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Very informative and enlightening, thoroughly enjoyed the day. M.S., Counsellor, London

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Editorial – Claire Brown

Too hot to handle?

Why we have to take on the headline writers

The issue of stigma is so familiar to the drug and alcohol field it almost feels too big to tackle. Yet that's the task of the UKDPC and partners, as they launch the first phase of a project to understand stigma (page 14). Partnering with the mental health field, housing and young people's charities is giving an opportunity to put heads together and share experience. As daunting as the prospect of changing public opinion might be, hearing from colleagues in the mental health field about how attitudes to people with psychotic depression have changed ought to give us courage that the media and their audiences are educable.

At DDN we are privileged to have insight to the circumstances behind addiction and be constantly educated by our readers. But five and a half years ago, starting up the magazine, we were on a very steep learning curve, which began with learning the pitfalls of using the 'wrong' language. (And this is still a minefield, with readers disputing words such as 'addict' which represents an offensive label to some, but which is a symbol of recovery to others taking the 12-step route.) We had the advantage of being able to learn from people who have shared their personal stories with us, as well as those who work with them – which makes me believe that educating the mainstream media is not a lost cause. Many of the people at the UKDPC's seminar last week demonstrated that their lives were a complicated crossover between personal experience of addiction and professional expertise in the field – so surely it can't be impossible to tap into the fact that most people, whether they write the papers or read them, have experience of addiction in some form. If prejudice is born of ignorance, we have to press on with educating the press.

And before you get on with reading the issue... a quick thank you to everyone who came to the 'Right here, right now!' conference in Birmingham last week. Highlights will be in our special issue, out on 1 March.

This issue

FEATURES

REGULARS

News in Brief

Tenderness or tension?

More than one in four relationships is marred by alcohol, according to new research from Drinkaware. Twenty-six per cent of British adults had argued with a partner because of alcohol, 14 per cent had worried about the effect of drink on their relationship and 11 per cent had been embarrassed by a partner's drink-induced behaviour. 'Lots of things influence our relationships and alcohol is no exception,' said consultant psychiatrist and member of Drinkaware's medical advisory panel Dr Jonathan Chick. 'While many couples enjoy a drink together, for some alcohol can spoil the evening. You don't have to be an alcoholic for alcohol to damage your love life. People should think more about the role alcohol plays in their relationship – they might see it's causing more tension than tenderness. *www.drinkaware.co.uk*

Custody concerns

A new website providing independent advice to ministers on deaths in custody has been launched by the Independent Advisory Panel, part of the Ministerial Council on Deaths in Custody. The website features good practice and guidance on preventing deaths. 'The aim is that, as the website develops, it will be used as a resource for those working within the different custodial sectors to share good practice and learning on preventing and reducing the number of deaths in custody,' said chair of the panel, Lord Toby Harris. *iapdeathsincustody.independent.gov.uk*

Friendly business

Nearly 80 per cent of young people can get hold of cannabis in under an hour, according to research from the Joseph Rowntree Foundation (JRF). Most of the 11 to 19-year-olds questioned for *Cannabis supply and young people* said they bought the drug from friends, with only 6 per cent having used an unknown seller. Seventy per cent said they shared the costs with a group of friends. 'The researchers conclude that cannabis supply among the young people was social rather than commercial and not linked to more overtly criminal drug markets,' says JRF. 'However, cannabis use was embedded in their social world. Change in the drug's legal status may have little impact.'

Licensing changes 'too weak'

New powers allowing local authorities to make changes to the opening hours of licensed premises in their area have been condemned as weak by alcohol charities.

Under the powers, which form part of the Crime and Security Bill, councils would be able to impose a blanket ban on the sale of alcohol after 3am in entire streets or even city centres affected by alcohol-related disorder. The ban – which could be imposed all week or just on certain days – will include clubs, bars and shops, and operate between 3am and 6am.

The number of 24-hour licences remains low however, says the Home Office, and local authorities will need to show the restriction was necessary to 'prevent crime and disorder or public nuisance, or to promote public safety'. The powers would 'help ensure that licensees take their obligation to run responsible businesses more seriously,' said licensing minister Gerry Sutcliffe. The bill is currently before Parliament.

Alcohol Concern said the measure was a 'belated acknowledgement' that the government had failed to tackle the problem of alcohol-related crime and disorder. 'These changes will still not allow residents any greater say over local licensing issues – a travesty for those who've had to suffer alcohol-fuelled night time disorder for too long,' said chief executive Don Shenker. 'The government urgently needs to add a public health objective to the Licensing Act and must create new mechanisms for residents' views to be considered.'

Survey finds illegal drugs holding sway over 'legal' highs

Despite the much-reported upsurge in the use of 'legal highs' – in particular mephedrone (*DDN*, 18 January, page 6) – far more drug users are still encountering illegal class A drugs like cocaine and ecstasy, according to a survey of delegates at the *DDN*/Alliance *Right here, right now!* service user conference in Birmingham recently.

Sixty-three per cent of those polled by drug and alcohol-testing provider Concateno had encountered a class A drug in the preceding six months, while 19 per cent had encountered mephedrone. The survey also found that, while most drug users said they had been given information on bloodborne viruses (BBV) by their drug workers, significant gaps in knowledge remained, particularly around transmission routes.

'There's been so much publicity about "legal highs" recently that we wanted to find out what the real picture was amongst drugs users,' said Madeline Coleborn of Concateno's healthcare team. 'We discovered that most drug users were still experimenting with class A drugs and that many users had a good knowledge about some of the additional health risks of drug use other than the addiction – such as catching bloodborne viruses like hepatitis.

'Eighty-five per cent said their drug workers gave adequate information on the risks of BBV, but the survey also revealed some gaps in their knowledge – two thirds did not know you could catch or transmit hep C by sharing a rolled-up note or straw for snorting cocaine,' she continued. 'As cocaine came out as the highest "new" drug that users had tried in recent months the health risks could be significant.'

Among the other drugs that respondents said they had encountered in the previous six months were solvents, muscle relaxants and alloy wheel cleaners.

See the next DDN for our Right here, right now conference special

Anthrax outbreak spreads to England as agencies call for emergency plan

Two cases of anthrax in injecting drug users in England have been confirmed by the Health Protection Agency (HPA) and local NHS services.

The cause of death in an injecting drug user in Blackpool has been confirmed as anthrax, and it has also been confirmed that an injecting drug user being treated in a London hospital has tested positive for anthrax.

An outbreak of the disease in Scotland, which began with the identification of cases in the NHS Greater Glasgow and Clyde area last December, has so far claimed the lives of eight people and led to calls from drugs agencies for the Scottish Government to implement an 'emergency public health plan' including the prescription of dihydrocodeine by GPs (*DDN*, 1 February, page 4). Similarities between the English cases and those in Scotland – 19 of which have now been confirmed – suggest that either heroin or a contaminated cutting agent is the source of the infection. There has also been a case in Germany.

'While public health investigations are ongoing it must be assumed that all heroin in the north west carries the risk of anthrax contamination,' said director of public health at NHS Blackpool Dr Arif Rajpura. 'I urge all heroin users to be extremely alert to the risks and to seek urgent medical advice if they experience signs of infection such as redness or excessive swelling at or near an injection site, or other symptoms of general illness such as high temperature, chills or a severe headache or breathing difficulties, as early antibiotic treatment can be lifesaving.'

There has been comment from some in the drugs field that the lack of major public health interventions, and corresponding lack of mainstream press coverage, could stem from a perception of drug users as a low priority and undeserving group.

Corruption-riven Afghanistan could see fall in heroin production

This year's opium poppy cultivation in Afghanistan is expected to remain stable, with a 'possible' decrease in production, according to a new report from the United Nations Office on Drugs and Crime (UNODC).

Afghan opium poppy cultivation has decreased by 36 per cent from a record level of 193,000 hectares in 2007 to 123,000 hectares last year, says *Afghanistan opium survey 2010 – rapid winter assessment*.

