DDN
Drink and Drugs News
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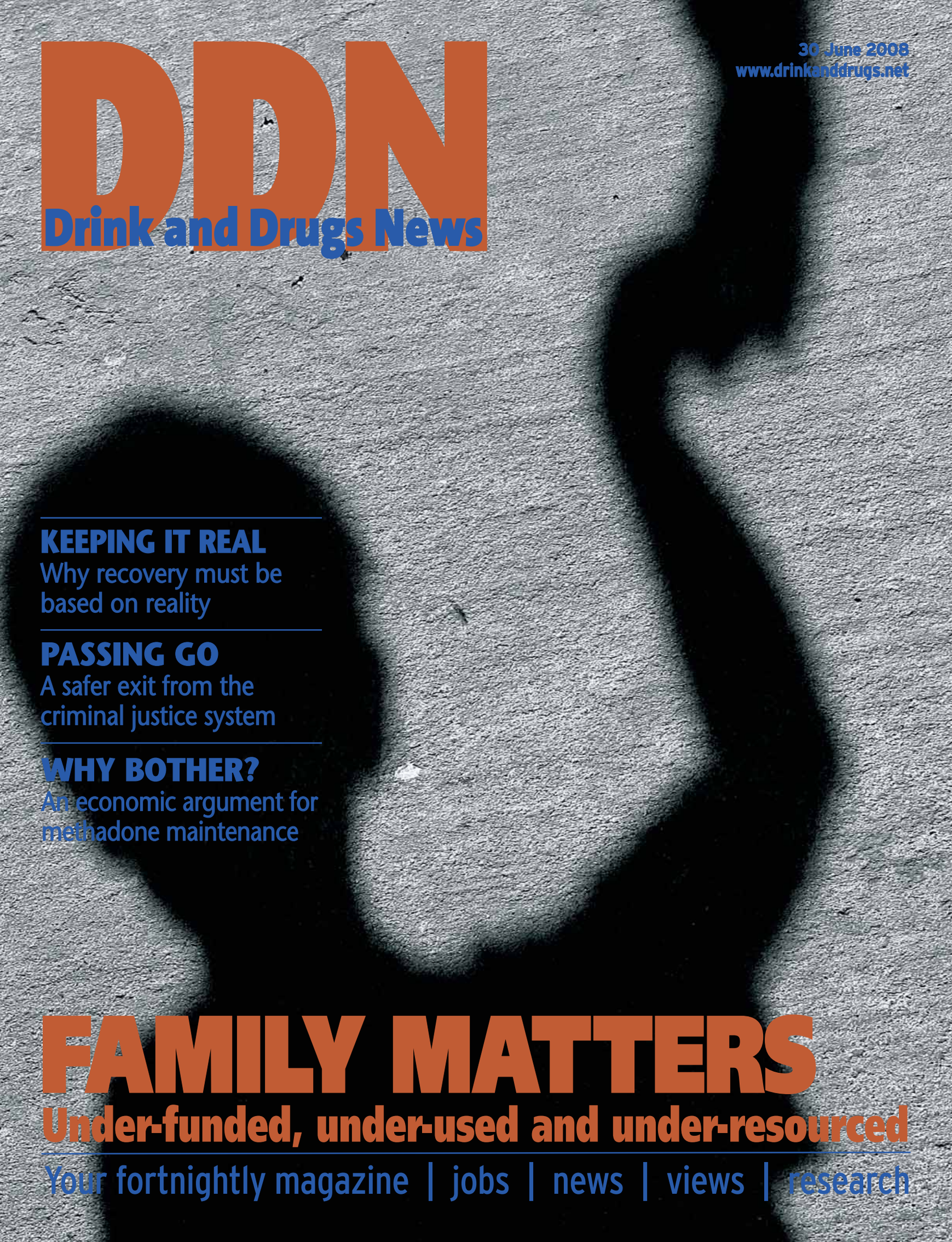

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- Anger management programmes make offenders MORE dangerous - Home Office Report (2006)
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DDN Drink and Drugs News

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Editorial – Claire Brown

Come on, out with it!

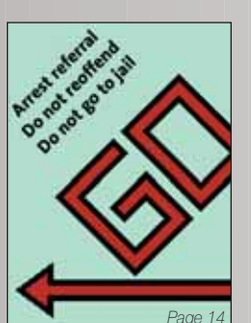
Why open debate can only be healthy for this field

Reading about Jane's experience as she walked into a family support service is a powerful reminder of what support services are about (page 6) – whether they are drug treatment services, carers' support networks, or the wider services that help put life's building blocks back into place. Her overwhelming relief that there were people there who not only understood what she was going through, but could put a practical action plan together for her to cope with the trauma of facing up to her son's behaviour, put her back on track in a way that struggling on her own could never have done.

We're engaged in debate about recovery at the moment (following last issue's article on the UKDPC recovery statement, debated at the NTA's annual conference) and part of that process is experiencing the painful railing against polarisation that manifests itself on bulletin boards and blogs, as well as directly to us here at DDN. But I make no apology for carrying debate, because that's exactly what DDN is here for. If you're part of a harm reduction network, you know why you're there; if you're contributing to a blog that supports abstinence you know you're among like-minded friends. But addiction doesn't microchip its subjects with the 'right' treatment mode; that's for us to work out, by debate, by knowledge-sharing, and by convincing others through the benefit of research and experience. If we don't get it right, Jane's son continues to terrorise his family and presses the self-destruct button harder; if we do get it right... well read the cover feature (page 6) and tell me if it's worth it.

Direct experience speaks volumes, particularly Christopher Hallam's article – a personal account of how methadone maintenance has helped him create a new and productive life, in which he spells out what the threat of being without it means to him. The article speaks volumes about the individuality of drug treatment and should surely stop in their tracks anyone who believes that treatment is about herding everyone down the same road.

This issue



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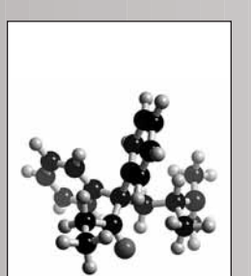
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News in Brief

Quarter LEAP

LEAP (Lothians & Edinburgh Abstinence Programme) has now celebrated its 25th patient to graduate from the community-based programme, a partnership between NHS Lothian and local DAATs. Launching last September, it includes counselling, group work and family therapy along with vocational training and education courses over a three-month period (*DDN*, 14 January 2008, page 6). 'This latest graduation marks a milestone for LEAP,' said clinical lead Dr David McCartney. 'The programme is both intensive and demanding so our patients need to be motivated to get clean and stay clean, so I would like to congratulate today's graduates for showing the commitment and determination to reach this goal.'

One stop cannabis shop

A new two volume 700-page monograph on cannabis has been launched by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The first volume concentrates on the political, social and legislative aspects of the drug, including supply and production, and is aimed mainly at policy makers while the second focuses on epidemiology and health effects and is targeted towards treatment professionals. 'The EMCDDA's cannabis monograph addresses one basic question – how can I find quality information on cannabis amid all the bias and opinion?' says the centre. Available to download at *www.emcdda.europa.eu/html.cfm/index53347EN.html*

Home Office thanks

The Home Office has issued a 'big thank you' to all of the organisations and individuals that took part in this year's *Tackling drugs, changing lives* week. More than 300 events took place across the country to mark the awareness raising event, put on by DAATs, police forces and others.

Scots look to tough new drink measures

Raising the minimum age for alcohol off-sales purchases to 21, setting a minimum price for a unit of alcohol and an end to 'three for two' type promotions are among the strong measures contained in a new consultation document from the Scottish Government. Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach also includes proposals for alcohol only checkouts and imposing a 'social responsibility fee' on some alcohol retailers.

The proposals could form part of new legislation to be introduced to coincide with Scotland's new Licensing Act, which will come into force in September 2009. Action is needed in four main areas, it says – reducing consumption, supporting families and communities, improving support and treatment and changing public attitudes towards alcohol.

Scotland has one of the fastest rising death rates from liver cirrhosis in the world, with overall alcohol-related death rates more than doubling in the last ten years. Alcohol-related hospital admissions have increased by 50 per cent in the same period, and the cost of the country's alcohol misuse is estimated at £2.25bn per year. Alcohol is also cited as a contributory factor in one in three divorces, and 65,000 children in the country live with a parent or carer with a drinking problem. Nearly half of Scottish prisoners in 2007 said they were drunk when the offence was committed.

The introduction of a social responsibility fee would reduce the burden on the taxpayer by making some alcohol retailers help pay for the consequences of alcohol misuse, says the government, while the introduction of alcohol-only checkouts would send the message that alcohol, like cigarettes, is a 'special case' rather than a normal product. The idea has already been dubbed the 'walk of shame' by some newspapers, with the government being accused of being in 'crusade mode'.

'Now is the time for action to diffuse the health time bomb alcohol misuse is storing up for the future,' said cabinet secretary for health and wellbeing Nicola Sturgeon. 'People across all sections of society, of all ages, are drinking ever greater quantities of stronger alcoholic drinks. It should come as no surprise that alcohol-related health problems have risen hand in hand with this increased consumption.

'We believe that by raising the age for off-sales purchase of alcohol to 21, together with better enforcement, we will reduce excessive consumption among young people,' she continued. 'Setting a minimum price for a unit of alcohol will mean price better reflects the strength of alcoholic drinks. This will end the heavy discounting which allows strong drink to be sold cheaper than bottled water. We all have a personal responsibility to drink sensibly but government also has a responsibility to show leadership.'

Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach available at www.scotland.gov.uk/Publications/2008/06/16084348/0 Consultation period ends 9 September.

South America sees sharp rise in coca cultivation

Cultivation of coca in Columbia, Bolivia and Peru is at the highest level since 2001 and 16 per cent up on 2006, according to the United Nations Office on Drugs and Crime's (UNODC) 2007 Andean coca survey. The total area of land under coca cultivation in those countries now stands at more than 180,000 hectares, with by far the biggest increase in cultivation found in Columbia, at 27 per cent.

A recent report by UNODC on opium found that last year's poppy cultivation in Afghanistan was the largest ever, creating 'unmanageable' problems across the world (*DDN*, 5 May, page 4). However, even with the increased cultivation, production of cocaine in Columbia has remained relatively unchanged, says the UN.

UNODC is calling for large scale agriculture and forestry schemes to be implemented in coca growing regions to limit cultivation and give farmers a route out of poverty without needing to become part of the drugs trade. Almost half of cocaine production in Columbia, and a third of the cultivation, takes place in just 5 per cent of the country's municipalities.

'The increase in coca cultivation in Columbia is a surprise and a shock,' said UNODC's executive director Antonio Maria Costa. 'A surprise because it comes at a time when the Columbian government is trying so hard to eradicate coca; a shock because of the magnitude of the cultivation. But this bad news must be put in perspective. Just like in Afghanistan, where most opium is grown in provinces with a heavy Taliban presence, in Columbia most coca is grown in areas controlled by insurgents. In the future, with the FARC in disarray, it may be easier to control coca cultivation. With greater control over national territory, governments can help farmers switch to licit livelihoods and turn their back on drugs. This is the best way of eradicating poverty as well as coca.'

www.unodc.org/documents/crop-monitoring/Andean_report_2008.pdf

Cocaine is the drug most children know

Cocaine is the drug most widely known to children, according to a nationwide survey of nearly 1,500 9-11 year olds carried out by education charity the Life Education Centre. More than 70 per cent of children named cocaine, compared to 64 per cent naming cannabis. More than half of the children surveyed could name four or more illegal drugs.

