol related problems. You will have experience of managing an individual case load and be able to demonstrate flexibility and creativity when developing support packages.

Interviews to be held on Tuesday 21st April 2009

Project Worker (Alcohol & Young People)

Based: Buckinghamshire (countywide)
Salary: £21,408 – £23,724
Application deadline: 6th April 2009

This 3 year post is funded by Comic Relief and will enable you to work specifically with young people under 21 experiencing alcohol problems.

FUNDED BY COMIC RELIEF

Interviews to be held on Tuesday 21st April 2009

Email: sue.eaton@virgin.net
Phone: 07595 056915

The OASIS Partnership is an equal opportunities employer.
Registered charity no 1054524
Company Limited by Guarantee no 3164431

Putting the Community First

BARNET LONDON BOROUGH

DAAT Performance Officer

£31,353 - £34,101 pa inc.
1 year fixed - term contract

An exciting opportunity has arisen within the Drug and Alcohol Action Team (DAAT) in the London Borough of Barnet for a skilled individual with performance/data analysis experience. You will support the team in the performance management of Barnet's drug and alcohol services and lead on the collation and analysis of a variety of service user and treatment information at both statutory and localised level.

You will be able to understand and interrogate data sets, assess strategy, policy and best practice guidelines and recommend on their implementation at operational level. The ability to present, both written and verbally is desirable as is experience of Partnership working and experience of planning and delivering service performance/value for money reviews.

For an informal discussion please contact Michael Kelly on 020 8359 5621.

For an application pack, please visit our website: www.barnet.gov.uk alternatively call: 0870 161 1613 (24-hours).

Please quote reference: SS/061/09

Closing date: 27 March 2009.

Barnet Council is committed to promoting equality, challenging discrimination and developing community cohesion.
We welcome applications from all sections of the community.
We are committed to the Investors in People Standard.

Visit our website at www.barnet.gov.uk

We are committed to the protection of children and vulnerable adults

POSITIVE ABOUT DISABLED PEOPLE
MINDFUL EMPLOYER
AGE POSITIVE
SMOKEFREE GLOUCESTERSHIRE

excellence

NHS Gloucestershire

Clinical Specialist for Smoking Cessation - Drug and Alcohol

Band 6: £24,103 - £32,653

37.5 hours per week

31 Park Road, Gloucester (location may change)

Secondment/Fixed-term contract - 12 months

An exciting Band 6, 12 month fixed-term/secondment opportunity has arisen for a suitably experienced worker to join our specialised smoking advice team. Applications are invited from highly motivated individuals who have the necessary skills to develop appropriate smoking cessation services within drug and alcohol services. In addition to developing stop smoking services for clients with drug and alcohol problems who wish to quit, you will be expected to work with other client groups, particularly in areas of health inequality.

While this post will require direct delivery of smoking advice and support to clients in 1:1 and group situations, it is expected that you will raise awareness of Tobacco Control in all settings and train other colleagues in appropriate smoking cessation techniques. The ultimate aim of the secondment is for clients with drug related problems to have better access to support and treatment for stopping smoking which is tailored to their needs.

This development post requires a dynamic individual who can adopt innovative thinking while working independently, often to deadlines. You will be joining a highly skilled team of smoking cessation specialists who have a commitment to improve the Public Health of Gloucestershire.

For further enquiries please contact, Michael Richardson, NHS Smoking Advice Service on 0845 422 0040.

Ref: 744-G8-538

Closing date: Midnight, Tuesday 7th April 2009.

A full job description and online application form is available on www.jobs.nhs.uk Alternatively, for an application form and information pack please call 0845 422 1949 (voicemail) quoting the relevant reference number.

Your Space – at our place

drinkanddrugsnews.com is the new home of DDN magazine. We have created a site not just for the magazine but for you to be a part of a new, integrated online community.

Magazine:	*All issues are online, see the back issues for a full library of the last four years*
News:	*More news more often, on the site and emailed direct to your inbox*
Jobs:	*Enhanced options for recruiters and candidates*
Your Space:	*A free page for you and your organisation to talk about the work that you are doing. Write, add videos, upload a photo gallery, this is your space to promote yourselves.*
Forums:	*Discuss the key issues affecting the drug and alcohol field*

Don't just read – get read... Register now...

www.drinkanddrugsnews.com

www.conwy.gov.uk

Varied landscapes, a huge range of careers and a wealth of benefits. If you're looking to work for an organisation where diversity is the watch word, one of North Wales' largest employers has more to offer than you think.