Production has also declined, from 8,200 tons in 2007 to 6,900 tons last year. In recent years Afghan farmers have seen bumper yields from their opium crops, at around 56kg per hectare compared to just 10kg per hectare in the 'golden triangle' countries of South East Asia. However, bad weather during the growing season could reduce the productivity of the crop this year, says the report.

Market forces are partly responsible for farmers turning away from opium cultivation, it says, with a quarter quoting low prices and yields as the reason for not growing opium – however, as the price of crops like wheat is falling faster than that of opium, this could change. Only 39 per cent of farmers in the south-west region of the country – where most opium poppies are grown – cited the government's ban on opium growing as a reason to stop cultivation. Around 80 per cent of villages with poor security conditions and strong insurgent presence grow opium, says the report, compared to just 7 per cent of those unaffected by violence.

'There is a good chance that Afghanistan will produce less opium this year,' said UNODC executive director Antonio Maria Costa. 'With appropriate local community-inspired measures three quarters of the country could become poppy-free in the near future. The Afghan authorities must lead and own their drug control strategy – the rest of the world has a vested interest in its success.'

According to a separate UNODC report from last month, bribes now generate as much revenue in the country as drugs. Most Afghan people regard corruption as their biggest problem, with 59 per cent saying that their daily experience of public dishonesty is a bigger concern than security. According to *Corruption in Afghanistan – bribery as reported by the victims*, those entrusted with upholding the law are seen as most guilty of violating it, with around 25 per cent of Afghans having to pay at least one bribe to police and local officials during the survey period. Afghans paid out $2.5bn in bribes over the past 12 months, equivalent to almost a quarter of GDP. 'By coincidence, this is similar to the revenue accrued by the opium trade in 2009 (which UNODC estimates at $2.8bn)' says the report.

'Drugs and bribes are the two largest income generators in Afghanistan – together they correspond to about half the country's (licit) GDP,' said Mr Costa. 'The rapid influx of vast drug – and aid – monies have created a new caste of rich and powerful individuals who operate outside the traditional power/tribal structures.'

Both reports available at www.unodc.org

'As an added bonus you could always get shot dead or kneecapped.' Iain Cameron from the Belfast User Group describes the long hard road to service user involvement to delegates at the DDN/Alliance Right here, right now conference in Birmingham. See the next DDN for our full conference special issue.

Alcohol-related death rates double

Rates of alcohol-related death in the UK have doubled since the early 1990s, according to a new report from the Office for National Statistics (ONS). In 1992 the death rate stood at 6.7 per 100,000 population but had risen to 13.6 per 100,000 by 2008, according to *Alcohol-related deaths in the United Kingdom 1991-2008*. Between 2007 and 2008 the number of deaths rose from 8,724 to 9,031.

There are more than double the number of alcohol-related deaths in men as women, says the report – 18.7 per 100,000 men compared to 8.7 per 100,000 women. The rate of male deaths has more than doubled, from a starting point of 9.1 per 100,000 in 1991, and in 2008 deaths in males accounted for around two thirds of total alcohol-related deaths, at just under 6,000. Highest death rates for both sexes were in the 55-74 age group – in men in this age range, the rate had increased from 23 per 100,000 in 1992 to 45.8 per 100,000 in 2008.

'The number of alcohol-related deaths in the United Kingdom has consistently increased since the early 1990s,' states the ONS. 'Although figures in recent years suggested that the trend was levelling out, alcohol-related deaths in males increased further in 2008. Female rates have remained stable.'

The figures relate to deaths from causes 'regarded as being most directly due to alcohol consumption,' says ONS, such as alcohol poisoning, chronic liver disease and cirrhosis and alcohol dependence. They do not include diseases where alcohol has been shown to have a causal relationship, like cancers of the liver, mouth and oesophagus, or road accidents.

The Department of Health recently launched a £6m press, TV and billboard awareness campaign to alert people to the unseen health harms caused by what Alcohol Concern has called 'regular drinking of what many people mistakenly consider to be low level quantities' (*DDN*, 1 February, page 4).

'As levels of consumption have increased over the last 10 to 15 years we have seen a huge rise in alcohol-related problems,' said Alcohol Concern chief executive Don Shenker. 'These deaths are tragic and avoidable. They are all the more shocking by the government's lack of action in tackling the cheap price of alcohol. There is a wealth of national and international evidence that shows that the cut-price booze, predominantly sold in supermarkets, is the main driver of increased drinking in the UK. Even the government's chief medical officer has recommended that minimum pricing should be introduced.

'We understand that such a measure would not be popular in an election year – but public health needs to come before politics,' he continued. 'Evidence has shown that most people significantly underestimate the amount they drink and this lack of awareness is storing up catastrophic health implications for the future.'

Report available at www.statistics.gov.uk

'Either we could continue to ignore what is happening like everyone else in the addiction field and therefore indirectly support practices where individuals, especially women and children, are tortured and even killed, or we could tackle this head-on.'

Casting out evil spirits is not something that most families opt for when a relative is addicted to drugs or alcohol. But that's what Mo's family (name changed) thought he needed. Mo, a 30-year-old man from Ealing, was a heroin addict and his parents believed that evil spirits, or jinn as they are known in the Muslim community, were the source of his drug addiction.

For them, the only cure was to seek religious help. They sent their son to a Muslim cleric called Maulana Ilyas Qadri, who ran a drug rehabilitation centre in Pakistan.

Qadri was known in Asian communities in London and the Midlands because he had distributed leaflets with titles like 'War against drug abuses'. The leaflets claimed that 'a patient once admitted will never use drugs again' and 'not a single doze [sic] of medicine is given. Addicts of heroin, opium and hashish from all over the world are treated here spiritually through Quranic verses.' However, the 'treatment' involved being chained up, beaten and starved in order to drive the spirits out of Mo's body.

It sounds like a tale from the Middle Ages. Yet it illustrates the lengths some families will go to when they believe that a person's addiction to drugs is caused by them being possessed by spirits.

Mo's case came to light in 2006, when police in Pakistan raided and shut down Qadri's premises, releasing more than 100 men who were held together with a 220 feet chain. Southall based charity Drug and Alcohol Action Programme (DAAP) played a key role in highlighting the case.

The link between the belief in spirit possession and addiction hit the headlines recently when Amy Winehouse was quoted as blaming her drug addiction on Satan. And according to media reports, she asked faith healer Peter Hippolyte, whom she met while recording on the Caribbean island of St Lucia, to help her.

'The use of spiritual methods to tackle addiction is not uncommon,' says DAAP chief executive officer Perminder Dhillon. 'In addition to cases like Mo's, we have dealt with several others over the past five years which show just how far desperate families will go, often paying huge amounts of money for dubious cures. Yet, worryingly, the addiction field seems to be oblivious of this issue.

'One recent case involved a woman who seemed to have multiple personalities,' Dhillon continues. 'According to her father, she misused illegal and prescription drugs when she was young and hadn't left home for 26 years. The family spent thousands of pounds trying to find a spiritual cure, often being taken for a ride by charlatans.

'Another case we dealt with involved a cannabis and alcohol user who complained of hearing voices telling him that he was someone else. He said that when he heard this particular voice, he seemed to have a complete transformation of personality. His way of dealing with it involved surrounding himself with close family members who did not leave his side until the voices stopped.'

The belief that a person's addiction to drugs and alcohol is caused by a spirit taking over their body is a common one within many communities including the UK's minority ethnic communities.

Dhillon says her concern is that people who need professional help are being exploited by so called healers.

'In the past, communities in the Indian sub-continent for example would often consult what was termed a 'wise person' when families faced such situations. The wise men or women used their wisdom and experience to provide family advice and support. Unfortunately families now approach people who do this as a business, which is very lucrative. Something like £150 is a minimum just for a few prayers to be offered. Often very complex rituals are used, which certainly don't do anything to help a person's addiction.'

Last month, more than 60 service users and their families joined addiction professionals for a seminar in Southall, west London, organised by DAAP called *Can addiction lead to possession or can possession lead to addiction?* to explore the issue.