The children were also questioned on their perceptions of adult drug-taking – 19 per cent thought heroin was legal while 28 per cent thought ecstasy was legal. Nearly 40 per cent thought the main reason adults took drugs was to 'look cool' while just three per cent thought adults chose not to take drugs because they knew they were addictive.

The charity, which operates in more than 4,000 schools, wanted to gain an understanding of what primary school children regarded as normal behaviour. 'These results show that there is a vast amount of work to be done in teaching the next generation about the realities of drugs,' said the charity's national director Stephen Burgess. 'It is no use pretending that children under 11 don't know about drugs. These results show that they do and in order for them to approach the potentially challenging period of adolescence knowing the full facts rather than responding to hearsay and peer pressure we need to reach children early – at primary school. That is the only hope we have of stemming the ongoing issues so many adults face with drugs.'

Red card: The Royal Borough of Windsor and Maidenhead's DAAT chose the first Euro 2008 semi-final to launch its safer summer drinking campaign. Free condoms supplied by Berkshire East PCT were included in 5,000 information packs which also contained useful contact numbers, sensible drinking advice and a lollipop. 'We picked Euro 2008 to launch this latest safer drinking campaign because we know this will be a time when people are drinking more,' said the council's lead member for adult services Simon Dudley. 'We want everyone to enjoy themselves and the packs should provide everything they need to stay safe and look after each other. The message is simple – enjoy the football but don't drink to excess and don't be violent and get into fights when you are out.'

Service users call for more support for families

A third of drug users in treatment would like to see more support for families and carers, according to the NTA's annual survey of drug treatment clients. The figure represents a five per cent increase on last year and comes as a new report from Adfam, Identifying the role of families within treatment, points out that support services for families are 'very limited and geographically unevenly distributed' (see feature page 6).

The NTA's 2007 user satisfaction survey found that most service users felt their treatment had had a positive effect, leading to better physical and mental health as well as improved housing and employment prospects – more than 90 per cent reported less drug use and crime since beginning treatment and around 80 per cent reported an improvement in their overall health. Service users had higher levels of satisfaction if they received a comprehensive assessment, started treatment and were allocated a key worker within a short time, it says. Care plans also increased levels of satisfaction, especially among those whose plans had been reviewed recently.

The new drug strategy and drug treatment guidelines from the National Institute of Health and Clinical Excellence (NICE) both state that family members and carers can be a valuable resource in drug treatment, but need support themselves. 'Treatment of drug dependent individuals is the focus of the NTA, but we also recognise the importance of families as carers and that this is an area of concern for service users,' said NTA chief executive Paul Hayes. 'We are therefore looking to encourage higher levels of engagement with families and carers throughout the treatment system.'

Full results available at www.nta.nhs.uk/publications/ documents/nta_2007_user_satis_survey_tier2and3_service_users_england.pdf and www.nta.nhs.uk/publications/documents/nta_2007 _user_satis_survey_tier4_service_users_england.pdf

Chief executive leaves FDAP

The Federation of Drug and Alcohol Professionals' chief executive, Simon Shepherd, is leaving FDAP after six years, to become director of The Butler Trust, a charity that promotes reform in UK prisons.

While at FDAP's helm, Mr Shepherd has developed the charity's membership and influence, and has been a pioneering force in workforce development. His 'DANOS may be dull, but its nothing to be scared of' presentations have encouraged many professionals to see ongoing training as a natural part of continuing professional development, while his initiatives including CoG – the Competence Group – brought expertise together to galvanise workforce development and troubleshoot obstacles. FDAP's work with the Open University has put many more workers and line managers within reach of training to professional awards standard.

Mr Shepherd's networking skills and go-ahead style were a key factor in establishing DDN, as he helped the publishers to develop and launch the magazine. We would like to wish him every success in his new role, in which he will be driving forward excellence and innovation within prisons.

News in Brief

Come together

An end to the polarisation between abstinence and harm reduction is one of the key themes in a new report from EATA which lists its members recommendations for government agencies implementing the new drugs strategy. Based on the outcomes of a series of regional meetings, other main points include a policy shift towards public health, guidance on diversity issues, information on best practice and more information on what providers need to do to achieve the strategy's aims. EATA will be organising more regional meetings in the autumn. Report available at *www.eata.org. uk*

Back in the day

The final selection in the 'old gold' series of key studies designed to illustrate current concerns has been made available on the *Drug and Alcohol Findings* site. This time the focus is on substitute prescribing, starting with the landmark 1920s Rolleston report, through 1960s research into methadone prescribing in the US and up to recent studies looking at whether prescribing methadone is better than prescribing heroin.
Available at findings.org.uk

THOMAS's strategy engine

T.H.O.M.A.S (Those on the Margins of a Society) has established a strategy unit to 'give a third sector perspective on the issues that affect people who are trying to embrace a life free from drugs and alcohol but are trapped by the system'. The unit will aim to support those in the criminal justice and treatment systems while promoting a total abstinence lifestyle, as well as provide advice to the government and public sector. 'Fourteen years ago we launched our national publication *Edges* that now has a 15,000 distribution throughout the UK,' said chief executive Jim McCartney. 'Our strategy unit will be a sister project influencing the national debate.'

Family matters

Many services are ignoring the fact that family members need support too, and overlooking the positive role they can play in treatment. **David Gilliver** reports

'I'll never forget the feeling I had when I walked in the first day and saw other parents there,' says Jane (not her real name). 'I realised we weren't alone.' Jane first accessed the Leicester-based Snowdrops family support service five years ago, after struggling to cope with her son's drug problems for more than a decade. 'I just talked and talked and cried and cried,' she says. 'It was the first time in 12 years I'd spoken about it.'

According to a new report from Adfam, *Identifying the role of families within treatment*, family members and carers of people with substance misuse issues are being woefully neglected by services. This is not only traumatic for the families, it says, but counter-productive as available evidence shows that participation of family members in treatment can have a genuinely positive effect. The paper calls for more research into family involvement in the treatment of adults, as up to now the focus has been on adolescent substance misusers, and states that when family members are willing and able to help, their needs should be included in treatment and support plans.

Jane's son has been a drug user for 18 years. 'I was in denial at first – as a mum I didn't want to believe it,' she says. 'We're a family with four sons and a mum and dad, very stable. He had a really good upbringing with both parents there for him. People associate drug taking with broken homes and families that don't care, but our son came from a loving, caring home. I never told people because I felt ashamed – I thought they'd judge me and think I wasn't a good parent. We felt so isolated as a family that I can't put it into words. There was just nowhere to turn.'

It is precisely this all-powerful sense of stigma that stops many parents and carers from accessing the services they so desperately need. 'Even if there is support available families often don't access it,' says Adfam chief executive Vivienne Evans. 'And they don't make a fuss about the fact that there isn't any because they don't want to talk about it.'

Christine McEvoy is parents and carers development worker at the Drug Advice Centre in Leicester and founder of Snowdrops, the service Jane turned to five years ago. 'Sadly by the time people come to me it's because they've tried struggling with the problem themselves for so many years in isolation and have come to the end of the road,' she says. 'They carry a lot of guilt and shame around.'

And of course when they do summon up the courage, there's often little or no support available. 'In Leicestershire and Rutland I'm the only worker who works specifically with that group of clients,' she says. 'It's very under-funded. Family members are an under-used resource, because they often very much want to be part of a person's treatment and recovery programme, with the consent of the client of course. To be fair community drug team caseloads are huge – there are the odd workers that will go the extra mile and try to involve families, but generally they don't have either the resources or the time.'

Often the first point of call is the family GP, but the report points out that most are simply out of the loop and unaware of the services that do exist. 'I try to get information to GP surgeries as often as I can,' says Christine McEvoy. 'But it would be nice if they had someone they could refer parents and carers to rather than just writing them a prescription for sleeping pills, which is what we tend to hear goes on.'

This is certainly borne out by Jane's experience. 'First I took him to the doctor because I thought "he'll know", but he didn't,' says Jane. 'There was no referral to anything. I was desperately ringing any numbers I could find for advice and support, but for parents there was absolutely nothing.'

She eventually got her son onto methadone, but he continued injecting heroin and getting into more and more trouble with the police. 'I can't put into words the strain it put on the family,' she says. 'Our son was chaotic but so were we – we didn't know what to do. And of course a drug user is great at manipulating the parents, so I'd be giving him money and thinking I was doing the right thing while his dad was very angry with him, which put a huge strain on our marriage. His brothers didn't want to be in the same room with him. I knew nothing about addiction or how to cope with it. This went on for 12 years.'

Her health suffered and when the family moved for work reasons, Jane let her son stay in the house. 'I ended up working more or less just to pay his bills and keep him in his addiction,' she says. 'I was enabling him, but I didn't know that at the time because there was no support – we didn't know what else to do. He eventually went to prison.'

Jane finally heard about Snowdrops through the local church. The effort of making the first call, however, was overwhelming. 'I thought "I'm going to let people know I can't cope, and they're going to think I'm a bad mother",' she says. 'But I made the call, and once I walked through the door and saw there were other parents there – I'll never forget it. I could speak openly and honestly and didn't feel ashamed – to be there with people who understood and without being judged was amazing. I remember coming home and just crying with my husband and saying "we're not on our own, it's ok, there are other people out there like us".'

One of the main benefits of the support was to enable her to establish boundaries with her son for the first time. 'As I went to the meetings I started to get stronger,' she says. 'I was going on training days and was able to empower my husband and my other sons as well – the dynamics in the family really changed for the better. I'll never forget the first time I told him I wasn't going to give him money. He was astounded, saying he'd have to go out and steal. I just said if he did that he could face the consequences. I wouldn't have been able to do that before – I would have given him the money.'

Adfam's report, however, makes the point that some services may be reluctant to involve family members and partners in treatment because they feel they could be a negative influence – especially if they have their own substance misuse issues. 'Clearly practitioners will come across dysfunctional relationships in families, co-dependence and situations where the family is either unable to help or a very real part of the individual's problem,' says assistant director (policy and service development) at Princess Royal Trust for Carers, Alex Fox. 'But that shouldn't stop them recognising the potential for some families to contribute to their relatives' support and work with them to raise their understanding of substance misuse, the factors that influence it and what's helpful and what's not, because that's not necessarily something families will intuitively understand.'

So from a policy point of view, what needs to happen? 'Obviously it would be

'I'd love to go and meet the government face to face in their cosy offices. They're always banging the drum about how important families are and the holistic approach yet there's so little family support – let them put their money where their mouth is.'

great if there was a specialist support service for carers and family members in every locality,' says Vivienne Evans. 'If I'm being realistic, that's not going to happen, so I would say we need to encourage existing services for carers to get skilled up to deal with drug and alcohol issues – perhaps second a specialist worker, as well as encouraging drug and alcohol services to run a family service. But you need to have a great deal of sensitivity, not just people walking into a drug service and someone saying "the family bit's over here". It needs to be thought through.'

Another problem is that many of the services that do exist focus exclusively on drugs. 'Specialist services to support families tend to be in DAAT areas where there's a commissioner who's passionate about family work and prepared to put some money into it,' says Vivienne Evans. 'But there's a disproportionate focus towards drugs rather than alcohol which needs to be addressed, and there's also all the people out there, and we have no idea how many, living with someone with a drink problem who don't go for help at all – people nowhere near treatment because they don't want or think they need it.'

