DDN
Drink and Drugs News
26 March 2007
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RELAPSE PREVENTION
High-risk situations and sustained recovery

THE BENZO DEBATE
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drugs and alcohol today

Pavilion

drugs and alcohol today

London

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The exhibition and seminar programme provide a unique opportunity for professionals and managers involved in preventing and treating substance misuse, people who use services and those interested in joining the profession to come together to debate the big issues, share best practice and network.

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- Tier 4
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  - Broadening the perspective of Tier 4
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  - Harm reduction strategy
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Drink and Drugs News

26 March 2007

Editor's letter

There's been an unwelcome chasm reopening between abstinence and maintenance in the last two years, Daren Garratt told the National Drug Treatment Conference last week – a statement frequently reflected in our letters pages.

It was interesting then to read Sara Moralioglu's investigation of harm reduction in North America (page 8) – a story made all the more remarkable by the scale of progress – particularly in the United States, where the climate of incarceration for drug users has made campaigning for harm reduction initiatives a dangerous game.

Back home we seem stuck on how to classify harm. Following on from the RSA Drugs Commission report earlier this month, calling for a rethink on drug strategy, an article in the latest *Lancet* demonstrates how an expert panel would reclassify 20 drugs according to their actual level of harm – relating to physical harm, dependence risk and wider impact on society (news, page 4). The project involved experts working in all areas of addiction, medicine, psychiatry and law and was an attempt to offer 'a systematic framework... that could be used by national and international regulatory bodies to assess the harm of current and future drugs of abuse', instead of a system that is considered by many to be arbitrary, without much scientific basis.

But the BBC has already reported Home Office Minister Vernon Coaker's reaction as: 'We have no intention of reviewing the drug classification system.' Classified by the trial system, alcohol and tobacco would be recognised as (together) accounting for about 90 per cent of all drug-related deaths in the UK.

Alcohol Concern has already criticised the chancellor for ignoring the chance to increase alcohol excise duty in this week's budget. Can policy in this country ever shift to a public health approach?

We're taking a break for Easter, so our next issue is out on 23 April. See you then!

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In this issue

Expert panel classifies alcohol as more harmful than ecstasy

A new drug classification system that relates more closely to harm, has been proposed in the latest issue of *The Lancet*. The article follows hot on the heels of the RSA Drugs Commission recommendations on rethinking drugs policy, earlier this month.

Authors Professor David Nutt, Leslie King, William Saulsbury and Professor Colin Blakemore challenge the current classification system, set by the Misuse of Drugs Act 1971, as being based on methodology that is not transparent which, they say, 'reduces confidence in their accuracy and undermines health education messages'.

The authors recommend a new system based on 'fact and scientific knowledge'. Three factors would be used to determine a drug's harm: the physical harm to the user; its tendency to induce dependence; and its effect on families, communities and society – which included damage from drug-induced crime.

When graded by panels of experts using the new system, 20 drugs were given scores for their overall harm rating. While heroin and cocaine were still at the top of the table, the exercise turned many current perceptions on their head by moving alcohol and tobacco towards the top of the table, above cannabis and ecstasy.

Commenting on their findings, the authors say they saw no clear distinction between socially acceptable and illicit substances. Hoping that public debate on illegal drug use would take account of the appearance of alcohol and tobacco in the upper ranking of harm, they say that replacing prejudice with the new form of assessment could 'help society to engage in a more rational debate about the relative risks and harms of drugs.'

'Development of a rational scale to assess the harm of drugs of potential misuse' is published in The Lancet, vol 369, no 9566.

Global drug controls are working, says Costa

The world drug problem is being contained, with global controls broadly stabilising supply and demand, according to Antonio Maria Costa, executive director of the United Nations Office on Drugs and Crime.

Opening the 50th session of the international Commission on Narcotic Drugs, Mr Costa noted much progress had been made, but stronger 'social vaccines' were needed to tackle some very specific problems. In Europe, cocaine was becoming a serious concern, and this was not helped by the glamour status it now had.

'Globally, demand for cocaine has been contained but not reduced. The decline in North America has been offset by an alarming rise in some European countries where addiction levels are among the highest in the world,' Mr Costa said. 'Europe must learn that cocaine is an illicit drug, not a status symbol, and if addicts in dark alleys in New York, Delhi or Moscow are nothing more than "junkies", then the same must be said about those pop stars and models whose shooting and sniffing habits have been celebrated by the press.'

On a more positive note, he added the European markets for heroin and synthetic drugs, such as ecstasy, were 'slowing down'. But again achievements in this region were offset by a rise in demand in other countries, particularly developing countries. There was a need for greater awareness of newer drugs, such as methamphetamine, and the widespread damage they could cause.

Mr Costa called for all nations to adopt a policy of 'shared responsibility' toward the global problem. Countries where demand was high, typically wealthier countries, had to work to lower abuse and work with other nations to stem the supply. And, to strengthen society's resolve against drugs, Mr Costa urged governments to invest more in supporting families and schools which were the 'first line of defence against drugs'.

Cannabis cultivation soars to record highs in UK

Cannabis cultivation is hitting record highs in Britain, according to new research from DrugScope. Ten years ago, only 11 per cent of cannabis sold in the UK was home grown – this figure now stands at more than 60 per cent. However, recent law enforcement tactics have proved to be successful, with cannabis farms being raided at a rate of three a day. In the last two years, more than 1,500 farms have been closed down in London alone.

The research is published in the latest issue of DrugScope's bi-monthly magazine ***DrugLink***.

'Stop tinkering round the edges of alcohol harm,' says AC

The government must show more 'ambition' in reducing the levels of harm caused by alcohol, which are now 'escalating beyond reason', says a new report by Alcohol Concern. As the government reviews alcohol harm strategy and considers its next steps, the charity has released its own strategy, featuring five key goals, which it believes the state should be aiming for.

In *Alcohol strategy – the way forward* charity chief executive Srabani Sen argues that 'tinkering around the extreme edges of alcohol harm' would not solve the UK's alcohol problems. An integrated approach was needed, which recognised how deeply embedded alcohol excess was within the psyche of British culture. Rather than just focusing on binge drinking, related issues must also be addressed, such as society's attitudes to drunkenness and the availability of cheap alcohol.

One of the five goals set out in the strategy is to raise awareness of alcohol harm, so that alcohol becomes a 'public health issue with the same status as tobacco and obesity'. All drinkers should know how to drink safely and understand the risks of not doing so, and all social, healthcare and criminal justice staff should be able to recognise when one of their clients is drinking above safe levels. These objectives, the charity suggests, could be achieved through a sustained public awareness campaign, which could include mandatory point-of-sale information on safe drinking.

Other goals included reducing societal alcohol consumption to 1970s levels; decreasing alcohol related harm – specifically violence and domestic violence; integrating support for those with alcohol problems across the health, social care and justice systems; and developing strong local and national leadership on the problem.

The charity was also quick to criticise lack of strategy to cut alcohol misuse in this year's budget, which only increased alcohol excise duty in line with inflation.

'Once again the Treasury shows how unwilling it is to make the difficult choices required to cut down the level of alcohol-related harm in the country,' commented Srabani Sen.

'There was a real opportunity for the Treasury to show some leadership and contribute to positive change... But for this year at least, that chance has been lost.'

'Alcohol strategy – the way forward' is online at www.alcoholconcern.org.uk

Toolkit will help countries assess treatment demand

A new joint work programme aimed at identifying the global level of need for drug treatment has been agreed by the United Nations Office on Drugs and Crime and the European Monitoring Centre for Drugs and Drug Addiction. The five-part programme enhances cooperation between the two bodies on epidemiology, demand reduction, supply reduction, legal information systems and new drug trends.

'Within Europe and globally there is now an explicit understanding that effective drug policy depends on basing our actions on hard evidence,' said Wolfgang Gotz, EMCDDA director.

It is hoped the greater exchange of knowledge and information between the two bodies will lead to the development of better-informed policies and guidance to help nations tackle the world's drug problem.

'In many countries, people who are dependent on drugs are stigmatised and excluded from mainstream society. They should be helped, through treatment, to get back into society, free of addiction,' said Antonio Maria Costa, UNODC executive director. 'For this to happen it is necessary that they have access to appropriate services and that practitioners have information on the people seeking treatment.'

The two bodies have already jointly released a toolkit designed to help countries compile comparable data on the demand for drug treatment. It aims to examine the practical issues that need to be addressed so that nations can develop a standardised, consistent data set on drug treatment demand and includes a three-stage model for building the foundations of a treatment demand system.

The toolkit, 'Guidance for measurement of drug treatment demand' is online at www.emcdda.europa.eu/?nnodeid=400

Euro poll shows British ignorance on binge drinking

A new poll on alcohol consumption within the European Union has ranked the UK as one of the worst countries for binge drinking. Commissioned by the European Commission's health and consumer protection directorate-general, the poll took a snapshot of the drinking habits of EU citizens, quizzing them on the alcohol consumption in October and November last year.

British participants revealed that when they sat down for a drink, 25 per cent of them consumed between three and four drinks, while 24 per cent consumed five or more. These figures placed the UK third, behind only Ireland and Finland.

While 29 per cent of participants claimed never to have drunk five or more drinks in one sitting, 19 per cent said they did so once a week, while 12 per cent said they did so several times a week. Young people aged 15 to 24 and self-employed or manual workers were the demographics most likely to indulge in binge drinking.

Although not all of those who consumed alcohol are binge drinkers, the poll did reveal how big a role alcohol had in British society, with one-third of those surveyed indicating they had drunk two to three times a week during the month before the poll.

The poll also sought to establish attitudes to alcohol policies and interventions. In the UK, 58 per cent of those surveyed did not give the impression that individuals were responsible for their own alcohol consumption. However, 75 per cent would also support warnings on the dangers of alcohol being placed on bottled beverages – similar to those now found on cigarette packets.

The findings also revealed that 70 per cent of the Britons surveyed did not know the legal blood alcohol limit for drivers.

'Attitudes towards alcohol' is available as a pdf at http://ec.europa.eu/public_opinion/archives/eb_special_en.htm#272b

National Drug Treatment Conference, London

Drug and alcohol treatment must go hand in hand

Chronic alcohol abuse is responsible for many complications with drug users – which makes a joint drug and alcohol approach sensible, said Trevor McCarthy, best practice manager at the NTA.

Not only did it make sense, but there were risks in not taking this approach, he warned. Alcohol could dramatically increase depression on the immune system, as well as producing potentially dangerous compounds; for instance alcohol and cocaine, when metabolised, produced cocaethylene.

Fewer than half of drug users had had advise on alcohol during treatment, according to the NTA's 2006 user satisfaction survey, and alcohol use was often not being addressed in service users' care plans, Mr McCarthy told delegates.

'We need to commission evidence-based, comprehensive and integrated drug and alcohol systems, he said. 'Everyone needs to give this a try.'

