

# DDN

Drink and Drugs News

**'People don't have to go through assessments elsewhere, they don't have to go through the funding rigmarole and wait for three months... If they're detoxed, if they've taken that first step, then they can come to us.'**

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## **MATERNAL MATTERS**

Giving mothers the help they need for recovery

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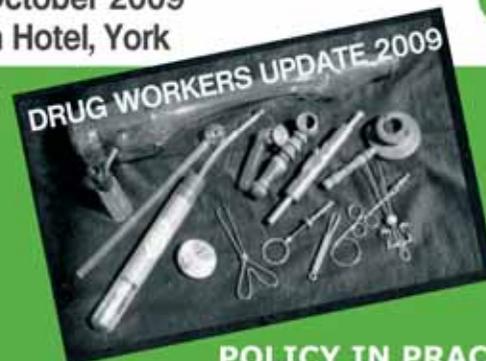


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Editorial - Claire Brown

## Trial by public

The importance of not playing to the gallery

At this year's DDN/Alliance service user involvement conference back in January, one of our speakers reported on her participation in the Random Injectable Opioid Treatment Trial (RIOTT). A survey half way through the trial had reported considerable success in reducing chaotic drug use through a regime of supervised diamorphine injections, she said, telling our conference delegates 'the way forward is for service users to ask joint commissioners to start trials in their areas. It makes sense – it works, it saves lives.'

This week the results of the RIOTT were made public and debate took to the airwaves, newspapers and blogosphere. Reporting that the reductions in heroin use have been 'quite spectacular', Professor John Strang, who led the trial, called for the treatment to be made more widely available (news, page 4). But the impressive outcomes have inevitably been drowned out by clamour against the prospect of 'shooting galleries' up and down the country. Even where some broadsheets have attempted to examine the topic rationally, readers have not followed suit in their online fora – all of which detracts from the essential point that this trial is directed against a small but significant percentage of the treatment population, people for whom this evidence-based intervention could mark a life-transforming turning point.

From RIOTTs to calm... and our cover story finds out more about a holistic programme based in the Cotswolds that gives clients a chance to look at spiritual wellbeing as well as physical needs. One of the interesting aspects of Inishfree's work is the focus on social responsibility, beginning with a harmonious relationship with the local community – from supplying volunteer workers for local businesses, to looking after pets while their owners are away. It's a far cry, and a welcome one, from the 'them and us' culture manifested in placard-wielding protests to a new treatment centre, sent to me in press cuttings recently – and in reactions to the RIOTT trial.

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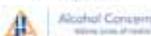


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the Treatment of Addiction



## This issue



Page 14



Page 12

### FEATURES

#### 6 THE CALM WITHIN – COVER STORY

David Gilliver hears about the intensive holistic help offered by Cotswolds-based supported housing programme Inishfree.

#### 10 THE ECONOMICS OF RECOVERY

At a time when the field is facing unprecedented financial pressures, Peter Martin discusses the value of a recovery-based drugs policy.

#### 11 'YOU HAVE A NEW MESSAGE'

The drinks industry has won the battle of regulation, says Don Shenker.

#### 12 MOVING TOGETHER

Nick Barton and Emma Gulliver describe how the M-PACT programme is helping to protect young people from the harmful effects of parental substance misuse.

#### 14 THE MOTHER OF ALL ISSUES

Rosemary Jambert-Gray, Kevin Lucas and Valerie Hall look at the issues surrounding drug use and motherhood and urge commissioners to remove the barriers to a mother-friendly service.

### REGULARS

4 **NEWS ROUND-UP:** Prescribed heroin success for entrenched users • UNODC targets 'precursor chemicals' • Users mix low quality drugs • Ban all drink ads, says BMA • New codeine guidance • News in brief

8 **LETTERS AND COMMENT:** UKDPC calls foul, national recovery agency?, half-baked debates.

9 **RECIPES FOR RECOVERY:** Benefits of home-growing go way beyond taste, says nutritionist Helen Sandwell.

15 **POST-ITS FROM PRACTICE:** Treatment must view service users as individuals, says Dr Chris Ford.

16 **JOBS, COURSES, CONFERENCES, TENDERS**

## News in Brief

### Addicted to news

A new set of guidelines to promote the 'constructive, accurate and responsible' reporting of opioid dependence, *Addicted to news*, is to be launched by the International Harm Reduction Association (IHRA) and partner organisations next month. 'It is essential that we help journalists to better understand the issues around opioid dependence, strike a balance in their reporting to avoid stigmatisation and help encourage a different perspective which communicates positive messages about drug treatments,' says IHRA. Similar guidelines are already used to prevent sensationalist reporting in the fields of HIV and mental health.

### Presidential plea

The former president of Brazil, Fernando Henrique Cardoso, has added his voice to calls for a drug policy based on harm reduction and decriminalisation. Writing in *The Observer* he said 'It's time to admit the obvious. The war on drugs has failed.' A solution need not necessarily be a 'stark choice between prohibition and legalisation' he said – 'to be credible and effective, decriminalisation must be combined with robust prevention campaigns.'

### Gender duties

A new briefing on the gender equality duty for drugs agencies has been produced by alcohol and drug-related domestic violence agency the Stella Project. It sets out the obligations of both service providers and commissioners to make sure that women have equal access to services, as women often face extra barriers to accessing services and equal treatment. *Gender quality duty briefing for substance use service providers available at [www.gldvp.org.uk](http://www.gldvp.org.uk)*

### C the message

A successful hepatitis C awareness campaign on the theme 'easy to get, easy to avoid' has been mounted by Peterborough-based SUGAR (Service User Group Around Recovery) in partnership with local drug services, DIP and IDTS, as well as Exchange Supplies, who designed the campaign's T-shirts. The campaign focused on peer education, stressing that drug users should not share 'water, filters, spoons or even citric,' alongside the obvious message of not sharing injecting equipment.

# Prescribed heroin success in treating entrenched users

**Prescribed injectable heroin under strict medical supervision could be the key to retaining the country's most chronic drug misusers in treatment, according to findings from a trial project by King's Health Partners.**

The Randomised Injectable Opioid Treatment Trial (RIOTT) (*DDN*, 23 March, page 11) is the first controlled trial in the UK to compare injectable opiate treatment – both heroin and methadone – to high quality oral methadone for severely entrenched injecting drug users. It found reduced rates of street heroin use, particularly among the heroin group, along with less involvement in crime and less money spent on drugs.

The trial's participants were long-term 'hard to treat' heroin users who were injecting heroin almost daily despite being in active treatment. They were 'randomised' to treatment with either supervised injectable heroin, supervised injectable methadone or 'optimised' oral methadone in injection clinics in London, Brighton and Darlington. There were also high levels of psychological and social support.

The trial found better retention (88 per cent) in the injectable heroin group, compared to 81 per cent in the injectable methadone group and 69 per cent in the oral methadone group. All three groups reduced their use of street heroin, but three quarters of the heroin group substantially reduced their use, a quarter of those remaining totally abstinent from street heroin. Benefits were seen within six weeks and maintained throughout the six-month study period, while reductions in the injectable and oral methadone groups were more modest.

The heroin group also cut their spending on drugs to an average of just under £50 per week at six months, compared to £300 a week before the trial. Rates of self-reported crime fell sharply, with the proportion of those reporting crimes more than halving across the groups, and fewer crimes being reported among those still committing crimes. Those in the heroin group had committed a total of 1,731 crimes in the 30 days before entering the trial, falling to 547 after six months, while crack use also reduced across all treatment groups and there were improvements in physical and mental health and social functioning.

'The cost of producing positive results in this 'difficult to treat' group is around £15k per patient per year,' said a statement from King's Health Partners. 'These are the most severe of the heroin using population, many of whom are typically committing a high level of crime to fund their addiction. By comparison the typical cost of prison is £44k a year per person, not to mention many other costs to society.'

Coordinated by the National Addiction Centre, the research was funded by the Big Lottery in partnership with the NTA. The results will now be made available in a peer-reviewed scientific publication with a view to continued research, said professor of addiction research at the Institute of Psychiatry, Professor John Strang. 'The reductions in heroin use have been quite spectacular and as a doctor I would like to see this become more widely available,' he said.

The trial has, unsurprisingly, provoked controversy in the press, with the NTA issuing a statement refuting a story published in *The Independent* before the findings had been officially released. Under the headline 'Clamour grows for heroin on the NHS', it wrote that 'a group of government-appointed drug czars will call for a nationwide network of "shooting galleries" to provide injectable heroin for hardened drug addicts across the country.'

