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DDN
Drink and Drugs News

31 July 2006
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PRESCRIBING CHANGE
Nurses get to grips with new legislation

MENU OVERHAUL
Introducing nutritious food to clients in recovery

HIDDEN EXCESS
Dr Chris Ford finds medical students surprisingly useful

RAISING THE BARRIERS

Lincolnshire outreach goes one step further to improve service access

PLUS: Residential Treatment Directory

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A ONE DAY CONFERENCE

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Director, University of Glasgow
Centre for Drugs Misuse Research

Detective Superintendent Gillian Wood,
National Drugs Coordinator,
Scottish Drug Enforcement Agency

Jack Law,
Chief Executive,
Alcohol Focus Scotland

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31 July 2006

Editor's letter

Considering we're in the middle of one of the hottest summers on record, we've got a very active issue!

Our 'lifting barriers' cover story is an inspiring case study in redesigning services to fit the users. North East Lincolnshire found their service users felt out of touch with mainstream services, so they built an outreach service person by person, through listening to their needs. If that's not a good use of research and networking, I don't know what is.

The service user fact file on page 5 is a similar story of getting on and doing it, as the Cumbria Users' Project shares their experiences of trying different ways to make a user network gather momentum with everyone on board.

More energetic (and brave) decisions from the Clouds team on page 12, where the head of treatment services describes an experiment that could have gone horribly wrong – but is in practice successfully transforming the menu and eating habits of clients who come for their six-week programme. We had plenty of interest in Helen Sandwell's nutrition article back in January; it's interesting to see this team take her suggestions and put them into practice with such positive results.

Newly prescribing nurses give their feedback on how it's working for them on page ten – and if this has all been a bit hectic, Prof David Clark puts the research aside to browse his bookcase for favourite reads on page 15.

On that note, we're taking our summer break for August, while the advertising market goes quiet. We'll still be here for letters, articles, Q&A responses, and feedback though (and forward advertising bookings of course...) so stay in touch, have a good summer, and we'll see you on 11 September!

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In this issue

Criminal justice system failing alcohol offenders

Alcohol misusing offenders are being failed by a system that does not offer them a route from the criminal justice system into treatment, according to a report published this week by the Probation Inspectorate.

The picture contrasts starkly with the situation for drug treatment, where referrals from the criminal justice system have tripled over the last four years. More than 14,000 offenders started treatment as part of a Drug Treatment and Testing Order or a Drug Rehabilitation Order in 2005/6.

The report highlights the contrast between drug and alcohol treatment, pointing out that the help available for alcohol using offenders is a poor reflection of the extent of alcohol related crime. Andrew Bridges, Chief Inspector of Probation, commented that the scarcity of treatment for alcohol misusers amounted to a 'glass half full and half empty' situation.

'It will be important that more alcohol treatment services are made available in order to meet the identified level of need, and so help contribute to a reduction in re-offending,' he said.

Recommendations to the National Offender Management Service and some local Probation Boards included a requirement for more alcohol treatment services to meet demand, and a recommendation that Probation Boards should develop working opportunities with local DAATs and treatment providers.

The Probation Inspectorate also wanted simplified guidance for staff on dealing with Drug Rehabilitation Requirements, to make sure the seriousness of offences matched the level of treatment offered.

Probation Inspectorate Report on substance misuse work with offenders is available at www.inspectorates.homeoffice.gov.uk/hmiprobation

Home Office Minister Baroness Scotland met service users in Brighton while formally opening the new Brighton and Hove Drug and Alcohol Treatment Service. Since opening its doors in April, the integrated service, run by CRI, Equinox and the Sussex Partnership NHS trust, has reduced waiting times for treatment from 11 weeks to one week and doubled the numbers in treatment. Staff are anticipating many more admissions this year through DIP and DRRs. The Baroness thanked staff for the difference this holistic service was making to people's lives.

Drug drivers ignore risks and the law

Most drug-taking drivers do not take the risks seriously and do not expect to be caught by the police, according to research commissioned by the Scottish Executive.

The research team, from MORI Scotland, the Centre for Drugs Misuse Research at Glasgow University and Napier University's Transport Research Institute, investigated attitudes among drivers aged 17 to 39.

Views that emerged from the survey indicated that the decision to drug drive was based on lack of deterrents, as well as often being more convenient than using public transport. Of the 13 per cent who had been passengers of a drug driver, most had been taking drugs themselves and were taking part in a social journey.

Sensation-seeking risk takers were found to be more likely to drug drive, with those who had settled with a partner in the last 12 months more likely to have desisted.

Transport Minister Tavish Scott commented that drug driving was just as dangerous as driving when drunk.

'The effects can last for hours or even days. Our message is simple – drugs can affect your driving. It isn't worth the risk,' he said.

Assistant chief constable Ian Learmonth of the Association of Chief Police Officers in Scotland, explained that specially trained officers could detect people who were unfit to drive and subject them to a Preliminary Impairment Test, involving eye pupils being examined and four psycho physical tests.

'Your chances of being caught are higher than ever,' he said, warning that courts could impose the same penalties as for drink driving.

Flint launches consultation on detail of summer 07 smoke-free law

Consultation has been launched on draft regulations for smoke-free premises and vehicles, ahead of legislation to be introduced in England next summer.

Public Health Minister Caroline Flint unveiled the proposals as the result of working with stakeholders, the public and the commercial sector to protect everyone from second-hand smoke, as well as providing a smoke-free environment where it is easier for smokers to give up.

Opening the consultation is intended to plot the detail of how the legislation will be implemented and enforced, and encourages feedback on exemptions and signage requirements.

In her Ministerial Statement to the House, Caroline Flint said the smoke-free provisions in the Health Bill were 'a huge step forward for public health by reducing exposure in enclosed public places and workplaces to the hazards of second-hand smoke'.

A recent survey showed strong public support for the move to restrict smoking.

The consultation period runs for 12 weeks, closing on 9 October. To submit your views online visit www.dh.gov.uk/consultations/liveconsultations or email smokefreeregulations@dh.gsi.gov.uk

Quizzes and beer goggles hit the spot

Local awareness raising sessions on drug and alcohol issues have struck a chord in Ayrshire and Arran.

More sessions had to be organised by North Ayrshire Community Health Partnership when nearly 800 local people wanted to attend. Day and evening sessions made them accessible to adults and young people.

Peter McArthur, information and research co-ordinator, explained that the sessions were developed when prevention officers met with representatives from local groups and schools in the area. Sessions not only helped people understand more about health effects of drugs and alcohol, but also focused on wider social issues, he said.

Interactive elements such as a 'Who wants to be a millionaire' style quiz brought the occasion to life, and young people could try on 'beer goggles' that mimicked the effects of alcohol.

The areas involved, Ardeer and Vineburgh, were part of a 'better 'neighbourhood services' initiative, and the sessions were designed to contribute to the programme's aims of improving community safety, increasing community participation and improving health.

Ikon and Jaxx become the first clubs in Bolton to sign a safer clubbing contract that includes initiatives to reduce underage drinking and disorder and send out the message that drug offences will not be tolerated. The Safer Bolton Strategic Partnership includes the council, police, prison, probation service, PCT, mental health trust and fire and rescue service. Detail in the statement includes an agreement to set a minimum price for alcoholic drinks and a dispersal policy to make sure club goers are guided to taxi ranks and leave the town safely. Inspector Phil Unsworth of Greater Manchester Police called the initiative a blueprint for other clubs on how venues should be run. Partnership organisations are now working together on a three-year Crime, Disorder and Drugs Misuse Reduction Strategy to reduce drug-fuelled crime and anti-social behaviour.

Fact File

Service User Groups

This issue: Maggie Messenger co-ordinator of

the Cumbria Users' Project

When and why did you start your group?
The Cumbria users' project was funded by Cumbria DAAT in 2002. The main objective was to empower and involve drug users in the planning and provision of local drug services. The project has three development workers in the north, west and south of the county. They are based in the Citizens Advice Bureaux so as to be independent of drug and alcohol services in the area. Cumbria is a large rural area and to try and contact service users throughout the county was impossible. So supporting users to set up groups in each area was the best way forward.

How many members do you have?
We started with a few dedicated users who worked really hard at spreading the word. Now we have a core of about 20 users in each area, and an active core of 10 or 12 users who are part of local user groups. There are also transient users passing through the area for rehab or detox who have been involved with us on different projects and whose insight has been invaluable.

How did you obtain funding?
We have just secured another three years' funding from the DAAT and an increase in our user involvement budget to pay for training, conferences, and remuneration for service users. Each user group is autonomous but is supported by the development worker in their area. They apply for funding through local neighbourhood forum monies and community regeneration funds.

Where and how regularly do you hold meetings?
Originally we had a user forum every six weeks that was open to all SUs. We rotated the venue but meetings could become quite chaotic. It became clear that we needed to be more focused, so we changed the format and wrote guidelines for users about their roles at these meetings. Now users engage in mini forums in their own areas every two to three weeks and select two representatives from those meetings to attend the countywide service user forum that is also attended by the DAAT commissioner. These are held usually every two to three months – just before DAAT planning days, so they can add concerns to their agenda.

What do you hope members get from attending?
We hope members feel that they are listened to and their views are important. We want them to feel valued, respected and supported by peers and service providers. Our members are able to use their knowledge and expertise to improve services, break down prejudices and build bridges in their communities by showing that users have a positive role to play. We hope they get friendship, enjoyment, increased self-esteem – and also have a good laugh along the way.