'For us the choice was simple,' says Dhillon, explaining the reason behind the seminar. 'Either we could continue to ignore what is happening like everyone else in the addiction field and therefore indirectly support practices where individuals, especially women and children, are tortured and even killed, or we could tackle this head-on and create awareness and needed discussion.'

The keynote speaker was medium John Devereux who has carried out rescue work for more than 50 years, which involves using his experience as a spiritualist minister to 'drive out the spirits that are possessing an individual'.

He supports Dhillon's assertion that the belief in spirit possession isn't exclusive to minority communities.

'I've dealt with a number of possession cases which have involved addiction to alcohol, illegal or prescription drugs,' he says. 'Many young people, after smoking cannabis at a party or having a few drinks with friends will get out a ouija board for a laugh. Some may experiment with holding a séance after watching television programmes like *Most haunted*.

'Soon after they've complained of hearing voices or in worst case scenarios find themselves completely entranced, unaware of their surroundings for long periods of time. The biggest problem is that many of the people I come across will admit to being an alcoholic or drug misuser but very few will admit to being possessed by a spirit for the simple reason that they're frightened of being locked up, laughed at or mistreated. Although some people might describe what I do as 'exorcism', it's not a term that we use anymore because of the negative connotations promoted in the media and in big budget movies.'

Devereaux admits there may be scepticism from some about the existence of spirits, but points to the work of respected academics like Professor Gary Schwartz of the University of Arizona, an expert on parapsychology and who in his book *The afterlife experiments: breakthrough evidence of life after death* described a series of scientific experiments which used mediums to investigate and prove the existence of spirits and an afterlife.

'Spirit possession involves behaviours that you wouldn't normally associate with everyday anxieties,' he says. 'We're talking about sudden mood changes, blank expressions, extreme agitation and or aggression, the appearance of listening to something or someone which can't be seen, speaking in a language they've never spoken before, unusual speech inflections and people hearing voices telling them to act in ways that are out of character.'

There was a lively discussion during the seminar about the widespread belief in spirit possession in Asian and other cultures. One woman brought along her son whom she felt was possessed.

Addiction professionals also shared their experiences. A counsellor told how he didn't know what to do when clients he supports tell him that they are hearing voices.

A nurse shared her experience of caring for a very ill woman who firmly believes she is possessed. She said she was torn between what her medical training told her to do and what she herself witnessed when she was with this woman.

After the seminar a number of counsellors present asked Devereaux to come back and do an intensive workshop with them on how to best help clients who believe they are possessed. And since the event, DAAP has been contacted by several people who believe that spirit possession is playing a part in their own or a family member's addiction.

'It is vitally important that we hear people's experiences rather than dismiss them,' says Dhillon. 'We have to signpost them to safe and recognised ways of dealing with this phenomenon. The Spiritualist Movement in the UK has built up

very good experience in this field and we must learn from them. At the same time, I categorically condemn any practice that seeks to torture, harm and even kill people in the name of rescue work. That is why we have teamed up with the charity Stepping Stones to seek government support to ban such practices.'

The use of alternative therapies including spiritual healing is something that has been taken more seriously by health practitioners in recent years.

In June last year, mental health professionals gathered in London for a conference called *Spirit possession and mental health* organised by campaign group Ethnic Health Initiative.

Melba Wilson of the National Mental Health Development Unit believes it is vital for the substance misuse field to be open to new ideas.

'One issue over the years has been that people with mental health problems who also have substance misuse issues often get lost between the two services,' she says.

'In the mental health field, there's some recognition of the impact of belief systems on service users. However, if addiction professionals and spiritual healers are to work together, there needs to be a balance between people's needs being met in ways that are useful to them and adequate guidelines, but these two things need not be polar opposites. Professionals can learn from the spiritual community and vice versa. Faith healers can also learn about mental health and addiction issues and begin to adapt some of the ways in which they work.'

Dhillon agrees. 'We hope this begins an important debate in the substance misuse field, one which will help us better understand and support the needs of clients who believe they are possessed and prevent their exploitation.'

For further information about the issues raised during the seminar, visit the website www.daap.org.uk or call DAAP on 0208 843 0945

Driving out evil spirits to rid a person of their addiction sounds like a tale from the Middle Ages. But as Vic Motune **reports, it's happening in the UK and needs to be tackled**

FACING THE SPIRITS

COMMENT

'THE NTA REPRESENTS EXCELLENT VALUE FOR MONEY'

With letters in our last issue critical of National Treatment Agency spending and targets, **Stephen Hodges**, the NTA's director of corporate services responds

A NUMBER OF RECENT LETTERS to *DDN* (1 February, page 9) have made misleading allegations about the NTA, its activities and funding, on the false premise that because we don't directly treat addiction we therefore don't have a valid role in the treatment system.

As a public body we already provide a large amount of information about the organisation on our website, and through our published accounts and board papers, which any member of the public can access. But I thought it would be helpful to set out some of the facts for *DDN* readers, and some new information as well.

As a special health authority set up specifically to improve the availability, capacity and effectiveness of drug treatment, the NTA receives funding from several government sources. Our current grant from the Department of Health (DH), about £10m, has remained static in cash terms for the last four years, which means our available cash has reduced by about 10 per cent in real terms. It is due to be further reduced by another five per cent in 2010/11.

Over a five-year period, therefore, the NTA has in common with other public sector bodies been making efficiency savings and securing value for money. This process will no doubt intensify in future as the public spending squeeze bites. However in addition, the NTA has in recent years received ad hoc funding from other departments to carry out particular tasks on their behalf. This was worth another £10m in 2008/9.

About one quarter of our total £20m income funds the National Drug Treatment Monitoring System, arguably the most comprehensive dataset in daily use in the National Health Service. Without it, no one would know what was happening in the treatment system, and whether the government's investment in drug treatment was providing value for money.

Another quarter funds our network of nine regional teams, which between them hold local drug partnerships and providers to account. The NTA's role is not to provide treatment, but to monitor national standards and assure the quality and quantity of treatment provided in accordance with clinical standards set down by the National Institute for Clinical Health and Excellence.

A further quarter of our income is spent on delivering specific projects for various government departments. This includes running system change pilots for the Home Office, rolling out the integrated drug treatment system in prisons for the Ministry of Justice, and overseeing the RIOTT injectable heroin trials for DH.

About ten per cent of our income is spent on providing specialist expertise, for and on behalf of DH (our sponsor) and other parts of Whitehall. This includes supplying guidance to the field, dealing with clinical queries, answering parliamentary questions, providing ministerial briefings, and handling media inquiries or freedom of information requests.

Finally, approximately one-sixth of the budget is spent on our own infrastructure, overheads and back-office functions, a proportion which compares favourably with other public sector organisations. These costs include maintaining the website, which is our primary channel for communicating with the treatment field.

Although it receives a healthy average of well over 2,000 visits every day, the current website is difficult to navigate and we are seeking to update it in the light of social media and technological developments to make it more user-friendly for customers in the treatment field and members of the public alike.

While the NTA is confident that the £20m we spend represents excellent value for money, it is of course only a fraction of the £800m the government spends on drug treatment annually. Part of our role is to make the case for continuing to invest in drug treatment, by demonstrating that anyone who needs treatment can get it quickly.

It was therefore gratifying that the drug treatment outcomes study commissioned by the Home Office confirmed recently that drug treatment was not only effective but also cost-beneficial, with an estimated £2.50 saved in terms of health and crime costs for every £1 invested.

It said: 'The majority of treatment seekers received care-coordinated treatment, expressed satisfaction with their care, were retained in treatment beyond three months, and reported significant and substantial reductions in drug use and offending as well as improvements in social functioning.'

We are proud that through the efforts of commissioners and providers alike, record numbers of drug users are receiving help, the numbers dropping out of treatment early are falling, the numbers staying in long enough to benefit are rising, and the numbers successfully completing treatment for dependency are increasing year on year.