'No one is suggesting that this should be the front line treatment for heroin addiction,' said NTA chief executive Paul Hayes. 'Heroin has been available on prescription since the 1920s to a very limited number of addicts, and these pilots are simply to explore whether controlled prescribing of injectable heroin will be effective in overcoming their problems, minimising the harm to the public, reducing crime, and cost effective to the tax payer. In particular the pilots need to identify how many individuals might benefit from this treatment, but at most we are talking about a very small proportion of the 160,000 heroin addicts in treatment.'

'It would be a misreporting of our study to say that this was what we were calling for across the whole treatment population,' Strang told the BBC's *Today* programme. 'We're talking about this for probably the worst five per cent.'

[www.kingshealthpartners.org](http://www.kingshealthpartners.org)

## UNODC targets 'precursor chemicals'

**A new campaign to curb the trafficking of chemicals used in the manufacture of illegal drugs has been launched by the United Nations Office on Drugs and Crime (UNODC).**

PRELAC, a three-year partnership project with the European Commission to address the trafficking of chemicals used to manufacture heroin, cocaine, amphetamines and ecstasy, will aim to 'strengthen the capacities of national administrative control authorities to

prevent the diversion of precursor chemicals,' states UNODC – particularly to Latin America and the Caribbean.

Previous attempts to address the problem have been hampered by limited knowledge and information sharing capacity, says UNODC. The project will cover 12 countries in Latin America and the Caribbean and will include the establishment of a web-based information sharing system along with standardised legal frameworks and control mechanisms.

## Users mixing range of 'low quality' drugs

**The declining quality of street drugs means users are increasingly combining a range of low quality drugs to 'top up', according to DrugScope. Falling quality could be accelerating the 'longer-term trend towards poly drug use' says the charity's annual *Street drug trends survey*, which is based on feedback from 70 drug services, service user groups, DATs and police forces across 20 areas of the country.**

Seventeen areas reported declining quality of crack and powder cocaine, with police in one area seizing cocaine of just 2 per cent purity. There was also widespread reporting of falls in the quality of heroin, amphetamines and ecstasy, along with the sale of fake prescription tranquilisers like diazepam. Eighteen out of 20 areas reported growing ketamine use and for the first time services reported concerns over the use of 'legal highs', a range of substances used in the production of which were recently banned by the government (*DDN*, 7 September, page 4).

It was essential that services had the capacity to help people who'd developed problems with a range of substances, including drugs like ketamine and GHB, said DrugScope chief executive Martin Barnes. 'While overall levels of drug use have remained relatively stable in recent years, the range of substances appearing on the radar of drug services and enforcement agencies appears to be increasing,' he said. 'There has been a long-standing trend towards people using a varied menu of drugs, but it could be increasing because of the low quality substances that appear to be dominating the UK street drug market. The fact that older teens and young adults are increasingly combining substances including ketamine, cocaine, cannabis and cheap high-strength alcohol is particularly concerning.'

Report available at [www.drugscope.org.uk](http://www.drugscope.org.uk)

## Ban all drink ads, says BMA

**The British Medical Association (BMA) has called for a total ban on alcohol advertising in its new report *Under the influence – the damaging effect of alcohol marketing on young people*, which proposes ways to address the 'excessively pro-alcohol social norms' to which young people are exposed. The ban would include sponsorship of music and sports events.**

The alcohol industry spends around £800m a year on promotion and marketing, says the report, which looks at viral campaigns and the use of social networking sites alongside traditional advertising. It makes nine recommendations for government, chief of which is to 'implement and rigorously enforce a comprehensive ban on all alcohol marketing communications'. Others include minimum price levels, reducing licensing hours and increasing alcohol excise duty above the rate of inflation, with tax rates linked to alcoholic strength.

Young people's irresponsible drinking is a 'social phenomenon driven by values and norms that are prevalent throughout society and underpinned by clever alcohol marketing in all its forms,' says the document, with the industry's use of 'stakeholder marketing' – including partnership working and the funding of health campaigns – enabling it to influence policymakers and regulators. The fact that the industry had been involved in advising government about alcohol reduction policies amounted to a 'perverse situation' akin to 'putting the fox in charge of the chicken coop' said BMA head of science and ethics Dr Vivienne Nathanson.

'Politicians showed courage before by not bowing to the tobacco industry – they need to do the same now and make tough decisions that will not please alcohol companies,' said Nathanson. 'The reality is that young people are drinking more because the whole population is drinking more and our society is

awash with pro-alcohol messaging and marketing. The BMA is not anti-alcohol. As doctors our focus is to ensure that individuals drink sensibly so they do not put their health and lives in danger. When the BMA initially called for a ban on smoking in all enclosed public places there were outcries but I doubt most people would want to return to the days of smoky pubs now. This shows that behaviour can change and this needs to happen with alcohol consumption.'

The report was welcomed by Alcohol Concern who said there was 'no longer any doubt' that the combination of marketing and low prices was encouraging young people to drink at a level that health services struggled to cope with. 'It's high time the government listened to the medical profession,' said chief executive Don Shenker. Not all health bodies have backed the call, however. Faculty of Public Health president Alan Maryon Davis said that while it was clear that voluntary codes were not working, his organisation had 'reservations about a blanket ban on marketing alcohol'. 'We strongly advocate minimum pricing as one way of stopping all of the ultra-cheap offers in supermarkets, clubs and pubs that tempt so many young people into dangerous bingeing,' he said.

Chief executive of drinks industry body The Portman Group, David Poley, accused the BMA of criticising the system 'while failing in their duty to alert the independent complaints panel to their marketing concerns'. 'The BMA is ignoring all the evidence that advertising causes brand switching, not harmful drinking,' he said. 'Lasting social change can be achieved only through sustained education accompanied by proper enforcement of the alcohol laws.'

Report available at [www.bma.org.uk](http://www.bma.org.uk)

Don Shenker comments on the battle to change our drinking culture, page 11.



**Bottling it up:** just four per cent of alcohol sold in supermarkets features the five elements that are meant to make up industry best practice labelling, according to a survey by Alcohol Concern. Just over half carried unit information but only 18 per cent had information about sensible drinking levels, according to *Message in a bottle*, which looked at ten promoted products in branches of five leading supermarkets. The organisation is calling for mandatory health labelling on all alcohol products. 'There is a huge disparity between the drinks industry's enthusiasm to promote and advertise alcohol to the public and their willingness to give consumers the facts about what they are drinking,' said chief executive Don Shenker. The BMA has now called for a total ban on all alcohol advertising (see story above).

## New codeine guidance

**New advice on over-the-counter medicines containing codeine has been issued by the Medicines and Healthcare products Regulatory Agency (MHRA) in response to concerns about addiction.**

The measures – on medicines containing both codeine and dihydrocodeine (DHC) – include clear and prominent warnings on the label and patient information leaflet about the risk of addiction and the importance of not taking the medicines for more than three days. The move follows advice from scientific advisory body the Commission on Human Medicines (CHM), and there will also be updated advertising controls to make sure the warnings are clearly presented, as well as new guidance on pack size. The guidance also asks pharmacists to recommend the products appropriately and warn customers of potential risks.

Medicines containing codeine and DHC could be addictive, said the MHRA's director of vigilance and risk management of medicines, Dr June Raine, but the MHRA was 'taking action to tackle this risk', she said. 'The MHRA is ensuring that people have clear information on codeine-containing medicines, on what they are to be used for and how to minimise the risk of addiction.'

Guidance available at [www.mhra.gov.uk](http://www.mhra.gov.uk)

**W**B Yeats' poem *The Lake Isle of Innisfree* is about finding inner peace in a rural setting, and this is what clients who come to the Inishfree community in Gloucestershire hope to achieve. Set in the southern Cotswolds, Inishfree (the spelling was changed as 'Innisfree' was already in use) is a residential drug and alcohol-free community that offers accommodation, support, training and therapy for up to nine people recovering from drink or drug dependency.

The community's work is underpinned by anthroposophy, a fusion of science and mysticism developed at the end of the 19th century by Rudolf Steiner, who described it as a 'spiritual science'. 'A group of us felt there was a need for a different kind of approach,' says project coordinator Andrea Sprenger. 'We were working in drug treatment, sexual abuse, self-harm – all kinds of fields connected to causes rather than symptoms. For us it's more about the cause.'

The group began the groundwork to set up the organisation in 2000, and by March 2003 funding was in place and Inishfree opened its doors. The aim is to focus on the physical, emotional, spiritual and social needs of the client all at the same time, and one of the core aspects of Inishfree's work is the benefit of physical activity like gardening, alongside interaction with the community's animals. 'Working with the animals is a very important part of it,' says Sprenger. 'It's extremely positive for the clients because it's just a very different, non-challenging, non-confrontational relationship.'

Social needs, meanwhile, are met by the very act of living in the Inishfree community, which also helps foster a sense of social responsibility. 'Clients can be anxious about making contact with others because they don't really know how to communicate with people when they're not using – so it's really building up their confidence that they can be with other people and be appreciated,' she says.