To see our full range of jobs visit www.conwy.gov.uk/jobs and apply by email to jobs@conwy.gov.uk Alternatively call 01492 576124 or apply through your local jobcentre.

If you don't have access to the internet call in at any library and the staff will help you to access our Jobsboard.

Community Development Services - Youth Services

SUBSTANCE MISUSE OUTREACH WORKERS (2 Posts) (Ref: 247)

JNC Pay Range Point 14-17: £11,315 - £12,321 pro rata Part Time - 18.5 hrs pw (until 31 March 2009 with the possibility of extension until March 2011)

You will be a member of the Substance Misuse Youth Outreach Service, providing support and guidance to young people involved in substance misuse within the county of Conwy. The posts will involve providing young people with a range of diversionary activities and programmes whilst addressing their substance misuse issues.

For further information and an informal chat contact either Jane Williams on 01492 575051 or Dewi Roberts on 01492 575054.

APPLICATION FORMS TO BE RETURNED BY MIDDAY 14/04/2009.

If not informed within 3 weeks of the closing date, candidates must assume they have not been shortlisted for interview and will therefore not be notified in writing.

In promoting equal opportunities Conwy welcomes applicants from all sections of the community.
All disabled applicants who meet the essential job requirements will be guaranteed an interview.

- ☑ Competitive Salary and Benefits Package
- ☑ Final Salary Pension Scheme
- ☑ Generous Leave Entitlement
- ☑ Excellent Training/Development Opportunities

Sunderland Partnership

NHS South of Tyne and Wear
serving Gateshead Primary Care Trust, South Tyneside Primary Care Trust and Sunderland Teaching Primary Care Trust

Directorate Commissioning & Reform

Reducing Re-offending Strategic Manager

Band 8a (Salary £37,106- £44,527 pa)
Full Time 37.5 hours per week – Permanent
Ref No: 735-SOTW09-C049
Location and Base: Sunderland Civic Centre, as part of the Safer Sunderland Partnership Team

This is a new, exciting and challenging role. You will lead on the development and implementation of a partnership approach to Reducing Re-offending for the Safer Sunderland Partnership to ensure we are able to meet all local, regional and national responsibilities. The post is hosted by Sunderland TPCT on behalf of the Partnership.

We are looking for an individual with a proven track record of developing and implementing crime reduction initiatives with management experience in a relevant sector including line management of staff. Experience of multi-agency working, financial management and knowledge of relevant legislation, national strategies, policies and interventions in relation to community safety and substance misuse including the Crime and Disorder Act 1988 and the Data Protection Act are also essential.

You will be educated to degree level or equivalent. You will have extensive proven experience of developing, implementing and managing crime reduction initiatives in a Partnership setting and extensive management experience in a relevant sector including line management of staff.

Relevant posts will be subject to an appropriate CRB disclosure.

If you wish to apply for this post please apply online at www.jobs.nhs.uk if you are unable to complete your application form online please contact the Human Resources Department, NHS South of Tyne and Wear, Pemberton House, Colima House, Sunderland Enterprise Park, Sunderland, SR5 3XB, 0191 5297073.

Please ensure that you provide appropriate individuals as referees. Refer to the essential guidance before completing your application form. ***If you have not received a reply within 4 weeks of the closing date please assume that your application has been unsuccessful.***

Closing date for receipt of applications 30th April 2009.
Interviews will be held on 5th June 2009.

TRAFFORD COUNCIL

Exciting opportunities to develop a new substance misuse treatment service.

The Safer Trafford Partnership commissions services for drug and alcohol treatment services for adults in the Borough. We have plans to set up and develop several pilot schemes and as a result, have created the following exciting opportunities:

Safer Trafford Family Worker – Substance Misuse (2 Posts)

£23,405 -£25,940 per annum • Ref: PPD/24

Set up and pilot strategies to manage the information flow between adult substance misuse services, CYPS, Child Protection and other Family or Health Workers.

Transition Lead Professional – 18–25 year olds Substance Misuse

£23,405 -£25,940 per annum • Ref: PPD/25

Set up and pilot strategies to manage the transition of clients from Children and Young People's Services to adults.

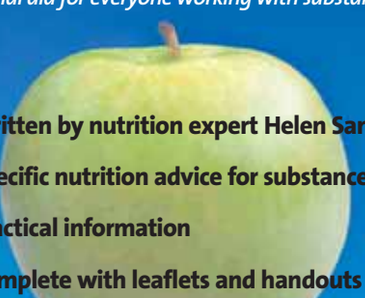
Both posts are fixed term until April 2010, with possibility of extension, therefore secondment applications are welcomed in agreement with current employer.