Online opinions

A taster of our website forum at www.drinkanddrugsnews.com

I would be very interested in moving into the substance misuse field. However, I seem to be drawing a short straw with regard to gaining voluntary experience… I do need to work while volunteering, but seem to be getting stuck and wonder if anyone can offer any advice as to how to move into the field?

Posted by Joanna

I am also trying to get into the drink and drugs misuse sector. I have been volunteering for the YMCA homeless shelter, and have been contacting rehab clinics for voluntary positions without much success.

My plan is to just keep trying to get a voluntary placement, as well as the YMCA work. I would also like to try outreach work but will take anything I'm offered to gain more experience. I have also been looking at related jobs like social work, as I want to retrain completely.

Maybe other people who already work in this area could post and tell us how they got involved?

Posted by Rob

I have a friend who is a substance misuse practitioner. He arranged for me to become a volunteer trainee (had a word in someone's ear and recommended me). I was involved in service user involvement/NTA service user forum/council. I had an interview and started volunteering. Before long I had a caseload of six clients!

From there I started networking at conferences etc, got myself known as someone who was very committed and BANG! Headhunted. I had an interview over the phone and plonked myself at the top of my salary band. I've been working in the field ever since. It's about perseverance, the continuing desire to learn and progress and literally 'putting yourself out there'. Many service providers offer volunteering places – Turning Point, Addaction, Phoenix Futures, Equinox, St Mungo's, CRI, Westminster Drug Project, to name but a few.

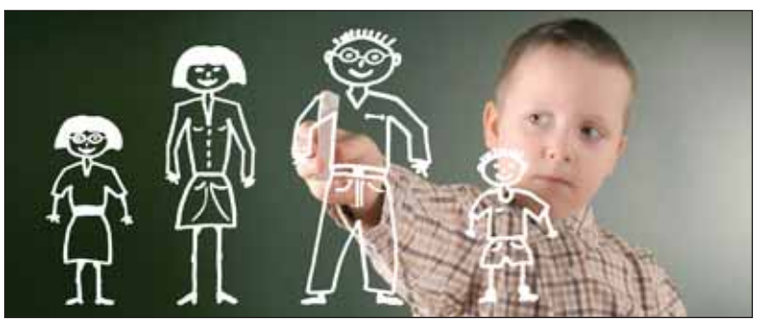
Think perhaps of forming and managing a peer-led project to put something on your CV. Show people you can think outside the box! Put all this together and add or create your own luck and you will get there. Trust me!

Posted by Sking

Conference report

FOCUS ON FAMILIES

The London borough of Tower Hamlets has a young population and high levels of drug and alcohol use. DDN **hears about the measures the borough is taking to safeguard its children**



TOWER HAMLETS is a densely populated London borough with one of the youngest populations in the country. Among its 220,000 residents are 6,600 dependant drinkers and 3,826 problematic drug users, and 68 per cent of people entering treatment for the first time in the borough are parents.

The local DAAT mounted a conference earlier this month to bring drug and alcohol service providers together with children's services to share best practice and make sure that families were centre stage in all work.

The conference saw the launch of a hidden harm strategy to make sure that the most is being made of existing routes to reach families – including the development of clear referral pathways, inter-agency training and a hidden harm handbook – alongside a new M-PACT (Moving Parents and Children Together) project with Action on Addiction to support children suffering the effects of parental substance use (see *DDN*, 21 September 2009, page 12).

Since 2008 the council's DAAT has been represented on the local safeguarding children board, and a full-time hidden harm coordinator, Emma Bond, was appointed last summer. 'Tower Hamlets decided that they really wanted to prioritise hidden harm work and so needed someone full time to drive forward the protocols and procedures,' she says. 'We commission 12 services and – because some are national companies and some are local charities – we really needed to get one coherent approach.'

Her first task was to write the protocols for referrals from treatment services into children's services. 'I went to a lot of team meetings and found there's a lot of anxiety in the drug and alcohol world because they knew a lot of their clients had children but didn't know who would support them, and I found a similar thing in some chidren's social care teams – they knew there was parental substance misuse but they didn't know what the procedures were to refer parents into alcohol services.'

She set up a steering group and started to bring all the teams together – surprisingly, perhaps, without a culture clash. 'I think there was a risk of that, but it was all facilitated well,' she says. 'With drug and alcohol services there's that suspicion that "if I involve social services they'll take the child – bottom line". But actually they'd work with the family and offer all this support. It's nice to cut through all the old prejudices on both sides and have a steering group that's really driving the strategy forward on hidden harm. The whole reason behind my job is to link services that historically almost haven't known of each other's existence, or known exactly what the other does.'

Tower Hamlets now has a nominated safeguarding children's advisor in all of its adult drug and alcohol services, to act as a first port of call. 'If a drug worker identifies there's children and they're concerned, they talk to this nominated person in their team who can say 'ok we need to escalate this quickly' or find out if there's social services involvement, find out who's the lead professional and liaise with them, and either advocate on behalf of the parent or let them know the parent's not engaging in treatment. It's a much better family approach.'

There's also been a terrific response from workers, she says. 'There's a real keenness to drive this forward from people who really haven't worked together before.'

Recovering happiness

Why should we embrace recovery? Because it can bring vital quality to life beyond addiction, say **David Best** and **Mark Gilman**

In the introduction to his 2003 book *Authentic happiness*, Dr Martin Seligman – known to psychology students worldwide as the originator of thinking about learned helplessness – talks about the life expectancy of nuns. Why did he do this? Because of a study that examined the essays of 180 novice nuns and used these to predict how long they would live.

Based on the assumption that nuns are pretty consistent in their lifetime use of alcohol, tobacco, drugs and guns, this was thought to be a population that had a fairly standard lifestyle, and so it would be interesting to look at what predicted their longevity.

To quote Professor Seligman, 'when the amount of positive feeling [in the novitiates' essays] was quantified by raters who did not know how long the nuns lived, it was discovered that 90 per cent of the most cheerful quarter was alive at the age of 85 versus only 34 per cent of the least cheerful quarter'. Having controlled for other factors, Seligman concluded that only the amount of positive feeling in the sketches predicted how long the nuns lived.

Seligman was famous for his work on depression but is now devoting his professional life to what is called 'positive psychology' because it is his belief that a focus on misery and pathology is misleading and largely self-fulfilling. Like depression, the addictions field is one that has been dominated by a pathology model in which the both our science and our interventions have been designed to reduce symptom severity and alleviate distress.

The first parallel to recovery is not to denigrate such science or clinical practice but to suggest that, alone, they are not sufficient. The starting point for the recovery movement in the UK is that, irrespective of disease or symptoms, our goal should be wellness and happiness – why should drug users (or alcohol users or people with mental illness) not expect the science and practice of addiction professionals to offer them suggestions about a better and fuller life?

At the very least, the recovery movement should encourage all users to ask their social workers, drug workers, GPs and psychiatrists about what is on offer that will make them live happier, and hopefully longer, lives. This is empowerment by raising awareness and expectations.

So what does recovery offer? Through this article we want to suggest that we have a hierarchy of goals for a recovery movement and look at how we might measure the success of such endeavours. What is proposed is a set of concentric circles that are the long-term yardsticks of recovery as a lived experience for individuals, families and communities. As William White described in 2007, the rings are not mutually exclusive but are in effect a series of milestones for those attempting to create recovery-oriented systems of care:

Intensity, extent and frequency of personal recovery
At the most basic level, the measure of an effective recovery system is how many people experience enduring, satisfying life quality that transcends not only their experiences while addicted, but their lives before addiction.

The impact of personal recovery on intimates
Andreas and Callan (2009) have shown that participation in mutual aid groups by fathers after treatment results in significant reductions in psychiatric symptomatology in their children. Personal recovery is crucial but the political and economic viability of recovery means that the measures of quality of life gain must be extended to partners and other family members. This should also include 'hard' measures of reductions in numbers of children on child protection registers and in care and the levels of domestic violence among the family members of those in recovery.