Little alcohol knowledge is a dangerous thing

The 'significant sub section of people who have severe alcohol dependency while on opiates' made it essential for substitute prescribing and heavy drinking to be managed properly, said Michael Farrell, consultant psychiatrist at the National Addiction Centre.

Alcohol rarely came on its own, but was often accompanied by tobacco, coke, benzos or other drugs, he pointed out. The issue of alcohol and opiates was 'age old' – as in alcohol and laudanum in the mid-19th century – but there were 'major variations on how people handle alcohol' that needed to be understood by those working in treatment services.

Finding out about people's alcohol dependence depended on a thorough assessment. 'Ask people what they do,' urged Mr Farrell. Equally important was doctors being able to differentiate between opiate and alcohol withdrawal symptoms, as ignorance could kill a patient.

'Our efficacy with long-standing patients is not very good,' he told delegates. In answer to questions, he admitted that it was always difficult to find out about patients' drinking patterns while respecting people's dignity, but that persistence in asking the right questions was essential.

Risky drinking needs a harm reduction approach

Some people will always engage in risky behaviour, so we need to focus on harm reduction relating to alcohol, suggested Jack Law of chief executive of Alcohol Focus Scotland.

The social acceptability of drinking gave families a tendency to downplay problems, he said. With alcohol more affordable than ever, and well within pocket money range, it was little wonder that there were problems with young people's drinking.

Harm reduction interventions would need to be 'pragmatic and strategic', looking more seriously at drinking environments, community safety initiatives, planning and effective licensing laws and better training of licensees. At policy level it should be recognised that alcohol was too cheap and too easily available, said Mr Law. Parents had a key role to play in developing personal responsibility, by being aware that their drinking behaviour was watched and copied by children.

In Scotland, efforts were being made to change the way children drink through providing alcohol-free discos. Mr Law reported that public health initiatives were gaining ground north of the border with a whole community approach to tackling alcohol, and he urged other areas to go further with an agenda focused on public health.

Attitude change needed to killer cigs

'Which other legal product kills half of its users?,' Gay Sutherland asked delegates who had not yet gone out for a cigarette break.

Armed with statistics on the harms of tobacco, Ms Sutherland pointed out

National Drug Treatment Conference, London – continued

that despite between 70 and 90 per cent of people who were in drug treatment smoking, there were few attempts to take the drug seriously.

Smoking rates were high among treatment staff and cigarettes were 'part of the culture, used to build rapport'. Staff were unlikely to encourage smoking cessation – 'and many even discourage it', said Ms Sutherland.

Contrary to perceptions, research showed that stopping smoking could improve outcomes of drug treatment, she explained, although there was conflicting data on whether drug and tobacco should be treated concurrently.

The smoking ban, to be enforced from 1 July, would create more demand from clients to quit, she believed. Intensive support would be needed, particularly as drug treatment clients tended to be more nicotine dependent than the general population of smokers, and would experience a range of withdrawal symptoms that ranged from depression to respiratory and digestive disorders, for about a month.

Intensive behavioural support, either one-to-one or in groups, had proved to be the best method to quit, Ms Sutherland (an ex-smoker) suggested. It was important to get the client using enough nicotine replacement, and nasal spray had been shown to give one of the most rapid forms of relief. Nicotine by itself was 'not much more harmful than caffeine', she added; it became dangerous when smoked with 600 additives to make the hit more potent.

Urging drug workers to take advantage of smoking cessation training available from primary care trusts, she said: 'Every situation in life is a cue to smoke. We somehow have to get staff on board to help clients to quit.'

'Get clients off roundabout of failure'

'If we don't look at what people need, we're keeping them on a roundabout of failure,' Daren Garratt told delegates.

In presenting to services, all that many clients wanted was a script. But professionals – whatever their role in drug treatment – needed to recognise clients' holistic needs.

'Is their care plan working – and if not why not?,' he told delegates to ask, adding that *Models of Care* should be putting people in touch with the services they needed.

Treatment services needed to be wary of a 'one size fits all' approach, said Mr Garratt. All too often drug users were batted away as 'someone else's client', when they needed continuity and firm support structures.

Reminding delegates that 'relapse is a fact of life', he called for patients' needs to be assessed with sympathy and realism. While abstinence was a goal for many, it was counterproductive to make clients run before they could walk. He warned against demonising methadone maintenance and said there was an unwelcome chasm reopening between abstinence and maintenance in the last two years.

'Drug users seem to be the only members of society we can discriminate against,' he said, adding that all of us needed medical care for one reason or another, and had a right to be prescribed according to our needs.

'Show taxpayers the benefits of tackling drug use'

To tackle drug problems you have to deal with the underlying social issues said Mike McCarron, national drugs liaison officer for Scottish Association of Alcohol and Drug Action Teams.

Drawing on his 30 years working in the Strathclyde region social work department, Mr McCarron said that he was 'not coming with any solutions, but wanted to share some thoughts'.

Reports and studies showed a high association between poverty and drug use, and that a quarter of Scotland's problematic drug users lived in the poorer areas of Glasgow, despite the city as a whole being home to only 12 per cent of Scotland's population.

However there were reasons to be optimistic, including the Housing Act Scotland – which promises permanent housing for all by 2012 – and many of the recommendations in the RSA report.

'It is essential that we engage with users and learn from their expertise. We also need a strategy to provide access to training and welfare,' said Mr McCarron. To do this would take investment that some taxpayers might find unpalatable, but McCarron was convinced that if the facts were made available to them they would see it is a desirable long-term goal.

Drug war must switch to debate

'The war on drugs has failed; it is time to have a wide-ranging debate for this century,' stated Brian Iddon, MP for Bolton South-East and chairman of the All-Party Parliamentary Drugs Misuse Group.

'There needs to be a war on the causes of drugs', said Mr Iddon. He claimed that current drug policy caused displacement, whether that was cocaine growers in South America moving production from Columbia to other countries, or users in the UK switching from illegal drugs to prescription drugs, which were now readily available online.

Mr Iddon agreed with the RSA recommendations around changing the classification system to one that reflected a 50:50 split between harm to the user and harm to the general public. He added that the 1971 Misuse of Drugs Act was 'not fit for purpose' and said that we needed a flexible system that offered alternatives.

Treatment has to move away from 'bleak pessimism'

'We know more treatment gives better outcomes, so why do people get so little and why does it go on so long?,' asked Dr David Best, senior lecturer in addictions in the department of psychiatry at Birmingham University.

Referring to a study of more than 300 patients in a criminal justice setting, Dr Best demonstrated that the average fortnightly sessions, which also involved case management as well as advice and support on related issues such as housing and employment, often meant that clients only received just over 20 minutes of actual counselling a month, or around four hours a year.

'What can we hope to achieve in this time and why has it been going on for so long?,' challenged Dr Best.

Much of this practice stemmed from our 'bleak pessimism that addiction is not self-curing' that could lead to us seeing treatment in maintenance terms.

We needed to be optimistic, look for exits from treatment and start to 'think of addiction as a career with a beginning, middle and end, not as a permanent chronic condition', he believed.

Misuse movies

I work as a CARAT (counselling assessment referral advice through-care) worker in HMP Everthorpe, a male category C training and resettlement prison, just outside Hull.

I would like to ask if anybody has DVDs or training material that could be used within the prison to promote substance misuse treatment/ recovery and harm minimisation.

We intend to show the DVDs through the in-cell TV system, providing important information on services available to offenders while they are in custody and on release into the community.

We would also like to use the material to promote information to staff, so they can pass on useful and practical information to offenders during the working day.

If you have such resources and would like them to be promoted and used as a treatment option, I would very much like to hear from you. Your services are vital to us when reintegrating offenders back into the community to reduce the risk of reoffending and to the public.

Nick Wood, CARATs, HMP Everthorpe. Phone 01430 426581; fax 01430 426776

What's so radical?

Having studied the RSA report on drugs, I am unable to detect anything 'radical' (*DDN*, 12 March, page 4).

The suggestion that some drugs can be re-classified is no more than an attempt at modification, rather than the change in attitudes that is desperately needed to address the escalating problems of drug abuse, addiction and the associated criminal activity, that the present Drug Intervention Programme and strategies have failed to address.

Close study of the report reveals a number of anomalies and apparent self-contradiction, which are far too lengthy to address in detail in a letter. However there is one statement in the report that is so seriously inaccurate and potentially dangerous that it cannot be left unchallenged.

We are informed thus: 'The evidence suggests that a majority of people are able to use drugs without harming themselves or others.' This loosely worded statement is so

> '"The evidence suggests that a majority of people are able to use drugs without harming themselves or others." **This loosely worded statement is so nebulous as to be almost meaningless, yet it has been seized upon by the pro-drug lobby as a reason to legalise drugs.'**

nebulous as to be almost meaningless, yet it has been seized upon by the pro-drug lobby as a reason to legalise drugs. It is also open to considerable misunderstanding, much in the same way that the so called 'relative harms' of cannabis have caused confusion.

I believe the statement is grossly misleading and irresponsible, since it fails to identify which drugs – if any – can be used, the frequency that they can be used, and the quantities that can be used, whether or not it applies to addictive, psychoactive drugs. Nowhere in the report have the authors considered it necessary to define their claim, or qualify it in any way. This glaring omission allows the authors to conclude that the use of drugs without incurring harm is not only possible, but common. The scope for misunderstanding and misinterpretation is self-evident.

The bulk of medical and clinical evidence is unanimous in concluding that habitual and or regular use of addictive psychoactive drugs results in mental and physical damage to the user. Psychosocial studies show how that harm impacts on others. The failure to make that evidence clear in the report is not only irresponsible, it is deeply puzzling.

Peter O'Loughlin,
The Eden Lodge Practice

Battle for our souls

I too agree with the sentiments of your correspondent ('Who watches the watchmen?', *DDN*, 12 March, page 9).

Treatment providers are being performance managed to death by the NTA and the DATs, and Paul Hayes' interview not only displayed arrogance but also a kind of barely concealed contempt for treatment service providers.

My understanding is that more and more DATs are adopting a macho commissioning approach with an inherent power imbalance instead of allowing the professionals get on with the work they know how to do best.

Why have a group of mostly amateur bureaucrats been given the work of commissioning complex professional services?

And the NDTMS is just another layer of red tape that's been lumped on to service providers in order to meet KPIs (the new mantra of commissioners) – if you don't meet the targets you get berated; if you do meet their targets they give you stretch ones, believing the original must have been too easy!

There are too many NTA priorities coming down and not enough attention paid to clinical ones, and services are being distracted with all the top-down priorities.

Why are we allowing ourselves to be pushed around like this?

Commissioners who don't understand the way services work are calling all the shots with a minimum of discussion with treatment providers – the so-called 'partnerships' are medium/high level committees that don't include voices from the field.