Closing date for both posts: 13th April 2009.
Further details at www.trafford.gov.uk/jobs
or telephone 0161 912 1010.

Minicom for text telephone users 0161 912 1224
We are members of NowPeople - nine councils, one website, countless opportunities, please see the website at www.nowpeople.co.uk

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"



- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how. Available on CD Rom.
Introductory price £19.95 + P&P

To order your copy contact Charlotte Middleton:
e: charlotte@cjwellings.com t: 020 7463 2085

Our residential projects offer a medically supervised detox and structured drug treatment programme for those with substance misuse issues.

Service Manager

£37,363 - £39,986 pa **London, E5**

Delivering effective and efficient management of the project, you will ensure that service users receive a professional and high quality service. You will be a qualified nurse, RMN/RQN or both, and NMC registered with a current PIN. **Ref: SM/LCR/0309/EXT**

Assistant Service Manager

£32,117 - £34,604 pa **London, E5**

Supporting the Service Manager, you will be responsible for the prescribing partnership and safe management of the detoxification and stabilisation programme. You will also ensure effective supervision of all clinical practice within agreed protocols, policies and procedures. You will be a qualified nurse, RMN/RQN or both, and NMC registered with a current PIN. **Ref: ASM/LCR/0309/EXT**

Qualified Nurses

£28,713 - £34,270 pa (F1 – F7) 35 hours per week **London**

Hackney E5 – First level Nurse, RGN or RMN with responsibility for delivering detoxification programmes and ensuring service users' medical care. A background of working within substance misuse services and assessing and monitoring service users' physical and mental health is required, as is a flexible approach to shift work (rota includes weekend, bank and public holidays).
Ref: NUR/LCR/0309/EXT

Kennington SE11 – Qualified RGN required to work night shifts. A background (pre or post registration) of working within substance misuse, homelessness or mental health is required, as is knowledge of the processes involved in detoxification and a background of implementing and evaluating programmes of care.
Ref: NUR/BD/0309/EXT

We are fully committed to staff development and can offer a supportive working environment and flexible employment policies, as well as a pension scheme and generous holiday allowance.

Download an application pack and see your potential at www.equinoxcare.org.uk

If you are unable to download the application pack from our website, please telephone 020 7939 9813 quoting the relevant reference. Closing date: 8 April 2009.

seeingpotential

Equinox

Equinox actively promotes equality of opportunity and diversity for all.

alcohol and drug treatment community services hostels and supported housing mental health

looking for new opportunities?

bdp

Bristol Drugs Project is an experienced, energetic and resourceful service delivering effective harm reduction and treatment services to over 3,500 individuals a year.

HARM REDUCTION WORKER

Full-time, 35 hours – ref: DD3

This is an exciting opportunity to be part of a 6 day harm reduction service for drug users where reducing risk is the goal. Why do injectors share? If you understand why and can work imaginatively to do something about it, we are keen to hear from you. Some out of hours work will be involved. A full UK driving licence is essential.

For an informal discussion contact John Maliphant, Harm Reduction Services Coordinator on 07973 544 904.

SHARED CARE WORKER

Full-time, 35 hours – ref: DD4

Bristol's successful Shared Care scheme provides treatment to over 1,500 drug users. Based in GP surgeries in the heart of communities you will assess opiate users, provide advice to GPs, monitor prescriptions and develop and implement a care plan. If you are assertive, diplomatic, with excellent organisational skills and are able to work well within pressurised primary care settings, this is for you. Some early evening work will be required.

For an informal discussion contact Jayne Peters, Treatment Services Manager, on (0117) 987 6019.

DRUG-USING PARENTS WORKER*

Full-time, 35 hrs – ref: DD5

Part of our Family Support Service delivering services, including personal counselling, to parents who are drug dependent within the community and as a core part of the Bristol Maternity Drug Service.

** This post is female only; section 7(3) of the Sex Discrimination Act applies.*

For an informal discussion contact Justin Hoggans, Structured Support Services Manager on (0117) 987 6007.

YOUTH WORKERS

Full-time, 35 hours (1 permanent post and 1 maternity locum 8 months) – ref: DD6

As part of the Bristol Early Intervention Service you will deliver effective, evidence-based services to young people within Bristol's Secondary Schools and to young people not currently in school. You will need experience of working with young people and of working with people with drug or alcohol problems.

For an informal discussion contact Justin Hoggans, Structured Support Services Manager on (0117) 987 6007.

Salary scale for all posts: £17,024 progressing to £25,592, starting salary for suitably qualified candidates: £22,699 (based on 35 hours a week).