The emergence of recovery champions
In the key studies of UK recovery (McIntosh and McKeganey, 2005; Best *et al*, 2007), social learning has been a central principle of the recovery experience. Having a 'mentor' or simply seeing an individual recognised as a peer who has achieved significant recovery can act as a significant catalyst for change. Not only is the identification of peer champions of recovery an essential component of a burgeoning recovery system, they are at the heart of a contagion that has characterised the most successful UK recovery communities.

Growing recovery from individual to community level
This is measured not only in terms of the range and diversity of recovery groups (AA, NA, CA groups, SMART groups and other peer-led community groups) but

also in terms of what they do. In the language of recovery definition, this is the operationalisation of 'citizenship' (Betty Ford Institute Consensus Group, 2007; UKDPC, 2007; White, 2008), not as a measure of how many people have a job but what the range of community activities the recovery community are engaged in. This means politicisation, community engagement and challenging stigma as three catch-alls for the domains of activity.

Reaching the 'tipping point'

Using Malcolm Gladwell's idea from 2000 of a 'tipping point', the ultimate indicator of a mature recovery system is reached when it is sufficiently prominent and active in a local community that it begins to exert influence on the substance-using behaviour of the general population. This has previously been observed in the drinking cultures of native American townships but has not been studied in a UK context – and it is the point at which recovery exerts an influence in terms of primary prevention.

So where is the evidence? To be blunt, at present, the evidence is American, learned from the mental health movement, and anecdotal. The work of William White has begun the process of collating the international evidence around addiction recovery but with a heavy reliance on the US. In the UK, Mike Slade has written a key text, *Personal recovery and mental illness* (2009), that charts the evidence around the achievements of the mental health recovery movement and the astonishing speed with which this has influenced mainstream and clinical thinking.

Finally, there is the gradually growing evidence from evaluations and personal accounts in diverse media such as *Wired In*, the Serenity Cafes, the Lothian and Edinburgh Abstinence Project (LEAP) and Burton Addiction Centre (BAC). But that is not good enough or robust enough, so we have a major challenge in testing the applicability of the recovery principles, and this task is underway.

Our research group has been privileged to enlist the trust and support of the Welsh Assembly and the local commissioning teams in North Wales to put some of these questions to the test.

Over the course of 2010, we have been commissioned to develop a recovery systems approach that starts with an extension of the treatment effectiveness work conducted in Birmingham and the North-West of England (Simpson *et al*, 2009; Best *et al*, 2009).

'...a focus on misery and pathology is misleading and largely self-fulfilling. Like depression, the addictions field is one that has been dominated by a pathology model.'

In clinical research terms, the basic aim is to extend the engagement component of the treatment process model (Simpson, 2004) to consider sustainable psychosocial change and how workers can initiate recovery community engagement and give post-treatment recovery support.

However, the aims of the project are much more ambitious, reflecting Slade's commitment to culture change in staffing, structures and systems of service delivery, and to the longer term goals of generating communities of recovery where the aim is not only personal recovery, growth and wellbeing, but community engagement and change.

The aim of the recovery movement is not to work out which nuns are happier but to make the nunnery a better place to live and a kernel of growth and hope in ailing communities.

Dr David Best is reader in criminal justice at the University of the West of Scotland and Mark Gilman is NTA regional manager for the North West

In the last couple of years a lot has been written about the need to get those claiming benefits back into work. The welfare to work agenda has had a plethora of organisations clambering to get a slice of the action to help 'hard to reach' or socially-excluded groups get back into the employment market, and many organisations are tendering for – and being commissioned to provide – services to groups that they have no previous experience of working with.

This may be part of a new enlightenment gained by commissioners, but I doubt it. The introduction of public service agreements seems to have raised awareness that those on the fringes of society invariably cost the most if they are not engaged with specialist support services.

Organisations that employ individuals with what one worker called a 'colourful background' don't shout about it, simply because it was always an integral part of their ethos. But those organisations that make a big fuss about employing ex service users are becoming part of the problem, with the new employee forever labelled with the unenviable moniker of 'ex' service user/addict/offender/alcoholic. The more enlightened organisations describe their staff as graduates, ex customers or survivors, but whatever the term it's a thinly veiled re-labelling exercise – a process that is service led and not person centred.

Not every future employer is going to have altruistic motives when recruiting. The uncomfortable truth is that mainstream employers will always have reservations about employing staff who have had a history of involvement with the criminal justice system or drug and alcohol misuse. The main areas of concern will be in relation to honesty, reliability and trust and, as a consequence, for the majority the opportunities to volunteer or return to employment are limited to lower-paid positions within third sector organisations and where services are aimed at offering support to individuals with similar backgrounds.

In some areas the hardest to reach groups in our society are being served by their current and ex peers. While some are well placed to engage with individuals, and if need be assist them with basic tasks, that's about as far as it will go unless they can acquire specific skills through in-house training and professional qualifications at diploma/degree level, paid for by their employer.

From my experience of various social welfare and criminal justice settings, the 'revolving door' group – people caught in a cycle of crisis, crime and mental illness – can be particularly hard to work with, because the system in which they are forced to exist can de-motivate the most enthusiastic and committed worker. Many workers have lost their belief in the human ability to change – couple this with the negative external factors stacked against the clients and the chances of a successful outcome are limited.

This apathy and the mutually held belief that both parties cannot influence positive change leads to an erosion of the quality of care. For most organisations 'investing in people' is all about investing in plaques and photographs of the senior management team with smiling faces. In my experience, the award does not correlate with real investment in frontline staff or service delivery.

At a recent consultation event facilitated by the NTA, participants voiced their concerns about a lack of career structure for those finding employment. Many felt they were stuck in dead-end jobs with little chance of improving their prospects. The development of portfolios of achievement that capture all the positive contributions individuals make to any organisation they are involved with, including skills-based certificates acquired while serving in prison, can be a very effective way of recording progress. These can include a comprehensive list of all the training the individual may have completed, letters of thanks or commendations and details of any presentations they may have made on behalf of the organisation.

The emphasis should be on the employer to develop individualised employment contracts. Quality supervision can go some way to breaking down barriers and motivating staff to achieve, allowing them to build confidence in their own ability. It is worth taking a moment here to dispel the myth that those with direct experience of homelessness, addiction and chronic social exclusion have an innate ability to empathise and engage effectively with those traditionally viewed as 'hard to reach'. It is simply not true.

Ex-service users are not a homogenous group and in my experience some are able to make the transition to employment within the 'caring services' more easily than others. Some, when given their first taste of power and responsibility, adopt an authoritarian approach, where the 'oppressed becomes the oppressor'. Others find it

MISSION OYABLE

Everyone agrees that getting service users back into employment is vital for sustained recovery. But it needs to be done properly, argues Tony Wright

difficult to say 'no' or enforce rules and regulations. Both need to be addressed through supervision or role modelling by experienced and professionally trained staff. However, new staff should not be treated any differently from other work colleagues after a mutually agreed trial or probationary period.

I believe that the positive benefits of employing ex service users far outweigh the negatives. Yet the responsibility to make the move from welfare to employment a positive and life-changing experience is that of the employer. When things go wrong it's said that the individual who failed just wasn't ready, but I would argue that it is the responsibility of the employer to accurately assess work readiness and offer appropriate support.

If you are going to employ ex problematic drug users then get real and plan for relapse, as at some point or other it may happen. I have witnessed a domino effect where others who looked up to that individual 'throw in the towel' and lose all self-belief.

If given an opportunity and support, ex service users can bring a wealth of experience, insight and professional competence to the workplace. The level of support needed for any new member of staff is considerable and needs to be sustained over a significant length of time to be effective. The presenting issues for ex service users are complex and dynamic in nature and a significant amount of time needs to be allocated to support employees if they are in crisis.

Many problems can be resolved by pre-empting issues through open and honest communication, and independent employee support workers can be effective 'life coaches' to those returning to the workplace. There are numerous examples of good practice to be found within the mental health field where individuals recovering from episodic periods of mental ill health are reintegrated back into employment positions.