Basic funding comes from Supporting People, but that doesn't cover therapy or activities like the horticultural work, work on the community's smallholding or work with the animals. 'That comes from donations and fundraising,' she says. 'A tiny bit is paid by the clients, but only by those who have the capacity to pay some towards it.'

Clients are a mixture of referrals and self-referrers – they may come from prison or their family members may have found the website. A crucial element in all

cases, however, is that they can go to Inishfree without having their funding sorted out first. 'That's the biggest advantage and it's why we were set up through Supporting People – people don't have to go through assessments elsewhere, they don't have to go through the funding rigmarole and wait for three months,' she says. 'If they're detoxed, if they've taken that first step, then they can come to us and we assess them here to see if they're eligible and motivated enough.'

Once clients have arrived detoxed and drink and drug free, the programme lasts a year. 'That's what we think gives them a good foundation if their problems are severe – and you don't go into residential rehab unless you've had prolonged problems,' she says. 'That gives you a good chance, with ongoing support, to stay abstinent. Quite a few clients stay for the year, and we've got a couple who are staying for their second year – that's the maximum we can offer. When I say good foundation that's what I mean – it doesn't mean "that's it, you're cured". It's a very strict programme, but with support.'

So how would she explain the concept of anthroposophy to those unfamiliar with it – what are the basic tenets? 'It basically means that you can find out about the spiritual world – a world beyond the visible world – by using the same kind of methods that you would use in science,' she says. 'It means the spiritual is not something that we just have to speculate about, but something we can actually find out about.'

How does that manifest itself in day-to-day dealings with the clients though? 'That's a good question,' she laughs. 'It really manifests in what we offer. It's not about what we preach or talk about – because we don't really talk about it a lot – but what we offer is a very holistic programme. We work with our hands on the land, with natural processes – we bake our own bread, grow our own vegetables. It's all about observing change.'

Inishfree is no cult, however – the concept is something that underpins Inishfree's work, rather than a philosophy that's explicitly stated to the clients. 'There are occasions when clients ask about what we're doing here and we'll answer that, or there are times when people's crises become so acute that they're asking themselves those kinds of questions about what they're doing in life. But it's that rather than 'we're working out of anthroposophy and Steiner did this, that and the other'. Some people want to learn about it and are interested and others

# THE CALM WITHIN

David Gilliver hears about the intensive holistic help offered by Cotswolds-based supported housing programme Inishfree

never ask about it at all, and that's fine. It's left to them.'

If someone asked the key difference between Inishfree and more mainstream services would it be that it addresses those deeper philosophical questions? 'Yes, it address the whole of the human being – not just the addiction part. Self-worth and self-esteem and being able to discover your own talents are big parts of what happens here because there's a lot of artistic work. Clients will think "no, I can't do that" and then suddenly realise that they can. People can just get on with their projects here – we've got someone who was just doing woodwork in his spare time and he's building furniture now.'

Something else that sets it apart from other services is that feedback from the local community has been almost entirely positive from the start. Is that partly to do with the rural setting? 'It's that and because we're small and our clients are very well behaved – they're not going out and coming back drunk or anything. And also people can see that the land we're working on – which had basically just been left to its own devices – has been turned into a wonderful market garden. They can see there's work being done – it's about doing something really positive that people can see and enjoy.'

Even so it's not always the case that treatment facilities have such a harmonious relationship with the local community. 'We're very lucky,' she says. 'We're in a small village and we've got a parish council that are incredibly supportive – we have a stall at their village fête and they even make collections for us. They're very inclusive and happy that we're here, which is a bit rare I agree. And we have neighbours who are very supportive and get vegetables from us. We do have one neighbour who's quite sceptical, but he's coming around because we've been in these premises almost two years and he's realising that actually we're no nuisance at all.'

The positive relationship may also have to do with the range of services that Inishfree provides to the local community, including volunteer workers for local businesses and farms. It even operates a community pet scheme, looking after animals when their owners are away. 'We've got a chinchilla at the moment, so even animals that don't belong to us can come here for respite,' she says. 'Once people have been here for six months and are stabilised they can go for a placement for

one to two days a week with a local company. Whatever their interest may be – retail or woodwork or farming or craft – they can go and volunteer.'

What about the feedback from the clients themselves? 'One question is if people do relapse, where do they go afterwards – do they come back here? And they do. The people that we have here come because this is what they want, and although they find it a very intense programme they always find it very, very beneficial. If people stay here it's because this is what they think they need, so the feedback is always positive.'

One of Inishfree's strengths, she believes, is that the work is extremely structured but not focused on groups. 'That's what people are looking for – they're happy that they don't have to sit in groups all the time and listen to lectures and watch DVDs. There is some of that – we have two groups per week and some one-to-ones – but the rest of the time they're engaged in the actual work.'

The intensive nature of the programme means that places are limited – at the moment Inishfree can accommodate up to nine clients, but there are plans for expansion and a move to new premises. This means the community will be able to take on clients with different needs – such as those with mental health issues or learning disabilities – but the organisation is committed to retaining the intimate nature of the work. 'Having clients with different needs will mean that it becomes less of a monoculture,' she says. 'We plan to have a farm and a bigger community, but not all in one household – we'll always be looking at about a maximum of nine people in each household.'

But isn't anthroposophy something of an esoteric concept for a treatment facility these days? 'The word isn't used very much, but if you know about Steiner he inspired so many different aspects of life – education with the Steiner schools, agriculture with biodynamic agriculture, working with learning disabilities in Camphill communities, medicine and social life.'

Ultimately it all comes back to Yeats' vision of inner and outer calm – being at peace with yourself and the world. 'It explains what recovery can be about, which is inner peace – it's not about everybody coming here and then going away and becoming farmers.'

[www.inishfree.org.uk](http://www.inishfree.org.uk)

**'People don't have to go through assessments elsewhere, they don't have to go through the funding rigmarole and wait for three months. If they're detoxed, if they've taken that first step, then they can come to us.'**





**'Tolerating some level of drug dealing is exactly what the UKDPC report is advocating in its recommendation to drug enforcement agencies, and it is precisely for that reason the report has drawn such a critical response from some quarters.'**

### UKDPC calls foul

Roger Howard has called foul on what he describes as the 'inevitable media misreporting' for accusing the UKDPC of advocating an approach to drug enforcement that amounts to 'tolerating some drug dealing' (*DDN*, 7 September, page 12).

The thrust of the UKDPC's report *Refocusing drug-related law enforcement to address harms* is to encourage drug enforcement agencies to adopt a harm reduction focus in their work – tackling the most harmful drug markets and nudging them, in the words of the report, towards a 'less noxious form of selling'. I don't know about you but that sounds to me awfully like tolerating a level of drug dealing in those markets that are deemed to be less harmful.

But whether I and the media are right or wrong in that interpretation is less important than what the UKDPC report actually says about the issue of adopting a harm reduction focus in drug enforcement work. Page 62 of the report says that 'Adopting such an approach will be a challenge. Some of the more radical suggestions such as prioritising open markets and thereby "tolerating" other activities (eg closed dealing conducted away from residential areas) can be seen as letting dealers get away with crime. The current media and political climate would seem unfavourable to such an approach. However, where resources are finite, sometimes these sorts of decisions are made implicitly, and if they can be shown to reduce harms in the long term then attitudes might change.'

The media and the UKDPC critics have been wrongly charged by Roger Howard. Tolerating some level of drug dealing is exactly what the UKDPC report is advocating in its recommendation to drug enforcement agencies, and it is precisely for that reason the report has

drawn such a critical response from some quarters.

**Neil McKeganey FRSA, professor of drug misuse research, University of Glasgow**

### A national recovery agency?

It is good to see Paul Hayes moving towards a recovery strategy, but the NTA will regrettably apparently continue with 'treatment', even though research tells them that under 3 per cent of methadone users will recover and history shows that only 21 per cent of those in other 'treatments' will return to a normal life.

Unfortunately, when 'treatment' succeeds in so few cases, it is just not worth investing in something that has far more chance of failure than of success.

Proven over many decades and numerous countries, a massively successful recovery rate rests in training users to recover themselves, and while this costs society what methadone costs every three years, such an abstinent recovery result is for life. Almost nobody recovers from methadone – ever.

Addiction generates addictive behaviour whether the drug be amphetamines, cannabis, cocaine, crack, crystal meth, heroin or methadone and their usage is closely interrelated whether they be illegal, licensed or prescribed.

As a result, trying to determine who uses 'what' and 'where' is basically futile when real recovery activity 'should be available for anyone who has a problem with their drug use' – as Hayes himself says.