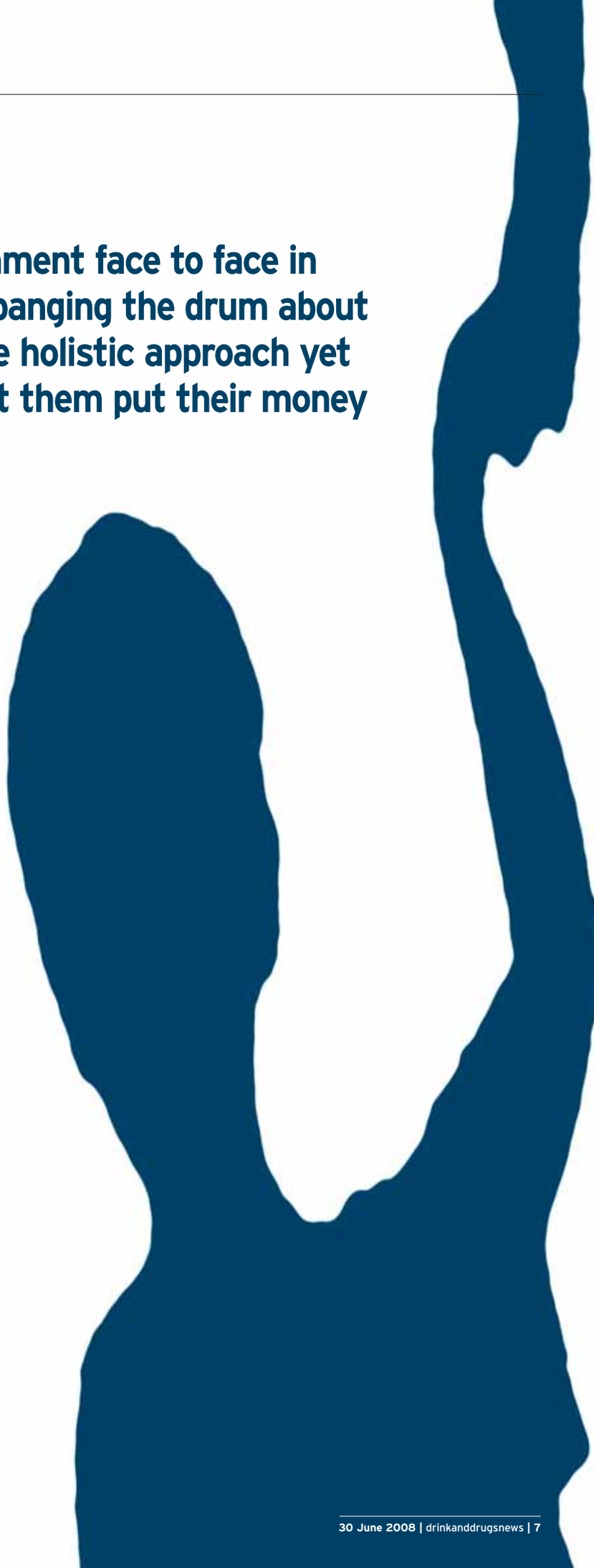
Is there some hope that things could change? 'I haven't seen any signs of it,' says Christine McEvoy. 'I've been in post six years as a lone worker and each year we hope things will improve, but nothing seems to change. We thought families would be more of a focus in the new drug strategy, which they are in terms of children and siblings but not parents and carers. I know it always comes down to funding with everything, but I would like to see some core funding made available because projects are struggling from one year to the next.'

'I think the NTA's new guidance for DAAT commissioners on family support is going to be a positive step,' says Alex Fox. 'What we'd like to see is some resources behind that in terms of training and awareness raising, because there are still DAATs that would probably take the view that supporting families isn't their business. Many people with substance misuse problems never reach formal treatment, so the only way of positively influencing their substance misuse is by reaching their families, and that doesn't necessarily have to be a particularly expensive exercise.'

The irony, says Jane, is that investment now would save money in the long term. 'We could save the NHS so much. I'm closely involved with so many families who are suffering through drugs and alcohol and I'm not even a worker. I've had meetings with the NTA and DAATs and it still feels as though people aren't listening, or not acting on it if they are. I'd love to go and meet the government face to face in their cosy offices. They're always banging the drum about how important families are and the holistic approach, yet there's so little family support – let them put their money where their mouth is.'

Jane's son is now using again after being drug free for 18 months, but the support they've received means the family can now cope with the situation far better. 'The help we've had has united the family,' she says. 'His brothers get on with him now, and we've set boundaries – like him not using in the house – that more often than not he'll respect. Years ago we wouldn't have been able to do that. I don't judge him any more.'

Identifying the role of families within treatment is available at www.adfam.org.uk



'Addiction is for life; once contracted, it will never go away... I have yet, as an addict in recovery, to come across anyone who has said they do not want to be totally abstinent.'

Waving the flag

It was reassuring for me to read 'Back of the net' (*DDN*, 16 June, page 6). Too much for too long has been focused on substitutes for addicts' drugs of choice.

Addiction is for life; once contracted, it will never go away. So the only way forward for us addicts to ever return to anything resembling normality is total abstinence. It is difficult for most and a hard slog to put right that which has gone wrong, but it is logical to support addicts in learning to live in the correct way without the presence of our drug of choice. I have yet, as an addict in recovery, to come across anyone who has said they do not want to be totally abstinent.

Because of different beliefs from agencies, and depending on what stage the vulnerable addict is at, choice of other routes further complicate the recovery process. There are always many issues that need to be addressed, and simplicity can, and has, been proven the most affective for us addicts.

Honesty, humility, discipline, tolerance, acceptance and loyalty are usually among the many major issues that need to be explored by the individual to allow any character changes, which are usually necessary as most addicts tend to change from what is socially accepted as normal. I needed to do this myself, and have seen so many others follow the same path. It's a massive undertaking, yet essential and extremely necessary for peace of mind and a full and useful re-integration back into society.

So I wave the flag and hope that the likes of Jacquie Johnston-Lynch keep blowing the whistle. The message of total abstinence is the logical way forward that hopefully others will wise up to.

S. Rendell, by e-mail

Motivated by passion

It was another excellent and thought-provoking letters page in the current edition of *DDN*. With regard to the comments made by Stephen and Bryn Hoyle respectively (*DDN*, 16 June, page 8) in response to my letter in a previous edition (*DDN*, 2 June, page 6), I respect wholeheartedly their viewpoints. My only sense of dismay is that no mention was made by either of the ethics and morals of methadone maintenance, which was my principal purpose for writing the letter.

I used the word 'perverted' deliberately, in its purest sense, as in, 'diverted' rather than 'depraved'. But we could get caught up in all sorts of side issues here.

I came into hard drug addiction and chronic alcoholism by way of psychedelics. I remember once when convinced I was in ecstasy and in a visionary state, a friend said 'do it without drugs!'. That statement stuck in my mind.

Peyote-eating visionaries and creative writers may be able to do what they do without drugs – although if so, why use them? There is a toxic cost to all sustained drug use, usually resulting in physical addiction and psychological difficulties of one sort or another. Once addicted, I actually agree (reflected clearly in my letter) that many do not want to be abstinent or struggle greatly attempting to become abstinent. It is not for everybody, and of those who do not want it, many may go on to live fulfilling and long lives. I am sure many methadone-maintained individuals will agree with that.

My professional experience is such though, that most, if not all, people I have come in contact with want to be free of their active addiction, not maintained in it.

I wrote the letter off the top of my head after reading what I though was an excellent article by David Best and his colleagues (*DDN*, 2 June, page 6). Maybe I should have been more specific and defined my comments about achieving human potential by way of abstinence linked to meditation practice and work as being my own personal experience. (I thought I had, actually.)

I make no apology for my passion for abstinence-based recovery. I recognise passion for their own viewpoints in Stephen and Bryn's letters. Surely they will not begrudge me mine.

John Graham, self-employed addiction treatment practitioner

Released prisoners need continuity

When prisoners are released into the community, it is often the case that neither they nor the prison has had adequate notice of the release date – another symptom of prison overcrowding.

If they are released at short notice, they may not have had time to get a drug worker set up to make sure their script is not interrupted. This is not the drug worker's fault, as they should have a full history that has been sent from the prison.

Ex-prisoners may also have no accommodation in place, nor indeed any funds. They cannot access benefit for ten days and although the prisons do give them some money, without a script they will probably spend what money they have on scoring or commit a crime to fund emergency drugs. People are re-offending simply to continue getting what they have been prescribed in the prison where they served their sentence.

This is clearly an issue for government, as prison staff themselves may not be told until that day that they are releasing certain prisoners. For all our sakes this should not happen. Surely this blatant gap could be sorted out if the governors were given upcoming release dates in enough time to pass the information onto the shared care GP practices.

When an offender is released from prison they should be seen and prescribed with the same dose that they had when they were inside. The many people passing through the gap would not then have the trauma of committing more crime to feed their habit.

Bri Edwards, Cumbria

In the real world

To E. Kenneth Eckersley (*DDN*, 16 June, page 9): A relatively small amount of investigation goes at least some way to validating the statement that 'the bulk of our population will experiment with or use drugs for some part of their lives'.

This is taken from the British crime survey 2006-07 (which is considered to underestimate drug use as it excludes prisoners, university students in shared

halls along with those with chaotic lifestyles):

'The 20 to 24 and 25 to 29 age groups reported the highest levels of ever use of any drug in 2006/07 (50.7 per cent and 50.8 per cent respectively).'

As these figures are above 50 per cent presumably they represent the bulk and clearly these people are going to get older. Presumably E. Kenneth agrees that it is best if these people cause the minimum of harm to themselves and others when choosing to do so.

A 'drug free society' is clearly not going to happen, so to damage people in search of this unattainable, unrealistic and arguably undesirable goal is clearly wrong.

Niall Scott, dual diagnosis development worker, North Shrewsbury CMHT

Better services quicker

It was with interest that I read Phil Coles' comment 'Criminal Injustice?' (*DDN*, 16 June, page 10).

The Drug Interventions Programme (DIP) is indeed an initiative funded through the Home Office and Welsh Assembly Government that seeks to reduce drug-related crime within our communities by enabling drug misusers to access appropriate treatment services. For many years substance misusing offenders were denied access to treatment through their 'criminal justice' status – leaving them at heightened risk through prolonging their drug use and communities at risk through further offending.

CRI is a charity that seeks to help create safer communities by enabling individuals to lead healthier lives. One of the ways that we achieve our charitable objectives is through providing DIP services across England and Wales. These services seek to reduce drug related crime by enabling drug users within the criminal justice system to quickly enter effective treatment. We also work extensively in the community with people who voluntarily seek treatment for drug and alcohol problems.

We are proud of these 'best intentions' and of the opportunity given to us to extend our work in the Cardiff area – building upon the successful services we have delivered under Gwent DIP and Cardiff and Bridgend Drug Rehabilitation Requirement (DRR) work for the last two years.

Far from 'dumping' existing service users, we are working closely with the outgoing providers to ensure that all service users are supported through this transition, that their case notes are appropriately handed over and, indeed, that existing staff are able to transfer into the new service. We are also working with all other provider agencies to review existing care and treatment pathways. Contingency arrangements are in place, with significant funding to maintain existing service users in treatment and the rapid access prescribing service available through Kaleidoscope will provide a treatment option that previously did not exist.

The other obvious point to make is that the new services were commissioned through existing DIP resources. Our intention is to make better use of these resources to deliver a more effective and creative service that better meets the needs of service users. The service was also commissioned following extensive consultation with a range of stakeholders and service users – as has been highlighted in previous editions of *DDN*.

We are confident that the new DIP service working across Cardiff, the Vale, Rhondda Cynon Taff and Merthyr will provide a more focused model of delivery that will enable more drug users within the criminal justice system to access better treatment services more quickly.

And that doesn't sound like a bad outcome to me.