The question that needs to be asked is whether ex service users will ever be accepted as equals or patronised and tolerated in a tokenistic way simply because it is economically not viable to continue trading without the additional funding they attract. Let's hope the economic downturn will not mean the unhealthy spectre of a return to the 'deserving and undeserving' debate.

Tony Wright is a social worker

Post-its from Practice

Reality lapse

We have to be ready to support rather than punish ex-drug users in the workplace, says Dr Chris Ford

I WAS ASKED TO SEE JACKIE by a patient of mine. I'd met her at a national meeting a couple of months previously when she had been positive about her new job as outreach drug worker and her drug-free state.

As Jackie came into the room I realised something was very wrong. She explained that she had had a lapse and was planning to talk to her manager about it. At that point, the manager entered and told her that a colleague (the only person at work Jackie had so far confided in), had informed her that Jackie was taking heroin again. Without allowing for any explanation, Jackie was suspended, marched off the premises and told that a disciplinary hearing would follow. The project had known about Jackie's history when she had applied for the post.

There were several things to deal with, the first being to assess Jackie's drug problem and start effective treatment. That happened immediately – she is having counselling and is on a reducing dose of buprenorphine. That was the easy bit.

We then agreed to try and talk to her manager to support her, which was where the problems began. Although the manager knew Jackie's history and had worked in the drugs field for over 15 years, she would not accept that relapse was a possibility in anyone who has used. To quote her, she 'certainly wasn't having an addict working in her service.' I realised that approach wasn't going to work, so I asked for the project's employment policy on drug and alcohol use and there was none. I suggested she ought to get one – but perhaps not quite as politely as that.

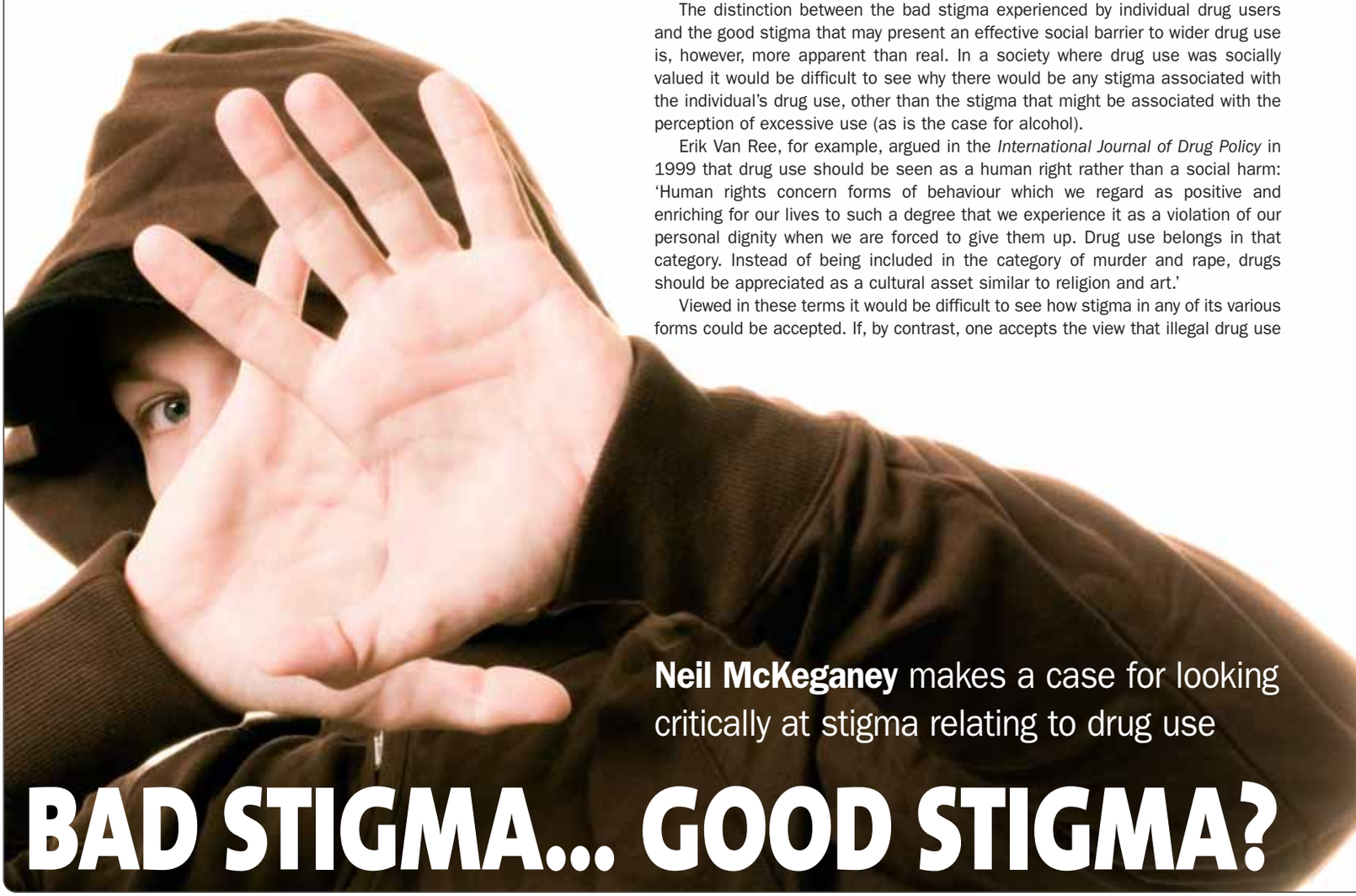
I then rang several places to get their policies and found none, with the exception of The Alliance, whose policy was excellent. One large mental health trust had a policy on using at work, but not if a worker developed a problem while in post. They also informed me that anyone on substitute medication would not be employed and although it wasn't written down, applicants were expected to have been drug-free for two years before applying for posts.

On my next contact with the manager I tried a different tack by bringing out my softer side and asked if she thought Jackie was competent in her job. The response was 'absolutely 100 per cent plus!' This confused me even further and made me begin to get angry again. If she was competent, why was she going to be put through a disciplinary? Silence was the response.

There are a number of issues here: firstly in my opinion people should be employed for their skills and if they develop an illness, drug relapse or other problem then they should be given support to deal with it. Secondly, to quote a better person than me, 'if I ruled the world I would make it compulsory for all those working in the addictions field to have at least some understanding of dependency, co-dependency, what they are and how they manifest... I've seen loads of drug workers of all disciplines who are utterly obsessed with fixing, controlling and punishing the punters and being totally unaware of their own stuff...'

Sometimes there is a silver lining. As it turned out, Jackie's manager realised her mistake, which I now think was a decision driven by fear rather than lack of care, and Jackie is due to restart her job in three weeks' time, still on a small dose of buprenorphine. The disciplinary action against Jackie was withdrawn – instead she has weekly meetings with her line manager along with her counselling. Could it be that the lack of clear guidance betrays our fears of not knowing how to deal with these issues? Please help me with any useful thoughts to chrishelen.ford@virgin.net.

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP
To become a member of SMMGP, receive bi-monthly clinical and policy updates and be consulted on important topics in the field, visit www.smmgp.org.uk



Neil McKeganey makes a case for looking critically at stigma relating to drug use

BAD STIGMA... GOOD STIGMA?

When it comes to the stigma that is often attached to the use of illegal drugs there are two statements that are easy to make: the first is that it should not happen, and the second is that when it happens it should be challenged. But just as there is good cholesterol and bad cholesterol perhaps there may be good stigma and bad stigma, with the real challenge being one of finding a way to reduce the bad stigma while retaining the good.

The idea that stigma associated with the use of illegal drugs should be challenged resonates with a basic humanitarian concern for the welfare of those living in difficult circumstances. These may be individuals whose drug use has led them to be highly vulnerable, and for whom it seems fundamentally wrong to increase their sense of personal suffering through the use of stigmatising labels and characterisations. Equally a proportion of those using illegal drugs will have been the victims of abusive childhoods. To stigmatise individuals for behaviour they may have had little choice in adopting, and which may have been the only way of coping with an intolerable early life, would seem to add an unnecessary insult to an unasked injury.