How do you keep it going?
By being honest and keeping it real. We don't offer things we don't have, or give promises we can't keep. We know everyone has bad days and any involvement from users is always of benefit. We publicise our services, produce guidelines for involvement by users and providers, and produce a directory, *User and carers' guide to drug services in Cumbria*, with referral pathways. We support each other: our members are the best resource we have and their motivation and commitment inspires others to get involved.

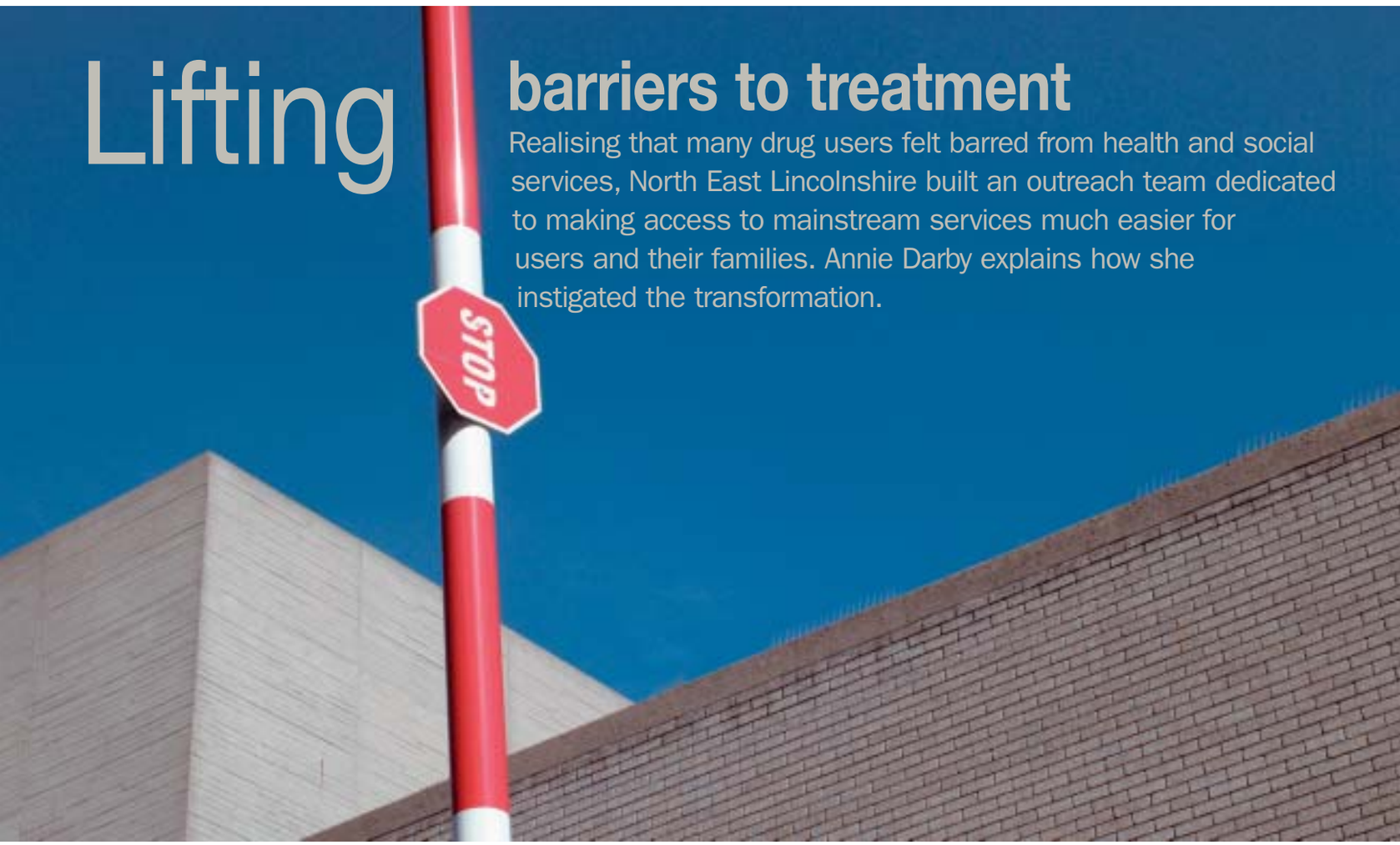
What have been your highlights so far?
User involvement on all the relevant drug and alcohol forums, committees joint commissioning planning days and consultation meetings with the DAAT have all increased users' confidence and self esteem. Members have been instrumental in changing policies, procedures and perceptions around drug users. We have two service users who represent Cumbria at the North West Users' Forum, supported by the NTA.

How do you communicate with your members?
We meet regularly at countywide forums and local groups. We also communicate with other users through our users' newsletter by service users in the south of the county. It is a respected mouthpiece and also a way of highlighting service gaps and giving feedback on training, conferences and harm reduction initiatives.

Have you any tips for others starting a group?
Be realistic, don't overstretch yourselves, and decide on a name and an identity. Look at what you want to achieve and decide on your rules. Get in touch with your user involvement worker or DAAT for guidance if you are on your own. Tap into magazines like *Black Poppy* and websites for other user groups. Support each other, be patient, consistent and honest and hopefully your motivation and drive will inspire others to join you.

Lifting barriers to treatment

Realising that many drug users felt barred from health and social services, North East Lincolnshire built an outreach team dedicated to making access to mainstream services much easier for users and their families. Annie Darby explains how she instigated the transformation.



Drug users can find it hard to access mainstream health and social services, and often see their own health and social needs as low priority. They might feel that their needs are not being met by mainstream providers because they are drug users, and believe that workers see their problems as self-induced. Consequently they become even more isolated from mainstream services and will only present when there is a crisis.

In North East Lincolnshire DAAT/PCT we decided on a new approach to get people into services – and keep them there until they had had the help they needed. Our region covers 192 square kilometres and comprises three main towns – Grimsby, Cleethorpes and Immingham, along with several villages. The population is approximately 164,000; unemployment remains above average in the area, and around 14,500 children are dependent on means-tested benefit. Lack of housing and escalating crime are major problems, and it is estimated that between 65 and 70 per cent of acquisitive crime is related to funding drug use.

I began working with North East Lincolnshire DAAT as specialist health visitor (SHV) in October 2002, initially for two and a half days a week. My first task was to begin networking with other agencies to find out what they perceived the problems to be, in relation to drug using families. I also wanted to hear families' views, so I conducted a small-scale survey by sending questionnaires to 22 drug-using families, which could be returned anonymously. The response was excellent; many respondents also attached comments, such as 'it's about time you listened to us'.

My sample ranged from parents expecting their first baby, to those with children in their late teens. Some had statutory involvement, with children on the Child Protection Register or being looked after; others had no agency involvement. A control group of similar families with no known drug or alcohol use gave me comparison of the take-up of mainstream interventions, such as childhood immunisations.

The research confirmed that drug using families found it difficult to access mainstream services, because of actual or perceived barriers. One respondent explained: 'I did used to go to the baby clinic but one time I could see two of the other women pointing at me. It could have been anything, but I just thought they know I use drugs and they are going to sprag me up. I never went back. A few weeks later I had my health visitor on the phone wanting to know why I had stopped going, but I didn't feel I could tell her.'

Appointments were often difficult for families – particularly as drug-using parents can have a large number of agencies involved with them, all making demands on their time. One parent said: 'I know I miss a lot of appointments for me and the kids, but I have to get my methadone. If I don't get that, I'm stuffed.'

Drug using parents often recognised that their habit was difficult for their children. 'I wish he had somewhere to go, to get away from the pressure I put on him, so he can chill out,' commented one.

The reluctance of some drug users to access mainstream health services meant that general health problems were not being assessed or treated, resulting in further exacerbation of pre-existing conditions. 'I did go and see my doctor, because I was having breathing problems, but he just kept on about my drug use,' was another response.

The networking and research gave enough information to start identifying interventions and services that would improve outcomes for clients, and gave a foundation for the team that is in place now.

Among the proposed services were:

- a support service for children who live with drug using parents, that could enhance resilience, self-

esteem and give them some essential 'time out';
- a child-focused worker to undertake intensive work with drug using parents in their homes to promote child safety, parenting skills and promote social inclusion;
- a general health nurse to meet the needs of drug users and their families.

It was becoming clear that a team approach could be effective – but that this needed to be an outreach service that would also assist families to integrate into mainstream services and the community.

As the service is designed to meet a wide range of needs, most of the team are general health and social care professionals, who have excellent core skills – especially in areas like communication, advocacy and empowerment. They have all had drug and alcohol training, but the team does not work with the addiction itself; their role is to support drug users in engaging in and maintaining treatment.

Team members have to be flexible, recognising that drug and alcohol use is a relapsing condition. Both users and families will have periods when they are stable and need little support, and times of relapse when it will need to be more intensive.

Having strong and proactive links with all agencies across the area helps to minimise the 'domino effect', where frequent house moves lead to changes of professionals, and scant knowledge is retained about families. Children of drug users are highly susceptible to becoming 'invisible', but by avoiding the usual restrictions of being GP/ PHCT attached, the team can stay involved with the client and provide some consistency.

Working on the ground alongside drug and alcohol users and their families has given our professionals a more accurate picture of parents' experience. It is easy to assume that they have a level of knowledge that in many cases is just not there – often because they have had fragmented childhoods themselves.

This was demonstrated by a case where the parent was generally providing good care. There was plenty of emotional attachment, but she found it difficult to get up in the morning because of her methadone dose, and consequently the children were late for school. The client said she did not really know what her routine should be, as she had been in care for much of her childhood; so one of the team went in three evenings one week to show her how to prepare as much as possible the night before, while arming her with several alarm clocks. The methadone timing was also adjusted – which all helped to get the child's school attendance back on track.