Is it time for all treatment providers to come together and say enough is enough?

As your correspondent said on 12 March – 'let's hear some voices', don't let's sell our souls for the NTA shekel.

Drug and alcohol manager, name and address withheld

Send us your views!

Please email letters (of not more than 350 words and without references) to claire@cjwellings.com or post them to the address on page 3. Letters may be edited for reasons of clarity and space.

Comment

Why we need this bureaucracy

Since explaining the new system of allocation for this year's pooled treatment budget (*DDN*, 12 February, page 8), Paul Hayes has been accused in our letters pages of piling on bureaucracy through the 'wretched' NTDMS forms. Here he argues that the data collection system needs to function this way to bring about tangible improvement.

Imagine the scene – the *Newsnight* studio in the run-up to the next general election. The new Prime Minister is telling Jeremy Paxman about the value of treatment and how this is at the heart of the Government's new post-2008 drugs strategy. Paxman says: 'So you tell us you're spending across Government £850m a year on treatment. How many people does that mean there are in treatment?' The PM smiles and says, 'Well Jeremy, I can't actually tell you that, we don't count how many people are in treatment.' Paxman scents political blood, he looks incredulous and interrupts: 'You don't know?'

The PM continues: 'We did used to count this, but we were persuaded by the highly trained professionals delivering drug treatment that their time was better spent treating people rather than completing forms. So we dispensed with the bureaucracy to allow them to focus on their clients. After all, we're spending £850m on treatment, not bureaucracy.'

Paxman leans back in his chair and says: 'Let me get this right. You are spending £850m of our money on drug treatment. You don't know how many people are in treatment or, I take it, what sex, age or ethnicity they are, what drugs they use, or if they stay in treatment once they start. Do we know if the treatment works?' PM: 'No.' Paxman: 'So we are spending £850m a year on drug treatment and we have no idea how much of it we are getting, who gets access to it, or if it works.'

Before 2001 the straight answer to any of the questions posed by Paxman in this fictional *Newsnight* would have been 'pass'. Before NDTMS we really didn't know how many people were in treatment, who made up the treatment population, what treatment they received, how much it cost, how long they waited, how long they were retained, who referred them, and crucially, if the treatment they received made their lives better.

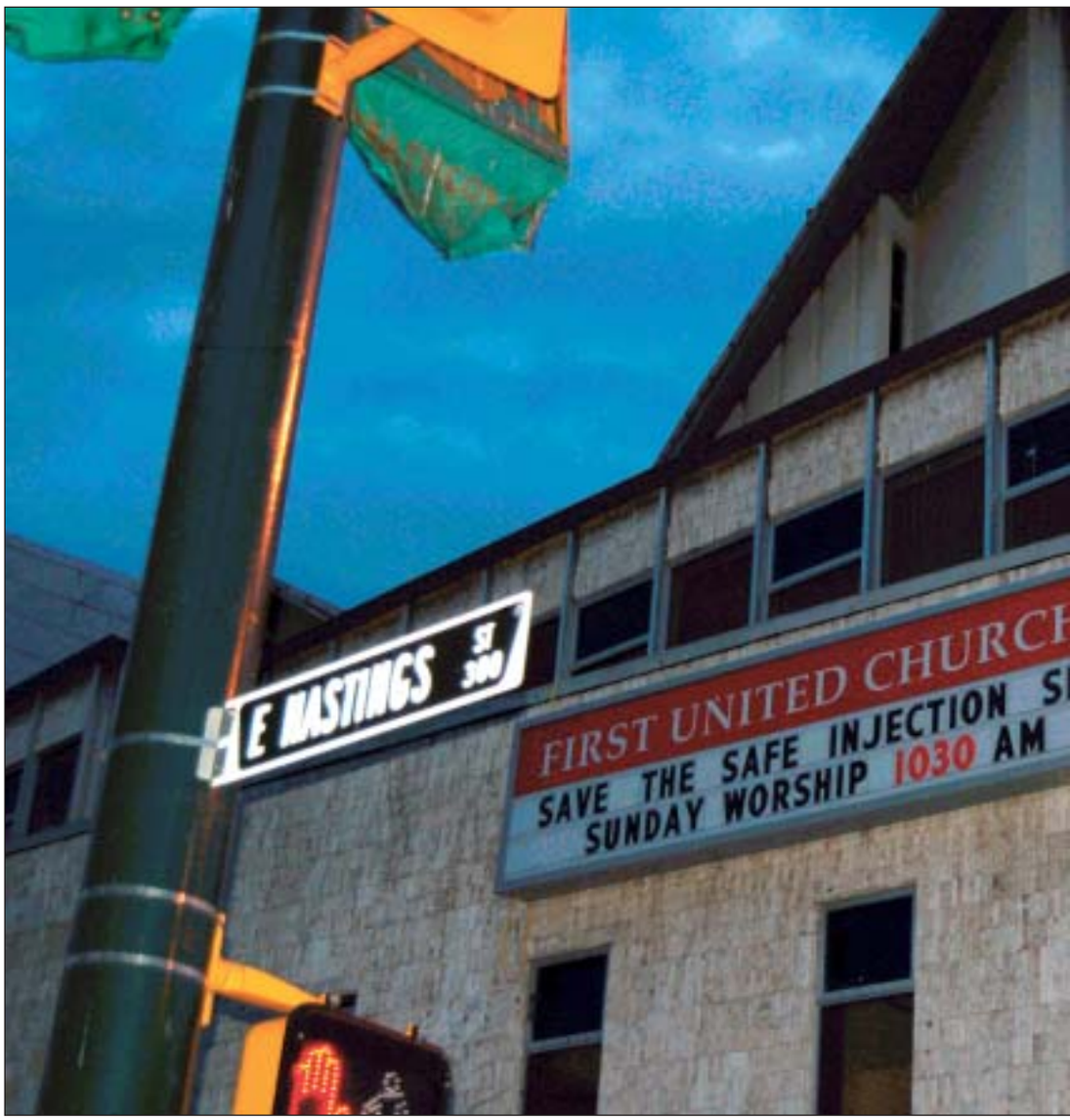
While it is clear that no politician can be expected to approve the spending of £850m a year without knowing who it's spent on, or being able to judge if it represents value for money for the taxpayer, the real value of NDTMS is not to the politicians and central bureaucracies, like the NTA, but to local service users, providers, commissioners and communities. Without accurate, reliable information about the operation of their treatment system, commissioners will be unable to create effective local treatment systems that meet the needs of their population. Providers and practitioners will be unable to judge the impact of their own practice, compare it with others and seek to improve. Service users and communities will be unable to challenge commissioners and providers to meet their needs as effectively as possible.

From this perspective NDTMS is not a bureaucratic burden but an integral part of the process of delivering professional drug treatment which informs practice, commissioning and accountability.

Next year this will be highlighted even more. The projected implementation of the Treatment Outcomes Profile (yes, another 'form') will, for the first time, enable information about real improvements in service users' lives to be collected via NDTMS. Linked to care plan reviews, TOP will regularly review individuals' progress in relation to drug use, offending, health, employment, accommodation and social wellbeing. This will build a comprehensive picture of the real impact of treatment and enable meaningful comparison across systems, modalities, providers, and practitioners, and help us all to focus on learning from the best performers to improve practice everywhere.

NDTMS is part of the national bureaucracy and the need to account to taxpayers means it will never go away, but its real value is not about national monitoring but local improvement.

Harm reduction in North America has achieved remarkable progress since the first user groups risked their freedom for the right to save lives. **Sara Moralioglu** reports



Streetwise Stateside

The downtown Eastside in Vancouver is home to an estimated 5,000 drug users. Between 1991-2003 there was an average of one overdose per day in the area – an area that only covers ten square blocks. In 1997 injecting drug use was costing the British Columbian government an estimated $96 million. As a result of this massive problematic drug use in the area, and the high number of deaths, Vandu – the Vancouver Area Network Drug Users – was born. It is one of the world's most powerful drug user groups.

When you speak to Anne Livingstone the founder of Vandu, you can understand why their work has been so effective. She takes no prisoners when it comes to fighting for the justice of drug users. 'I'm not afraid of getting arrested for the work I do', she exclaims on the phone to me. 'They can go ahead and arrest me – for what? Trying to save lives!' It's a powerful start to our conversation about the work of Vandu.

The group started in 1994. Livingstone had received $100 from the City Youth Board to try and organise drug users in Canada's most impoverished area. She bought pop and pizza and invited drug users to a meeting. In 1995 there were only 20 members of Vandu, but by holding meetings and actually asking drug users what they felt would better the situation, this number grew and to date there are more than 1,600 members.

Livingstone has worked hard to encourage drug users to have the confidence to voice the problems they face in a bureaucratic setting. This has been vital in Vandu's work and key in opening North America's first Supervised Injecting Room 'In Site' in 2003, set up as a pilot project. Vandu campaigned for the site for 12 years; it now receives an average of 607 visits per day and there are currently 7,278 drug users registered at the facility. In the first two years of running there had been 500 overdoses – but no fatalities. It is proven that visitors to 'In Site' are more likely to enter detox programmes. Despite the project's success, it was initiated as a three-year pilot and in 2006 was up for review; the government only granted another year's permit.

Although Livingstone considers the opening of the site 'a political victory', it is still not enough to save lives, she claims. 'They really need to open three more centres here – that is how big the problem is in the area'. The situation in Canada however, is vastly different from the picture in the United States.

In the US to this day, 50 per cent of all needle exchange centres are running illegally. More than half of the estimated two million people in prison in the US are there for drug-related charges. Since 1990 the number of adults incarcerated has tripled and the majority of those people are African American, Latino and other minorities who have been disproportionately affected. 'That is the USA's "War on Drugs"', says Allan Clear, Director of the Harm Reduction Coalition, based in New York City – where overdoses kill more residents than suicide or homicide. In cities such as San Francisco and Portland, it is the leading cause of death.

Allan Clear set up one of New York City's first

needle exchange programmes on the Lower East Side. It was 1990 – a time when HIV and Aids were rapidly spreading and when running a needle exchange centre was illegal. Clear opened knowing full well that the population of injecting drug users was rapidly dying as a result of sharing needles and lack of education.

At that same time Dr Sharon Stancliff – newly arrived in New York City – had quickly acquired a set of patients who had HIV and Aids; 'Within five or six years all of them had died'. 'Until 1996 there really wasn't much doctors could do for patients with Aids', Stancliff explains. Aware that most of her patients were injecting drug users and had contracted the virus from sharing dirty needles, Stancliff felt propelled to visit the needle exchange centre that Clear was running.

Stancliff volunteered as an outreach worker and from that point on for the next seven years. She worked every Saturday handing out clean needles. This was done while she did a Fellowship on Aids and drug use, was director of a Spanish Harlem Methadone Programme, and worked for the State Department of Health. 'We would spend our Saturday mornings looking for drug users, chatting with them and giving them clean needles', she says. 'I got a great deal of satisfaction from giving out the syringes'.