Mike Pattinson,
CRI director of operations, Brighton

Knowing the unknowable

If 'no one will admit to it', then how does Phil Coles (*DDN*, 16 June, page 10) know that 'people asking for help are being told by well-meaning workers to go out and nick something from the local shop, get caught, get a criminal conviction, get your methadone!'?

Peter Penny, service manager,
Cranstoun Drug Services, Oxfordshire CDA

Apologies

Regarding my comments on 'Criminal injustice' (*DDN*, 16 June, page 10), I need to apologise for any offence caused to individual organisations and any inaccuracies contained in the comment. I was not fully aware of the facts and processes involved in tendering for contracts and/or services to be implemented by the organisations I mentioned. I have since been corrected.

I would like to reiterate, as stated in the article, that the views expressed were mine and do not reflect those of my current or former employers. My intention was to raise a debate on current service provision amongst workers in the field; not to cause offence, disruption, or to bring disrepute upon any organisations, including my own.

Phil Coles

We welcome your letters

Please email letters to the editor, claire@cjwellings.com or post them to the DDN address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.

Media Watch

Ditch the alcohol crusade and get down to a 'properly toned debate', said Labour's Pauline McNeill, hitting out at Scottish government this week – in particular Kenny MacAskill, justice secretary, for making 'analogies with child pornography'. Following a week of proposed crackdowns, including raising the buying age and the price of cheap booze, public health minister Shona Robison stressed the government was not against alcohol, only alcohol abuse.

The Scotsman, 26 June

With almost half of men and a third of women in Northern Ireland admitting to binge drinking, chief medical officer Dr Michael McBride has said his country's 'drink problem' must be addressed. 'Young people are growing up in a modern, complex world. They are exposed to television and adverts glamourising alcohol. And they watch adults speak about alcohol and they notice how adults behave when they drink too much,' he said. 'We are all quick to point the finger… at everyone except ourselves.'

BBC News, 23 June

'You wouldn't start a night like this, so why end it this way?' is the strapline of the Home Office's new £4m anti-binge drinking advertising campaign. The accompanying images show a man bashing his head on a cupboard, urinating on his shoes and ripping out his earring, while the woman rips her clothes, vomits, and tears the heel off her shoe. 'This new campaign will challenge people to think twice about the serious consequences of losing control,' said home secretary Jacqui Smith. 'Binge drinking is not only damaging to health but it makes individuals vulnerable to harm.'

The Guardian, 17 June

Cannabis smoking when pregnant can harm the brain of the developing foetus, researchers from Aberdeen University announced this week. According to Prof Tibor Harkany and colleagues, the drug can affect the signalling system between molecules in the brain, disrupting how nerve cells recognise and connect with each other, and affecting the brain's functionality.

BBC News, 27 June

A 'heroin tsunami' could hit Europe if Iran's efforts to stem drug trafficking from Afghanistan are undermined by the West, according to UN director Antonio Maria Costa. A stand-off over Tehran's nuclear programme is threatening to jeopardise enhanced co-operation on Iran's anti-drugs effort, as the package deal of technological, political and economic incentives is conditional on Iran suspending uranium enrichment. Iran's most senior anti-drugs official protested that 'fighting drug trafficking should not be politicised'.

The Scotsman, 27 June

The current debate on recovery, highlighted most recently by the UKDPC working group's proposed definition (DDN, 16 June, page 12), has attracted heartfelt response. The perspectives featured here point in opposite directions, but all are justified by their authors; can we move beyond the debate in a climate of mutual understanding? In our first response Christopher Hallam asks for mercy from the zealots...

The chemistry of mercy

The recent UKDPC statement attempted to provide a working concept of 'recovery'– and to their credit, those involved explicitly avoided a futile attempt to confine the term within an essential and unchanging definition.

One of the stated motivating factors for the project was the desire to transcend the polarised state of the UK drug treatment field and establish a consensus. The configuration of the treatment discourse into binary concepts and practices of abstinence (on the one hand) or methadone maintenance (on the other) was lamented as sterile and extreme.

Philosophically, I have some sympathy with this stance. Indeed, the necessity for services to supply a range of options, including both abstinence-oriented practice and opioid maintenance, seems to me to qualify eminently as what our transatlantic cousins might call 'a no-brainer'. However, in this politically and ethically saturated domain, a consensual notion of 'recovery' and the associated broad church of clinical and psycho-social practice enjoy a tenuous existence at best. We cannot just wish away conflict and dissensus.

In these circumstances, it is necessary to say a few words about my motives in writing this article. One of my intentions is to defend the employment of opioid agonists such as methadone – though the case does not hinge on the pharmacological agent in question. I feel compelled to make this case not out of some form of extremism, or from an ideological or 'ecumenical' commitment. Quite simply, as one who is maintained on methadone myself, the recent chorus of voices calling for a greatly restricted use of the drug – ever more strident in its pronouncements – is profoundly alarming; I am distinctly uneasy at the prospect of my new life being snatched away in the name of 'what's best for me'. In the face of this very real threat, I believe it is time to speak out.

It's not the first time that the theory and practice of maintenance has been under fire in Britain. In 1922, a painter by the name of Thomas Henderson called at the Home Office to try to persuade the government against changing the prescribing regulations, which would have left him without the morphine maintenance that enabled him to live and work. He handed a letter to Malcolm Delevingne, the civil servant in charge of these matters at the Home Office, in which he appealed to him 'to see with unbiased eyes' and begged him 'not to crush me out under this new law'. 'I only ask to be left in the hands of my doctor,' he implored.

It was the question of maintenance prescribing, entirely frowned upon in America at this time, which prompted the setting-up of the famous Rolleston Committee, the report of whose eponymous chairman was to lay the foundations of the medical approach that became known as the British System. While that system was at least partially abandoned in the 1960s and 70s with the advent of Dangerous Drugs Units at large psychiatric hospitals, in many ways the concept of maintenance prescribing it enshrined, and endorsed as a valid medical practice, has remained in place to this day. With the setting up of the NTA under New Labour in the 1990s, maintenance received an enhanced therapeutic respectability, taking its place alongside other modalities of addiction treatment.

Over the last few years, however, as the fortunes of the labour government waned and a punitive populist turn entered British politics and culture, a militant form of abstentionism has begun to make its presence felt in the drugs field. While many would accept that there has sometimes been an over-reliance on methadone (though the problem has usually been with the quality of the broader treatment delivery rather than methadone *per se*), the militant anti-methadone tendency has focused its intervention on the drug itself, and is underpinned by a moral abstentionism which regards anything other than a state of being 'clean' or 'drug-free' as constituting only a pseudo-recovery. The movement is perhaps associated most strongly with Professor Neil McKeganey, who has recently called for a two-year limit on the use of methadone, with all users to be compelled to take part in 'drug-free programmes' after that point. The Scottish government's new drug strategy has been strongly influenced by this discourse, proclaiming its 'new vision' for recovery and a society free of the 'scourge of drugs'.

This 'new vision' is, in truth, neither new nor visionary. Politically, it represents another example of the familiar populist tactic of being 'tough on drugs'. I want to briefly consider these two approaches here, bearing in mind that both terms can only function as shorthand in the space available: methadone maintenance and reduction/compulsory withdrawal of the drug. I will do so through the prism of my own experience.

A few snippets of personal history, then. I had been fascinated by drugs and by states of mind that were 'out of the ordinary' since my earliest memories of childhood. A literary and musical bohemian, I emerged from the youth culture of the 1980s with a heroin habit of heroic proportions – and I was far from alone in this. After a number of years spent under the intolerable strain of supporting a dependence upon expensive illegal drugs of highly variable quality, I bit the proverbial bullet and sought treatment. At the time, this consisted of methadone prescribing guided by the principle of abstinence – the drug was prescribed in already low doses, which were compulsorily reduced to zero over a period of a few months.

This low-dose prescribing – there was a customary practice of placing a ceiling of 40mls a day on all patients – meant that the methadone, for myself and for almost everyone I knew (and I knew hundreds of addicts), was used to top up one's illicit heroin, or to get one through times when there was no money, or those rarest of occasions when the illicit supply ran briefly dry. Visiting the treatment service meant lying about one's use of street drugs (a recourse to which one was driven by the threat of 'therapeutic termination'), and endless arguments with a stressed doctor or demoralised key worker to try to avoid having one's dose cut still further. It was not, in short, a happy experience – for any of the protagonists.

The medical intervention, such as it was, did little to relieve the enormous psycho-social pressures and stresses into which the social and cultural phenomenon of addiction plunges the user and those with whom he or she is intimate. My phrasing is chosen consciously – for it is not so much the pharmacological effects of a substance like heroin that draws the user into the perfect existential storm, but the relations, routines and repertoires within which the drug is couched – the heroin complex, if I may put it so. The perpetual work of acquiring funds, buying drugs, and taking drugs really is the most exhausting of disciplines. It is the heroin complex that wrecks the body and unquiets the mind, and from which maintenance permits the user to escape. There is no guarantee

'The process of recovery from problematic substance use is characterised by voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'
UK Drug Policy Commission statement

'As one who is maintained on methadone myself, the recent chorus of voices calling for a greatly restricted use of the drug is profoundly alarming; I am distinctly uneasy at the prospect of my new life being snatched away... I believe it is time to speak out.'

that the user will make their escape, of course – they must be ready.

Any form of therapeutic intervention must alleviate this whirlpool, which generates such terrible anxieties and feeds back directly into the need for the drug. Some of those who are calling for a much more restrictive use of methadone do acknowledge a role for the drug in stabilising 'chaotic users'. However, stability is not easily defined, and reaching it does not take place according to a schedule imposed arbitrarily by clinicians or magistrates. A time-limit and compulsory withdrawal will, for many people, result only in a return to the illicit market and the appalling complex of stress it entails; it will result in escalating crime and infection, plummeting states of health and wellbeing, and revolving-door treatment.

Underlying the militant abstentionist notion of recovery is the moral judgement that drugs are wrong, bad and unnatural. This is a contention that they are perfectly entitled to make, although my personal opinion is that drugs are, like everything else in life, as good or as bad as the uses to which they are put. Drugs are not voodoo; they possess no magical qualities that make them different to other tools and materials.

I have argued here that, by and large, it is the drug's psycho-social complex which can lead people into serious harm. If one is absolved from the distress which follows on from it, it is perfectly possible to live a good life – and for now let's say that a good life is one in which one grows, experiences pleasure and satisfaction, but also a degree of pain and suffering, but which above all allows ones capacities and talents to unfold. It is quite possible to live such a life with a drug in one's body. I know because I've done it; and I've seen countless others who have done and are doing it too.

As for me, I eventually found a good private prescriber, with whom I developed an effective therapeutic partnership – one that endures to this day. My treatment does not cost the state a penny; moreover, I am working full time as a researcher and writer. And paying taxes. For me, being maintained works, according to any reasonable appraisal. There are many others like me, for whom the reliability and legality of their supply has meant that they are able to direct their attention to building satisfying and meaningful lives, while at the same time contributing to the communities in which they live. For us, the consequences of enforced abstinence would be genuinely disastrous.

Christopher Hallam is researcher at Release

Challengers to the UKDPC's inclusive definition are equally convinced that including the idea of 'controlled substance use' in the definition makes a nonsense of the term 'recovery'. Professor Neil McKeganey, credited with driving the 'drug-free' agenda, explains his view.

Consensus? What consensus?

'The UKDPC definition of recovery may fail… because politicians are increasingly coming to the view that whatever else drug treatment may achieve, the one thing that it must do is to help as many of its clients as possible to become drug free.'