Half of the team's referrals come from social services, but other agencies include our local user group, The Roundabout; drug and alcohol services; probation; housing; pharmacies; health; police; and maternity. Self-referrals have increased by 5 per cent this year.

When a client is introduced to our service, we ask their consent to share information. We then assess their needs and compile a care plan. Our aim is to address the presenting problem and empower the client to access appropriate services. The work is usually short term, but as this is a relapsing condition, we use a revolving door approach, with most clients returning to the team at variable intervals. Service agreements are in place for structured work, which clients are asked to sign.

The service is evaluated in two ways – with the team member and through a form for the client (which is still being developed further), asking about their levels of confidence in accessing mainstream services. The point of this exercise is to compare where the client was at the point of referral with where are they at point of closure. An example might be drug treatment: if they were not involved before, are they now – and how is their compliance?

Our evaluations have shown that for more than 60 per cent of clients, the service is helping them to engage – particularly in drug treatment services and mainstream health and social care. It has helped them to address their health needs: contraception uptake was particularly high, and clients are now immunised against Hepatitis B and C.

The work of the child and family support worker is particularly encouraging. On the last evaluation it was shown that of the ten families audited, six of them had had the amount of statutory involvement reduced from Child Protection Registration to Child in Need. Two families no longer needed any social service involvement. Social isolation had been reduced in 58 per cent of clients who are now engaging in diversionary activities like job training and support groups.

Despite our successes, a significant number of individuals and families will become disrupted and may break down. The advantage of our outreach team is that individuals and families can still receive a service, even if they see a different team member. If the children are removed to grandparents, for example, they need not lose touch. The child and family support worker may hand over to the carer development worker – but they will still keep the client in their sights.

Annie Darby OBE is service manager/ specialist health visitor for substance misuse at North East Lincolnshire PCT/DAAT.

Who's who - the magnificent seven

Specialist health visitor/ service manager
Funded by the DAAT, I manage the team and develop services. I'm also involved in regional and national projects, training and development. My work with clients is around assessing the needs of drug-using families that have been referred by social workers and drug workers, and identifying what interventions can be introduced. I look for inequalities in provision, particularly in geographically isolated areas of the PCT, and develop specific services for women. I use my bereavement skills to work with the police, coroner and ambulance service to support those affected by a drug-related death.

Nurse practitioner
A post joint-funded by the DAAT and the Drug Intervention Programme to access clients in their homes, hostels and drug treatment services. Key tasks include treating general health needs (vaccinations, wound care, contraception), chronic disease management, and assessing and treating minor illnesses and injuries.

Child and family support worker
Funded by two local children's centres, this experienced nursery nurse with drug and alcohol training provides a non-judgmental service for drug using parents. She promotes home safety, empowers families to access mainstream services, and improves lifestyle by working with families on routines, child growth and development, and preparation for parenthood.

General support worker
Funded by the PCT, this role has been crucial in delivering advocacy and integration work. A former health care assistant with training in drug and alcohol work, counselling, diversity and advocacy, she works very much on the ground with clients, accompanying them to health appointments, supporting them through treatment, and putting them in touch with job training.

Carer development worker
Funded by the DAAT, the only member of the team with a drug and alcohol worker's background supports all carers especially those caring for children, many of whom are grandparents. He also facilitates the carer support group and manages volunteers.

Children and young person's worker
Now a full-time post funded by the DAAT, this role is based and managed in the young person's service but links in with the team. Coming from a social service and childcare background, the post-holder provides one-to-one support and facilitates group work. The role grew from a project supported by the Children's Fund, which involved children in talking about their needs as part of a steering group and helped to shape the service.

Accommodation / substance misuse link worker
The most recent member of the team tackles housing problems to reduce the 'domino effect' on children. He comes from a housing and social care background and is managed by a local housing support agency.

'I am shocked that no-one seems to recognise that classifying/criminalising drugs and boosting the level of sanction associated with their production, supply and use may actually make things worse.'

Escalating the odds of abuse

I was intrigued by Delia Venus Wynn's assertion that making meth a class a drug would 'provide the impetus to develop effective responses'. ('The ice age is coming', *DDN*, 17 July, page 10.)

I am shocked that no-one seems to recognise that classifying/criminalising drugs and boosting the level of sanction associated with their production, supply and use may actually make things worse.

It's almost as if classification is dislocated in people's minds from its place in the Misuse of Drugs Act 1971. It isn't just a benign 'early warning system', it's a system of criminal sanctions applied to specific acts. It is almost unique in criminal law in applying legal sanctions to individual and public health harms in this way. Think alcohol, tobacco, boxing, parachuting, scuba diving, prozac, benzodiazapenes, plutonium, uranium... All regulated and controlled in various ways but not banned.

What is the evidence for reducing harm through increasing classification?

Danny Kushlick, Transform Drug Policy Foundation

A place for hypnosis

Libby Ranzetta's article on hypnotherapy and alcohol problems (*DDN*, 17 July, page 13) was to say the least interesting.

It is true that there is no empirical evidence that hypnosis is effective in persuading someone who has become dependent on alcohol to quit; one can hypnotise someone when they are drunk, (not that it would be sensible to do so) and when they emerge they would still be drunk.

However, as a registered clinical hypnotherapist, I have for a number of years been using hypnosis with clients experiencing alcohol, and other drug misuse/dependency for the purpose of reducing anxiety levels and for increasing self-esteem. Given that conditions are common in such cases, and the fact that the former in itself is a precursor to relapse, together with the fact that hypnosis was endorsed by the British Medical Association, as far back as the 1950s as effective for addressing anxiety levels, it makes eminent sense to do so.

At its simplest, hypnosis can be described as an altered state of consciousness, with the trance like state being similar in many respects to prolonged day dreaming – something in itself which is not an unpleasant experience. In this state it is possible to reframe concerns and worries that the client has expressed. It is also helps clients to focus on what they would rather do than drink or use. However it is not a miracle worker, but it can accelerate the time in which a client can engage in progressing through the stages of the 'Cycle of Change'.

A word of warning, under no circumstances should hypnosis be attempted with those who have displayed psychotic symptoms, as adverse – or what is sometimes referred to as severe abreactions – could be induced.

Peter O'Loughlin, The Eden Lodge Practice.

Victorian principles

How depressing to see Duncan McNeill, MSP regress the debate on drugs and parenthood to Victorian values that miss some fundamental truths about poverty and addiction (*DDN*, 17 July, page 5).

George Sims, writing in 1889, said: 'It is not only crime and vice and disorder that flourish luxuriantly in these colonies, through the dirt and discomfort bred of intemperance of the inhabitants, but the effect upon the children is terrible. The offspring of drunken fathers and mothers inherit not only a tendency to vice, but they come into the world physically and mentally unfit to conquer in life's battle.'

Socialist contemporaries of Sims, such as Keir Hardie and Snowden, understandably saw societal and political controls on substances, and the promotion of abstinence, as important adjuncts to poverty-reduction policies. Nobody disagrees with the need to protect children from parental substance use. More than a century on, however, McNeill's views emanate from no such intellectual or political vanguard.

The problems with his ideas are manifold. Aside from their sidestepping of the need to address the root causes of poverty, exclusion and addiction, here are another three:

Firstly, sheer inconsistency. If he truly believes in this, then what about alcohol? The Aberlour Child Care Trust estimated this year that there are nearly 60,000 children affected by parental drug use and over 100,000 by parental alcohol use. The legal status of their parents' drugs of choice makes no

Frankie goes to work

Frankie reports on how she's getting on with compiling her professional portfolio – the first stage in her quest for promotion.

Compiling my portfolio isn't proving as difficult as I thought it might be really. My main challenge is making time to record experiences and relate them to the different DANOS occupational standards.

I've just finished looking at standard AC3 – 'contribute to the development of the knowledge and practice of others'. There were a few examples I could have used, where I've been involved in workshops and training sessions.

But earlier this year I worked on developing a course which focused on young people and alcohol. We had been liaising regularly with the local Youth Offending Team, looking at the training and development needs of staff in their organisation.

They asked us to help them address their gaps in knowledge and skills around identifying levels of alcohol use among young people. We needed to suggest brief interventions and approaches to young people who are heavy drinkers.

We looked at their needs and developed a course that included practical opportunities to use a variety of screening and assessment tools. It explored

difference to the children whose lives are blighted, so why the policy stance focusing on illegal drugs?

The second problem is medical ethics. Even supposing that clinical and counselling staff could stomach the dubious ethics of withdrawing treatment from desperate and addicted clients, many of whom already have children, who on earth would it help? It is like refusing to throw a life jacket to a drowning swimmer because you think they aren't trying hard enough to swim or that they are already too far away from the reach of your throw.

If we simply leave drug using parents to drown, who will they take down with them as they flail frantically for survival on their own? Their existing children? Innocent victims of inevitably desperate crimes which some would commit? Withdrawing treatment, as a punitive measure, would simply change the probability of innocent victims into a near-certainty. And threatening this sanction on the arrival of pregnancy or after childbirth, when clinical care and support services become even more crucial, would be fundamentally counter-productive.

And a third major problem is the fundamental nature of addiction. Of course, in an ideal world, babies wouldn't be born to addicted parents, but the deep psychological and physical power of addiction so often outweighs the power of rational decision-making. Drug and alcohol users in treatment know this only too well. Failing to break their habit, or relapsing, is punishment enough. McNeill simply overestimates the power of negative threats at the expense of positive incentives of decent housing, jobs and an otherwise 'normal' and stable existence.