If an addict's family can immediately contribute only x percent of the recovery costs, then the state should contribute the balance, and the family repay the difference over the next years – in the same way they pay for a new car.

This is a fantastically rewarding activity

for the whole nation as, unlike those on currently failing 'treatments', we would be returning addicts, now supported by the Exchequer, to a productive lifestyle, no longer burdening the taxpayer with excessive medical and benefits costs.

Training people in DIY recovery not only allows them to recover their natural abstinence, but also provides the lessons they need to stay off drugs and find a normal position in society.

If Paul Hayes focuses away from long-term 'treatment' and onto short-term 'training', he will enjoy the thanks of a nation, because we will be stronger, healthier, more productive and free of a major degree of crime.

**Elisabeth Reichert, school head**

### Half-baked debates

That the UK Drug Policy Commission has the same initials as the UK Disabled People's Council is only one confusing factor that makes it unsurprising that Roger Howard is having to defend his equally confusing drug policy enforcement review.

And he's still playing the same old game – lots of generalities about the 'principles' which his commission feels need applying, but nothing about exactly what to do. Typical of the half-baked debates we hear in every pub.

Illicit street drugs are just one factor in Europe's largest addictive substances problem area – the UK. But one seldom if ever finds mention by the UKDPC of licensed alcohol and legal prescription drugs, even though they are demonstrably the major inextricable

parts of the same overall problem.

And it is the policies governing alcohol, tobacco and prescribed addictive substances which provide the sales opportunities for illicit, basement and attic-produced supplies of street drugs – plus the smuggled and stolen tobacco, alcohol and pharmaceutical products flooding our communities.

Economists show that by increasing prices one kills demand for a product, but this has no relevance to addictive substances, for which people will ignore personal health and death warnings and will steal, cheat, mug and even kill for their supplies.

With beer at an exorbitant £3.00 plus a pint, and cigarettes at the highest price ever, it is little wonder that terrorists, smugglers and other criminals can make an easy multi-million pound living out of cut-price booze and fags.

That massive criminal niche in the market is mainly created by the chancellor's undisputed need for major tax income.

But taxes on these products can easily be collected by a system other than inclusion in the retail prices. A system that would slash such prices by well over 50 per cent and thus totally eliminate the current profitable market for illegal supplies of alcohol and tobacco and, if extended, take control of the criminal supplies of street drugs.

Unfortunately lack of space renders it impossible to expand here on the policy alluded to in the last paragraph, but a free copy can be obtained by phoning 01342 810151.

**Kenneth Eckersley, CEO, Addiction Recovery Training Services.**

### We welcome your letters...

Please email them to the editor, [claire@cjewellings.com](mailto:claire@cjewellings.com) or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at [www.drinkanddrugsnews.com](http://www.drinkanddrugsnews.com)

# Recipes for recovery

## GAINING THE PLOT

Home-grown fruit and veg can have benefits way beyond a better taste, says nutritionist Helen Sandwell



**OVER THE SUMMER** I moved house and, for the first time in my adult life, I have a decent sized, south-facing garden. Despite all the chaos reigning inside the house while builders pulled it apart and put it back together again, I've managed to set up a few small fruit and vegetable beds outside, and reap the harvest from them too. Take a look at my updated website – the photo features just some of our late summer crop. On top of that, we're still harvesting cucumbers, tomatoes, parsnips and beans, with corn, squashes and lots of greens still to come.

The reason I'm sharing this with you is because I've become somewhat of an evangelist about growing and eating home-grown fruit and veg. It really doesn't take much skill. Admittedly, I'm lucky because I have a green-fingered family (father and brother are professional horticulturists), but bar one previous feeble attempt with an allotment I never visited enough to water or weed sufficiently, this really is my first go.

For those of you with any outdoor space at all on your premises, I really do encourage you to turn some of it over to cultivation and hand the project over to your clients. And for those of you who have only windowsills or small back yards, your clients don't have to miss out. Herbs and salad leaves grow well on windowsills and just about any container can be used to grow veg.

The benefits they will experience from running a veg plot are manifold. As I mentioned two columns ago, outdoor physical activity is the best type for improving mental health. Not only will they be benefiting from the vitamin D produced in their skin, but it's also now thought that exercise and omega-3 fats together have a synergistic positive effect on brain function.

Of course home-grown fruit and veg taste much better than shop bought ones. You eat them freshly picked and properly ripened and can choose varieties grown for taste rather than perfect presentation. The freshness and ripeness of your produce are likely to mean that they are more nutrient-rich than their air-freighted, cold-stored counterparts. Tomatoes can be picked so red (and hence full of the antioxidant lycopene) that tomato sauces and salads will taste just like those you've had on holidays to the Med.

What's more, the growing cycle is utterly fascinating and could provide a hugely positive and rewarding activity, completely removed from the introspection of day-to-day drug treatment. There's something compulsive about nurturing plants – germinating the seeds, tending the plants, watching them grow and the edible parts ripen until the day comes to pick and eat them. For clients who've missed out on nurturing experiences in their lives, involvement in such a process is surely a positive contribution to their recovery. And for those whose previous disordered and dysfunctional life-course has prevented them developing a taste for healthy and varied food, cooking and eating what they have spent the last couple of months growing provides a gateway to experimenting with new foods.

Now is the time to allocate a suitable sunny patch and start making plans for next spring. If it's clay soil, autumn is the time for digging it over – or for light sandy soils, throw an old piece of carpet over the ground and leave it over the winter for the weeds to die down first. Start diverting your kitchen waste (minus meat products) to a compost bin. Come the spring, you'll be ready for your clients to start reaping the rewards.

*Helen Sandwell is a freelance nutritionist. Her website is at [www.goodfoodandhealth.co.uk](http://www.goodfoodandhealth.co.uk). Helen's nutrition toolkit, giving healthy eating advice relating to substance use, is published by DDN on CD-rom – email [charlotte@cjwellings.com](mailto:charlotte@cjwellings.com) for details.*



**Online opinions:** A taster of our website forum at [www.drinkanddrugsnews.com](http://www.drinkanddrugsnews.com)

I have for some time been questioning the 'two year rule'. My fear is that in attempting to manage the personal lives of people, we are, in fact, discriminating against the very clients we are paid to help.

Why can any person apply for a position and be subjected to one set of standardised risk management processes, while another (our client) has to go through additional measures? How can this be ethical and where is the justification, evidence of effectiveness or 'proof' that having such a system works? I think it's time to treat individuals as individuals, listen to what people have to say and accept that any recruitment has risk of the unknown, leading to problems.

My final point would be that we don't discriminate against all people with a history of substance misuse issues – just those who have accessed treatment for it.

Posted by KT



# The economics of recovery



At a time when the field is facing unprecedented financial pressures, **Peter Martin** discusses the value of a recovery-based drugs policy

**P**arachuting back into the drug and alcohol treatment field after a gap of four years, I had expected major changes. I'm now at EATA, the professional body for treatment and rehabilitation services, rather than running a large drugs charity as I used to do, but I find more similarities than differences. Of course, the environment is changing because of the projected downturn in public sector funding, and Paul Hayes is to be congratulated for leading the NTA towards recovery and reintegration (*DDN*, 7 September, page 10), against a backdrop of intransigence and strong resistance from some quarters.

Voices are now being raised about developing a manifesto for drugs and alcohol for a new government in 2010, and the debate is, I believe, becoming healthier. The recent formation of The Recovery Group UK, which I am privileged

to co-chair, is an indicator of a new, positive focus. The group, comprising academics, treatment agency chief executives and service users in abstinence-oriented recovery, has two purposes. First, to lobby for effective drug and alcohol treatment with a recovery orientation and second, to act as a reference for commissioners, providers, politicians and other interested parties about what is needed and how to go about setting up recovery-oriented treatment. The group is committed to instilling hope and aspiration and a future away from dependency and will help support delivery of those ambitions.

It is true that short-termism has played a part in policy. While politicians both Labour and Conservative have over the last three decades taken courageous steps to invest in harm minimisation and put a greater emphasis on treatment, the justification for investment has always been to use criminal justice and cost effectiveness as drivers. But in practice, as many of us know, cost effectiveness can be interpreted by the nervous as the need to get fast results – short-term commissions which work against holistic treatment and are increasingly tied to too much process-driven bureaucracy.

At the end of a period of unprecedented investment, many of us have, understandably, reacted to the failed expectations of political and media commentators with 'We could have told you that if only you'd listened!' But we too have been partly to blame for arguing endlessly within a rigid paradigm of abstinence versus methadone maintenance, instead of accommodating each other to move forward.