Over the last decade or so we have come to challenge the stigma that was previously associated with mental health problems and it is perhaps within the context of that successful campaign that we have come to accept the need to challenge the stigma often associated with the use of illegal drugs. But drug use and mental illness are not the same and the commitment to challenge stigma in the mental health field may not be entirely the same as the call to challenge stigma in relation to drug use and drug users.

Stigma is a supremely powerful social force that derives its influence from the simple fact that at heart we are deeply social animals, acutely mindful of the views of others and committed to seeking their approval. For this reason stigma can be used as a social device explicitly designed to reduce what are seen to be socially harmful behaviours. In the case of drink driving campaigns, for example, stigma has been used as a marketing strategy to encourage the view that those who drink and drive are socially irresponsible. Within such campaigns driving under the influence of alcohol is seen not as a form of socially valued risk taking, but as a selfish, socially irresponsible behaviour that threatens the lives of 'innocent others'.

In the case of illegal drugs there may well be a degree to which stigma has been an important social barrier in reducing the wider adoption of a pattern of illegal drug use. Different drugs are associated with different levels of stigma and different levels of use. Cannabis, the most widely used illegal drug, has very little stigma associated with it. From politicians to pop stars, individuals can report their use of cannabis with little or no adverse impact on their career.

When it comes to class A drug use the level of stigma goes up, the level of reported use goes down, and the consequences of personal use become more dramatic. Cocaine is more stigmatised than cannabis but less stigmatised than heroin. In quantitative terms, the level of its use sits between these two other drugs and revelations of its use can have seriously adverse consequences on one's career – depending of course on the nature of the career in question. In the case of heroin, by contrast, we have a drug more stigmatised than any other and whose use, even by rock and pop stars, can be seen as indicative of personal destitution and weakness. As well as being the most stigmatised drug heroin is also the illegal drug that is used less frequently than almost all others. One of the positive outcomes of stigmatising heroin in this way may well have been that its use remains so rare.

The distinction between the bad stigma experienced by individual drug users and the good stigma that may present an effective social barrier to wider drug use is, however, more apparent than real. In a society where drug use was socially valued it would be difficult to see why there would be any stigma associated with the individual's drug use, other than the stigma that might be associated with the perception of excessive use (as is the case for alcohol).

Erik Van Ree, for example, argued in the *International Journal of Drug Policy* in 1999 that drug use should be seen as a human right rather than a social harm: 'Human rights concern forms of behaviour which we regard as positive and enriching for our lives to such a degree that we experience it as a violation of our personal dignity when we are forced to give them up. Drug use belongs in that category. Instead of being included in the category of murder and rape, drugs should be appreciated as a cultural asset similar to religion and art.'

Viewed in these terms it would be difficult to see how stigma in any of its various forms could be accepted. If, by contrast, one accepts the view that illegal drug use

is a behaviour that society does not wish to encourage, and which is seen as being socially harmful, it would seem important to retain some element of the view of drug use as a stigmatised behaviour. The stigma directed at individual drug users, and which we may rail against, may only exist within a broader context where drug use itself is seen as a stigmatised behaviour.

The push to reduce the stigma directed at the drug user is easy to understand and to support. What is perhaps less evident are the dangers of reducing the stigmatised view of drug use itself. At present the social barriers against wider drug use consist largely of criminal justice sanctions against drug possession and the negative health consequences associated with drug use. Since the criminal justice sanctions for drug use are relatively rarely applied (when one considers the overall number of drug users and the level of their use) and the health consequences of drug use are a matter of near constant, heated, debate, stigma may well be the single most influential barrier against the wider use of illegal drugs.

For this reason, while we may rightly reject the stigma directed at individual drug users we may wish to retain the stigma that is directed towards drug use itself. We may need to be careful to ensure that our attempts at challenging the stigma experienced by the individual drug user does not inadvertently reduce the use of stigma as a barrier to wider drug use. The question for which there may be no easy answer, however, may be one of deciding whether we place greater value on reducing the possible expansion of a socially harmful behaviour (thus retaining the stigmatised view of drug use) or reducing the social exclusion experienced by those who are engaged in that behaviour.

The consequences of getting the balance between these can be dramatic for society at large, as well as for individual drug users. While the experience of being seen as a 'junkie' may be a catalyst to some people's eventual recovery, for others it may produce a sense of personal despair and hopelessness that undermines rather than enhances individual's efforts at finding a road back from addiction.

Within the therapeutic relationship stigma may need to be challenged in all its forms. But as we confront the challenge of drug use in society we may need to retain the view of drug use as a socially-harming behaviour, and in doing so retain some elements of the stigma that is then inevitably associated with an individual's drug use. By contrast if we succeed in removing the stigma associated with individuals who are using illegal drugs we may unwittingly make drug use itself that much more acceptable and that much more widespread. When it comes to drug use and stigma there may be a lot more involved than immediately meets the eye.

Neil McKeganey is professor of drug misuse research at University of Glasgow

'Since the criminal justice sanctions for drug use are relatively rarely applied... and the health consequences of drug use are a matter of near constant, heated, debate, stigma well be the single most influential barrier against the wider use of illegal drugs.'

TACKLING STIGMA

At a UKDPC seminar this week, stakeholders from a range of sectors involved with drug treatment and support met to discuss stigma faced by drug users and their families – the start of a research project to tackle the issue. DDN joined in the debate.

'THE REACH OF PAPERS IS FURTHER THAN EVER BEFORE but their income is less – so it's all about selling papers in a difficult market,' said Malcolm Dean, former assistant editor of *The Guardian*, who chaired the debate and explained its context.

There were a number of reasons why stigma thrived, he said. Journalists were dumbing down, putting politics before policy and concentrating on negatives instead of positives. Penal populism had got into the system when Margaret Thatcher took her hard line on law and order from the US in 1979, he said – and, now it was out, 'like toothpaste it's going to be very hard to get back in'.

'The more we separate drugs and crime the better it will be,' he added.

Professor Colin Blakemore, leader of the stigma research programme, highlighted the need for tolerance, particularly towards those going back into society from prison, but warned that if drug users' priorities are low ranking now, they may become lower still in the difficult economic climate.

'The cycle of prejudice needs to be broken,' he said. 'A very low proportion of employers will consider employing former addicts.' The first phase of the project would be concentrated on gathering information, conducting a survey of public attitudes and looking at differences around the world. The work and surveys carried out in the mental health field would be a valuable guide, as attitudes to people with psychotic depression had changed.

John Howard of Reading User Forum gave insight to the stigma he experienced during his transition from chaotic drug use to present day stability and employment.

'I was told I was unemployable by a DSS manager,' he said. 'The attitude of services can change when you say you're a drug user. Even at conferences people bring their bag a bit closer when you say who you are and what you do.'

Viv Evans, chief executive of Adfam, pointed out that stigma was not restricted to drug and alcohol users, but extended to families, who told the charity they could not access support because they feel unable to speak out. 'Often parents feel that they have failed,' she said.

Often stigma faced by families was also experienced by those who worked with drug users, such as social workers, she added. '[Drug use] can be a stigmatising experience for all who touch it.'

Gareth Mead of Hammersmith and Fulham Council had both a professional and personal view of stigma. As the director responsible for allocating social housing he came face to face with the challenges affecting drug users and strongly supported peer advocacy to help settle people in the community. As the brother of a long-term heroin user who had been using since the age of 15 and been in and out of prison, he had witnessed his brother's struggle to become rehabilitated after detoxing.

'In 2001 he managed to get a job and lied to employers, despite my advice not to. He maintained it for six months and it gave him purpose, pride and a sense of wellbeing – he stayed clean,' he explained. 'Then after the 7 July bombings his employers made criminal record checks, found his record and summarily dismissed him. His world collapsed and he went back to hard core use. He was not mad or wicked or evil – he needed help and compassion and support.'