I am sure Duncan McNeill wants to help, but in translating a moral view about what else substance users shouldn't do into policy proposals for social punishment when they do, he would only serve to make a bad situation even worse. It is even immaterial whether or not you have any sympathy for substance users because this particular debate is about harm to others, and McNeill's half-baked ideas would serve to protect no-one.

Mark O'Donnell, Edinburgh

motivating and contributing factors to why young people drink, and explored different interventions.

As well as my written account of the training, I included a handout of my powerpoint presentation in my portfolio, as well as the evaluation forms. If I was doing it now, I'd ask a colleague to do a peer observation of one of my sessions, so they could have given me a written statement to add to my ring-binder.

I might still try to get an impact assessment from the group I trained, to see how effectively the learning has been applied to practice. It wasn't long ago, so surely the knowledge won't have been forgotten yet!

I'm getting used to the business of collecting evidence. Every time I do something like this now, I try to get a statement – or some material that records the activity for my portfolio. It brings the experience to life and backs up your claims very efficiently.

More soon!

Frankie

Comment

A penalty too far: can I challenge it?

Stopping his benefits has plunged a client with a Drug Rehabilitation Requirement in drastic circumstances. Could this be challenged as a human rights issue?, asks Kate Clarke.

I am hoping readers may be able to offer me some advice on a significant issue for us. I am a drug worker working with people who are on Drug Treatment and Testing Orders (DTTOs) and Drug Rehabilitation Requirements (DRRs).

A client of mine who is currently on a DRR has recently been to court for being in breach of the order, and as a result has had all benefits (JSA and Housing Benefit) suspended for four weeks from 24 July. He was breached by Probation as he failed two appointments there. This was because he had his door kicked off in his privately rented bedsit and was frightened to leave his belongings as he could not make the room secure.

The landlord refused to provide written proof of this to cover him for Probation. On 20 July he was given seven days' notice to move out of the bedsit, and after a lot of hard work I managed to find an emergency bed in a hostel for last night. However, this offer was withdrawn when the hostel found out that his Housing Benefit had been suspended.

I have exhausted all possibilities known to me, but have been unsuccessful in finding him anywhere to stay, as all roads lead to Housing Benefit. Consequently, my client is not only homeless but also without the means to buy basics such as food.

We have been to the local Jobcentre and he has made a claim for Hardship Allowance, but we were advised that it would take a few days for a decision, even as an emergency case. We were also advised that even if the decision is in his favour, he will get nothing to cover the first two weeks of the suspension. To add insult to injury, the court also gave him a £25 fine which he has no means of paying as he has no income!

Stopping benefits for breaching a community order has been a sanction available to the courts for some time, but has only just begun to be implemented for DRR clients. While I accept that this is acceptable in law, I am extremely concerned about the devastating consequences it will have for clients and wonder if a legal challenge could be made as a human rights issue. Surely he has a basic right to food without having to wait several days for a decision about Hardship Allowance?

Is anyone aware if such a challenge has already been made anywhere else in the country? The irony is that my client will probably end up in prison a) because he will probably commit offences just to buy food and b) because prison looks like a safe and stable alternative right now and he may purposely try to get arrested to get into custody. What a tragic outcome for someone who has done well on an order for the last 12 months and has worked hard to stay out of prison.

> **'The irony is that my client will probably end up in prison a) because he will probably commit offences just to buy food and b) because prison looks like a safe and stable alternative right now and he may purposely try to get arrested to get into custody. What a tragic outcome for someone who has done well on an order for the last 12 months and has worked hard to stay out of prison.'**

I know that this is about just one client, but am sure that the implications are far-reaching if this penalty is going to be more widely used. I would be extremely grateful if readers could offer me any advice on any of the housing/benefits/legal issues this case raises, or could suggest anyone who can.

Kate Clarke, Drug Worker

Prescribing **change**

Last year a change in the law allowed nurses to prescribe medication. At ANSA's first conference on the subject, nurses and other medical professionals debated how this is working in practice. Malcolm Carr reports.

'If it ain't broke – break it', alongside 'we must not be afraid of change' and 'we must work to make change work' were the closing words of ANSA's first national non-medical prescribing conference in substance misuse. They were a reflection of changing times and changing roles within the field of healthcare provision.

Delegates had gathered to listen to key speakers talking about the change in law allowing 'non-medical' personnel to prescribe medication and the nitty-gritty of being nurse prescribers. The conference was organised by ANSA (Association of Nurses in Substance Misuse), with support from SMP and Brent DAAT, to respond to questions and concerns raised during their annual conference last year. Most who attended were nurses, who were joined by commissioners, pharmacists and doctors.

Dr June Crown gave a history of the changes in prescribing law, beginning with the Crown Report (1999) and culminating with the changes enacted this year identifying the role of Nurse Independent Prescribers (NIPs). It was interesting to hear of the concerns of the BMA some 15 years ago, when a small group of nurses were able to prescribe (alongside bandages and dressings) 'Nystatin'. 'This will be the thin edge of the wedge', a doctor was reported to have said. Indeed it was, but it has been a thin wedge and a long time forcing the door open.

Shan Barcroft of the NTA explained the NTA's work in trying to identify and develop the role of non-medical prescribers in the field of substance misuse. In a later session with Stephane Ibanez de Benito of SMP, she looked at how the roles could be further developed by identifying the needs of those who had completed additional training in non-medical prescribing.

Simon Greasley and Beverly Harniman, both actively working as nurse prescribers within their primary care teams, gave an overview of some of the problems they had encountered and some of the systems they had developed to facilitate their role.

The question and answer session was busy, with questions to all members of the panel. One of the most disconcerting was from a nurse who having completed training as a non-medical prescriber felt under pressure to work above what she felt was her level of competence. One of the messages that came across very strongly was that non-medical prescribers should not be seen as a cheap alternative to doctors, but rather as a separate part of the substance misuse workforce, able to work alongside and complement the skills of doctors. Virginia Radcliffe who led a session on 'interprofessional approaches to prescribing' reinforced this message.

The afternoon debate was one of the highlights of the day with Dr Chris Ford proposing the motion 'this house believes that all substance misuse prescribing should be done by medical doctors', to be answered by Dr June Crown. Dr Ford inevitably gave a spirited performance, which once again emphasised the point that non-medical prescribers of any discipline need to work alongside and in partnership with other professionals for the benefit of the service users. The outcome of the debate was a forgone conclusion, considering the audience, but the content of the debate was of higher importance in reminding all present that the needs of service users should always be paramount.

The low point of the day was the straw poll at the very start which identified that over half those attending had completed non-medical prescriber training but were unable to practice because of local or internal politics. It was a sad reflection on the earlier comment on putting service users' needs first.

Still to come? ANSA is already thinking about format of a further one-day prescribing conference early next year to complement its annual three-day conference held each September.

Malcolm Carr is vice chairman of ANSA.

Nurse prescribing in practice

Two nurse prescribers explain the difference their enhanced role has made to services – and the positive reactions from drug-using patients.

As a clinical nurse specialist for substance misuse at a London medical centre, **Beverley Harniman** works alongside a GP and a senior house officer to run a weekly prescribing clinic. She also manages the drug clients on substitute prescriptions, registered at the GP practice.

Clients are able to collect a script without having to wait around for a signature or having to return later. Harniman can carry out supplementary prescribing for methadone, buprenorphine and diazepam (with the initial diagnosis made by a doctor) and can independently prescribe a range of other drugs such as naltrexone, antidepressants, and drugs for alcohol withdrawal.

'Our clients are very happy with the service,' she says. 'It makes it easier for them to stay in treatment.' Her GP colleagues are 'positive and supportive' she says, and it is important to work within a shared care framework and have prescribing protocols in place.

'Nurses need to formally agree with their employers what dose ranges and medications they are happy to prescribe,' says Harniman. 'They must also realise that as the person who signs the script they are accountable, so they need to make sure they have adequate indemnity cover.'

But with clear clinical management plans in place, she says the benefits for patients are obvious. 'We can strengthen the shared care framework considerably. I can treat holistically, looking at blood borne virus screening and Hepatitis B vaccination, as well as prescribing. It's satisfying for me to manage all aspects of a client's treatment.'

Simon Greasley is a nurse prescriber at the Kakoty practice, a GP practice in Barnsley, South Yorkshire. The clinic was the first practice in the UK to take advantage of changes to the Misuse of Drugs Act 2005, which opened the gateway for nurse prescribing.

Greasley believes the self-managed nursing team is needs-led in providing an accessible service for patients. The team is supported by a GP with special interest in substance misuse, but now has the capacity to offer drop-in appointments, catching patients who 'are too chaotic to jump through all the hoops to access secondary care services'.

Staff use a computer template devised by the practice to make sure all assessment procedures are followed, and a urine test and examination are carried out. A clinical management plan is then agreed, following a joint consultation with the doctor.

The practice has a good record of retaining patients, most of whom provide negative samples. More importantly, all have reduced harm. 'As long as we're following RCGP guidelines, we should give patients what they want – methadone up to 120mg and subutex up to 32mg,' he says. 'Where's the sense in some people who have done the prescribing course still not being allowed to prescribe?'

Want to be Unhooked?

William Pryor invites you to take part in an alternative interpretation of addition

Do you suspect there might be a better way of describing and understanding addiction? Do you feel your practice might work better if you had a more persuasive interpretation of the phenomenon you work with every day? How do you like your theory of addiction – what mix of the medical, sociological, neurochemical, psychological, psychiatric, philosophical, political and spiritual do you want it to contain? What part do you think families, relationships and love play in the genesis of the phenomenon and in its treatment?