We cannot sacrifice our duty of care to drug and alcohol users by a failure to understand the threats posed by the tightening of the public purse. We must accept the truth that massive resources have been, and are still being, used up. When we realise that almost 70 per cent of the allocated treatment budget is spent on outdated psychiatric services for drug and alcohol misuse, including methadone maintenance, which do not progress the drug-using individual away from dependency in any meaningful way, we can be forgiven for thinking that ambitious policies have been reduced to 'social management', not the real transformational change of 'social wellbeing'.

Our field has seen obfuscation and protectionism that less generous observers might view as self-serving attempts to sustain medical hegemony over treatment. I have no doubt that rationalisation of NHS services in drugs and alcohol is required, not just for financial reasons but for reasons of good practice. And recovery is good practice.

The National Council for Voluntary Organisations (NCVO) has warned that the whole voluntary sector could be a soft target for cuts. Continued funding depends on organisations being able to demonstrate the value of their work – we can and must do this, but our arguments must spring from the cost effectiveness of recovery.

EATA's overarching position is that we should adopt a recovery-oriented approach to treatment from first contact. This is not revolutionary thinking, neither is it unrealistic. Rather it is a different kind of 'quantitative easing' applied to the social sphere, one which needs to be factored in to future investment in recovery programmes particularly when budgets are likely to be tight. This solution will pay for itself in the longer term.

How could anyone disagree with making recovery a leading part of the continuum of care? The recovery model comprises three elements – first point of contact (prescribing and detox), residential rehabilitation and structured day care, and aftercare (including employment and training for work)

It does not require the cost of an NHS trust to supervise it, nor expensive psychiatrists. There is no strength in the data on psychiatric interventions and drugs misuse for the vast majority of drug users – I accept the NHS and psychiatry has an important role to play in dual diagnosis, and it should be used for what it is best at.

All of us who care about reducing drug and alcohol misuse at a time when we are at an economic crossroads need to get behind the mantra that there is real value for money, and for society as a whole, to be had from basing policy and funding on the recovery model.

*Peter Martin CBE is chief executive of EATA*

## ‘You have a new message’



The drinks industry has won the battle of regulation, says **Don Shenker**

What's the best way to get the message across that alcohol in excess can be harmful? The Campaign for Smarter Drinking was announced in July amid much fanfare (*DDN*, 27 July, page 5). It is the drink industry's £100m response to Gordon Brown's challenge to put its house in order last year. The industry has come up with the goods just in the nick of time, staving off mandatory legislation for unit and health information at all supermarkets, pubs, bars and off-licences.

The scheme is backed by 46 companies including Molson Coors, Diageo and Tesco, however some supermarkets are not playing ball, in particular Sainsbury's and Asda. The campaign will be voluntary, so those not wishing to take part will not be penalised. The message too, will be chosen by the drinks industry, so you will soon see 'Why let the good times go bad?' on beer mats, bottlenecks and outdoor adverts, rather than the Department of Health's sensible drinking guidelines.

The Campaign for Smarter Drinking's social marketing push, aimed at curbing binge drinking in young adults, has been endorsed by government in a letter of understanding sent to the industry by Andy Burnham MP, secretary of state for health. The letter confirms that as long as the campaign runs successfully, mandatory point of sale information will not be thrust upon retailers and producers. The irony in this is that the Home Office has just completed a public consultation where mandatory point of sale information was a suggested as a national condition for all.

The real story here is actually that the Drinkaware Trust, the government's last great hope for a drinks industry social responsibility campaign, had run out of money and not received its intended share from industry coffers. The Campaign for Smarter Drinking will now continue to fund the Drinkaware Trust for at least a year, much to government's relief.

Having been involved in the discussions at the time of the creation of the Drinkaware Trust, Alcohol Concern and other stakeholders are now obviously concerned to see the creation of another voluntary vehicle prior to any independent review of Drinkaware's actual efficacy in raising awareness of sensible drinking. According to the Office for National Statistics (ONS) although 70 per cent of people had heard of sensible drinking limits, only two-fifths of those actually knew what those limits were – hardly positive progress after three years' work.

Drinkaware's website is riddled with assumptions that if only drinkers were simply more aware of the hazards of drinking, everything would be alright. This, sadly, comes from an industry hell-bent on not telling its customers how many units are in its products. Drinkaware also likes to position itself as the consumer's friend, yet has refused funds for alcohol charities that would like to promote harm reduction.

Of equal concern is that the creation of the Campaign for Smarter Drinking will unduly delay decisions government should be making, with regard to making point of sale information mandatory. Having set out government's position on



**As long as the industry rather than professional public health promoters are in charge of the message, there is the very real risk that the message will simply serve the interests of the industry rather than the consumer**

the importance of labelling and point of sale information in Safe Sensible Social, surely it is imperative now for government to act, rather than rely on the goodwill of the drinks industry.

It is highly unlikely that another voluntary agreement with the industry will yield the results government are looking for, namely compliance among all retailers to raise alcohol and health awareness. Previous government research on on-trade retail practices and product labelling have long demonstrated the fallibility of relying on self-regulation.

In addition, there is a very real concern that the very message 'Why let the good times go bad' will actually reinforce the notion that you need alcohol to have a good time. As long as the industry rather than professional public health promoters are in charge of the message, there is the very real risk that the message will simply serve the interests of the industry rather than the consumer. In the context of tobacco, there is actually evidence that some industry-funded tobacco information campaigns actually increased smoking rates.

In my view, two things need to happen. Government should establish a levy from industry to pass onto a health promotion body, wholly independent of the drinks industry, albeit funded by it. This body, answerable to the Department of Health and Home Office, should create the health and awareness messages that consumers need to see, raising unit literacy and changing the culture of drinking to get drunk.

Secondly, industry should be mandated to carry these health and unit information messages on all its products and wherever alcohol is sold. Failure to do so should result in a fine or loss of licence. Pie in the sky? Quite possibly, but it's the most sound solution I can think of to ensure consumers receive objective consistent advice about drinking in a targeted way.

*Don Shenker is chief executive of Alcohol Concern*

# Moving together

Action on Addiction's **Nick Barton** and **Emma Gulliver** describe how Moving parents and children together (M-PACT) is helping to protect young people from the harmful effects of parental substance misuse



Shepard & Hudson

Fifteen year-old 'Joe' had come to the attention of the youth offending team because he had been stealing clothes. It was easy to see that soon he would be cast in the eyes of authorities as simply a persistent offender. The downward spiral was being made to measure, so it was suggested that he and his mum – who had a serious alcohol problem – should take part in an M-PACT programme. During this it emerged that Joe never had clean clothes because the washing machine at his house was broken and had been for some time – his mum spent too much time intoxicated to get it fixed. Joe had come to believe that the only way for him to get hold of some clean clothes and avoid the wrong kind of attention was to steal them.

For every person with an alcohol or drug problem there are usually others close to them who are badly affected. Their number runs to several million and includes children, from unborn babies to adolescents – a significant proportion of whom end up on the 'at risk' registers of social services or, like Joe, in trouble of one kind or another.

The plight of these vulnerable and disadvantaged children was highlighted by *Hidden harm*, the Advisory Council on the Misuse of Drugs' (ACMD) 2003 report which made no less than 48 recommendations of the kind of responses necessary. More recently, Dr Vic Manning of the National Addiction Centre was commissioned by Action on Addiction, with the support of the Wates Foundation, to carry out a study estimating the number of children in the UK who live with an adult binge drinker or illicit drug user. He came to the alarming conclusion that some 3.4m children are living with a binge drinker or even more severely alcohol-abusing adult.

Everyone agrees that something must be done and NICE guidelines and the 2008 drug strategy echo this. But what can be done for the children who grow up in households where, in relationship terms, they may come a poor second to substances? One or two excellent initiatives have sprung up around the country but they are isolated and unconnected, and something a good deal more systematic is required.

In 2006, in direct response to families asking what our service did for children, the team at Action on Addiction's Families Plus set about researching and developing a programme that would provide an effective response to the problems faced by children living with the daily reality of parental substance misuse. The 'strengthening families' model offered the basis for a viable format and one that had enjoyed the benefit of extensive testing – however, the model required adaptation to fit the specific purpose we had in mind. Our background research also included separate consultations with parents and children, who were asked to give their views on what might help them.

This work resulted in the programme Moving parents and children together, known as M-PACT. We understand 'moving' in two ways – parents and children coming together after the fragmentation caused by addiction, and then moving forward as individuals and as a family. One of the advantages of M-PACT is that

**Joe never had clean clothes because the washing machine at his house was broken and... his mum spent too much time intoxicated to get it fixed. Joe had come to believe that the only way for him to get hold of some clean clothes and avoid the wrong kind of attention was to steal them.**

it takes a whole family approach, with children able to address their distress within the context of the parental relationship, and we hope this approach may help to avoid family break-up.