Eventually, in 1992, legislation passed allowing needle exchanges to run legally in New York. In 1990 to 1992 half of all injecting drug users in New York City were HIV positive. By 2002 it had dropped to around 15 per cent. 'When I heard those statistics I almost cried', says Stancliff. 'The difference the programmes had made was remarkable.' By 1994 the Harm Reduction Coalition was officially recognised as a non-governmental organisation (NGO).

Stancliff started running overdose workshops with fellow volunteers. They set up their booths on street corners, storefronts and out of vans in 13 areas in New York including the Lower East Side, the South Bronx, Harlem, Williamsburg, Queens, Brooklyn, and East New York. Groups of known drug users or those affected by drug use in the area would be invited to come with the incentive of a $4 transportation card. The groups learn what to do in the event of an overdose. Stancliff then prescribes Naloxene – otherwise known as Narcan – a drug that can reverse an overdose situation without side effects.

'In 1995 there were only 20 members of Vandu, but by holding meetings and actually asking drug users what they felt would better the situation, this number grew and to date there are more than 1,600 members.'

Until April 2006 doctors were not allowed to prescribe the drug that could save lives because of a legal loophole – namely, it would be illegal for a physician to prescribe it to someone for whom it was not intended. At the Harm Reduction Coalition a large group of workers from needle exchange centres throughout New York lobbied to legalise prescribing the drug.

By the time the law had changed, Stancliff had already openly prescribed Narcan to approximately 1,000 drug users. 'I was very open about it; I had friends at the Department of Health in New York City joke about how I would look in an orange suit in jail.' In the South Bronx – a hot spot for overdoses – Stancliff and volunteers would stand on the street corner with their table. 'It is rather extraordinary when people come back to you and say they did a reversal for an overdose victim', she says.

Currently the Harm Reduction Coalition is preparing an anti-stigma campaign aimed at educating healthcare workers on addiction. They hope to change the views of many doctors and nurses who only come face-to-face with drug users in emergency rooms. One key part of this campaign is training doctors to give overdose kits with Narcan at the Columbia University Hospital.

Luciano Colonna, originally from New York, moved in 1997 to Salt Lake City, Utah – the State he describes as 'middle America – the fly over state', and 'home base of George Bush's flag waving conservatives and the Mormon Church'. Colonna became the executive director of the Harm Reduction Project in Salt Lake City. The project was given some office space in a medical clinic working with the homeless. There, Colonna set up an illegal needle exchange, which is still running – illegally.

With small grants they would provide programmes for sex workers, native Americans, methamphetamine addicts, heroin addicts, crack addicts, African Americans, Mexicans 'undocumented workers', homosexuals – anyone who needed their help. This was in 1997 to '98; at the time, says Colonna, they were noticing high numbers of overdoses and many addicts with abscesses from using dirty needles.

In such a conservative state, the challenge was to reach the right people and to educate them. In 1999 the Harm Reduction Project received funding to set up an overdose hotline: 1-866-STOP-ODS. They would receive calls and confidentially inform users on overdoses, how to use Narcan, resources and treatments available.

In 2001 Colonna was asked to set up a similar harm reduction project in Denver, Colorado. 'It was flattering because it is rare that other states ask agencies outside of their own state to aid in setting up an NGO', explains Colonna. The Denver office offers many of the same programmes and is faced with the same problems of lack of understanding on harm reduction and drug addiction.

Salt Lake City and Denver differ from working on the east or west coast of the States, as they encounter different trends in drug use. Middle America is where methamphetamines first became a real problem in the US, says Colonna: 'In the mid-'80s this was the capital for production of methamphetamine. Now many of those production labs have been busted and have moved down to Mexico, but it still affects many drug users here.'

As a result of their expertise on the subject of methamphetamine, the Harm Reduction Project organised the first ever Methamphetamine Conference in Salt Lake City last year, and most recently in February this year, attended by more than 800 specialists.

The harm reduction organisations in North America have had a massive impact in the last 15 years. These groups have operated illegally, risked incarceration, and despite obstacles have carried on operating out of sheer willpower to change public opinion, legislation, and ultimately to save lives.

Sara Moralioglu is a freelance journalist.

Closure orders were intended to give police swift powers to deal with crack houses. But the law is starting to fall far wide of its targets, warns **Christopher Cuddihee**

Unfair crackdown?

In 2001 the government announced it intended to provide police with a swift summary power known as a 'closure order', which would allow them to shut down crack houses that were an all too common blight on communities.

As a solicitor practising in South London, I have frequently represented tenants and families in these proceedings. I am concerned that while this legislation was originally intended to target a narrow but growing problem for communities, the use by police of this legislation is becoming more common, that the proper legal safeguards for those defending the proceedings are not always recognised, and that closure orders are expanding into areas never previously conceived.

Part 1 of the Anti Social Behaviour Act 2003 formally introduced closure orders. The act allows a police superintendent to issue a 'closure notice' where they have reasonable grounds to suspect an address is the source of 'serious nuisance or disorder' and associated with the use, production or supply of class A drugs. The notice has the effect of prohibiting all but the lawful occupiers from entering the premises. Anyone contravening the closure notice commits a criminal offence for which they can be sent to prison for up to six months.

A closure notice must be brought before a magistrates court within 48 hours and the court invited to make a 'closure order'. The legal test for the court to apply is essentially the same as for the superintendent – but with the additional requirement that the court find the closure order is 'necessary'. The legislation has been interpreted as requiring the proceedings to be concluded within 14 days – to provide police with a speedy remedy to this serious problem.

The critical effect of a closure order is that in making such an order, a court seals up the premises for a maximum of three months. Once again, any individual who enters or attempts to enter the premises in that time commits a criminal offence punishable by a sentence of imprisonment of up to six months.

So who are the individuals affected by closure order proceedings? The answer is, anyone who is a lawful occupier of the premises in question. I have represented a 77-year-old bed-ridden lady whom police and social services planned to move to a home, because her son's behaviour had led to closure order proceedings. I have represented a mother of four children whose partner appeared to be dealing drugs while she was at work and they were at school – and even though she had forced him to leave the premises, the police proceeded on the basis nothing else would appropriately deal with the problem.

Another client was a mentally ill man who was drug dependant and friendly with local prostitutes. I also represented a female drug addict who allowed her premises to be used for the consumption of drugs by local users. As you might expect, a wide variety of individuals are affected by these types of proceedings and not simply the narrow group of dealers and peripatetic users at whom these types of proceedings were originally aimed.

A particular problem for those defending closure order applications is the speed of the proceedings. The legislation has been interpreted to require the proceedings to be con-

Dan Atkin

cluded within 14 days. That apparently strict time limit is supposed to provide a party seeking to defend the proceedings – who may be a tenant, landlord, owner or lawful occupier – with a fair opportunity to do so. In my experience, there is no other legal proceeding that is required to be completed within such a short period of time.

The courts have intervened to extend that time limit. In *Commissioner of Police for the Metropolis v Hooper [2005] All ER* it was held that in 'exceptional circumstances' – which in Miss Hooper's case included her being medically unfit to attend court – that time limit could be extended. Also, in *The Queen on the Application of Brian Turner v Highbury Corner Magistrates Court [2005]* it was held that 'exceptional circumstances' did not just mean circumstances that were 'rare', and where it was in the interests of justice to do so, the 14-day time limit could be extended – opening the way for adjournments, for example in order for the police to disclose relevant evidence, an opportunity for a party to interview witnesses or to seek to adjourn proceedings because witnesses could not attend at short notice.

One of the difficulties for parties seeking to defend these proceedings, is obtaining expert legal advice. These are civil proceedings most naturally falling within the category of housing law. However the Legal Services Commission has designated them criminal proceedings for the purposes of public funding, so legal aid is only available to parties through solicitors with a Criminal Defence Service contract with the Legal Services Commission – and of course those solicitors usually have little concept of civil law. This can make life difficult for those seeking to defend this type of proceeding, who should have early access to legal advice with expertise in this area.

'I have represented a mother of four children whose partner appeared to be dealing drugs while she was at work and they were at school – and even though she had forced him to leave the premises, the police proceeded on the basis nothing else would appropriately deal with the problem.'

Another area of concern is that on account of these being civil proceedings the prosecution are able to use hearsay evidence, and usually this comes in an anonymous form. Hearsay evidence, at its simplest, is a statement from an individual repeating what they were told by another. In criminal proceedings hearsay evidence is used very rarely because the veracity of the original statement cannot be tested. The individual repeating the statement (the hearsay witness) is not likely to be able to offer any confirmation as to the truth of the statement, because he or she may not have witnessed the event being described.

Where the prosecution seeks to protect the identity of the original maker of the statement, then things can become very tricky for the defence. For example, how does a tenant prove that there has not been a steady stream of visitors to their home during the course of the day, apparently buying drugs and causing serious nuisance or disorder to other residents, in response to an allegation from an anonymous witness who gives evidence by hearsay?

Fortunately the administrative court to a large extent levelled the playing field for the defence in closure orders – and indeed in other ASBO-type legal proceedings – in *The Queen on the Application of Carol Cleary v Highbury Corner Magistrates Court [2007] 1 All ER 270* Lord Justice May stated that magistrates courts should treat anonymous hearsay evidence with great care as there was the risk of serious injustice. He also reminded the magistrates courts that they should give appropriate weight to anonymous hearsay evidence, and suggested that where courts have reliable live evidence from witnesses for the defence which contradicts anonymous hearsay evidence from the prosecution, the defence case was more likely to succeed.

I have noted with interest the successful use of closure orders against nightclubs – two in the Old Street area were closed by order of the magistrates court for six weeks over the last Christmas and New Year holidays, which must have cost the club owners an awful lot of money.

The use of closure orders looks set to expand. As the 'respect action plan' launched by the government on 10 January 2007 states at Chapter 7: 'Severe nuisance and anti social behaviour centred on a property is not always related to the use of class A drugs but current powers limit the closure powers to these circumstances. We will be consulting on a new power to allow the closure of any residential or licensed premises for a set period regardless of tenure which is causing significant, persistent and serious nuisance to local communities.' This suggests that access to expert legal advice and representation will become all the more important in the future.

Christopher Cuddihee is a solicitor at Kaim Todner and can be contacted by email at ccuddihee@kaimtodner.com

For more information on responding to a closure order, see the 'resources' section of the KFx website at www.ixion.demon.co.uk

Reducing the risk of relapse

Relapse prevention counselling can arm us against being caught out by high-risk situations, says Terence Gorski.

Relapse prevention is a critical component to recovery planning; it is the process of preparing for, mitigating, responding to, and recovering from a potential or actual relapse. It is a dynamic process, identifying, mapping, and managing personal reactions to high-risk situations.