Unhooked Thinking is precisely that: unhooked, uncertain, discursive, open, free to go wherever it needs to go, having let go of the insecurities that prop up the more doctrinal approaches to addiction. Unhooked Thinking has no doctrine except to say that to be unhooked from addiction it helps to be unhooked in your thinking. One of the many charms of Unhooked Thinking is that we make it up as we go along – like life. We offer no prescriptions. And there seems to be an appetite for this approach.

A list of the subjects Unhooked Thinkers are interested in would be endless, but here's a few: addiction as expression of family dysfunction, the relationship between prohibition and addiction, the stories or myths that keep addiction afloat, the connection between addiction and the self, treatment as life-training, the idea that love is the absence of addiction, and much, much more. None of these subjects has any kind of 'answer', definitive or not, but they are all the source of a lot of unhooked discussion.

Bolstered by the wide range of positive feedback we've had from Unhooked Thinking 2006 (see for yourself at the website to: www.unhookedthinking.com), we, the management group, are now planning Unhooked Thinking 2007, which will happen from 9 to 11 May next year in the Guildhall in central Bath, a venue with much better acoustics and breakout facilities than the Assembly Rooms where we held this year's event. The theme of the conference will be: 'Love and Baggage – the part love, families and relationships play in addiction and its treatment'.

'How do you like your theory of addiction – what mix of the medical, sociological, neurochemical, psychological, psychiatric, philosophical, political and spiritual do you want it to contain?'

And we're inviting your participation. As the theme implies, not only will the conference be for drugs and law enforcement workers, doctors, service users and academics, but for that largely forgotten group, the families of users. We believe that such apparently very different groups can and want to talk to each other. If you have any ideas for a solo or group presentation or a seminar or other breakout session, please let us know. We particularly want to encourage women and ethnic minorities to participate. In the first instance email a short (50 words or less) synopsis of your idea to william@unhookedthinking.com.

Introducing more nutritious food to clients in recovery sounds worthwhile – but how easy is it to do in practice? Claire Clarke and Sue Williams told DDN how Clouds House got on when they made the brave decision to overhaul the menu.

Serving up **healthier** recovery

When people come into treatment we see them in a low physical state, says Claire Clarke, head of treatment services at Clouds House residential rehab in Wiltshire.

'Their teeth are bad, their skin is bad, their hair is falling out – all sorts of things. We have always known that one of our tasks is to help build their physical strength during their detox, and help them follow on afterwards.'

Clarke knew the role nutrition played in repairing the body – 'I used to be a cook myself, I knew about the benefits of good food' – but had not really thought about relating her knowledge to the recovery programme she worked with. Hearing nutritionist Helen Sandwell speak about using food as fuel for recovery at the last FDAP conference suddenly struck a chord. On the way back to Clouds, she began planning a review of the menus.

'We already had a pretty healthy diet, but there were things we weren't paying enough attention to,' she says. 'We weren't really monitoring levels of salt, sugar and fat in our patients' diets – so we set about re-evaluating our menus.'

Out went foods with 'no nutritional value whatsoever', which meant sacrificing vending machines stocked with sweets and fizzy drinks. In came fresh fruit throughout the day, water dispensers everywhere – and a redesigned six-week menu plan, devised by Clouds' chefs.

The chefs' remit was to reduce salt, sugar and saturated fat, and replace convenience food with fresh fruit, vegetables and homemade sauces. Their challenge was to make a clientele with a sweet tooth take to the new regime without protest or refusal.

Reducing sugar intake made perfect sense, explains Clarke. 'We know that blood sugar is an important factor in controlling mood disorders... poor blood control and sugar cravings are really common among drug and alcohol users. When people use a lot of caffeine and sugar, their blood sugar levels peek and dip – similar to the effects of alcohol – causing irritability and roller coaster mood swings.'

Depriving people of caffeine and refined sugar can be like breaking another addiction, and staff were initially worried that the fresh food would be met with refusal. Clarke is still surprised that the change was greeted so positively by clients, but credits the staff team with making the transition such a positive experience.

Chefs go into the dining room after the last serving in an evening to make sure everybody has eaten, and that there are no problems. Clients with specific medical needs or cultural variations for religious reasons are encouraged to talk to the chefs so they have an instant link with someone who is providing their food and will make sure that their needs are met. Beyond the personal touch, imaginative presentation has become an enjoyable challenge – rewarded by seeing a man who had never eaten vegetables tucking into broccoli and salad, and weaning another client off a two-year diet of Weetabix.

Staff throughout Clouds have supported the programme willingly as they have witnessed the wider implications of seemingly small changes like replacing sugary desserts with a fruit platter in the evening, and cups of coffee with herbal tea. The night nurse team reports more settled behaviour and better sleep patterns. Clients are noticing the benefits for themselves, and take an interest in the nutrition lecture that gives advice on maintaining healthy eating without hassle when they go back home.

Now that the brave step to change has been taken, new clients accept that healthy eating goes with the territory of holistic treatment for recovery. Clouds offers alternative therapies like shiatsu, reflexology and Indian head massage, alongside doing tai chi and auricular acupuncture. Good nutrition becomes part of the toolkit for repairing body and soul.

Certainly it seems one part of recovery that can be arranged

relatively easily, by basic awareness.

'Food of any type is low on the priority list for drug and alcohol users,' says Clarke. 'With their chaotic lifestyle they are much more likely to spend money on drugs than to get a good meal inside them.' Eating the right foods regularly can do wonders for morale, as the benefits show pretty quickly.

Clouds House administration manager Sue Williams confirms that the quiet revolution has worked on many levels. Full buy-in from an enthusiastic chef team was a fundamental force, but the logistics of ordering different ingredients was not prohibitively disruptive or expensive. They have the same suppliers delivering, but are buying a little differently with the same budget, to incorporate more fresh ingredients, she says.

over. Small changes make healthier dishes more imaginative – adding spring onions or stilton to mashed potatoes, for example. Replacing lamb casserole with lamb cutlets and salad is a small change for another nutritious option. 'It's about making food interesting while keeping it healthy,' says Williams.

'So much care has been taken with the food they're eating – and they value that,' she adds. 'That often doesn't happen to those with addiction problems in the outside world. People don't show them that level of care – it's something that's really lacking in their lives.'

It all contributes to the culture of wellbeing, learning to care for your body, deserving high-grade fuel. As the changes took place, the whole community was told what was going

'The chefs' remit was to reduce salt, sugar and saturated fat, and replace convenience food with fresh fruit, vegetables and homemade sauces. Their challenge was to make a clientele with a sweet tooth take to the new regime without protest or refusal.'

'We always had fresh fruit, vegetables and herbs as part of the everyday diet, and there had always been a salad option. It's just moved on that bit further, so the salad might take the main focus of a meal.'

Williams also stresses that the meal plan is not about forbidden foods, but about getting a balance – highly important if there is going to be a transition to foods that clients are likely to eat back home.

'When the chefs prepare homemade burgers they serve chips with them, because that's what they will eat when they go home,' she explains. 'But they will serve healthy chips or oven baked potato wedges, rather than greasy fatty ones. They are being realistic so people can feel they can eat this sort of food at home.'

Comfort eating has taken on a whole new meaning. Instead of the regular stodge that characterises much mass catering, clients are given carefully presented food that the chefs have obviously taken trouble on and the healthier options were explained. Instead of chaining themselves to the KitKat machine, clients took to the on-site shop's offerings of oat bars, fruit and nut bars and sugar-free lollipops.

It's been an encouraging reaction, and one that has inspired the chefs to build on their successes. After all, the proof is in the (sugar-free) pudding: when the chefs go into the dining room at the end of the last serving to see if everything's all right, they find a really positive atmosphere in there, says Williams. So far so good… 'If the change hadn't worked, they would be shutting the kitchen door and legging it!' she points out. 'It's been a big change, but the chefs have done it wholeheartedly and it has worked very well.' **DDN**

Nutritionist Helen Sandwell's article 'Fuel for recovery' was published in DDN, 16 January 2006, page 6-7, and is available in the archived back issues on our website, www.drinkanddrugs.net

Post-its from Practice

The effects of hidden excess

Make no assumptions, give thanks for medical students, and don't forget to check everyone's alcohol!, says Dr Chris Ford.

Every few weeks, a group of medical students comes to our practice. They come with a range of experience and knowledge, depending on their seniority, and are often surprised how exciting and varied general practice is. One previous group were especially keen and asked to go out on a home visit.

That day, I had a request to visit an 85-year-old Asian woman who had fallen again. Several doctors had visited her for similar episodes and so far, no cause had been found. So I phoned the patient and obtained her permission for the students to go ahead of me and make their assessment first.

After about 30 minutes, I went round to discuss the students' findings. They presented them rather well and rounded up their summary with a question: did I think it was relevant that she was drinking half a bottle of brandy per day..? Now nobody previously had recorded her alcohol intake, maybe because we had assumed that Asian octogenarians don't drink! Yet the patient had been drinking this amount for years and didn't think it was a problem.

Excessive alcohol is so often the condition patients don't think to mention and doctors don't want to discover. It is not only harmful to the liver, but also increases the risk of coronary heart disease, hypertension, diabetes, obesity, depression and other psychiatric illness, and is associated with gastric symptoms, accidental injuries and domestic violence – the list seems endless.