Drug abuse treatment in the UK has been put under the microscope by the BBC Home Affairs editor Mark Easton in a series of interviews with Paul Hayes, Head of the National Treatment Agency. Within the context of those interviews Easton revealed to the public that barely three per cent of drug users in England completed their treatment drug free.

In the aftermath of that disclosure, the world of drug abuse treatment is faced with a tough choice. Either it is going to have to get much better at getting people off drugs, or it is going to have to persuade the government that abstinence is not the important measure when it comes to assessing the success of drug treatment. With the publication by the United Kingdom Drug Policy Commission of a consensus vision of recovery it would seem as at least one influential body is going down the second of those two roads.

The UKDPC has characterised recovery as 'voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'. This definition is likely to receive enthusiastic applause from many of those working in the drug treatment field.

On the face of it the definition has much to recommend it. For example, in talking about voluntary exercised control there is a sense in which the thorny issue of drug user abstinence has been effectively sidestepped. But how is control in this context being defined? Does this definition mean that an individual continuing to use illegal drugs but in a more controlled way can be considered 'in recovery'? Does it matter in terms of evaluating the effect of services if that element of control cannot actually be defined or measured? Does it matter if, as a result of this definition of recovery, we will not know whether the control that is being exercised is increasing, decreasing, or remaining the same over different lengths of time in treatment?

Aside from the difficulty of measuring the element of control, there is also the question of whose definition of control is going to apply in assessing whether the individual is indeed in more or less control of his or her drug use – that of the drug user, the doctor, or the addict's family? Also what happens if these people disagree in terms of their assessment of how much control the individual is indeed exerting over his or her continued drug use?

If the difficulties of defining control seem substantial, what about the difficulties of delivering on the other element of the UKDPC's recovery definition – maximising the individual's 'health and wellbeing and participation in the rights, roles and responsibilities of society'. These are grand terms, but what exactly do they mean? Do they mean that drug treatment services need to be enabling drug users to become good parents, to find work, to be housed, to vote, to understand current political issues, to be happier in themselves, to have better relationships with their families and friends, to not commit crime, to be greener in their lifestyle?

The list is potentially endless of the things that drug treatment services could see themselves doing which are all cumulatively about maximising an individual's sense of health and wellbeing. But how well placed are drug treatment services to take on these additional challenges when they have found it so difficult to take on the challenge of enabling individuals to recover from their drug dependence?

The UKDPC has been steadfast in its consensus-building process to stress that recovery is not about abstinence. The trouble with this view, however, is the simple fact that most people, even if they were to accept all the other elements of the UKDPC definition, would still wish to include abstinence or the progression of the individual to a drug free lifestyle as a key part of that definition.

In Scotland, for example, the Nationalist government has made recovery a key part of its new drug strategy. Recovery here has been defined as a 'process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society'. Importantly, the Nationalist government in Scotland have taken up the recovery issue not because they are fundamentally at odds with the achievements of the previous drug strategy, but simply because of a feeling that effective drug treatment has to be about enabling individuals to overcome their drug use and go on to lead lives that are not constrained in some fundamental way by their continued drug dependency.

The UKDPC's fear in relation to abstinence, however, has arisen in part as a result of a constellation of factors that are only in part to do with drug treatment. With a New Labour government less popular now than at any time in the recent past and a rejuvenated Conservative Party, we are possibly less than two years away from a change in government. The fear that some in the drugs field are now expressing is that an incoming Conservative government may seek to undermine the achievements of the harm reduction polices of the past by emphasising the importance of abstinence as the key element of effective drug abuse treatment.

It is perhaps relevant in this respect that the key players within the UKDPC movement are also those who have been fundamental to the development of a harm reduction approach in UK drug policy over the last 20 years. It is in a sense their own legacy that may be seen to be most in danger by a rejuvenated abstinence movement within the UK. If that is their fear, it can hardly have been reassuring for the UKDPC and its consensus group members to have heard Paul Hayes in his most recent BBC *Today* interview stressing that the goal of treatment has to be about enabling individuals to progress to a drug free life.

If that is the new thinking within government, then the UKDPC definition of recovery may fail – not because it has failed to win favour amongst colleagues within the drug treatment field, but because politicians of all parties are increasingly coming to the view that whatever else drug treatment may achieve, the one thing that it must do is to help as many of its clients as possible to become drug free. We may not, in this sense, have heard the last of the abstinence word.

Neil McKeganey, is Professor of Drug Misuse Research at the University of Glasgow

'The process of recovery from problematic substance use is characterised by voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'
UK Drug Policy Commission statement

Comment

While some readers were adamant that the UKDPC definition had to acknowledge maintenance prescribing as a valid route to recovery, others felt equally strongly that abstinence was its only real basis, and were concerned at putting 'continuing dependence' on a par with abstinence. And while some attacked the reasons and processes behind the working group, others welcomed the chance to stimulate debate in the interests of better outcomes for those needing help.

Condoning dependence

As former members of the Social Justice Policy Review Addictions Working Group, we are naturally pleased to see the impact of our reports, published in December 2006 and July 2007, on the serious debate finally taking place about effective treatment and that this debate has been traced back to their publication.

We are also pleased to see the value of abstinence-based approaches at least mentioned, though sadly still not targeted, in the government's new ten-year drug strategy. However, we have read with increasing bemusement some of the defensive statements provoked by the resurgence of the word 'abstinence' culminating in the recent article 'A new definition of recovery?' (*DDN*, 16 June, page 12), the UKDPC website statement and in the Guardian's interview with Paul Hayes, CEO of the NTA (*Society Guardian*, 18 June 2008, page 7).

The stated justification for the UKDPC focus group process has been with the 'polarisation' of the debate, a word cited three times in one article alone. But this is something of a spurious argument. The Addictions Report of the Social Justice Policy Review for example recognised the value of methadone in the treatment process if used advisedly and in the context of 'readiness for recovery' stepping stones. Equally they recognised the importance of optimally delivered public and personal health harm minimisation services.

But the evidence submitted was clear. It was that methadone too extensively used – to the detriment of other choices, options and innovations – could make recovery more difficult and even entrench addiction. The majority of industry witnesses felt very strongly that the current treatment balance was wrong.

We cannot see why such argument should be interpreted as polarising the debate. We can only posit that it touched on a raw nerve in relation to the uncertain outcomes of 20 years of harm minimisation.

Not only do we find that the UKDPC's championing of 'an overarching vision of recovery' that could be applied to all individuals tackling problems with substance use is a strange departure from the organisation's stated aim of presenting objective evidence based analysis of UK drug policy, but it's also unrealistic and a step in control too far. It is all the more odd when there appears to be no equivalent attempt to define 'addiction' or 'dependency', which presumably is the condition from which recovery is sought.

We could be forgiven for believing that such a process is designed to claim the 'high ground' – copywriting recovery into the existing treatment hegemony by putting abstinence, at best, on a par with continuing dependence.

It would be foolish for anyone to believe that the NTA has reached the golden fleece of treatment. Yet Paul Hayes still exhorted their recent conference not to be distracted by the 'siren voices' of those who call for abstinence to be included in the substance misuse treatment menu. It was, he said, a treatment that had failed in the eighties. 'We must carry on doing what we're doing,' he insisted (11 June 2008).

Is it not such refusal to give serious time and consideration to the possibility of and need for abstinence-based recovery that has polarised the debate, if anything?

'If we do the same thing over and over,' as Ed Khouri recently said, 'and expect different results, we are thinking like addicts.' (Ed Khouri, ISAAC Conference, October 2007.)

We all need to brace ourselves for this challenge and continue to reveal the inconvenient truth.

Andy Horwood, Kathy Gyngell, Prisons and Addictions Forum, Centre for Policy Studies

Sustained control is no recovery

As a teacher, I know from bitter experience that a sixth form student on illegal or psychiatric drugs is unquestionably a problematic substance user, and certainly headed down rather than up in terms of his career. So without doubt sustained control over his substance use can in no way be regarded as 'recovery', the clue to his lack of salvation being the continuing 'use'.

This I assume is what has led to your asking for comment on UKDPC's attempt to give 'recovery' a new definition, but rather than negatively subjecting their wording to the sort of criticism it deserves, I would like to propose the following:

'Recovery is the comfortable achievement of the restoration of the natural abstinence into which an individual was born. Processes attempting this are valid to the extent that they succeed with a high degree of certainty, over a reasonable period, at moderate cost and in a majority of cases.'

It's likely that this wording can be fine-tuned, but for the addition of only 50 per cent more words than UKDPC, it seems to get the right concept across.

Elisabeth Reichert, school head.

Widen the definition

I am happy to recognise the work of Professor John Strang and colleagues on the 'consensus panel' that produced the statement on recovery presented at the NTA's recent conference. I think that such an exercise helps to stimulate important and timely discussions which must ultimately aim to bring the greatest possible benefit to those who seek our help.

I have two thoughts to offer:

Although I realise that there is a great danger of driving each other around the semantic twist by nit-picking over every word of the statement, I would like to offer an alteration that might achieve two things:

1. Defuse any friction that might be caused by the use of the phrase 'control over'.
2. Encompass all the significant others affected by substance misuse for whom recovery has a meaning just as real as if they were the users.

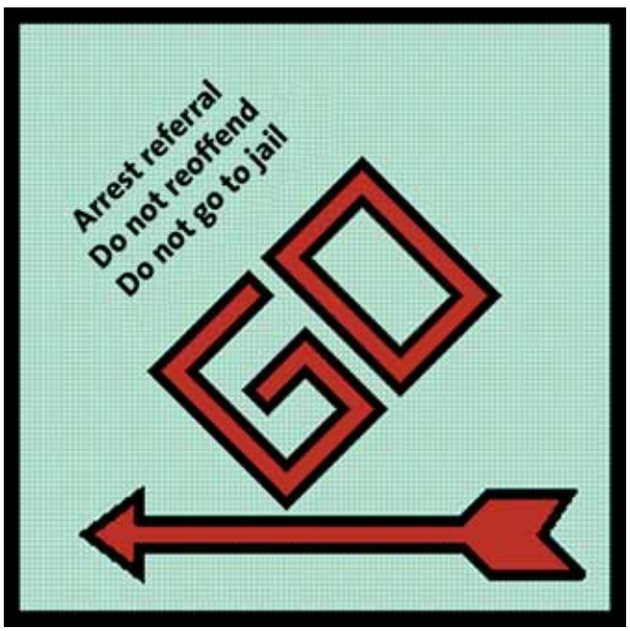
I suggest that the statement could therefore read:
'The process of recovery from problematic substance use is characterised by a voluntarily sustained change in the relationship to substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'

You don't have to live too long to discover that interpersonal relationships are many and varied, ranging from those that are obsessive, volatile and intensely consuming to ones of deliberate detachment and non-involvement. Don't people's relationships to substance use cover a similar spectrum?

My other thought is that we tend to talk about recovery 'from' but I think we should also recognise that a process of recovery includes recovery 'of' hope, faculties, judgement, health, confidence, interest, competence, generosity, relationships, freedom, choice.

Nick Barton, joint chief executive, Action on Addiction

Harm reduction can have a positive impact in steering people out of the criminal justice system as long as the directions are clear, says **Andy Stonard**



Passing go

For the new drugs strategy to work, the key interventions depend on engaging an individual effectively from first contact with a service. That contact needs to establish a real sense of addressing physical or psychological harm – and within a criminal justice setting it has to show that it can slow or change behaviour, break cycles and look at some simple steps that will demonstrate progress.