Relapse Prevention Counselling (RPC) provides the tools and recommended actions to assist our clients in increasing their chances to recover and prevent relapse. RPC presents seven powerful clinical processes that quickly identify and mange high-risk situations that cause relapse: special emphasis is placed on the management of irrational thoughts, unmanageable feelings, self-destructive urges, and self-defeating behaviours.

Making the commitment

When embarking on recovery, we ask our clients to make an honest commitment to stop using alcohol or other drugs. By reviewing the problems that motivated them to enter treatment, we show them the relationship between their current problems and their alcohol and drug use.

Because we are well aware of the power of addiction to entice even the most stalwart back to use, we ask our clients to set up a monitoring and accounting system to back up their commitment. We also ask that they enter into a written 'abstinence and treatment contract' that spells out the commitments they are making about their recovery and relapse prevention. When they sign the agreement, they are putting their personal integrity on the line.

Stopping relapse quickly

One of the goals of RPC is to prepare the client to stop using alcohol and other drugs quickly if they do start using. The chances that they will recognise their relapse and take steps to stop using are dramatically increased if they have a prepared written plan for what to do.

Identifying high-risk situations

We do not get into high-risk situations by accident, but rather set ourselves up to get drawn into them. Once in the situation we do not know what to do; we make excuses as to why or how we ended up in the situation. Planning is an essential part of preparing to prevent relapse, and identifying high-risk situations is the first planning activity.

Identifying high-risk situations can be difficult. They are personal to each of us and not all high-risk situations will elicit the same response.

We may not appreciate the effect certain situations will have on our recovery and just how vulnerable we are. But through preparation and a proactive approach, we can recognise potential high-risk situations and be proactive in preparing our defence with various intervention options.

Mapping and managing situations

We need to thoroughly understand our high-risk situations. The greater the level of detail in mapping, or recording such situations, the more prepared we will be if we find ourselves confronted by them.

To manage high-risk situations, we must know what they are and how we get into them. We can recognise them by reviewing a list of common high-risk situations, identifying those that apply to us, and assigning a title and personal description that make them easy to remember and recognise when they happen. The next step is to map the situation, by describing exactly what we do and how other people react to what we do that makes us want to use alcohol or other drugs despite the commitment not to. Remember, the more detail you can record in the mapping process, the better prepared you will be in the actual situation.

Try to see what you are doing and saying in the correct sequence and think about each consecutive action. The closer the map is to reality, the better prepared you will be if the situation should occur.

Managing personal reactions

High-risk situations can activate deeply entrenched habits of thinking, feeling, acting and relating to others that make us want to use alcohol or other drugs. To manage these situations effectively, we must learn to understand and control the way we react. Our chances of managing high-risk situations without using alcohol or drugs increase as we get better at recognising and managing our thoughts, feelings, urges, actions and social reactions that make us want to use.

Developing a recovery plan

We must have a recovery plan that helps us to avoid relapse. People who successfully recover tend to do certain basic things. You may not do all of the things that someone else does, but once you understand yourself and your recovery needs you will be able to build an effective personal programme for yourself. Your programme should include a regular schedule of activities, designed to match your unique profile of recovery needs and unique high-risk situations.

The challenge of recovery is never really over. It seems that once we start a recovery process we are either growing or we're stalled, or regressing. There is no standing still: We either commit ourselves each day to improve and refine our recovery skills, or we become complacent and slowly move toward relapse. We must make a conscious choice each day about which path to follow. Choose recovery and you will move from a place of pain and fear, to a place of power and serenity.

Terence Gorski is presenting 'Managing high-risk situations-relapse prevention counselling', in London on 21 and 22 May. For details contact Emma Linzell on 01483 757 572 or email elinzell@lifeworkscommunity.com

Towards sustained recovery

Going beyond the traditional concept of relapse prevention can give a better set of tools for sustained recovery, say Stephen Donaldson **and** Susan McAuley**.**

Relapse prevention has become a central concept within the addictions field. Interventions focus on high-risk situations as potential triggers towards relapse. In a successful scenario, if a client is able to manage high-risk situations, their ability and confidence to deal with such situations in the future increases, and their vulnerability to relapse decreases.

Multi-disciplinary teams often bring their own interventions to the mix, which go beyond high-risk situations, cravings and the lapse/relapse process, and introduce concepts such as anxiety management, negative thinking, and problem-solving, working in a cognitive behavioural approach.

The term relapse prevention can prove too extreme when it acts as a barrier to attendance. Clients often see relapse prevention groups as working with those who are abstinent. While some may argue that relapse prevention is indeed only applicable to those who are drink or drug free, the reality is that practitioners also use these skills with clients who are still drinking or using, but working towards abstinence or controlled use.

At the Windmill Drug and Alcohol Team we have been running relapse prevention groups for a number of years, with the aim of educating those who attend on skills they can use to aid their recovery. The groups take place in each of our four catchment areas and last for two hours. One evening group is offered for those who work.

The rolling programme on offer allows clients to attend at any point in the ten-week cycle, so service users can access the group when they need it, rather than having to wait for the beginning of the next cycle. The main ground rules are confidentiality, so that a supportive environment can be cultivated, and that clients should not attend under the influence of drugs or alcohol. They do not have to be abstinent, but need to commit to working towards that goal. Clients are encouraged to attend at least one cycle, although they can attend two if required. Some clients move on to other groups that we offer, for support or more in-depth group therapy.

Asking service users what they felt they gained from the groups, many felt that they were supportive, educational and also allowed a safe environment to explore issues. Some commented that the group allowed them to be with others and not feel they were the only one who had a drug or alcohol problem. For those that were awaiting inpatient care, the group was seen as a means of preparing them for group work or reaffirming skills, when they were back in the community.

In light of service users' comments, the relapse prevention groups were renamed 'managing addiction groups', as we felt this reflected the needs of the client group and the varying interventions we were promoting. A name change may seem minor, but the use of 'management' rather than 'prevention', suggests that service users can be an active participant in managing their own addiction and recovery, and does not exclude those who are reducing their substance use and able to attend the group without being intoxicated on that day. Our emphasis is on reducing the vulnerability to relapse, more than preventing it; while prevention continues to be the aim, we try to reduce the sense of failure, shame, guilt and negative feelings associated with the process.

In reviewing our group structure, we focused particularly on areas where clients reported experiencing difficulties. We looked at cravings in more detail; previously this was covered as part of the lapse/relapse group, but the change in emphasis allowed us time to explore with clients the distinction between cravings and physical withdrawal.

The groups are facilitated by two clinicians who come from different professional backgrounds within the multidisciplinary team; this offers different perspectives which clients have a higher chance of relating to. Facilitators also adapt their methods to service users' varying learning needs, ethnic and cultural considerations, and mental health needs.

Like us, many teams offer relapse prevention, and have debated individual versus group approaches. Group interventions have a cost benefit: clients can be treated by fewer professionals and in parallel. Groups can also increase a client's support network and allow the sharing of skills and strategies that have (or have not) worked in the past, within a safe and supervised environment. For some however, attending a group can be a daunting process. They may be anxious about confidentiality, associating with other substance users, or fearful of the unknown.

As group facilitators, we often see the difference in those who are able to reflect on issues with their key worker, which have arisen during the group programme. It could therefore be argued that a balance between group and one-to-one work is essential.

The most important element of any approach is that it supports the service user in reflecting on and challenging their own actions while they are in a safe environment to make changes.

Stephen Donaldson is substance misuse specialist and Susan McAuley is nurse specialist at Windmill Drug and Alcohol Team

Benzodiazepine Deficiency Syndrome

In her last 'post-its from Practice' column, Dr Chris Ford reignited the 'good guys, bad guys?' debate on benzodiazepines. **Dr Adam Bakkar** believes in their value, and pulls together evidence to show why.

I am glad Dr Chris Ford has challenged the outright ban on the use of benzodiazepines in many drug services in her recent 'Post-It' (*DDN*, 26 February, page 13). Last year I attended a lecture by Dr Stefan Janikiewicz, an inspirational speaker and one of our opinion formers in the field of addiction treatments. His lecture was clever and extremely funny at the expense of other doctors. Although he believed in the existence of a 'benzodiazepine deficiency syndrome', he did not share with us how this could be diagnosed or how it should be managed. On the contrary, his message was very clear: never prescribe benzodiazepines.

Benzodiazepines have an image problem. They are currently considered to be bad drugs mainly prescribed by lazy doctors who have no inclination to explore their patient's psychological needs. Benzos, it is said, don't solve the problems but make them worse. They lead to addiction, accidents and dementia and are used for 'date-rape'. PCT pharmacists have singled out benzos as a marker of poor quality prescribing when auditing GP practices; but are they really such evil drugs? Is their image deserved, or are they now under-used?

Benzos undoubtedly alleviate anxiety and insomnia reliably and quickly, at least in the short term. No class of useful drugs is without problems and benzos are no exception. Prescribers need to be aware of their drawbacks: in particular their abuse potential and risk of addiction. The addictive potential is actually no greater than that of dihydrocodeine[1] but interestingly, doctors who fail to prescribe dihydrocodeine where it is required would be considered to be the bad ones. A good doctor is not supposed to say: 'Your pain is likely to improve naturally, it would be wrong to give you strong drugs for it; better to wait for it to go on its own.' However, when dealing with angst, this is considered a reasonable response.

Why do addiction specialists want to make us believe that appropriate use of the benzodiazepines doesn't exist? In general practice we realise that this cannot be true. I certainly see many patients who have benefited from benzos and used them appropriately in situations such as bereavement, divorce, reactive depression, detoxification, muscle spasms, long-haul flights or court cases. I suspect addiction specialists hold this cynical view because they only deal with problem drug abusers, but there are also valid arguments for the use of benzos within the addict population, despite the abuse potential.

Heroin overdoses commonly occur in combination with benzos, and this is another reason that many doctors refrain from prescribing them for drug users. We are taught that the combination of opiates and benzos forms a toxic cocktail, likely to harm our methadone maintenance patients. I think this is short sighted. The risks of overdose occurs with haphazard, illicit benzo use in the absence of tolerance. There is a logical parallel to be drawn with substitution prescribing for opiates. We know that the provision of a consistent, legal supply, be it of methadone or buprenorphine (or morphine, or codeine), reduces the risk of opiate overdose. It is a logical hypothesis that legally supplied benzodiazepine might have similar effects on overdoses involving benzodiazepines.

The dominant expert opinion is that there is no evidence to support benzo maintenance prescribing, but a short browse on Medline suggest otherwise. I quickly found a controlled study of the exact sort that we are told doesn't exist: a trial showing clear benefits of benzo prescribing in methadone maintenance patients[2]: 78.8 per cent of the patients treated with maintenance benzos stopped their illicit use compared to only 27.3 per cent in the group where they were tailed off. Furthermore, the 'detoxified' patients were much more likely to drop out of the methadone programme.