It is estimated that about 25 per cent of consultations are directly related to alcohol and a further 25 per cent indirectly related. Putting this another way, 20 per cent of patients that consult their GP are excessive drinkers, which means that the average GP sees 360 patients each year who are misusing alcohol – or approximately seven patients every week. Yet 60 per cent of GPs only intervene with seven or fewer of these patients per year! Putting it more globally, a conservative estimate suggests we 'fail to diagnose and fail to treat' about six million people.

Many, if not most, of these excessive drinkers are unlikely to seek help for their drinking, and on the whole they do not actually need treatment as such. What they do need is early identification and early intervention, based on proven clinical techniques. Clearly our baseline practice needs to be improved, with minimum standards of screening and appropriate guidelines regarding treatment and interventions.

This elderly patient had long gone past the excessive drinking stage and was dependent. She did extremely well with a home detoxification, and has not drunk since. Her diabetes and hypertension are easier to control and, so far, she has had no further visits for falls.

So don't forget to ask everyone you meet about alcohol, wherever you work. Make no assumptions – you will often be wrong. And welcome those medical students in – they can be a blessing!

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP

Events

FDAP events

8 November – London

Annual drug and alcohol professionals conference, 2006

Organised by the Federation of Drug and Alcohol Professionals (FDAP) in association with *DDN*. FDAP's annual conference aims to help support the development of front line workers, managers and commissioners, and tackles the important issues of the day. This year's event includes the future of alcohol services, residential rehab and harm reduction, and next steps on workforce development. Practical workshops and seminars cover services for steroid users; meeting the needs of young people; gambling problems; brief therapies for alcohol problems; and, managing child protection issues. Delegates will contribute to policy debates on: whether psychological therapies work with substance users; whether there's a role for coercive treatment; and whether practitioners should have to be qualified to work in this field.

w: www.fdap.org.uk.

Other events

3-8 September – Edinburgh

49th ICAA conference on dependencies

Organised by ICAA, Castle Craig Hospital and Addiction Recovery Foundation. This year's conference, 'What makes good practice', will provide a platform for dialogue and enlightenment for professionals in the fields of substance abuse prevention, treatment, research and policy-making.

w: www.icaa-uk.org.

21 September – Brighton

10th Sussex conference on drugs and alcohol

Organised by Brighton and Hove, West and East Sussex DAATs. Topics covered in this year's event include: cannabis and mental health, treatment of young people, sexual abuse and substance misuse, dual diagnosis, methamphetamine, user involvement and community prescribing.

e: nick.cole@eastbournedownspct.nhs.uk.

20-22 September – Piran, Slovenia

4th International conference on nightlife, substance use & related health issues.

Organised by Centre for Public Health, Liverpool John Moore's University and others. This three-day conference will bring together experts from around the world to exchange information on the latest research, policy and evidence on protecting and promoting health in nightlife settings.

w: www.clubhealth.org.uk/conference.

3 October – London

Adult drug problems; children's needs

Organised by the National Children's Bureau. Examining challenges posed by the 'Hidden Harm' of parental drug use, and improving the professional response from assessment to care planning.

w: www.ncb.org.uk/conferences

Week after week I attend our regular team meetings – but frankly they're shambolic! There's no structure and people come away muttering that it's been a waste of time. The process demoralises me every week. My manager is good in other ways – but can anyone suggest a simple format for effective meetings that works?
Carrie, by email

Break the ice

Dear Carrie
What we do at our team meetings is to rotate the chair so that a different person is at the head of the meeting. We also start with a warm up, ice-breaker type of thing.

Then we also have a limited agenda, and agenda items have to be in two days before the meeting so as to avoid any other business at the end. We also have team meetings fortnightly – this we find really helps and has brought a bit of life back into our team meetings as they also used to be dull.

John and Shaun, Lifeline, Kirklees

A clear agenda

Dear Carrie
Problems with meetings happen when there is a lack of clarity over the purpose of the meeting and who is leading it. If you want to have an effective meeting you need first to agree the purpose of the meeting as a team and write this down. If this proves difficult ask the question, what would happen if we did not have the meeting? Maybe there is a better way to do what is required.

Establish who is chairing the meeting and agree that they are empowered to keep the meeting on track in line with the agreed purpose, agenda, and time constraints.

Meetings are for four things: giving information, getting information, discussing something or deciding something. Have an agenda for each meeting which sets out agenda items, likely time required, who is leading on the agenda item and what is required from those attending the meeting – *eg* people attending receive information, provide information, discuss something or come to a decision.

Things on the agenda should affect the majority of those attending the meeting – if not, deal with them in another forum. Stick strictly to a time limit, and if you finish the business early, celebrate and use the time to network with colleagues. Keep a record of key action points agreed at each meeting and hold people to account for delivery at the next meeting. Each take responsibility for ensuring that agreed actions are undertaken and that the meeting remains focused on the required task and is not hijacked.

Always spend at least two minutes at the end of each meeting checking out that the meeting is operating effectively – things can quickly slip back to the bad old days

For a whole range of tips on making meetings more effective try www.effectivemeetings.com

John Jolly

Encourage ownership

Dear Carrie,
Don't give up on your meetings – they are essential for communication within a team. Properly run meetings save time, increase motivation, productivity, and solve problems. Having meetings allows creative thinking and gives an opportunity to discuss new ideas and allows everyone in the team a chance to give their opinion on new initiatives.

Everybody has ownership of plans and strategy, which prevents people disassociating themselves with projects. The 'it wasn't my idea, nothing to do with me' attitude isn't an option if everything has been discussed by the group. Even in this day and age, good meetings provide a far more meaningful level of communication than telephone conversations and emails.

Bad meetings (which is what you say happen within your team) have the opposite effect. People feel that their time has been wasted, that 'I could have been getting on with some real work' or that the meeting has not provided a proper forum for sharing of ideas and planning but has been dominated by one or two people who may be the loudest or the most pushy.

You need to make sure your meetings have a proper structure to them – and that involves forward planning. They need a proper agenda that is circulated to everyone involved in advance, and you need a firm chair taking control of gathering input from all the attendees, getting agreement on outcomes and making sure that everyone agrees the responsibilities and action points they are taking away.

Someone has to take full notes of the meeting, and these notes need to be circulated soon after, so no one is in any doubt of what has been agreed and every person present knows what is expected of them. The next meeting should have an agenda item where everyone reports back on the progress they have made with their various action points.

All of this is fairly obvious stuff but by the sounds of it your problem is getting your manager to implement such a structure. You should voice your dissatisfaction with the way the meetings are running to your manager and suggest a more structured approach.

But maybe rather than putting the onus solely on him or her, why not suggest that everyone takes it in turn to chair the meetings and take the minutes? That way everyone has equal responsibility for making them a success.

Lee Hayes

Reader's question

One of our DIP workers, a nurse by profession, is a Special Constable who works at night in uniform. Am I being naive in thinking that this raises serious questions about confidentiality and conflict of interest?
Paul, West Yorkshire

Email your suggested answers to the editor by Tuesday 5 September for inclusion in the 11 September issue of DDN.

New questions are welcome from readers.

Some of my favourite reads

Professor David Clark changes tack from his usual Background Briefing and shares some of the books in the field that he has most enjoyed.

As it's the last issue before our August break, I thought I would do something completely different for this Background Briefing.

I have to confess that I am totally fascinated by the field of substance use and substance use problems. Given that I also love reading and purchasing books (when I can afford them), I spend many enjoyable hours reading about drugs and alcohol. Not that everything I read in this field makes for pleasant reading. It can be frustrating and irritating.

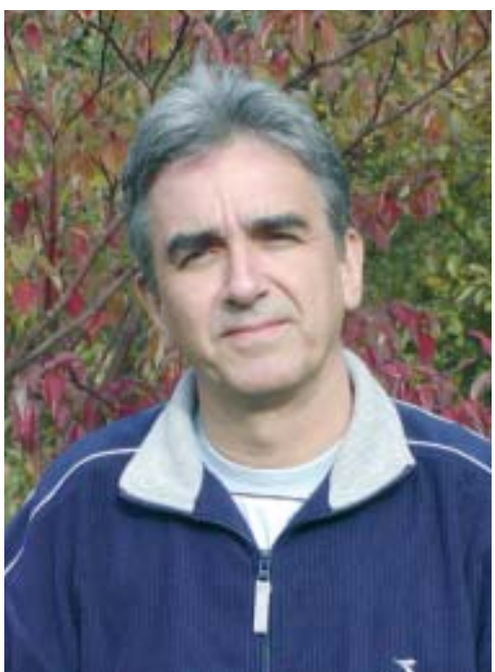
So I thought I would share with you some of my favourite reads – and no, I haven't cut a special deal with authors or publishers! The books I have chosen have been selected for a variety of reasons – some because of the practical advice, others because they have pulled at my heart strings, and still others because they are just so interesting and thought-provoking.

The books are not in any order of preference. I've selected them as I look at my bookshelves and they bring back pleasant memories.

Beating the Dragon: The Recovery from Dependent Drug Use by James McIntosh and Neil McKeganey (r.r.p. £20.99)
This is the book that inspired part of our research programme. I literally read it through from cover-to-cover in one sitting. This book provides insights into the process of recovery, as revealed by 70 people who have managed to overcome their long-term substance use problem. I still find it a fascinating read – and I am surprised by how few treatment professionals have seen it!

Addiction by Prescription by Joan E. Gadsby (r.r.p. £7.25)
A compelling and heartbreaking read from a courageous person and tireless advocate. 'In 1966, when Joan Gadsby's four-year-old son died of brain cancer, her doctor prescribed a "chemical cocktail" of tranquillisers, sleeping pills and anti-depressants. It was the first step in a 23-year addiction to benzodiazepines – an addiction which threatened her family relationships, financial security, career and personal health.'