Essentially what we are all charged with is stopping drug and alcohol users offending. In Scotland the Drug Courts make a very strong link between drug use and treatment with sentencing and use the court as the centre stage for attempts at rehabilitation. In England this link is not strong and instead tries, through arrest referral and the courts, to divert to treatment.

Harm reduction and assessment within arrest referral and the courts has to assess not only charging and sentencing, but to look at what type of sentencing or court order would be most effective and supportive to the drug or alcohol user. Alcohol treatment orders can be highly successful, as can drink driving courses; for some offenders a sentence can simply arrest behaviour that is becoming increasingly difficult and problematic. Then through the Integrated Drug Treatment System, the theory is that the care plan can take them from prison to rehab or community treatment – including prescribing if required.

However, the theory is never as easy in practice. Arrest referral could be made more effective through looking at varying practice, and considering how visits to individuals' homes rather than a simple referral process to a service can increase take-up. This involves looking at when and how individuals use or drink; their combinations, especially with prescribed drugs; creating daily diaries; and looking at triggers, behaviour and cognitive processes. To do this effectively, staff need to have the necessary skills in motivational interviewing, relapse management and prevention and to be able to try to support the individual in setting small but achievable daily goals, even if it means using or drinking half an hour later in the day.

The obvious harm reduction processes are of course trying to reduce drug use and risk behaviour and increasing prescribing options and healthcare. The more subtle ones come with teaching self-understanding of the psychosocial processes that are at work, and over a period of time to assist in the self-questioning of certain behaviours and lifestyles and what could be achieved potentially.

Abstinence may well not be an immediate goal, nor achievable, nor wanted – but then neither should prescribing necessarily be seen as any of these. Harm reduction, like Alcoholics Anonymous, is about assisting someone through their current day and then looking at what is feasible over the next week and so forth, until the bigger picture becomes clear.

To properly support this, staff need to really understand what happens chemically in their client's head – down to what a fiver or a tenner in their pocket can mean. They need to understand about working with the cycle of change, be able to assess whether residential rehab could work, look at what type of prescribing would best suit each person, and consider what responsibilities an individual can take on without failing.

Employment and training schemes need to become increasingly integrated with drug treatment, and there are wonderful examples of where this works brilliantly. But equally important for these most vulnerable of clients, harm reduction must be integrated to the criminal justice system, with its workers becoming key partners in the harm reduction process.

Within the prison service, the new Integrated Drug Treatment System was hailed by John Podmore, senior operational advisor for Offender Health, as 'one of the most significant developments in recent years', which would provide better clinical services such as improved detoxification and drug maintenance programmes, alongside greater continuity of care through the journey through prison and back into the community. 'It will help offenders address some of the deeper roots of their substance misuse,' he said.

With the expected levelling of drug sector funding, effective partnership working has never been more crucial in making sure harm reduction is not trampled beneath the inevitable number crunching, acronyms and punitive rhetoric.

Next month's conference organised by the Conference Consortium (a group of NGOs advocating for better drugs policy and practice) will bring together drug and alcohol workers and those in the criminal justice field to look at how harm reduction can run right through the system – from arrest and the courts, through prisons, probation and aftercare, to community treatment programmes.

Harry Fletcher, assistant general secretary of the National Association of Probation Officers (NAPO), commented: 'The ability to offer an effective service to clients has been hampered in recent years by the government's preoccupation with targets.' The conference, he said, would be 'an ideal opportunity to discuss how we work in partnership, which improves the quality of life for the individuals we are in business to help reform and rehabilitate. The emphasis will be about changing lives, not controlling them.'

Andy Stonard is chief executive of Rugby House and a member of the Conference Consortium.

'What about harm reduction? – Drugs, alcohol and criminal justice' conference will be on 17-18 July at Warwick University. See www.conferenceconsortium.org for details.

Louise Olson looks at the economic argument for offering methadone maintenance

Why bother...?

The National Institute for Health and Clinical Excellence (NICE) has advised the NHS that drugs used to treat moderate and late stage Alzheimer's disease are not to be distributed to those patients suffering from mild symptoms. The NHS will not pay this mere £2.50 per day for these sufferers but will prescribe methadone quite freely to heroin addicts. Is this fair when treatment with methadone costs as much as £8.22 per day?

This question is highly debatable. A Home Office official stated in 1982 that 'addicts have no rights simply because they are addicts'. Heroin use is self inflicted, not an illness, so why should £3,000 per year, on medication alone, be spent on these people? Wouldn't money be better spent worldwide developing medicines for terminally ill patients? Or in attempting to solve the 'postcode lottery' which exists in the UK for many of our so-called wonder drugs?

To fund their £12,000 annual habit, each UK heroin addict commits roughly 432 crimes each year, creating £45,000 in damage costs. Disturbingly, 60 per cent of crime in the UK could be drug-fuelled and as it could be argued that addiction parallels illegal activity, these criminals should be punished, not assisted. Shouldn't we just lock them up and throw away the key?

As easy as it is to criticise the management of those who have been unfortunate enough to become addicted to this opiate, governments do choose to support heroin rehabilitation. There are approximately 300,000 British, 900,000 American and 385,000 Australian heroin dependents, according to statistics from each government.

Methadone treatment is economically beneficial. Drug-related crime has decreased by 20 per cent since 2003 and more than 1,900 drug-misusing offenders enter treatment each month through government led UK 'Drug Intervention Programmes'. For every £1 spent on treatment, £9.50 is estimated to be saved in criminal justice and health costs, which is equivalent to a massive £78.09 saving per day per patient. Each day in America, 210,000 people are prescribed methadone and the economic benefit to cost ratio is 4:1. More than 70 per cent of heroin addicts registered on methadone programmes in America have reduced or eliminated criminal activity in their first year of treatment.

These savings have a major impact, not only financially for the individual and governments, but also assisting in getting a life back on track with improved personal relationships, employment and social status. Families and friends also benefit from treatment as they have suffered the addict's use. Home Secretary Jacqui Smith, speaking in July 2007, recognised that record numbers were entering treatment programmes, but said it remained vital to ensure that treatment was effective and the young were educated. The National Institute of Drug Abuse in America found that people receiving methadone maintenance treatment (MMT) decreased their weekly use of heroin by 69 per cent and full time employment increased by 24 per cent. This strongly suggests that MMT is working effectively in achieving the desirable goals of reducing heroin use and getting drug users back to work.

For over 30 years methadone has been regarded as the gold standard therapy in treating opioid addiction. Yet critics view MMT as 'substituting one drug for another'. Methadone also has a greater addictive potential than heroin and if treatment is withdrawn, more than 80 per cent of patients will relapse to heroin use within one year of terminating the treatment. So why bother? Methadone and heroin do have different properties. Methadone aims to treat the addiction motivated behaviour and cravings experienced by heroin addicts and can allow the individual to lead a 'normal' life.

Since 2001, an expensive alternative, buprenorphine has been offered. Controversially, heroin itself could be the best detoxification method and is currently undergoing trials within the NHS. Careful monitoring would reduce effects associated with impure heroin and dirty practices. Why not complement current needle exchange centres with heroin distribution? Apart from creating glorified drug dealers out of our health services, heroin costs an enormous £12,000 per year as opposed to the £3,000 for methadone per person. Also methadone is administered orally, therefore relatively safe as opposed to smoking or injecting heroin.

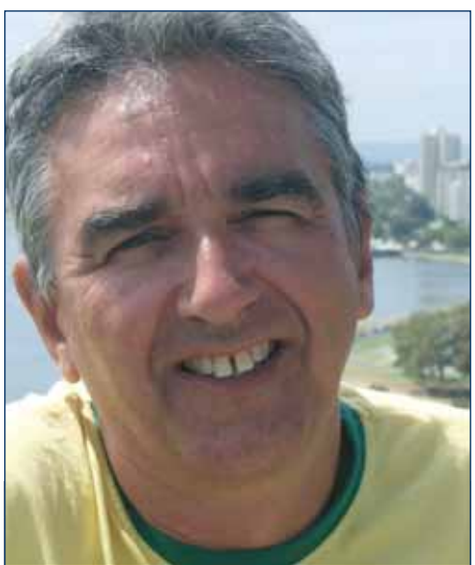
MMT programmes allow monitoring of family relationships, including quality of parenting and domestic violence. Also, by offering comprehensive advice and testing for hepatitis C, HIV and sexually transmitted diseases, the prevalence of these conditions are likely to decrease. Social support networks and counselling can assist with personal difficulties. American studies have found that of those addicts in MMT, 48 per cent have serious depression and anxiety issues. Therefore, by governments funding the treatment for heroin addiction a whole array of problems can be addressed. However, society's perception of any addiction still remains prominent – that addiction is a preventable, immoral behaviour.

The stigma surrounding heroin addiction will seemingly never be overlooked by some, creating this debate around the world as to whether health services should finance rehabilitation. Any decision on rationing healthcare and prioritisation of commissioning different areas of the health service is a difficult one but it needs to be made objectively and without prejudice. However, whatever individual feelings are we cannot escape the fact that there are overwhelming financial and social gains to be had from treatment which we cannot afford to ignore.

Louise Olson is a third year medical student at the University of Manchester, who has had work experience with Calderdale Substance Misuse Service. Full references are available for this article – email claire@cjwellings.com for the referenced version.

A journey into and out of heroin addiction

In his last Background Briefing, Professor David Clark began the story of Lydia's journey into addiction. In this Briefing, he hands over to the imaginary character of Lydia, to explain how addiction took control of her life, and her first experiences of treatment.



'Trying to juggle being in treatment and getting enough money for my heroin habit was really difficult.'

To begin with, using drugs was great. I had a great laugh with my friends, and it made me feel good about myself. It helped me to forget all my worries and the things that had happened in my life.

When I found heroin I knew that 'this was the one'. It made me feel like I was wrapped up in a warm blanket with not a care in the world – who wouldn't want that?

But those feelings didn't last for long. Soon things went from bad to worse. It wasn't until I had my first cluck that I even realised that I was taking heroin because I needed to, not because I wanted to.

I didn't want to experience another cluck so I did my best to make sure I had enough money to support my habit. I began committing crime – I couldn't see any other options.

It didn't take long before I got caught shoplifting. I was having a bad day and was feeling rough. All I wanted was enough money to get a bag, and then I could sort myself out. I was lucky. I got away with a caution. At the police station all I could think about was my next hit, and how I was going to get the money for it.

Before long, the shoplifting started to catch up with me. My face was being recognised everywhere, and I was banned from a number of shops. It was getting harder and harder for me to make enough money to feed my habit.

I began to get in more and more trouble with the police. The first couple of times I was arrested I got away with cautions and fines. The police got to know me and about my drug use. They looked down at me, treated me like I was a piece of scum.

Eventually, I was made to go to court for a number of shoplifting charges. I was sentenced to a big fine, which I had no hope of paying, and offered the choice between a prison sentence or drug treatment. Well, there was no choice really! I had to attend treatment every day and I was put on a methadone script.

At first, I thought that treatment was going to help sort me out. In a way I was quite glad that I had finally been made to go. My addiction was taking over, and I was losing far more from it than I had ever gained. I knew I needed help to kick it.

I had heard about methadone, but I wasn't too sure about going on it. People had told me that it was more addictive than heroin because it seeps into your bones. I was also told it would rot my teeth.

I didn't really have a choice – it was either methadone or prison, so I thought I would give it a go. I wanted something that would help me change my life. I needed something, because no matter what I tried on my own, I just didn't get anywhere. Hopefully, methadone would be that something.

I thought methadone was going to help me to stop using heroin, but it didn't turn out that way. I started on a low dose and was even told to use heroin on top! I couldn't understand that – why not just give me a proper dose of methadone? I thought the whole point was to stop using smack, not to use smack and methadone?