During an M-PACT programme, parents and children from up to eight different families meet weekly for two-and-a-half hours over eight weeks and work together to get a handle on the part played by parental substance misuse on family life. The group meets as a whole in separate groups of parents and children, with each family interviewed before the programme by one of our four facilitators to assess suitability.

Participants cannot be intoxicated, although those on prescribed medication are eligible, and non-using parents and those in recovery are encouraged to participate as much as those whose problem is current. Once the programme has finished, a review is carried out with each participating family and a reunion is held for all participants twelve weeks after the programme's end. The facilitators receive external supervision during the programme to help process the often-challenging material that surfaces and, naturally, a heavy emphasis is placed on child protection.

The aim of M-PACT is to reduce harmful patterns of behaviour and improve communication, coping skills and the safety of the home environment and, most importantly, draw on and build family strengths which have often become obscured in a home life distorted by substance misusing behaviour. Each of the eight sessions has a focus and a structure but participants are also consulted about the forthcoming session. Pilot M-PACT programmes have been evaluated by the mental health research and development unit (MHRDU) at the University of Bath with promising results, and a research briefing has also now been published.

Some of the main messages from the evaluations of the pilots are that the programme empowers families to make positive changes and that, by responding to children in a family context, the programme has the potential to take the pressure off other services by offering the kind of support that enables families to take the first steps towards positive change.

The biggest change was in what the families communicated about, and how they communicated – the group and family work allowed them to learn to listen to each other and accept different feelings and points of view, leading to an enhanced understanding of each other, the addiction and its impact. Being supported to set realistic and relevant goals was also valued.

Further evaluated programmes are taking place this year in different parts of the country – having developed an intervention that appeared not only to help the children who attended but the family unit as a whole, the next question was how to ensure that M-PACT became available and accessible to children and their families across the country.

The answer came via two key recommendations in *Hidden harm* – firstly that there should be dedicated services to meet these children's needs at local level,

and secondly the need for large-scale development of the workforce to ensure that those services can be provided. M-PACT was determined to achieve these two objectives and a project manager was recruited, her salary funded by BBC Children in Need and the Esmee Fairbairn Foundation.

The strategic aim of the project is to improve the safety and wellbeing of children and young people living with parents who have alcohol and drug problems by developing an evidence-based intervention that achieves the key outcomes of *Every child matters*. Alongside this is the need to ensure the intervention can be successfully applied in a variety of locations and settings among a diverse population, and that the country has an adequate supply of trained professionals able to respond effectively by being equipped to deliver the M-PACT programme under licence in their area.

A programme manual has been written, although this is not just a manual, it's a call to action. The purpose of the licence, which is awarded to organisations rather than individuals, is to ensure consistency and maintain standards. The manual is not a tablet of stone and is constructed to allow easy integration of changes. While variations are to be expected given the diversity of the population, it's important that the programme does not casually lose its fundamental shape – changes need to be thought through, planned and carefully integrated.

The licence is obtained by sending practitioners onto the M-PACT training course for which the manual is the principal resource. The course is accredited by the University of Bath, and practitioners from the licensed organisations will become members of the M-PACT network and learning hub. Programme information provided to Families Plus will be collated and distributed in updates to the manual and in longer-term evaluation of results. We also aim to have an annual forum of M-PACT practitioners to discuss the experience of practice and the outcome of evaluations. Interest around the country is growing with people in adult and children's services recognising M-PACT as a substance misuse specific intervention but one that also responds to initiatives like *Every child matters*, *Think family* and *Safeguarding children*.

With all large-scale plans it is often easy to lose sight of the fact that in the end it's all about the predicaments of real human beings. A woman who attended an M-PACT programme with her partner and 12 year-old son was on methadone and, we think, using on top. Nonetheless she and her partner and son participated in the programme and stuck with it – at the very end she said, 'Perhaps if M-PACT had been around when I was growing up with my alcoholic father, I wouldn't have become an addict.'

With a significant proportion of a generation at risk, we found that anecdote alone compelling and motivating.

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**Rosemary Jambert-Gray, Kevin Lucas and Valerie Hall** look at the issues surrounding drug use and motherhood and urge commissioners to remove the barriers to 'a substance misusing mother friendly' service.

Ruth Bailey / Alamy

# The MOTHER of all issues

**THERE IS A SERIOUS LACK** of drug and alcohol specialist midwives in the UK and, where they do exist, services have experienced a quadrupling of their caseloads in the last 12 years. Government policy stresses the importance of addressing the health inequalities experienced by substance-misusing mothers, despite the fact that its funding for specialist rehabilitation units has decreased, and there are now just 40 drug and alcohol specialist midwives in the country.

Drug statistics can be confusing. Aside from alcohol, opiates are quoted as the main drug of choice for pregnant mothers, and physical withdrawals – commonly known as neonatal abstinence syndrome (NAS) – occur when the mother has been using opiates or sedatives. It was recently reported by the British Association of Perinatal Medicine that one in 500 of all newborn babies need treatment for NAS and that in England the number of babies suffering from NAS has increased by 67 per cent over the past 10 years – from 751 in 1997/98 to 1,230 in 2007/08. Babies exposed to cannabis and stimulants such as cocaine and amphetamines are not included in NAS statistics.

According to the Home Office, there are 72,712 female opiate users across England, of whom 90 per cent are of childbearing age, while NTA figures state that the number of women approaching drug treatment services in England has increased by 60 per cent in four years, from 35,527 in 2003/04 to 56,936 in 2007/08. Risks associated with drug misuse in pregnancy include premature birth, low birth weight and increased risk of miscarriage. Alcohol is very toxic and the developing foetus is unable to process it, leading to a high risk of miscarriage in the first three months – the liver is one of the last organs to develop. Foetal alcohol syndrome (FAS) is used to describe a particular set of problems that affect the individual throughout their life, including restricted growth, facial abnormalities and lifelong learning and behavioural disorders.

The 2007 Department of Health report *Maternity matters* discussed measures to help reduce health inequalities in maternity care, especially those experienced by more disadvantaged groups

such as substance misusers. A major motivating factor for abstinence can be women's reproductive role – female clients often describe dramatic changes to their lives driven either by becoming pregnant, wanting to become pregnant, recent birth or feeling guilty about being a substance-misusing mother.

Pregnancy is a powerful motivator for reflection, intensified in the final trimester, and under careful medical and psychosocial surveillance many opiate-misusing women successfully complete methadone detoxification, resulting in decreased incidence and severity of neonatal withdrawal. However, chronic substance misuse may have dominated all areas of the mother's life over a long period and not all women will become abstinent during pregnancy.

Reluctance by substance-misusing mothers to engage in treatment, including maternity services, is mainly because of fear of stigmatisation and hostility. Many come from multi-generational drug-misusing families where they themselves have not had positive mothering role models. They are often in relationships where their partners are still actively using drugs and may well be threatened by the mother's concern over drug use.

Exposure to violence is often associated with this group, with one study finding that 76 per cent of drug misusing pregnant women had experienced physical abuse, 73 per cent emotional abuse and 40 per cent sexual abuse. Where women have histories of sexual abuse, it may be that they view their bodies as sexual objects rather than vehicles of nurture for their babies, and psychiatric co-morbidity is common, with very high rates of depression.

The Home Office's 2003 report *Hidden harm* highlights the impact of parental problematic substance use on children from 'conception to adulthood', with substance misusing mothers more likely to have left education early, be unemployed, unskilled or socially disadvantaged, and less likely to attend antenatal clinics. There is later recognition of pregnancy along with later contact with health professionals and booking into antenatal care.

Acquisitive crime is often associated with illicit drug use and in a family setting alcohol abuse can increase the risk of domestic violence and family break up. Drug misuse also increases the risk of child neglect and abuse. Breastfeeding is less prevalent in mothers from poorer socio-economic backgrounds, and mothers who are poly-substance users are more likely to bottlefeed their babies, while breastfeeding mothers are more likely to be engaged in treatment and not using other illicit drugs.

To many, drugs imply a secretive way of living – mothers fear entering ‘the system’, the perceived intrusion into their lives and the ultimate threat that their children will be taken away by social workers. Engaging women in treatment during the ante- and postnatal phase encourages them to take stock of their lives, and helps break the cycle of addiction and deprivation. As the baby’s wellbeing is dependent on the wellbeing of the mother, finding a way of making the mother feel more confident is vital and should be of major concern to all midwives.

*Maternity matters* urges commissioners to identify barriers to maternity services experienced by substance-misusing mothers and to provide more flexible services. According to the Department of Health, an estimated extra 23 hours of outreach work is needed to maximise the opportunity to keep mother and baby together, with the extra time spent working with substance misuse agencies, at antenatal appointments, dealing with social issues such as housing and working with social services on child protection concerns.