Ronald, a client at Nacro's Latch House housing and drug rehabilitation project, described how a probation officer had seen past the stigma he had become used to since childhood, to give him a chance in life. Aged ten, he had been paid £50 a day to sit on a wall for an hour, selling crack and heroin. This early training led to selling drugs in clubs and a drug habit of his own while living on the streets.

Three years ago, when he felt no one else trusted him, his probation officer showed him Latch House, where 15 people were receiving help with accommodation. For Ronald it was the turning point in accepting help and 'surrendering to recovery' from drugs. 'I think the government should invest more in places like Latch House,' he commented.

More information about the stigma project at www.ukdpc.org.uk

DDN/FDAP WORKSHOPS

We are pleased to offer the following workshops in 2010

23 February

Masterclass – registration with Care Quality Commission

All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

24 February

Healthy eating for a better life

Helen Sandwell, nutritionist, DDN columnist and author of the DDN nutrition toolkit offers advice and guidance on healthy eating for clients with drug and alcohol problems. Attendees of this workshop will receive a free download of DDN's nutrition toolkit, *Healthy eating for a better life*. *Cost: £115 + vat*

3 March

Legal highs and other new developments in drug use

This workshop will look at some of the latest developments in the use of pychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

18 March

What is clinical supervision?

Good performance management and clinical supervision are key elements of providing safe, efficient and effective services to clients. Where staff are not supervised and their practice monitored there is a risk of danger to the client, the organisation and to themselves. This one-day workshop explores best practice in clinical supervision and how to achieve this in your organisation. Run by Fiona Hackland. *Cost: £135 + vat*

19 March

What is management supervision?

Line managers are often expected to cope with everything and are not always given the support to provide staff with the resources they need. This course will help managers look at different elements of their role and identify how best they can ensure they offer appropriate, timely and effective supervision, so staff can develop their skills through reflective practice. Run by Tim Morrison. *Cost: £135 + vat*

SUPERVISION

Good performance management and clinical supervision are key elements of providing safe, efficient and effective services to clients that are constantly improving. Where they are not in place, all sorts of abuse can, and does, take place. Where staff are not supervised and their practice monitored, then there is a risk of danger to the client, the organisation and to themselves. Decent and consistent client care cannot take place without proactive and coherent management practice.

Line managers are often expected to cope with everything and are not always given the support to provide staff with the resources they need. These related courses will help managers look at different elements of their role and identify how best they can ensure they offer appropriate timely and effective supervision so staff develop their skills through reflective practice.

To assist managers with this DDN are pleased to announce two one-day workshops.

What is clinical supervision?

(18 March, Central London)

What is management supervision?

(19 March, Central London)

These courses are for managers or clinical supervisors new to providing supervision or for those more experienced who wish to refresh their skills.

After this course participants will be able to:

- Describe the purpose of clinical and management supervision.
- Agree the elements of a clinical and management supervision contract with a member of staff.
- Outline the role of clinical supervision in clinical governance.
- Describe the clinical supervisor's role in clinical governance.

These courses is mapped to the following DANOS or generic health and social care units:

- Unit BF5 Lead teams to provide a quality provision.
- Unit GEN35 Provide supervision to other individuals.

Delivered by experienced trainers Tim Morrison and Fiona Hackland, these one-day workshops can be taken together or independently.

15% discount to FDAP members.

All courses run from 10am – 4pm in central London, and include lunch and refreshments.

For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081. Or visit www.drinkanddrugsnews.com

DDN training is run as a partnership between DDN magazine and independent training providers. DDN offers trainers promotion, advertising and marketing resources, a central London venue, and admin support. If you are a trainer working in the drug and alcohol field and would like to discuss partnering with DDN on a training course, please contact us.

OPEN ROAD

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

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

Keyworkers – Harlow

1 x Full-Time, 1 x Part-time (15 hours per week)
£19,000 - £23,000 per annum pro rata

An exciting opportunity has arisen for 2 self motivated individuals. The role will involve working with service users and key partner organisations. You will work as part of a multidisciplinary team, providing assessments, planning, delivering and co-ordination of care, 1-1 work including keyworking, group work and referral to other service providers or agencies as part of an integrated process of care. The role may require you to work some evenings or occasional Saturdays.

For an application pack please contact Caroline Warwick on 07553 385569
or email Caroline.warwick@openroad.org.uk
Applications should arrive by Thursday 4th March 2010

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

www.openroad.org.uk

Registered Charity No. 1019915 Registered in England No. 2806113

Chief Officer

£30,851 - £35,430

York Alcohol Advice Service

We are looking for an experienced manager to lead the organisation in developing, delivering and achieving its aims, strategic objectives and priorities.

The Chief Officer holds overall responsibility for the effective and professional management of York Alcohol Advice Service, reporting to the Board of Trustees.

For further details about the post please contact;

e: Kathryn@yaas.info t: 01904 652104

Closing date: Wednesday 3rd March 2010

For further information about the service please visit our website.

www.yaas.info

Coventry Partnership

Towards a safer, more confident city

Coventry Community Safety Partnership

Hepatitis C Support Service Invitation to Tender

The Coventry Community Safety Partnership is seeking an organisation to provide services for current or former drug users with Hepatitis C resident within Coventry. The service will provide practical and emotional support to:

- encourage current or former drug users at risk of HCV to access existing testing services
- assist HCV positive clients to access and complete medical treatment
- assist the families of HCV positive clients to cope with diagnosis and treatment
- train staff of treatment agencies around HCV support issues

The contract will be for two years from June 2010.

This is a new service and organisations tendering should be aware that TUPE will not apply to this service.

Within the tender, organisations should be able to prove:

- a track record in either supporting drug users and/or supporting individuals with chronic conditions
- a strong background in providing counselling services
- an innovative approach to engaging socially excluded clients

This is an e-tender and the tender pack is available at

www.coventry.gov.uk/etendering

Closing date for tenders: 29 March 2010

To receive further details contact Barry Eveleigh via email on barry.eveleigh@coventry.gov.uk or telephone on 024 7683 2094 by no later than 23 March 2010.

www.nhslothian.scot.nhs.uk

Lothians and Edinburgh Abstinence Programme (LEAP)

NHS Lothian

Therapist (Aftercare)

Band 6 - £24,831 - £33,436
37.5 hpw

Lothians and Edinburgh Abstinence Programme (LEAP) is a community rehabilitation project which gives patients the opportunity to achieve abstinence incorporating a holistic approach to their treatment programme.

We are looking to employ an experienced and enthusiastic therapist/counsellor to work with clients in the post treatment period and to introduce recovery management based interventions. Experience of working in a related area and a good understanding of the 12 step model is required.

For an informal discussion, please contact Dr David McCartney on 0131 456 0221

Closing date: Thursday 4 March 2010.

For further information and to apply please visit www.nhslothian.scot.nhs.uk or call 0845 60 33 444 quoting ref or email: recruitment@nhslothian.scot.nhs.uk

Stonewall DIVERSITY CHAMPION

create CONSULTANCY

Alcohol Training Co-ordinator (brief interventions)

Create Consultancy Ltd. is a leading provider of support on health improvement and brief interventions on alcohol throughout Scotland and the North of England. We are looking to recruit a highly motivated and experienced Alcohol Training Co-ordinator to support the development and roll-out of a new and exciting brief intervention project across the Borough of Wigan. Based in Wigan, you will work closely with a range of partners in mainstreaming the provision of alcohol 'identification and brief advice' by statutory and voluntary practitioners. Candidates must have demonstrated experience in training design, coordination and delivery, partnership working and have excellent interpersonal, advocacy and communication skills. The contract is initially for a period of 16 months. Secondment/jobshare applications welcome.

Salary Scale: £26,016-£29,714 (negotiable)
For an application pack contact: dawn@createconsultancy.com
Informal Inquiries: Steven McCluskey (Consultant/Project Manager) 0141-445-5858
Further information on Create available from: www.createconsultancy.com
Closing Date: Monday 1st March 2010 at 12 noon.
Interviews: 10th March 2010, Wigan.