Another study analysing 222 consecutive opiate overdoses in Barcelona[3] found only two statistically significant risk factors associated with respiratory arrest: prior abstinence from opiates and prior abstinence from benzos. This endorses the principle of benzo maintenance, particularly for addicts who give a history of frequent accidental overdoses.

I also remain unconvinced about the alleged effects of benzos on cognitive function in the clinically anxious. Benzos can clearly impair recall in test situations in healthy volunteers, but there are also studies that show the opposite effect in nervous patients whose recall is impaired by anxiety[4,5] or insomnia[6]. In this situation, short-term memory seems to improve when anxiety is alleviated by benzos. Although I do warn patients about a possible increased incidence of dementia with long-term, high dosage, benzo usage, I am aware that this is a controversial opinion based on observational studies where control groups were not truly equivalent to the treatment groups.

It seems that addicts are routinely told at drug treatment centres that benzos are more difficult to stop than opiates. This I also refuse to believe. I prescribe both classes of drugs frequently for addiction, and in my own patients I see at least as great a cessation rate for benzos as for methadone. The continued use of benzodiazepine is less stigmatised than that of opiates, and patients usually perceive these medications as a solution rather than a problem. Despite this, many patients seem to be able to cut down and come off with just a little support when the time is right.

Of course there are some addicts for whom benzos are the main problem drug and who find it extremely difficult to quit. It is a shame that no drug treatment service in Britain has taken on benzo detoxification with the low-dose flumazanil method. This wonderfully simple and safe technique would be the ideal method to detoxify problematic benzo users. The technique was described by Gerra *et al* in 2002[7].

Micro-doses of flumazanil, an inverse GABA-agonist, are infused for just five days without generating insomnia or any other significant withdrawal symptoms. There is no problem with fits using micro-doses and the completion rate with flumazanil detoxification is excellent whatever the size of the habit. It all seemed a bit too fantastic, so I travelled to Australia to observe this technique in practice during my sabbatical. In two centres I observed patients on flumazanil and they were strikingly normal: not distressed, not agitated or sedated. They reported no symptoms, despite having just stopped what often sounded like industrial quantities of diazepam.

Adam Bakker is a GP at Lisson Grove Health Centre in Westminster and has been treating addicts for the last 12 years.

[1] El-Guebaly N. Managing addictions, Global Context and challenges. 7th International Society of Addiction Medicine Annual meeting, Mar del Plata, 24/4/2005.
[2] Weizman T, Gelkopf M, Melamed Y, Adelson M, Bleich A. Treatment of benzodiazepine dependence in methadone maintenance treatment patients: a comparison of two therapeutic modalities and the role of psychiatric comorbidity. *Aust N Z J Psychiatry*. 2003 Aug;37(4):458-63.
[3] Anoro M, Ilundain E, Rodriguez R, Rossell L, Iglesias B, Guinovart C, Gabari M. Factors related to experiencing respiratory failure in cases of opiate overdose for which care was provided in an open setting. Barcelona, *Spain Rev Esp Salud Publica*. 2004 Sep-Oct;78(5):601-8. Spanish.
[4] Desai N,Taylor DA, Barnett DB. The effects of diazepam and oxprenolol on short term memory in individuals of high and low state anxiety. *Br J Clin Pharmacol* 1983;15:197-202.
[5] Barnett DB, Davies AT, desai N, Differential effect of diazepam on short term memory in subjects with high or low level anxiety. *Br J Clin Pharmacol* 1981;11 411P-412P
[6] Peck AW, Bye CE, Claridge R Differences between light and sound sleepers in the residual effects of nitrazepam. *Br J Clin Pharmacol* 1977;4:101-108.
[7] Gerra G, Zaimovic A, Giusti F, Moi G, Brewer C. Intravenous flumazenil versus oxazepam tapering in the treatment of benzodiazepine withdrawal: a randomized, placebo-controlled study. *Addict Biol*. 2002 Oct;7(4):385-95.

I am currently employed by a large charity as a counsellor and am looking to move jobs. I am considering moving to a private treatment provider and would like to hear if any readers who have experience of working for the private sector, as well as charity or statutory sectors, have noticed a significant difference in attitudes and working practices – or is delivering care the same whoever is providing it?
Bryan, via email

Facilities and resources

Hi Bryan
I worked for a charitable organisation in my formative years as an addictions therapist. I did my counselling placement there and applied for a full-time post after many months of invaluable voluntary work.

The secondary unit, which was part of the continuum of care offered, was a sub unit of a larger trust offering support to people with housing and mental health problems. It was tough work but created a solid grounding in the therapeutic interventions needed in an addiction treatment setting. People could stay up to a year and then graduate, if it was felt helpful, onto tertiary treatment/support.

I moved across to the private sector in 2001, and the main difference immediately was facilities and resources. I'm not suggesting that the charitable service was ineffective or in any way clinically defective, but the collection of training, continued professional development, supervision, and internal opportunities just opened up. In turn, I believe this benefits the clients/patients because the clinical team are able to offer the best, most up-to-date research and evidence-based therapeutic interventions.

In my experience, the service users in both arenas suffer from exactly the same issues and history. They may, on occasions, come from different demographics, but the stories are the same and the traumas and attachments issues are identical.

If there is a shortcoming of the private sector, it is possibly of time. Length of stay is financially driven rather than clinically. Those coming through primary treatment on medical insurance can often only stay for 28 days with some daycare to follow. For some, maybe many, this is just not long enough to recover suitably enough to understand that they are suffering from a potentially life-threatening mental illness. That said, the company's treatment programme is intense and successful for many individuals, and with free aftercare for one year after discharge, it is often truly effective.

After starting as a primary addiction therapist in 2001, I worked up to being senior therapist at, what I considered the most prestigious primary treatment facility in the UK, Farm Place. I was offered the chance to run Priory Healthcare's stand alone secondary unit two and a half years ago.

The career path is yours for the making in the private sector I've found, but I owe my grounding in the treatment process to the charitable sector.
Richard C Renson,
manager at Coach House

Small is beautiful

Dear Bryan
You have hit the nail on the head; as you say, delivering care is (or at least should be) the same whoever is providing it.

In reality there are no hard and fast rules on how an organisation operates. In my 20 plus years working in the field I have been employed by all manner of organisations, from commercially driven private providers through to small charities and I am currently employed by a large local authority.

Each one had their own systems in place, some of which were extremely efficient, some of which were downright awful. As a general rule of thumb, the larger the organisation the more layers of bureaucracy there are for you to wade through. The one thing I would recommend when you visit any new establishment where you intend to work, is to try and get a feel for the personality of your immediate managers and how dynamic and proactive they seem. If you work with the right people you can achieve anything, at any place. Best of luck!
Arthur, via email

Reader's question

How do people without 'formal' drugs work experience gain a chance of being employed in substance misuse services, despite having ten years personal experience with a user who is a close family member and having a Level Two NCFE Certificate in Drug Awareness Studies?
Maria, by email

Email your suggested answers to the editor by 17 April for inclusion in the 23 April issue.

Post-its from Practice

Counter culture

Dr Chris Ford and her colleague Dr Beth Good have been coming across dangerous dependency from over-the-counter drugs

Jack returned to see us a few weeks ago complaining of severe abdominal pain. He had previously had a heroin problem, but after detoxification with us and six months rehabilitation in 2001 he had been drug free until about seven months ago when he had started to take Nurofen Plus bought over the counter because he felt depressed. He had started taking about four to six a day but it had rapidly increased to between 60 and 70 tablets a day. He felt some effects from the drug, but was unable to reduce and realised he was dependent. On examination he was acutely tender over his abdomen and his blood test revealed severe anaemia, from bleeding from his stomach.

Nurofen Plus is a compound analgesic available over the counter containing 200mg ibuprofen and 12.8mg codeine per tablet. Jack was the third person in as many months who had presented to us with Nurofen Plus addiction. All three patients had histories of opioid dependence, had been drug free for several years and presented with physical effects from taking the ibuprofen, the element of the drug not wanted. The first woman also had had gastritis, but no stomach bleeding and had been taking about ten tablets a day, while the second woman had a severe allergic rash and had been taking 12 tablets a day. All had suffered severe withdrawal symptoms from the codeine, the wanted element, when they had tried to reduce. Jack was taking a staggering 12,000mg or 12 grams of ibuprofen in order to obtain 768mg of codeine.

Codeine phosphate, a weak opioid drug, is only available on prescription but has been available over the counter in combination with aspirin and paracetamol containing up to 8mg codeine per tablet and up to 12.8mg when in combination with ibuprofen. An extensive literature search found no research into addiction to over-the-counter drug dependence in the UK. A Google search, however, revealed numerous websites and media articles documenting cases of addiction and offering support to those people trying to withdraw from these drugs.

Websites such as over-count.org.uk and codeinefree.me.uk tell many personal stories, often remarkably similar to Jack's and usually starting with appropriate use of analgesia for pain such as back injury or menstrual cramps. Over-count reports that 34 per cent of people regularly taking high doses of Nurofen Plus have suffered from pancreatitis, and that many require additional medication, such as ranitidine, to treat dyspeptic symptoms. They also report the most commonly reported addiction to be to Solpadeine (500mg paracetamol and 8mg codeine) and suggest that more than 4,000 people registered on their website currently have this problem.

Our first two patients have become drug free, one using a reducing dose of codeine phosphate, one lofexidine and both using weekly cognitive behavioural therapy (CBT). Jack is doing well and is reducing using dihydrocodeine, has had no further stomach bleeds and is going to NA meetings daily.

The extent of dependence on non-prescription drugs has been estimated to affect more than 30,000 people in the UK. Addiction to codeine included in painkillers has been recognised for many years but anecdotal reports suggest it is increasing – this would clearly seem like an area needing research to assess and monitor the extent of the problem.

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP; Dr Beth Good is a GP at Lonsdale.

Some of my favourite reads (Part 3)

Professor David Clark continues a perusal of his bookshelves to describe more interesting books in the field

Last year, I emphasised how much I enjoyed reading books relating to substance use and misuse. I described a number of my favourite reads in two Background Briefings, and I continue my list here. Once again, I am going to tease you with a wide range of material.

'Drugs and Crime' by Philip Bean (£18.04)
Many will argue that the scale of government investment in the tackling of drug misuse is due to politicians' belief that a high proportion of crimes committed in the UK are drug-related. But do drugs really cause crime? And should the treatment of substance use problems be so tightly linked to a criminal justice agenda? This book provides an authoritative and much-needed overview of a variety of issues related to drugs and crime. The topics it covers include the drugs-crime link, sentencing drug offenders, coercive treatment and mandatory drug testing, DTTOs and drug courts, policing drug markets, and the treatment of women drug users.