There are weaknesses in maternity services – according to the London Health Observatory’s 2006 report, *Women drug users in London*, mothers are given confusing and misleading advice, with provision for drug users – as well as interagency working – described as ‘lacking’. Only 29 per cent of NHS maternity units surveyed had formal contact with local substance misuse agencies, and there were problems caused by differences in confidentiality arrangements and lack of co-ordination between professionals. Mothers worried about being stigmatised and feared social service involvement, while lack of childcare also prevented mothers from attending services.

There is a huge demand for more specialist midwives, who are likely to see a huge increase in caseload in a very short space of time. When the first drug liaison midwife post was created in Manchester in 1995, the number of referrals of drug-using mothers increased from 43 over a 15-month period in 1992/93 to 200 a year in 1998. Working closely with social workers and addiction services, there are still only 40 registered with the national specialist midwife forum in the UK while, as previously stated, the number of women approaching drugs services has increased by 60 per cent in the last four years and the number of babies suffering from NAS has increased 67 per cent over the past ten.

*Maternity matters* urges commissioners to identify barriers to services experienced by substance misusing mothers, whom it describes as a ‘disadvantaged group’, but engaging these mothers into maternity services is a challenge. They have complex psychosocial and physical needs that can be overwhelming, and engaging them into care and treatment has long-reaching implications for family and community.

Working with this client group is time consuming and, where specialist services exist, they have attracted five times the number of women as services without a specialist midwife. Developing specialist drug and alcohol maternity services, working jointly with addiction services, could mean that the child a woman bears helps free her and her baby from the cycle of addiction and poverty. We would like to add our voices to the urgency expressed by *Maternity matters* in identifying barriers to services so as to engage more substance-misusing mothers into a ‘substance misusing mother friendly’ service.

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*Dr Kevin Lucas is senior lecturer in psychology applied to healthcare at the University of Brighton.*

*Prof Valerie Hall is professor of midwifery at the University of Brighton’s faculty of health.*

## Post-its from Practice

# Beyond the script

Treatment can never be effective unless we treat all service users as individuals, says **Dr Chris Ford**



**I RECOGNISED THE FACE** of the man standing at reception but I couldn’t put a name to it. Charlie reminded me that he had been a patient of mine 16 years ago, but had then moved out of London and left the list – he had with him a letter addressed to me from the local hepatology department.

He had originally come to me from a private doctor on a script for 16 methadone tablets – I had continued prescribing the same and he had remained on it during his various moves. For the past decade, he had been very settled on the same

treatment with a GP, who had recently retired. Most of this GP’s patients had been placed with other practices and those remaining, mainly more complex patients, were assured continuity of treatment by the local specialist service.

When Charlie attended for his original assessment with the specialist service, naturally his first question was could he get his tablets – the answer was ‘no’, so he left. He was undergoing hepatitis C treatment at the time, which was going well, so the hepatitis nurse wrote to me asking if I would prescribe for him. Our only restriction for treatment is that people need to live in the practice area and unfortunately Charlie lives over ten miles away.

I knew the retiring GP and had heard from her that she had been reassured that stable prescriptions would be continued after an assessment. I immediately explained to Charlie that I thought there had been a misunderstanding and I would talk to the specialist service manager. She was very helpful and quickly arranged a full assessment by the service’s lead clinician.

Charlie had been on the same script for over 18 years and for a large majority of that time he had not injected. His GP had also confirmed that he was unable to tolerate methadone mixture, that he had always worked to support his family, and was doing well with his HCV treatment. Given these facts I felt confident that all would be sorted.

Perhaps I was being more naive than usual but I was genuinely shocked when Charlie handed in a letter which said that the doctor had refused his request stating it was trust policy not to prescribe tablets at all, the clinical guidelines state you must not prescribe them, and that he was at risk of injecting them. And would he like injectables?

The clinical guidelines in fact state ‘Methadone tablets are not licensed for the treatment of drug dependence and should not normally be prescribed due to the increased potential for diversion.’

Like his old GP, I believed Charlie when he said that he had never injected or sold his tablets and that they allowed him to live a normal life.

Some may think I am a bad doctor because I do prescribe tablets if appropriate to the individual, and I feel we are wasting a sometimes useful tool from the toolbox. But perhaps even more importantly, I believe that drug treatment of any kind, whether it’s harm reduction, staying on maintenance or becoming drug free, cannot be effective unless we first treat people as individuals with individual needs.

*Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP. To become a member of SMMGP visit our website [www.smmgp.org.uk](http://www.smmgp.org.uk) and receive bi-monthly clinical and policy updates and be consulted on important topics in the field.*

**LEWISHAM  
DRUG AND  
ALCOHOL  
ACTION TEAM  
(DAAT)**

**TENDER**

Are you able to champion and drive forward high quality Drugs and Alcohol Services, providing skills in the field of Health and Community Services? Do you have a track record in Performance Improvement and sustaining high quality service delivery?

*The DAAT on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust invites expressions of interest to tender for the provision of an Adult:*

- Education, Training and Employment Service
- Parent, Carer and Significant Other Support Group Service
- Community Alcohol Service
- Drug and Alcohol In-patient Detoxification Service

Lewisham DAAT is seeking expressions of interest from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to deliver substance misuse services to meet the needs of a diverse population. Prospective providers are invited to tender for one or more of these services; consortium tenders will also be considered.

The expected term of each of the services will be from 1st April 2010 initially for three years, with six month no fault break clauses either side, with an option to extend for a further two years, subject to review. The contracts will be based in part on a performance payment in relation to achieving a set of Treatment Outcome Indicators.

*To request a tender pack, either in writing or by e-mail, contact Mike Hurst at the address below.*

Expressions of interest should be made by 19th October 2009, and completed tenders must be returned for receipt by no later than 12 noon, Monday 26th October 2009.

**Tier 4 services & Day Programme: extension of existing framework**

Lewisham Drug and Alcohol Action Team (DAAT), on behalf of the London Borough of Lewisham and Lewisham Primary Care Trust, is looking to increase the range of providers under the following categories ('lots') for a 4-year period. This is to extend the existing Framework Agreement of January 2009; those who already applied and were successful in being included in the original Framework do not need to re-apply.

**Lot 1: Structured Day Programmes (non abstinent & abstinent)**

To undertake a range of interventions in relation to a structured day programme format for individuals with a primary drug problem or now abstinent. Day programmes should be within reasonable travelling distance from the borough of Lewisham by public transport.

**Lot 2: Residential Rehabilitation Programmes (abstinent drug and/or alcohol)**

To undertake a range of interventions and approaches e.g. 12-step; therapeutic communities, cognitive based, behavioural, social learning, eclectic/ integrated, faith-based, skills based, single gender establishments for abstinent clients requiring rehabilitation. Can be based locally (borough of Lewisham/London) or outside of London.

**Lot 3: Residential rehabilitation day programmes or quasi residential rehabilitation day programmes (drug and/or alcohol)**

Where treatment is provided at a different location to accommodation, to provide a range of interventions and approaches (as in Lot 2) for abstinent clients requiring rehabilitation. Can be based locally (borough of Lewisham/London) or outside of London.

**Lot 4: Residential Programmes and/or residential rehabilitation day programmes drug and/or alcohol (miscellaneous)**

To provide a range of more specialist interventions in addition to rehabilitation e.g. for people on court orders such as DRRs and tags; mother and baby; family interventions; younger adults, people who may require medical support such as those with mental health problems, people with physical disabilities or health problems: people with learning difficulties; psychotherapeutic interventions for sexual/physical/mental abuse survivors; detoxification. Can be locally based (borough of Lewisham/London) or outside of London.

Expressions of interest are sought from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to be included in a framework to deliver these services to meet the needs of a diverse population. Providers may apply for one or more lots.

The term of the framework will be from April 2010 for four years, during which time contracts will be 'called-off' from the framework.

Expressions of interest should be made by 19th October 2009, and completed tenders must be returned for receipt by no later than 12 noon, Monday 26th October 2009.

*To request a tender pack, either in writing or by e-mail, contact:*

Mike Hurst, Procurement Team, London Borough of Lewisham,  
3rd Floor, Lewisham Town Hall, Catford, London SE6 4RU  
Email: [mike.hurst@lewisham.gov.uk](mailto:mike.hurst@lewisham.gov.uk)  
Telephone: 020 8314 6556



www.southessex-trust.nhs.uk

South Essex Partnership University NHS Foundation Trust  

South Essex Partnership University NHS Foundation Trust is one of the largest NHS providers of health and social care services for people with mental health problems and learning disabilities.

The Trust is one of the top 100 mental health and learning disability Trusts in the country, as named in the Nursing Times Top 100.