Safer Bristol

For all jobs you will need experience of working with drug users & we welcome past personal experience of problematic drug use.

Funded by Safer Bristol – Bristol Community Safety & Drugs Partnership

Closing date: Wednesday 15th April at noon

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

We are committed to anti-discriminatory practice in employment and service provision; we especially welcome applicants from Black and minority ethnic groups, as they are under-represented within our organisation. No CV's agencies or publications.

Registered Charity No: 291714 Company Limited by Guarantee: 1902326

Service Care Solutions

Criminal Justice Drugs and Alcohol Workers - Nationwide

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

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

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

For more information please contact:

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

What does the future hold?
It's up to you.

ADS
Addiction Dependency Solutions

To people with substance misuse issues, the future can look frightening and uncertain. In both of these critical roles, however, you will make all the difference to them. As the leading regional substance misuse charity with a wealth of experience there is an ever increasing demand for our services in a competitive and challenging external environment. Forward thinking and committed, we always go the extra mile for all our clients treating them as individuals, helping them rebuild their lives. In these exciting roles you will be key to delivering our future as part of a new Senior Management Team.

Director of Operations
c.£50k — Manchester

In this strategic role, you will lead, direct and manage the operations of ADS service delivery and influence all aspects of the business to improve both service effectiveness and efficiency. Reporting directly to our Chief Executive, you will hit the ground running and have an immediate and measurable impact on every area of our business. This is an excellent opportunity for an experienced Senior Director with gravitas and credibility, who has a background in the statutory, public, health or social care sector. Ref: 09/25

Business Development Manager
c.£35k — Manchester

Leading all business and service developments across our organisation, a key aspect of your role will involve winning new business ensuring that we get invited to tender, then taking responsibility for project – managing the whole process. With an in-depth knowledge and experience of world class commissioning and tendering in the public sector, you must have experience and be able to evidence your ability to compile, write and present successful bids. Ref: 09/26

For more information and to apply please visit our website.
Closing date: Friday 3rd April 2009.

Successful applicants will be required to consent to CRB checks We are an equal opportunities employer

www.ADSolutions.org.uk
Positive about change

Swanswell has over 40 years' experience of offering the prospect of change to people affected by drug and alcohol misuse. Working in partnership with primary care trusts, criminal justice services and local authorities, we actively involve our service users to improve and develop our services.

We help people change their lives for the better, so they can feel well, do well and be happy.

work
well
together

We are looking to recruit:

Operations Manager
(Maternity cover to Summer 2010)
37 hours per week, based in Birmingham
NJC points 37 to 45 (£30,456 - £37,555)

The postholder will be responsible for:

- Leading, managing and developing a well motivated team of Swanswell workers to provide a range of substance misuse treatments and support services
- Ensuring high quality, effective and efficient delivery of service, in line with contractual agreements
- Enhancing and protecting Swanswell's reputation as a service that is trusted by service users, funders, policy makers and partners.

Substance Misuse Workers
37 hours per week, based in West Midlands & Warwickshire
NJC points 26 to 31 (£21,937 - £25,940)

The postholders will be responsible for:

- Managing a caseload within a defined health action area
- Providing treatment and support services to directly referred clients
- Participating in supervision, continuous professional development and support activities

Our staff are our greatest asset, so we want to recruit talented people who can help us to make a real and lasting difference.

If you would like an application pack, please visit our website www.swanswell.org or email jobs@swanswell.org

Applicants with a disability who meet the essential criteria for the post are guaranteed an interview.

Closing date for applications: Monday 6th April 2009 at 12 noon.

Proposed interview dates: week commencing 20th April 2009.

swanswell

TRAFFORD COUNCIL

EXPRESSIONS OF INTEREST
are invited to deliver a Test on Arrest service in Trafford

Trafford Council, has Intensive Area status for DIP and are seeking applications from suitably experienced providers to deliver a Test on Arrest service within the borough. The contract is to provide

- **A screening and assessment process for adults arrested for trigger offences**
- **A process to ensure that those adults then attend the appropriate treatment service**

It is anticipated that the contract will be awarded in May with a proposed start time during Summer 2009. The contract period is two years *(possibility of extension subject to funding and performance)*.

Deadline for receiving Expressions of Interest: 12 noon, Monday 6th April 2009

For further information and to express an interest, please contact: Heather Stanton, Corporate Procurement Team, Trafford Town Hall, Talbot Road, Stretford M32 0TH. Tel: 0161 912 1287. Email: heather.stanton@trafford.gov.uk