I knew that I was an addict, I even understood that there were events in my past that shaped me into what I was – but what I didn't get was, why couldn't I stop? I felt let down that methadone hadn't worked for me. I'd gone along to the treatment place every day, so it wasn't as if I didn't try. If methadone didn't work, then what would?

It was starting to look like I'd never kick heroin. The only time I could even half cope with life was when I was using. So that's what I did.

Trying to juggle being in treatment and getting enough money for my heroin habit was really difficult. My days were taken up with being at the treatment centre, so I had to take risks to get money in the evenings. It was becoming increasingly difficult, but I couldn't see a way out. I felt like I was losing even more control of my life.

Whilst in treatment I met some good people. There was one girl who I really looked up to. She always looked so smart, with nice clothes and make-up. She really took me under her wing. I learnt that she funded her drug use with street work. She explained how much money I could make, and I began to see a future for myself. I thought that if I could get enough money to move away and get myself a nice flat then I could kick the heroin once and for all...'

Written by Lucie James and Kevin Manley of Wired In.

University of Kent | Kent Institute of Medicine and Health Sciences (KIMHS)

Training for Drug & Alcohol Practitioners

Programmes from 2008/09

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 practitioners who work with problem substance users, or expect to in the near future. The programme is delivered in Canterbury and across the UK where there are cohorts of 10 or more students. It is a recognised benchmark for those seeking an accredited qualification. The programme also offers beneficial training for all social, health and education professionals whose work includes contact with problem substance users.

18 month programme from September 2008 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 2008 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the biological, psychological and social perspectives of substance misuse, within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions, against the backdrop of current research and thinking in the field.

2 year programme from October 2008

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 implementation of a small research project. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. POST-GRADUATE RESEARCH OPPORTUNITIES are also available in this area of study.

2 year (top-up of Diploma) or 4 year programme from November 2008

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

Design & Print Centre 105884 02/08

HALTON BOROUGH COUNCIL

Safer Halton PARTNERSHIP
a member of the Halton Strategic Partnership

INVITATION TO TENDER

HALTON Substance Misuse Service (HDAS – HSMS)

Halton Drug & Alcohol Team, on behalf of the Safer Halton Partnership and Halton & St Helens PCT, is seeking expressions of interest from suitably qualified and experienced organisations to provide a fully integrated substance misuse service.

The successful organisation will have a strong, proven track record in achieving a change in the culture of the workforce with the outcomes of delivering a high quality service that is organised around meeting the needs of individual service users, actively supporting social inclusion and sustained recovery, and effectively contributing to protecting families and communities. Applicants will also need to evidence their ability to work creatively and effectively with a range of partner organisations that can also have a positive impact on service user's lives.

The contract will initially be for 3 years, with an option to extend for 1 further year, dependant on performance, revenue and national/local policy.

For organisations committed to supporting service users achieve choice and independence in their lives, this is an exciting opportunity to offer more than a prescription.

Stage 1 Expressions of interest must be submitted via e-mail by 4pm, 14th July 2008 to Elaine Fogg, Contracts Officer, e-mail elaine.fogg@halton.gov.uk.

All interested parties will be invited to attend a Consultation meeting / question and answer session from 12.30pm, Monday 4th August 2008, Civic Suite, Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD.

Stage 2 All interested parties will be required to complete a Pre-Qualification Questionnaire, the responses to which will be assessed to compile a short-list of parties to whom the final tender documentation will be issued.

The deadline for receipt of the PQQ is 4pm, 18th August 2008

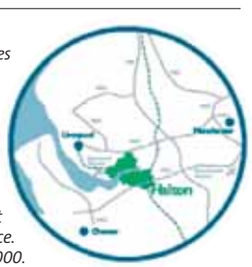
Stage 3 Tender documentation will be sent to the selected applicants week commencing 25th August 2008. The deadline for return of tender applications is 29th September 2008.

Under no circumstances will late applications be considered

Stage 4 Applicants are asked to note that interviews will take place week commencing 20th October 2008.

Please note that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) will apply to this service. The aim is for the new service to be operational by 1st April 2009. The duration of the contract will be a minimum of 3 years and no longer than four years and subject to future funding allocations.

HALTON:
The borough of Halton in Cheshire is made up of two towns - Runcorn and Widnes – situated between Manchester and Liverpool and linked by the River Mersey. The two towns are joined by the well-known Silver Jubilee Bridge – the only river crossing between the Mersey tunnels in Liverpool and Warrington. However, the Council is the lead agency in the Mersey Crossing Group, which is currently lobbying for a new Mersey Crossing. Halton Borough Council has been awarded Beacon status for Improving Urban Green Spaces, Better Local Public Transport and Planning for Business. The Council has been awarded an 'excellent' rating in a recent CPA inspection and won a Local Government Chronicle Award for its innovative Benefits Express – a mobile benefits service. There are 51,350 households in the borough and a population of just over 118,000.



SOUTHAMPTON CITY COUNCIL

TENDER FOR THE PROVISION OF AN ADULT COMMUNITY BASED DRUG ASSESSMENT AND CARE CO-ORDINATED CARE PLANNED TREATMENT SERVICE AND RAPID PRESCRIBING SERVICES

Southampton City Council ("the Council"), on behalf of Southampton Primary Care Trust and Southampton Drug Action Team, invites expressions of interest for the provision of a Tier 3 Rapid Prescribing, Substitute Prescribing and Care Co-ordination Service to residents of Southampton who are adults over 18 years.

The Council intends to award a contract with an annual value of approximately £1 million following a two-stage, restricted tender process starting with a Pre-Qualification Questionnaire stage. Providers will be required to demonstrate a proven track record of delivering high quality services to this client group, either in Southampton or in other local authority areas. Successful providers will also be required to demonstrate flexibility in their approach to the development and provision of Services, in line with the requirements of the new ten year drug strategy and the new funding arrangements for drug services introduced by the Department of Health and the National Treatment Agency for Substance Misuse. Following award, the successful provider will be expected to work closely and co-operatively with other providers in the drug treatment system in Southampton to ensure the most effective delivery of drug services.

The contract will run for a period of five years and may be extended by a further two years at the sole discretion of the Council.

It is anticipated that the Transfer of Undertakings (Protection of Employment) Regulations 2006 will apply to this contract award.

Whilst every effort has been made to consider the full scope of the requirement, the Council does not guarantee the volume of Services required resulting from this tender or that it will accept any tender on completion of the tender exercise.

Organisations wishing to express an interest or requiring further information should contact Ben Cook on Southampton tel: (023) 8083 3968, email: ben.cook@southampton.gov.uk

Completed questionnaires must be returned to: procurement@southampton.gov.uk by no later than 16.00 on Thursday 31st July 2008.

The Council undertakes to use reasonable endeavours to hold confidential any information provided in the proposal submitted, subject to the Council's obligations under law, including the Freedom of Information Act 2000. If the applicant considers that any of the information submitted in the proposal should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The Council will then consider the sensitivity statement before replying to any request received under the Freedom of Information Act 2000.

Tender documents or notice of non-acceptance, as appropriate, will be sent to all applicants.

The Open University

FDAP/Alcohol Concern Assessors and Verifiers

Introduction
The Open University VQ Assessment Centre is looking for qualified assessors and verifiers to help them, on a consultancy basis, to deliver a suite of vocational awards based on the DANOS units. These awards, ranging from three to ten units, have been developed in conjunction with the Federation of Drug and Alcohol Professionals and Alcohol Concern. The awards are designed to recognise and demonstrate the competences of managers and practitioners in the drugs and alcohol field - in line with the DANOS-based competence framework.

Job specification
Most assessment relating to these awards is desk based although we may have opportunities for assessors to visit groups of candidates on site to run 'Getting started' and support sessions. As a consultant assessor, you will be required to assess a case-load of candidates, enabling them to achieve their qualification.

It is essential that you already have the D32/D33 or A1 assessor, or the D34 or V1 internal verification qualification. You must also have at least two years of occupational experience within this sector and have evidence of assessment activity within the last 12 months.

The amount of work you will be offered will be dependant on the number of candidate registrations that the centre receives at each of its quarterly registration periods.

Closing date: 30 July 2008

If you are interested in working with us, please email nvq-enquiries@open.ac.uk attaching your most recent CV, an outline of your sector and assessment experience, an indication of the number of candidates you feel you will be able to support and the geographical area within which you may be able to visit candidate's on site.

DRUG & ALCOHOL TEAM MANAGER
£29,728 - £34,991 PER ANNUM
NEWBURY

Grade J, 37 - 43 (pay award pending)

The West Berkshire Safer Communities Partnership is recruiting a Drug & Alcohol Team Manager to continue the DAAT's excellent performance in this area and further improve outcomes for our service users and carers.

SAFER COMMUNITIES PARTNERSHIP West Berkshire

You will be part of the newly formed Safer Communities Partnership Team, which comprises staff from Thames Valley Police, Sovereign Housing Association and West Berkshire Council.

Your role will include:

- Co-ordination of the commissioning of drug and alcohol treatment services
- Ensuring that the DAAT is an effective partnership, delivering drug, alcohol and crime targets
- Ensuring effective action planning and efficient allocation of funding to local services.

Previous experience in a DAAT, community safety or social policy role is required, along with experience of commissioning of statutory or community services and the management and monitoring of service level agreements.

For an informal discussion about the post, please contact either Susan Powell on 01635 264703 or Rachel Craggs on 01635 264617.

For an application form please call 01635 519122 or email recruitment@westberks.gov.uk quoting the post reference number 00879. CV's will not be accepted.

Closing date: 16 July 2008.

West Berkshire Council is an equal opportunities employer and we are committed to providing equality of opportunity to all.

our values: AMBITION, INTEGRITY, RESPECT

www.westberks.gov.uk West Berkshire Council

rugbyhouse
alcohol & drug services

horizon training & assessment centre

PART TIME PROJECT DEVELOPMENT WORKER
Salary: NJC Point 30 - 34 (£27,724 - £30,773)
including London Weighting (Pro Rata). REF: CJU/SPD/J01
(28 hours per week including some weekend working)
BRIEF INTERVENTION PILOT- Based in Leytonstone
Fixed Term contract until March 2009

This is an exciting project that aims to measure the effectiveness of Brief Intervention therapy on the drinking and offending behaviour of those committing alcohol related offences. You will take the lead in developing relationships with key stakeholders including police, courts and domestic violence services, creating referral pathways, and in delivering and evaluating interventions. We are seeking a highly motivated self-starter with excellent communication skills and project planning ability:

- Minimum of 2 year's experience in substance misuse, social care, nursing or a research background.
- Experience of working with different stages of change.
- Ability to be self motivating and manage own workload and use your initiative.
- Good communication skills, and ability to write clear concise report, and implement monitoring and evaluation systems.
- Understanding of the key principles of Brief Interventions.

NVQ ASSESSOR AND TRAINER
Salary NJC point 26- 30 (£24, 591 - £27,724)
including London Weighting (Pro Rata)
Working hours – 35 hours
Based in Central London.
Initial 10 month Contract.

This post is based in Horizon – Rugby House's specialist substance misuse training & assessment unit and the post holder will work alongside the Workforce Development Manager in the delivery of internal and external qualification and training programmes. The post involves carrying a caseload of staff through various qualifications and awards including the NVQ, DANOS, and Common Induction Standards.

The Person:
We are looking for an individual with drive and commitment with the following qualifications and experience:

- NVQ Assessors Award.
- At least 1 year's experience of working as an NVQ Assessor within substance misuse field.
- Experience of delivering training.
- Knowledge and understanding of alcohol & drug related issues.
- Knowledge and understanding of the relevant theories and approaches used in alcohol & drug treatment.