The Treatment of Drinking Problems: A Guide for the Helping Professionals by Griffith Edwards, E Jane Marshall and Christopher CH Cook (r.r.p. £36.10)
A well-written, comprehensive and compassionate book that is not only recommended for professionals, but also for anyone interested in the treatment of alcohol-related problems. A definitive text.



'...no, I haven't cut a special deal with authors or publishers!'

Hooked: Five Addicts Challenge Our Misguided Drug Rehab System by Lonny Shavelson (r.r.p. from £12.85)
The author follows the lives of five addicts in the American treatment system: a compelling read. The book highlights the links between drug addiction, mental illness and trauma, including child abuse, and argues for an integrated approach in treatment.

Legalise This! The case for decriminalising drugs by Douglas Husak. (r.r.p. £12.00 or £10.25 from the DDN bookshop)
I don't get involved in arguments about whether drugs should all be legalised or not. However, this book really made me think about the issues and the American system that imprisons so many recreational drug users. Well-written, balanced arguments, and as I say, really thought-provoking.

Living with Drugs by Michael Gossop (r.r.p. £19.00, or £17.00 from the DDN bookshop)
This is still probably the best general text in the business about psychoactive drugs and society. It is easy to read and the arguments are well-balanced.

Illegal Leisure: Normalization of Adolescent Recreational Drug Use by Howard Parker, Judith Aldridge and Fiona Measham (r.r.p. £19.95 or £16.96 from the DDN bookshop)
Based on a five-year study following schoolchildren during the 1990s, this book explains how young people make decisions about whether or not to try drugs and how some become regular drug users. This seminal text questions how society is tackling the issues centred on widespread recreational use of drugs and alcohol by young people.

'Treating Drinkers and Drug Users in the Community' by Tom Waller and Daphne Rumball (r.r.p. £36.50 or £31.02 from the DDN bookshop)
Only just seen this classic – how have I missed it? This book looks at a wide range of interventions that can be used to help different people with different drug and alcohol problems at all stages. A breath of fresh air and a 'must read' for all practitioners and commissioners in the field.

The Heroin Users by Tam Stewart (r.r.p. £8.99 or £7.64 from the DDN bookshop)
The author was part of the heroin scene in Liverpool for many years, and she tells you what it's really like to be a heroin user. A refreshing read that reveals with insight and honesty what kind of people take heroin, why they do it, and how it changes lives. Challenges common misconceptions and assumptions, and also gives hope to those affected.

Crack in America: Demon Drugs and Social Justice edited by Craig Reinarman and Harry G. Levine (r.r.p. £15.95)
Another thought-provoking book, which got me thinking more about drugs in the wider context of society. Just to get you going, a comment from the back cover: 'The contributors make a convincing case that America is unable to solve the problems associated with crack because it is unwilling to deal with extreme economic and racial inequality except by stigmatising and punishing the unequal.'

To order books at discounted rates, visit our website, www.drinkanddrugs.net and click on 'drink and drugs books' to find the online DDN bookshop.

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

Certificate in Substance Misuse Management (Stage 1)

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

18 month programme from September 2006 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 2006 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

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

2 year programme from October 2006

BSc in Substance Misuse Management (Stage 3)

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

2 year (top-up of Diploma) or 4 year programme from November 2006

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 www.kent.ac.uk

Relapse Prevention Counselling (RPC)

Professional Training

Faciliated by Terence T Gorski

President, The Cenaps Corporation

A Brief Strategic Approach
Basic Competency Certification

2nd – 3rd October 2006
09:00am – 17:00pm

Fee: £345.00 for private sector
£260.00 for statutory or voluntary organisations

Venue: Regent's College Conference Centre, Inner Circle, Regent's Park, London, NW1 4NS

To book your place please call: 0800 081 0700 or email Emma on elinzell@lifeworkscommunity.com

LIFE WORKS
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WWW.LIFEWORKSCOMMUNITY.COM

Healthy eating for a better life

17 October, London
One day workshop

A balanced diet is important in helping maintain both a healthy body and a healthy mind.

Substance users often neglect their diets. This, together with the effects of their substance use, could mean they are lacking in some important nutrients.

Ensuring that those in treatment develop healthy eating patterns is a crucial, but often forgotten, part or their treatment.

This workshop is aimed at all those who work with substance users. It will explore why diet is so important to their physical and mental health. The workshop will focus on healthy eating related to the particular problems experienced by the individuals who come into contact with drug and alcohol workers, such as:

- Negative mood and behaviour
- Living with illness e.g. hepatitis C, alcoholic liver disease
- Eating healthily on low income

Participants will look at ways that they can introduce healthy eating into their treatment programmes, with the help of the toolkit that accompanies the workshop.

The cost for the workshop is only £110 +Vat (10% charity discount). Places are strictly limited and available on a first come first served basis.

For more information or to book your place, please contact Ian Ralph
e: ian@cjwellings.com **t:** 020 7463 2081

DipHE/BSc (Hons) Substance Use and Misuse Studies

Starting October 2006, February and June 2007, at our Ealing Campus

Programme Structure

The programme provides an essential insight into substance use and misuse issues from the perspectives of health and social care, mental health and public health, criminal justice, child protection, young people and community care. It explores various types of substances commonly used and introduces a variety of evidence based interventions.

Modules can be taken alone or combined leading to a Diploma or Degree.

This multi-disciplinary programme has been mapped against the Drug and Alcohol National Occupational Standards (www.danos.info).

Modules

- Substance use and misuse in context
- Substance use and misuse treatment intervention
- Enhancing practice
- Enhancing cultural competence in dealing with people with drug and alcohol problems
- Dual diagnosis: exploring interventions for people with mental health and substance misuse problems
- The Criminal Justice System and Substance Misuse

Who can apply

The programme is suitable for a wide range of professionals working with alcohol and drug users including nurses, social workers, drug and alcohol treatment workers, those who work in homeless and youth services and in the criminal justice systems, in both the statutory and voluntary sector.

Tel 0800 036 4036
healthenqs@tvu.ac.uk
www.health.tvu.ac.uk/sums

Apply on-line at **www.tvu.ac.uk/apply**

TVU Thames Valley University
London Reading Slough

Annual Drug & Alcohol Professionals Conference 2006

FDAP's annual conference aims to help support the development of front line workers, managers and commissioners, and to give delegates the opportunity to have their say on important issues of the day.

For more information and a booking form visit
www.fdap.org.uk

8 November 2006

Royal Institute of British Architects,
66 Portland Place, London W1B 1AD

Organised by The Federation of Drug & Alcohol Professionals (FDAP)
in association with Drink & Drugs News

fdap
DDN

National Criminal Justice Drug Workers Forum

Second Annual National Conference

'DIP INTO SYNERGY'

19-20 SEPTEMBER 2006
ROYAL YORK HOTEL, YORK

Aimed at drugs practitioners from all sectors of the criminal justice system, the theme of this two day event will reflect the diversity of roles and partnerships operating in this field. Focused on professional development and successful partnership working, the event offers presentations on key themes as well as a large range of interactive and informative workshops on the following:

Tough Choices, Housing Issues, Stimulant Users, Workforce Development, Race and Diversity, Increasing Client Retention, User Involvement and Prison Based Treatment Options

Certificates of attendance are provided as evidence of participation for the purpose of professional development. The programme includes an exhibition of products and services and a social programme with ample networking opportunities. An event not to be missed.

For a full programme and registration details, contact:

The National Criminal Justice Drug Workers Forum
Tel: 01759 388855, Fax: 01759 388563,
Email: gill@altura-events.fsnet.co.uk
Or visit the website: www.drugreferral.org

Leicestershire County Council

Commissioning Officer

Ref: L1446

£30,660 - £33,822 pa

Thurmaston

To take the lead on commissioning of services for the Drug and Alcohol Action Team. You need three years' post qualification experience in social or healthcare and/or in commissioning and contracting of services, and a knowledge of contract processes.

www.leics.gov.uk/jobs

Application forms and further details are available from the Service Point, Main Foyer, County Hall, Glenfield, Leicester LE3 8RA or telephone (0116) 265 6253 (at any time). Please quote reference. Minicom available (0116) 265 6870 or use BT Typetalk or similar. Leicestershire County Council is registered with the Criminal Records Bureau and will undertake checks for certain posts.

Closing date: 18 August 2006.

COMMITTED TO EQUALITY OF OPPORTUNITY IN EMPLOYMENT AND SERVICES

CommissioningNews

Investing in services for drugs, health, crime and social care — First issue – June/July 2006

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Next issue 11 September
Have a happy holiday

PRIORY

Farm Place is one of Europe's most established and respected Addiction Treatment Centres, specialising in all addictions.

The Priory Hospital Woking is an independent psychiatric hospital with an established addiction treatment programme. Both units work on a 12 step abstinence based model.

Addiction Therapists

Farm Place - Full-time
Woking - Part-time 25 - 30 hrs per week
£18,061 - £28,898

We are currently looking for energetic and experienced Therapists to join these teams providing 7 day treatment programmes to in, day and out patients. Candidates will be qualified therapists and have a minimum of 2 years experience in facilitation of group and individual therapy within the addiction field. FDAP accreditation or evidence of working toward this is required. The successful applicant must enjoy working as part of a multidisciplinary team and be willing to be flexible to the needs of a busy unit. In return for your commitment and hard work you will work in a well resourced, first class environment.