'The Pursuit of Oblivion: A Global History of Narcotics 1500-2000' by Richard Davenport-Hines (£6.59)
A fascinating book that draws on a massive range of sources to show how opiates, amphetamines, cocaine, LSD and cannabis came to have such an impact on Western society, and how each came into use as a legal medicine, only to be outlawed later as an illicit drug. It covers a wide range of topics, including the drug habits of famous people, the origins of national and international drug policies, the evolution of attitudes towards illicit substances, and an assessment of why illegal drug use continues despite harsh criminal sanctions.

'Addiction and Change: How Addictions Develop and Addicted People Recover' by Carlo C. DiClemente (£16.99)
The stages-of-change model has become widely known as a framework for conceptualising recovery from addiction. In this book, one of the originators of the model relates it not only to the behavioural change that occurs when people try to overcome an addictive behaviour, but also the path they take when developing such a problem. The book 'offers a panoramic view of the entire continuum of addictive behaviour change'. It also addresses prevention and treatment, discussing ways to tailor interventions more effectively to people at different points in the change process.

'Once again, I am going to tease you with a wide range of material.'

'The Twelve-Step Facilitation Handbook: A Systematic Approach to Recovery From Substance Dependence' by Joseph Nowinski and Stuart Baker
This is my favourite read so far among the literature relating to AA and the 12-step approach. Aimed towards professional counsellors and therapists, the book presents the techniques and protocols used in Project MATCH, the large scale American study comparing the effectiveness of different treatment approaches. It provides an excellent insight into key concepts, elements and objectives of the 12-step approach, as well as an overview of the systematic approach that is used to facilitate early recovery through this programme.

'Game of Shadows' by Mark Fainaru-Wada and Lance Williams (£7.00)
This best-selling book is about BALCO, the inside story of the steroids scandal that rocked the sports world, by award winning San Francisco Chronicle investigative journalists. A fascinating, sometimes mind-boggling read, about how an obscure self-proclaimed nutritionist, Victor Conte, became the 'steroid Svengali' to multimillionaire athletes desperate to improve their performance. It reveals how 'he created superstars with his cocktails of miracle drugs', how coaches and trainers encouraged athletes to use BALCO, and how the drug cheats stayed ahead of drug testers.

'Circles of Recovery: Self-Help Organisations for Addictions' by Keith Humphreys (£61.75)
Although this book is expensive, it merits its place on my bookshelf as a seminal piece of work on self-help. It provides an integrative review of research on self-help organisations across the globe, covering over 500 studies into the efficacy of self-help groups as an alternative and voluntary form of treatment. The author also provides practical strategies for individual clinicians and treatment systems to interact with self-help organisations in a way that improves outcomes for people with a substance use problem and for communities as a whole.

'Drug Misuse and Motherhood' by Hilary Klee, Marcia Jackson and Suzan Lewis (£28.99)
This urgently needed book is based on longitudinal research and in-depth interviews. It documents the experiences of women drug users during pregnancy, through childbirth, and into the early months of the child's life. It also describes the parenting strategies of drug users and the hazards faced by children as a result of their parents' drug use. The voice of drug-using mothers is balanced by the professional viewpoint on the same issues. This excellent book provides key information for improving service delivery, has strong policy implications, and is a welcome source of inspiration for practitioners.

'Rethinking Substance Abuse' by William R. Miller and Kathleen M. Carroll (£23.75)
This book brings together the thoughts of leading addiction experts to explore what treatment and prevention would look like if it were based on the best science available. The book includes neurobiological, genetic, psychological, social-environmental perspectives on how addictions develop and are maintained, as well as how they can be addressed at the individual, family, and society levels. The concluding chapter integrates and elaborates on major lessons learned and presents a coherent set of guidelines for building better systems of care.

Prices are Amazon. I must get back to my book!

UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2007/08

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2007 or by negotiation

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

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

18 month programme from September 2007 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2007

BSc in Substance Misuse Management (Stage 3)

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

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

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

LT 104505 3/07

Drugs, Drink and Mental Health

Responding to the Challenge

Thursday 14 June, 2007

Manchester Conference Centre

A conference which will debate, explore and develop responses to the challenge posed by dual diagnosis to public health and to public safety.

*BOOK FOR EARLY BIRD DISCOUNT
£170+vat
(£199.75 inc. VAT)

* Early bird offer available until 7 April 2007.

As from 8 April 2007 the normal delegate fee of £199 + VAT per delegate will apply, £233.83p inc. VAT

To register online go to: www.hit.org.uk/conferences
Email: ddmh@hit.org.uk
Telephone: 0870 990 9702

BOOK YOUR PLACE NOW!

Care Services Improvement Partnership CSIP
North West Development Centre
HIT.

West Glamorgan Council on Alcohol and Drug Abuse

Deputy Chief Executive

(Chief Executive Designate)

WGCADA is a registered charity based in Swansea with offices throughout the South Wales area which provides help, advice and support for people with Substance Misuse problems, and those significant others who are also affected by Alcohol and Drug Abuse.

The organisation employs approximately 100 people and over 27 years has developed a strong reputation for the treatment of alcohol and drug abuse. The treatment intervention involves Abstinence, Harm Reduction, and works in partnership within the Criminal Justice field. However, at heart, we are a "12 Step Minnesota Model" and the selected candidate will need to display the enthusiasm to take this part of WGCADA's profile forward.

You will need to have the necessary business acumen to manage this expanding organisation, combined with the appropriate experience and knowledge of Substance Misuse treatment. The right individual will eventually lead the Charity as its Chief Executive. A negotiable benefits package is offered.

Applications should be addressed to Dr Haydn Rees, Chair of Board of Trustees, WGCADA, 10 St. James Crescent, Swansea SA1 6DZ by 16th April 2007.

The first step to change

Langley House Trust specialises in providing ex-offenders with accommodation, support and drug and alcohol rehabilitation within a supportive Christian environment. We're changing people's lives – a transformation that begins with you.

Addiction Counsellor — Bradford

£20,000 on appointment, £22,000 with full accreditation

At the Rothera Project, we offer semi-supported housing for 18 women in shared and single person accommodation. Working a 2 year contract, you will take an active lead in delivering therapeutic care to residents, helping them manage their substance misuse in a community setting. With a Diploma in Counselling you will have the opportunity to expand on your experience of working in an abstinence based 12 Step or similar context. You will also need a full driving licence and your own transport.

We are a women only project and will therefore only accept applications for this post from women. Sex Discrimination Act 1975 Section 7(2) (d) applies to this post.

If you are in harmony with the Christian ethos of our organisation and wish to find out more, or to obtain an application pack, please visit our website at www.langleyhousetrust.org or telephone us on 01993 705999 quoting reference ROT/409/DDN.

We also have positions available for a Therapeutic Team Leader and a Counsellor in Coventry. Please visit our website for more information on these roles.

Closing date: 10th April 2007. Interview date: 24th April 2007

Charity Number 290059 and Registered Social Landlord Number H4250

EVERY DAY IS A NEW BEGINNING

In-patient Detox

A Tier too far?

A one-day conference, bringing together commissioners, providers and referral agencies to consider the future role of specialist in-patient detox (IPD) services.

Recent NTA and Department of Health initiatives have highlighted the critical role that Tier 4 addiction services can and will have in progressing the treatment agenda. This conference will bring together stakeholders to debate current issues in Tier 4 provision and review evidence and example of best practice.

Themes

The conference will give delegates an opportunity to share information around the regional commissioning developments inherent in the Department of Health capital funding initiative, particularly opportunities for supra-regional developments. With commissioners, Tier 3 and 4 providers and representatives from key national present, the conference will be the first to address specialist residential provision within the context of a recently published needs assessment and funded growth potential.

For further information contact Pavilion's customer service team on **0870 890 1080**, email **info@pavpub.com** or visit **www.pavpub.com**

Date: Wednesday 25 April 2007

Venue: Lancashire Cricket Club

unhooked thinking

The Addiction Conference
"Love and Baggage"
May 9th-11th 2007
The Guildhall, Bath, UK

The second international multi-disciplinary and iconoclastic enquiry into the very nature of addiction.

CLOUDS

THEMES FOR EACH DAY

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SPEAKERS INCLUDE:
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SUPER EARLY BIRD RATES APPLY - BOOK BEFORE 28th FEBRUARY AND SAVE UP TO £100

www.unhookedthinking.com

Papa Stour Project

Full Time Support Worker

Papa Stour Project invites applications from experienced individuals (or couples wishing to job share)

This is a residential post funded by SADAT. 37 hpw fixed term appointment 18/06/07-17/06/08 £15K+full- board. In partnership with Shetland Community Drugs Team and Alcohol Support Services.

We are looking for a self motivated and enthusiastic person able and willing to live as part of a small Christian-based supported housing service providing support for clients with alcohol/drug addiction in a remote small island location in the Shetland Islands.

For further information and to obtain an application pack (closing date 07/05/07) please contact:

Sabina or Andy Holtbrook

01595-873238
sabina@papastour.org
www.papastour.org

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the coretrust

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

Receptionist - £18,000 per annum - Marylebone

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

To request an application pack, please contact Morne Viljoen on 0207 258 3031 or email morne@coretrust.org Closing date: 3 April 2007. To learn more about The Core Trust, please visit our website: ***www.coretrust.co.uk***

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addaction

Residential Substance Misuse Therapist

37.5 hours per week Mon-Fri, 8.30-5pm with 1 hour break
£19,664 FTE, Fixed term contract for 6 months
Based in Chy Colom, Truro • Ref: ADDSW51

We are looking for a part-time Residential Rehabilitation Therapist at Chy Colom, Addaction's Truro based, 11 bedded, mixed-gender residential rehabilitation service for individuals with alcohol and/or drug problems.

You will be part of a skilled and committed staff team and will need to have a diploma in counselling/therapy. Residential experience is preferable and you will need to be competent in working on a one-to-one and groupwork basis.

Chy Colom provides 24/7 staff cover, and whilst this post operates primarily on a Monday to Friday, 8.30am - 5.00pm basis, we will expect some flexibility to cover occasional out-of-hours shifts.

We offer residents a client-centred eclectic programme, and in a typical week the programme will include one-to-one keyworking, process groups, relapse prevention, body/energy orientated therapy, auricular acupuncture, relationship groups, EFT, massage, CBT, TA, loss groups, creative/projective workshops, physical activity and information-based groups.

To download an application pack, please visit our website. Alternatively, please contact Myfanwy Scrivener on 01392 255151 or email m.scrivener@addaction.org.uk quoting reference ADDSW51.
Closing date: 5 April 2007.