For more information or to request an application pack, please email: jobs@rugbyhouse.org.uk or visit our website to download an application pack.
The closing date for all applications is 12:00noon Monday 7th July 2008

All advertised posts are subject to Criminal Records Bureau enhanced disclosure.
Rugby House is an equal opportunities employer and welcomes application from all qualified candidates.

www.rugbyhouse.org.uk

Development comes as **standard.**

One of only 30 UK PCTs with teaching status, Heart of Birmingham is harnessing the power of people. By recognising everyone's potential, we can make progress in improving the health of the diverse local community we serve.

Birmingham Drug and Alcohol Action Team, Aston

You will work as part of the DAAT leadership team to ensure an integrated approach to the delivery of the drug and alcohol agenda across Birmingham. You will play a key role in influencing service redesign and service improvement to meet differentiated needs of a diverse population. Accountable to the DAAT Strategic Lead working across the health and wellbeing, criminal justice and community safety arena, you will champion improved outcomes and ensure LAA and national targets are achieved.

Qualified to degree level with extensive experience as a manager in a multi-stakeholder environment, you will have experience of commissioning in health, social care or criminal justice arena; with a proven track record in developing effective partnership working.

Lead Commissioner for Drug Treatment Services

Band 8b £42,064 - £52,002 per annum **Ref: 158/08**

You will manage a multi-disciplinary Treatment Team and will have lead responsibility for the commissioning, contracting and performance management of drug treatment services across the city. You will work with a range of stakeholders, partners and service users to co-ordinate the delivery of the Adult Treatment Plan.

Interview date to be confirmed.

Alcohol Coordination and Commissioning Manager

Band 8a £36,112 - £43,335 per annum **Ref: 153/08**

You will have lead responsibility for the commissioning, contracting and performance management of alcohol treatment services across the city and will work with a range of stakeholders, partners and service users to co-ordinate the delivery of the Birmingham Alcohol Strategy.

Closing date: 14th July 2008.
Interview date: 25th July 2008.

To apply please visit www.jobs.nhs.uk and click apply now. Alternatively, for an application pack please visit our website at www.hobtpct.nhs.uk contact the Human Resources Department on 0121 255 0500 or email HR.Recruitment@hobtpct.nhs.uk quoting the appropriate reference number. Further copies of the application form in accessible formats are available upon request from the Human Resource Department.

HoBtPCT is an Improving Working Lives Practice Plus accreditated employer, that values the contribution of staff to improved patient care. The Trust is committed to equality of opportunity, life long learning and work-life balance for all our employees. All Trust premises have been designated com pletely 'smoke free' since the 1st June 2006.

Heart of Birmingham Teaching NHS
Primary Care Trust

www.hobtpct.nhs.uk

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adapt

HM PRISON SERVICE
Eastern Area

Area Manager, Eastern Area

Starting Salary £29,000-£31,000pa

ADAPT, a national provider of drug and alcohol treatment service in custody and the community, require an experienced Area Manager to be responsible to the Head of Custodial Services for the operational delivery of drug treatment services within a custodial setting in the eastern area. The post is demanding, but rewarding. Working in partnership with key stakeholders, you will ensure that ADAPT's contractual obligations are met and be pro-active in developing the service and taking forward good practice. You will need to be confident and capable, working as part of the operational management team as well as on your own intitative.
You will need to evidence:

- sound knowledge of key legislation relating to the field of substance misuse, and the ability to translate this into practice
- a minimum of two years supervisory and team management experience and five years of working in the substance misuse field
- a track record of developing existing and new frontline services
- ability to communicate appropriately at all levels
- analytical and report writing skills to a high standard
- willingness to take direction

It is essential that you own a car, have a clean driving licence and are prepared to travel daily to Establishments over a wide geographical area.

To request for an application pack please email adapt.ltd@btconnect.com, quoting reference E-16-08 the closing date for receipt of applications is 14th July 2008. Interviews will be held week commencing 21st July 08

HAGAM

HAGAM is an Uxbridge-based BACP-accredited agency providing counselling, advice, complementary therapies and group support for adult substance misusers and the wider community affected by substance misuse

We are pleased to invite applications for the following opportunities in HAGAM:

Head of Counselling

Hours: ***37.5 hours per week*** *(Job-share will be considered)*
Salary scale ***£29,958 - £33,403*** *(Dependent on experience)*

This is an exciting opportunity for a motivated and proactive individual to lead HAGAM's counselling service by combining effective management and direct delivery of counselling and group work. You will join an enthusiastic small team which is committed to making a difference to the lives of those affected by drugs and alcohol misuse.
Candidates will be experienced counselling professionals with clear commitment to ethical and professional frameworks. They will hold a diploma or equivalent qualification in counselling and be accredited by BACP. Candidates are expected to have 2 years experience of counselling substance misusers and 1 year management experience.

Counsellor

Hours: ***18.5 hours per week***
Salary scale: ***£25,520 - £27,096*** *pro rata*

We are seeking a counsellor qualified to diploma level with 2 years post qualifying experience to join our team of counsellors. We welcome applicants from all theoretical backgrounds.
The post-holder will offer substance misuse counselling, assessment, care planning, and occasional group support to vulnerable adults with alcohol/drug problems.
You will have experience of working with substance misusers and have offered a minimum of 100 hours of face to face counselling to clients. Experience of counsellor supervision and facilitation of groups will be advantageous.
Relevant training, support and professional development opportunities including clinical supervisor training will be offered.

Closing date for both vacancies: **5pm Monday 14th July 2008**

For further information or to request an application pack please contact us on 01895 207 788 or email help@hagam.org.uk. Alternatively application packs can be downloaded from our website www.hagam.com

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Please mention DDN when replying to adverts

WDP is a leading substance misuse treatment provider delivering a variety of services across a number of London boroughs and two neighbouring counties. We are currently looking for committed and passionate people for the following exciting roles.

Arrest Referral Workers

£23,088 pa (subject to negotiation dependent on meeting core role requirements) • Various locations
We have a number of vacancies for Arrest Referral Practitioners. You'll be working in police stations to assess the needs of drug users and refer them in to the appropriate treatment.

Throughcare and Aftercare Practitioners

£23,088 pa (subject to negotiation based on meeting core criteria) • Various locations
These exciting roles will offer you the chance to make a real difference to the lives of our clients. You will assess and support drug users within the community and criminal justice system to maximise their uptake of treatment services'. You must be committed, hardworking and highly motivated with experience of substance misuse, related health issues and evaluating care plans.

Sessional Workers

£15 ph • Various locations
As part of our ongoing recruitment programme we are looking to expand our bank of flexible sessional workers to cover short term vacancies across a number of our London projects. We are looking for candidate with a proven record within Arrest Referral and Through Care After Care roles who are dedicated to making a difference to the lives of our clients

Closing date: 14 July 2008

For more information and to apply for this role, please visit our website.

If selected for an interview, please advise us of any specific considerations or adjustments required as a result of a disability defined by the Disability Discrimination Act 1995 (2005). This request should be put in writing providing details of your specific requirement(s).

www.wdp-drugs.org.uk

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

K·C·A
Services in the Community

Operating in the drug & alcohol and mental health sectors, KCA (UK) provides a wide range of high quality and innovative specialist services for adults and young people. The organisation provides services from over twenty service bases across Kent, Surrey and the London boroughs, employs approximately 300 paid and unpaid staff and has an annual income exceeding £10.5 million.

OPERATIONS MANAGER – YOUNG PERSONS' SERVICES

Drug and Alcohol Services – Kent & Medway
Salary £34,991 – £42,681

(SCP 43 – 52) (pay award pending). Essential Car User Allowance.
Ref: 491 – Based in Kent. 37 hours per week.

The role offers a stimulating combination of tasks, including Service Manager support and project management covering quality, performance and operational issues. You will play a key part in ensuring contractual compliance and assist in service development work.

You will be able to evidence:

- Extensive knowledge of services for young people with substance misuse problems.
- Staff performance management and service management experience
- A sound grasp of business and strategic planning
- An appropriate professional qualification.

Should you wish to discuss this opportunity informally, please call Peter Gallagher or Claire Goulding on 01795 590635 or e-mail peter@kca.org.uk or claire@kca.org.uk

For an application form and information pack, please contact: KCA (UK), Dan House, 44 East Street, Faversham, Kent ME13 8AT. Tel 01795 590635, Fax 01795 539351, email recruitment@kca.org.uk, website www.kca.org.uk.

Closing date: 13th July 2008
Interview date: 21st July 2008

KCA (UK) is committed to the principles of equality of opportunity for all and welcomes applications from people with experience of substance use or who have had previous problems with substance misuse. Charity No: 292824

All staff enjoy ■ Part-time, full-time and term-time only roles ■ Flexible retirement policy ■ Childcare vouchers ■ Great training and development

Welcome to people like you

Chief Executive's Department

Governance and Quality Manager
£27,594 - £29,726 Ref: 20869
Full time, permanent
Based at Bedminster

The Safer Bristol Partnership is responsible for developing and delivering the crime and drugs agenda in Bristol's diverse, multi-cultural urban environment.

Following the promotion of the current post-holder, we are seeking a creative and energetic Governance and Quality Manager, to work within Drug Strategy Team at Safer Bristol Partnership to lead on the development of effective drug Treatment Services within Bristol.

You will take the lead in developing clinical governance mechanisms, in establishing processes for quality improvement and coordinating the work to ensure that Drug Treatment Services develop in accordance with the Models of Care Framework.

You will need to have specialist knowledge of the Models of Care Framework, a thorough and up-to-date knowledge of the field of drug treatment and the ability to analyse and interpret legislation and statutory guidance.

The ability to motivate behavioural change and negotiate are essential requirements along with the ability to think strategically, critically appraise and analyse national guidance and research for local implementation.

Closing date: 16 July 2008.

Our preferred method of application is online, if you are unable to apply online, please call 0117 922 4499. To apply in person, please visit our City Jobshop at 38 College Green. Our full range of opportunities are available online.

www.bristol.gov.uk/jobs

Our city a great place to work

Please note we cannot accept CVs. Applicants must be either EU nationals or hold a current permit that will enable them to work in the UK.

At Bristol City Council, we value having a workforce as diverse as the city we serve. We therefore welcome, develop and promote people from all sections of the community.

BRISTOL CITY COUNCIL

CRI

Warrington Substance Misuse Service

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

DIP Worker *(Ref NM060)*

37.5 hours per week
Salary £23,387 to £25,130

An exciting opportunity has arisen to join Warrington Substance Misuse Service DIP team and to be part of an innovative, integrated treatment service based in Warrington. The successful candidate will provide comprehensive arrest referral cover within the Warrington DAT partnership area. You will also contribute to outreach and attrition services for the hard to engage clients and those who have disengaged from treatment. Clients will be identified in the community and through pro-active contacts carried out in Police/ Magistrates custody, Prisons and post-community sentences. The successful candidate will have an excellent understanding of substance misuse and related offending and a sound knowledge of the Criminal Justice System. A professional qualification (or equivalent) would be an advantage, although not essential.

For further information please contact Damien Grainer, Service Manager or Carl Roberts, Team Leader on 01925 415176.

Closing date: July 14th 2008

For an application pack and further information visit: www.cri.org.uk or call our recruitment line on 0113 380 4643 (24 hour answer phone) quoting the relevant reference number.

The successful candidate will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

INVESTOR IN PEOPLE

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.

Safer communities, healthier lives Registered Charity No: 1079327