If you meet the above criteria, then call Joan Bendy for an application form and job description on 01483 489211 or email joanbendy@prioryhealthcare.co.uk

The closing date for these posts is Monday 14th September 2006.

Bank positions also available.

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

www.prioritygroup.com

Gateshead NHS
Primary Care Trust

DRUG AND ALCOHOL ACTION TEAM CONTRACT: COMMUNITY INTEGRATION SERVICE

Gateshead Primary Care Trust, on behalf of the Gateshead DAAT are looking to appoint a lead organisation to run and manage the new community integration service for drug misuse clients within the Gateshead area. The lead organisation will appoint a team leader/manager to run the service. The team will consist of staff from a number of partner agencies who will work collaboratively within the team alongside staff directly employed by the lead agency. There is an expectation that this service will employ significant numbers of ex-service users in support and/or volunteer worker roles.

The overarching aim of this service is to assist drug misusing clients back into mainstream community.

This service should be seen as a package of support that is integrated into the clients' treatment and care plan and long term goals for the future. It is envisaged that packages of support will be individualised to the client. Due to the close connection with the clients care plan, the lead organisation awarded this tender will need to work in collaboration with existing service providers.

The main areas this community integration service will be expected to work with are supporting and signposting clients into housing, training, employment opportunities and community opportunities.

This service will operate flexible opening hours, dependent on the needs of the clients. It is not envisaged that this will be a 9am to 5pm, Monday to Friday service.

Further information on these services and the requirements of the provider are available in the service specifications.

Service Providers expressing an interest in supplying the service must apply in writing to Judith Patrick, Deputy Supplies Manager, Gateshead Health NHS Foundation Trust, Queen Elizabeth Hospital, Sheriff Hill, Gateshead, Tyne & Wear, NE9 6SX. Telephone 0191 445 2988. Responses are to be received by no later than 18th August 2006.

TACKLING DRUGS CHANGING LIVES

Developing Initiatives Supporting Communities
DISC

PROJECT MANAGER

YOUNG PEOPLES DRUG SERVICES
based in Hartlepool
£24,897 - £29,537 (under review) + benefits

DISC is a dynamic charity working across the Northern region. We deliver a number of innovative services aimed at helping those marginalised within the community. DISC offers employees a positive working experience with good supervision and support, a team based approach to developing services, a commitment to staff training and development and up to 32 days' leave per year.

DISC's Young Peoples Drug Services provide a range of specialist interventions to meet the needs of young people, families and carers in Hartlepool and Stockton.

We are seeking an energetic, forward thinking manager to drive our service development in this area. Responsible for a small management team, you will work to ensure that we provide a range of high quality services to young people who require treatment and support.

You will have a sound knowledge of child care practice and legislation; be up-to-date with substance misuse policy and current treatment interventions; have a good understanding of Clinical Governance issues and have experience in partnership working.

Ideally you will have a qualification in Social work, Youth work, Nursing or similar. A management qualification would be useful however DISC are committed to ensuring all managers receive training that leads to a DMI qualification.

This is a challenging role and we are interested in hearing from you if you have the passion and commitment to succeed.

For an application pack please contact the address below, quoting the reference number 06/ds/37 or visit us on line at www.disc-vol.org.uk

DISC Training & Development Centre, Merrington House, Merrington Lane Ind Est, Spennymoor, DL16 7UT
Tel: 01388 - 424 453.

Closing date for completed applications is
12 noon on 14 August 2006.

www.disc-vol.org.uk

Registered Charity No. 515 710

Lifeline Project Ltd

Service Manager – Tower Hamlets Young People's Service

Based Tower Hamlets
Package up to £38k

Established in 1971, Lifeline is a leading drugs charity with a reputation for cutting edge campaigning combined with innovative service design.

In partnership with Tower Hamlets Drug Action Team and working closely with the YOT and CAMHS (ASATS) teams, Lifeline has developed an innovative and comprehensive approach to engaging and working with young people at both tiers 2 and 3 in a diverse and challenging East London borough.

To meet this challenge we're seeking an individual with proven project management skills and a background in working with young people's or drug services. You will have good people management skills, a strong commitment to partnership working and a track record of delivering results.

Lifeline will be able to offer you a competitive package, first class professional development, locally based senior management support and the chance to shape and develop an exciting young service.

Closing date for applications: 25th August 2006
Interviews: 7th September 2006 (Tower Hamlets)
For an application pack please e-mail: helen@lifeline.org.uk
For further information about Lifeline Project visit

www.lifeline.org.uk

Addiction Counselling Trust

A Company Limited by Guarantee No. 3164431 & a Registered Charity No. 1054524

Substance Misuse Worker

High Wycombe, Buckinghamshire

£20,421 to £22,628 per annum 18.5 hours per week, pro rata

ACT is the principal provider of non-statutory substance misuse services in Buckinghamshire.

This post will provide substance misuse counselling/support, as well as advice and information, group work and assessments within a multi disciplinary team. A portion of the work will be carried out in Chesham. Application closing date is 14th August 2006.

For an application pack please contact Nicola on 01296 425329 or email Nicola@addictioncounsellingtrust.com

ACT is an Equal Opportunities employer and is an Investor in People

Setting new standards for Social Care Professionals.

Specialising in the provision of Substance Misuse Personnel

Substance Misuse Workers
DIP Workers
Arrest Referral Officers
Project Workers
After Care and Thru Care Workers

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Email **info@rigsocialcare.co.uk**
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Recruitment & Employment Confederation

The Huntercombe Group
www.huntercombe.com

Huntercombe Hospital Maidenhead

Are seeking to recruit an

ADOLESCENT ADDICTIONS THERAPIST

FULL TIME £30,000 pa

To provide specialist interventions and guidance within the setting of a dedicated adolescent mental health facility.

Applicants should be DipSW or RMN qualified, and have at least 2 years experience working with young people with drug and alcohol problems.

Closing date: 14th September

For further information and an application pack contact: Mick Davies on 0191 5235516 or email mick.davies@fshc.co.uk

RAPt

'Stopping Addiction, Stopping Crime'

COUNSELLORS & DRUG WORKERS WANTED

Starting salary £21,000 plus a generous benefits package

RAPt, one of the country's foremost providers of drug treatment services in the criminal justice sector are always looking for 12-step Counsellors and Drug Workers for their prison and community-based projects.

For more information, or an application pack, please send an A4 SAE and covering letter to: Mandy Coburn, RAPt, Riverside House, 27 – 29 Vauxhall Grove, London SW8 1SY or email mandy.coburn@rapt.org.uk

RAPT strongly encourages applicants from Black and Minority Ethnic individuals and from those in recovery from addiction. Registered Charity No. 1001701

The first step to change.

Therapeutic Managers

£28,000 + benefits

Murray Lodge, Coventry — Ref: MURL/366/DDN
Chatterton Hey, Bury — Ref: CHAT/361/DDN

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

Langley House Trust has developed a new Drug Rehabilitation Programme based on an adapted 12 Step model aimed specifically at the needs of the ex-offender and homeless client population. The abstinence based programme combines a range of therapeutic elements with education, training and the development of life skills necessary to ensure smooth transition and return to the community. Support for clients continues after completion of treatment by the provision of ongoing aftercare.

Your knowledge and experience of drug treatment and rehabilitation will prove essential in making sure the programme, whether in Bury or Coventry is a success from the start. You will ensure that one-to-one counselling, therapeutic groups, workshops and education are delivered to a consistently high standard and you will play a key role in ensuring the Langley House Approach provides the support necessary to break the cycle of drug addiction and offending for good.

This is more than the opportunity to shape a brand new team; it's the rare chance to develop a team to deliver a totally new drug rehabilitation programme. If you have experience of staff management and development and wish to retain your own caseload this is the ideal role for you. You will need to be professionally accredited with at least 2 years' experience of working with drugs issues, in an abstinence-based 12 Step or similar context. If you possess the energy and passion with which to deliver an effective and robust treatment programme you will influence the successful launch of our project and the ongoing success of the Trust.

If you are a practicing/professed Christian and wish to find out more, or obtain an application pack, please visit our web site at www.langleyhousetrust.org or telephone us on 01993 705999, quoting the appropriate reference number .

Closing date: 14th August 2006.
Interview date for Coventry: 22nd August 2006.
Interview date for Bury: TBC.
Regulation 7(3) of the Employment Equality (Religion or Belief) Regulations 2003 applies to this post.

Langley House Trust

Charity Number 250059 and Registered Social Landlord Number H4250

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Avon and Wiltshire NHS

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The outlook's great

If you're looking for a brighter future, the forecast's good at our Trust. One of the largest and most innovative Trusts in the country, this is an opportunity to join us and bring some sunshine to your life and many others.

Service Manager RMN, DipN (MH), CQSW, Clinical Psychology

Location: Specialist Drug and Alcohol Service, Kingshill House, Swindon
Job Ref: DS296/261
Salary: Band 8A £35,232 - £42,278 p.a.

You will manage and lead a multidisciplinary community drug and alcohol team, working in partnership with key stakeholders and ensuring the delivery of an excellent treatment service.

You will have substantial experience in drug and alcohol services and at least two years' management experience in the health/ social care field; this should include the management of contracts and budgets, and the development of both staff and services.

For an informal discussion contact Ian Dickinson, Acting General Manager and Clinical Lead on 0117 918 6881 or 07974 723156.

To apply, e-mail: recruitment@awp.nhs.uk or tel: 01225 731602.

Date for receipt of completed applications: 11 Aug 2006

The Trust is committed to improving working lives and there are opportunities for flexible working.

a brighter future

Apply online at: www.recruitment-awp.nhs.uk