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www.addaction.org.uk

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www.nhslothian.scot.nhs.uk

NHS Lothian

Lothians and Edinburgh Abstinence Programme (LEAP)

Lothians and Edinburgh Abstinence Programme (LEAP) is a new initiative funded for two years by the Scottish Executive and managed by NHS Lothian. As a community rehab it will give patients the opportunity to achieve abstinence incorporating a holistic approach to their treatment programme. Experienced and committed, you will join the team responsible for the delivery of the programme.

Head Therapist

Band 7 – £27,622-£36,416 pa, fixed term for two years

You will have at least five years' experience working in a related area and working experience of the 12 step model is required. **Ref: SUB/ES/133**

Therapists – 3 posts

Band 6 – £21,985-£31,004 pa, fixed term for two years

You will have at least two years' experience working in a related area and working experience of the 12 step model is required. **Ref: SUB/ES/134**

For informal enquiries for both posts, please contact James Shanley on 0131 537 8300.

To apply, please contact the Recruitment Centre on 0845 60 33 444 or email recruitment@wlt.scot.nhs.uk quoting appropriate reference. Closing date: 13 April 2007.

We operate a no smoking policy

The Priory Hospital Roehampton seeks to recruit the following people to join our skilled and dynamic clinical team:

THE PRIORY HOSPITAL ROEHAMPTON

Addiction Treatment Counsellor

37.5 hours per week
Salary Band 6 (£18,061 - £30,102)

Ensuring that the needs of our clients are met, the post holder will hold a caseload of clients and lead groups, workshops and lectures within our addiction treatment programme.

Sessional Addiction Treatment Counsellors

Due to the continued success of our programme, we now seek additional clinical staff to join our bank of sessional staff for both regular and occasional work.

Short-listed applicants for all posts will be qualified to at least Diploma level in a relevant clinical discipline, be able to apply an understanding of dual diagnosis within a 12-step model of recovery and be either FDAP accredited or willing to work towards this.

We offer outstanding working conditions and a range of benefits, including excellent training opportunities, a contributory pension scheme, and subsidised meals.

For an informal discussion regarding any of the posts, please contact Nick Gully, Director of Addiction Services on 020 8876 8261. Please contact Esther de Klerk on 020 8392 4224, The Priory Hospital Roehampton, London, SW15 5JJ for an application pack.

The successful candidate will be required to apply for a Disclosure at the Enhanced level from the Criminal Records Bureau. Further information can be found at www.disclosure.gov.co.uk

Closing Date: 2nd April 2007

www.priorityhealthcare.com

PCP
a new beginning

Treatment Coordinator
Salary: £40,000

Luton, Beds

An exciting opportunity for an energetic person with experience in a 12 step treatment centre. You will be part of our existing admissions team dealing with assessments, family interventions, presentations and exhibitions. This is a challenging role with lots of prospects and growth.

Please contact: Perry Clayman
0207 421 1890 or 01582 730 113

Operations Manager

Federation of Drug and Alcohol Professionals

Harrow – £27.5k

The Federation of Drug and Alcohol Professionals (FDAP) is the professional body for the UK alcohol and drugs field. FDAP is a membership organisation which provides guidance, training and professional certifications to support the development of effective practice and appropriate recognition of practitioners' knowledge and skills.

The Operations Manager will have a wide range of responsibilities, including: membership services and administration; processing and supporting applications for certification; administering and organising training & events (including the FDAP annual conference); handling invoicing and book keeping; maintaining the FDAP & www.drinkanddrugs.net websites; deputising for and assisting the Chief Executive as required.

The successful candidate will need strong organisational skills, good written and verbal communication, a high level of numeracy, the ability to work on their own initiative, an attention to detail and a commitment to high standards.

The post is for 12 months initially. For further details email office@fdap.org.uk or see our website

www.fdap.org.uk

Closing date – 13 April; Interviews – 24 April.

fdap

want to join a young and dynamic counselling team?

Due to our unprecedented success, TTP are accepting applications for:

- **Senior Counsellors**
- **Counsellors**

You will immediately benefit from an excellent salary and training package and be part of the fastest growing 12 Step Treatment Centre in the UK. In the medium term a clearly defined promotion path will secure your future within the organisation destined to set the standards by which other centres gauge themselves.

If you are qualified, or training, to a minimum of Diploma level and have personal or professional experience of the 12 Step recovery program we would like to hear from you.

Telephone: Gavin Cooper on **0845 241 3401** or
Email your CV to: **gavin@ttpcc.org** or
Post to: Telford Place, 1 Telford Way, Luton, Beds, LU1 1HT

ttp counselling — alcohol and drug rehab — www.ttpcc.org

EXTRAORDINARY JOBS
EXTRAORDINARY WORKPLACE

HM PRISON BEDFORD

Substance Mis-use Worker
Drug Facilitator – Full Time (37hrs per week)

Salary: £17,029 – £20,892 plus a Local Pay Allowance of £2,600 p.a.

A vacancy has arisen for a Drug Facilitator worker in HM Prison Bedford.

Applicants should preferably have experience of group working within the criminal justice setting. Successful applicants will need to demonstrate a positive approach to rehabilitation orientation, have high levels of motivation & commitment, Excellent problem solving and communication skills, and be able to adopt a systematic approach. Full job description available on request. Annual leave entitlement commences at 25 days per annum plus 10.5 days for bank holidays/privilege days.

Please download an application form from our website *www.hmprisonservice.gov.uk* under the current recruitment section or contact Bedford Jobcentre Plus, Wyvern House, 53-55 Bromham Rd, Bedford MK40 2EH or tel. Tracey on 01234 361587.
Closing date: 16th April 2007

Please note that all Prison Service posts are open to part-time and job share applicants. Applicants are required to declare whether they are a member of a group or organisation, which the Prison Service considers racist. The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age, sexual orientation, disability or any other irrelevant factor.

INVESTOR IN PEOPLE

HM PRISON SERVICE

Basingstoke and Deane

You'll see them at their worst. And their best.

Client Services Co-ordinator

£25,437 - £28,221 plus car allowance

You're going to work with police, probation and other agencies to support and mentor prolific and other priority offenders. It's a multi-agency team based in Basingstoke dealing with approximately 60 identified offenders across four districts in the northeast of Hampshire. Some of them will have substance dependency issues and some will be trying to piece their lives together following release from prison. But one thing is certain, you're going to help them to gain the confidence and support to turn their lives around.

A strong understanding of drugs and alcohol misuse is important, as is a proven track record of working with hard to reach groups. You will need to be able to help identify funding streams so that we can continue the programme and extend it. This is all about helping people to resettle and rehabilitate from a life of offending so a positive and flexible approach will be key.

This is initially a temporary appointment until 31st March 2008.

Apply by application form only.

www.basingstoke.gov.uk/jobs

T: 01256 845584 E: recruitment@basingstoke.gov.uk

Please quote ref: CCS104.

Closing date: 6th April 2007.
Interview date: 23rd April 2007.

We are committed to providing opportunities for all and welcome applications from all sections of the community.

SMART

SMART is a well established Thames Valley substance misuse organisation that directly engages problem drug users through their contact with the criminal justice system. Our innovative projects are designed to break the cycle of offending and transform the prospects of problem drug users.

ALCOHOL SENIOR PRACTITIONER

Oxford
£25,100 - £27,153

SMART CJS strives to develop individuals within the organisation in an environment that is conducive to progress, by harnessing a team culture that is respectful, professional and open.

Key tasks include:

- Care co-ordination and quality management
- Staff supervision/programme development
- Performance monitoring, reporting and attending key meetings
- Managing complex client cases
- Ensuring all service users fitting the service remit are identified at the earliest opportunity and assessed appropriately
- Effectively managing the individuals' transition from the service and ensuring the routes away from the alcohol service are suitable for achieving success long-term

This requires experience of working with vulnerable adults in the social care context, along with supervisory experience and candidates should have experience of setting up/developing new services.

You will be supporting staff to deliver high quality client services, managing within a performance framework.

You will ensure all services are delivered to models of care quality standards and DANOS standards. Successful applicants will either hold a professional qualification or demonstrate a commitment to achieving one within a reasonable timeframe.

Previous experience in similar roles is essential.

In return, we offer an open, professional and friendly environment; flexible working hours; commitment to staff training and development, as well as a generous occupational pension scheme.

SMART CJS is committed to the principles of diversity and equality of opportunity and is striving to ensure that its workforce is representative of the communities it serves. Individuals from minority ethnic groups and those who have personally experienced and overcome drug/alcohol related problems are encouraged to apply.

For further information on this role and other opportunities with SMART CJS, please visit our website at: www.smartcja.org.uk

Closing date for applications is 16th April 2007. Interviews will be held in Oxford on Wednesday 25 April 2007.

For an application pack, please contact Helena Kennedy on 01865 515318 or email: enquiries@smartcja.org.uk

Registered charity number 1069087

www.smartcjs.org.uk

ADULT AND COMMUNITY SERVICES DEPARTMENT
COMMUNITY SAFETY AND PREVENTATIVE SERVICES

ADULT SUBSTANCE MISUSE CARE MANAGERS

£23,937 - £29,865 **Ref No: ACS079**

Inclusive of London Weighting

Location: Riverside Roxwell Road, Thames View Estate, Barking IG11 0PR

The Barking & Dagenham Care Management Team plays a pivotal role in the implementation of Models of Care within our treatment system. The team is forward-thinking and has a whole systems approach to care, support and 'wrap around' service solutions. Covering Barking & Dagenham, you will work alongside colleagues from other agencies in providing a range of evidence-based interventions for service users who have drug and alcohol issues.

With responsibility for your own caseload, you will receive referrals from a variety of professionals and provide assessment, advice and information to service users and their carers.

Your role will be to fully assess service users and develop individual care plans to assist in achieving individual treatment goals. Your creative thinking and problem solving approach will help service users maintain and successfully complete their chosen treatment. Combined with your knowledge of mainstream services, you will assist your clients to sustain their treatment achievements and re-integrate with their local communities.

Your social work and care management skills will serve to enhance and enrich the team in providing a holistic approach to treatment working within an integrated pathway of care. Knowledge of community-based and residential treatment options is essential, alongside a sound understanding of care management and care co-ordination.

This post is exempt from the Rehabilitation of Offenders Act 1974; and a comprehensive screening process will be undertaken on successful applicants including a Disclosure check (Applicant Declaration must be completed and returned with application).

The post is covered by the Council's Safer People for Safer Services policy and a comprehensive screening process will be undertaken on the successful applicant.

To apply for this post, please use our online application form. Alternatively call 020 8215 3001 to request an application pack or email Romfordba.eetapplicationforms@jobcentreplus.gsi.gov.uk quoting the reference number.

Please return your completed application form to: Recruitment Team, 3rd Floor, Maritime House, 1 Linton Road, Barking, Essex IG11 8HG.
Closing date: 6 April 2007.
Interview date: w/c 23 April 2007.

We are unable to process requests for application packs received no later than 3 working days before the closing date.

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