## Community Drug and Alcohol Service Community Substance Misuse Workers

Band 6: £24,831 - £33,436 pa Ref: 364 - 4922PH

Band 5: £20,710 - £26,839 pa Ref: 364 - 4921PH

Developments within the service have created exciting opportunities for RMN's/Social Workers who are interested in working in the field of substance misuse. The service is currently expanding to meet the challenges of current policy and there will be exciting opportunities to practice in different settings. The Essex Community Drug and Alcohol service covers Basildon, Brentwood, Billericay, Wickford, Castlepoint and Rochford.

You will join a specialist multi-disciplinary team that offers assessment, treatment, consultancy, advice and support to clients. Responsible for implementing care plans in-line with CPA, you'll provide practical, personal and emotional support to substance misusers. The work is varied and stimulating, offering opportunities to develop professional skills.

To arrange a visit or for an informal discussion please contact Jane Gooday, Essex Locality Manager, or Maggie Jones, Team Leader, on 01268 583154.

For further information and application packs please visit [www.southessex-trust.nhs.uk](http://www.southessex-trust.nhs.uk) quoting the reference number.

Closing date: 5 October 2009.

We are an Equal Opportunities Employer and positively welcome job share applications, as well as those from people with experience of using mental health services.



## Dudley Drug Rehabilitation Requirement (DRR)

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



safer communities, healthier lives

## Structured Day Programme Worker (Ref NM281)

Salary: £23,327 to £25,045 per annum  
37.5 hours per week

CRI are seeking to appoint a Project Worker to work within the Drug Rehabilitation Requirement (DRR) service providing structured drug treatment and support for service users sentenced to receive treatment by the courts in partnership with Probation services.

As part of this role you will be involved with the development and delivery of an innovative recovery day programme. The post holder will have specific responsibility for the delivery of 1:1 and group work sessions. You will work closely alongside a diverse team and other relevant agencies and partners including Service User Groups. Experience of working within substance misuse services, assessment, care planning and groupwork skills are required. A knowledge of the Criminal Justice System and a DANOS qualification in health and social care or equivalent will be an advantage. You will be required to work flexibly as required within an agreed number of hours to maintain the most appropriate level of service provision. This will include evening and weekend work. You will be expected to take responsibility for personal development, identifying personal training needs and participate in regular supervision and appraisal.

Closing date: 5th October 2009

Interview date: TBA

Only electronic applications will be accepted via [www.cri.org.uk](http://www.cri.org.uk)

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

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

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

Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

SMART is a rapidly growing not for profit organisation, delivering drug and alcohol interventions across the Thames Valley region. The organisation is recognised locally and nationally for innovative and effective interventions with substance misuse clients and has been cited by the Home Office as a model of good practice.



## REGIONAL DIRECTOR (Thames Valley)

based in Kirtlington, Oxfordshire / Salary Range £45,000 - £48,000

As we move forwards into our next phase of development, we are seeking an individual to join our leadership team, sharing our values and possessing the expertise we need to further consolidate our successes and maximise all future opportunities. The ideal candidate should be able to demonstrate: strategic vision; operational credibility and an ability to lead and inspire others.

We are seeking a professional with proven track record in:

- Driving organisational Performance Management
- Developing and implementing quality approaches, such as PQASSO
- Managing team development
- Supporting new business implementation
- Clinical Governance frameworks and service audit
- Managing partnerships with key strategic stakeholders

To meet the demands of this role you should already have extensive managerial experience ideally in the social care field, together with a sound understanding of the UK National Drug and Alcohol Strategies.

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

For an application pack please contact Mary O'Byrne on 01865 515318 or email [enquiries@smartcjs.org.uk](mailto:enquiries@smartcjs.org.uk)

Closing date for applications is Friday, 9 October 2009 by midday. Interviews will be held in Oxford week commencing Monday, 19 October 2009.

[www.smartcjs.org.uk](http://www.smartcjs.org.uk)



Great training and development

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**Neighbourhoods**

**Drug Service User Co-ordinator**  
 £25,220 - £28,353 Ref: 21751  
 Full time, permanent  
 Based at Bedminster

Our dedicated Bristol Drug Strategy Team is seeking a motivated individual to work with drug service users in Bristol. This is a challenging role so you will need plenty of commitment to the rights of drug service users, with the ability to co-ordinate user involvement activities in strategic and front-line environments. Good communications and organisational skills are crucial together with a flexible, understanding attitude. This post is subject to a Criminal Records Bureau Disclosure check.

**Closing date: 5 October 2009.**  
**Interviews will be held week commencing 2 November 2009.**

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

**Apply Online at [www.bristol.gov.uk/jobs](http://www.bristol.gov.uk/jobs)**

Please note we cannot accept CVs. Applicants must be either EU nationals or hold a current permit that will enable them to work in the UK. At Bristol City Council, we value having a workforce as diverse as the city we serve. We therefore welcome, develop and promote people from all sections of the community.

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 a great place to work

**Bristol City Council**

**Positive About Disabled People**

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**THURROCK DAAT**  
 DRUG & ALCOHOL ACTION TEAM

**TENDER**

**FOR THE PROVISION OF AN INTEGRATED SUBSTANCE MISUSE TREATMENT SERVICE IN THURROCK**

The Thurrock Drug and Alcohol Action Team (D.A.A.T.) invite expressions of interest from suitably experienced and qualified providers to tender for an integrated substance misuse treatment service in Thurrock, including:

- A) Tier 2/3 Open Access Adult Community Drug Services**  
 Tier 2/3 Open Access Services, will include: Open Access, Drop-in Service, Advice and Information, Outreach, Harm Reduction Services, Assessments, Key Working/Care Co-ordination, Brief / Other Structured Interventions, Group Work – Crack/Stimulant Specific and Relapse Prevention, Access to Blood Borne Virus Screening, Testing and Vaccination, Alternative/Complementary Therapies, Aftercare and Needle Exchange
- B) Tier 3 Structured Treatment**  
 Tier 3 Structured Treatment will include: Comprehensive Structured Day Care Programme and Structured Psychosocial Interventions.
- C) Criminal Justice Engagement Services**  
 Criminal Justice Engagement Services will include: Arrest Referral and Court Liaison Services, Throughcare and Aftercare Services and a 24/7 Helpline.

The services will be delivered from 1st April 2010 for a period of 2 years with an option for a further extension of up to 1 year. The approximate contract value is £350k per year.

The successful applicant(s) will be required to work as part of a clearly defined treatment system with other providers in Thurrock across the commissioned tiers of provision. Organisations with a track record of innovative and dynamic provision of services and a demonstrated capacity to respond to change are sought.

Prospective providers are invited to tender for the entire provision identified above, separate bids for each part will not be accepted. The commissioners would also welcome consortium bids from interested providers.

**A pre-qualification questionnaire will be available at [www.thurrock.gov.uk/business](http://www.thurrock.gov.uk/business)**  
**Please email [procurement@thurrock.gov.uk](mailto:procurement@thurrock.gov.uk) to express your interest.**  
**Deadline for submission of a pre-qualification questionnaire is 12pm on Friday 9th October 2009.**

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Helping people overcome their dependence on drugs and alcohol is both challenging and rewarding. Our pioneering work with individuals, families and communities has made us one of the UK's leading providers of social care services in this complex area – and with your help we aim to become even more effective in the future. Could you play a key role in the running of our Wirral Residential Service?

**WIRRAL ADULT RESIDENTIAL SERVICE**  
**Team Manager • £24,350 - £28,003**

We are looking for a highly motivated and committed manager to lead the promotion and development of the service. You will be liaising with outside agencies and commissioners so excellent communications and presentation skills are essential, alongside a good knowledge of drug and alcohol issues. Ideally you should have suitable experience and possess or be working towards management and relevant professional qualifications. You will be responsible for the supervision of care team members and for the effective day to day running of the therapeutic treatment programme and ideally should have strong experience of group work.

For further information and to apply visit [www.phoenix-futures.org.uk](http://www.phoenix-futures.org.uk) or email [recruit@phoenix-futures.org.uk](mailto:recruit@phoenix-futures.org.uk) using reference number 09/09/734/521221. Closing Date: 5 October 2009. Interview Date: 15 or 16 October 2009.

Charity registration number: 284880.  
 Committed to a policy of equality and diversity.

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**DDN**  
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**The Alliance**  
 Taking Treatment Forward



**FOUNDATION66** provides a range of community and residential services in London for people with alcohol and drug related problems. The Organisation is underpinned by a strong learning culture and actively encourages personal and professional development of its staff.

This is an exciting opportunity to develop a newly commissioned open access Tier 2/3 drug service in Redbridge. The Service will provide a range of open access services including, needle exchange, advice & information, brief and extended interventions, assessments, onward referrals, key work and group work.

We are now looking to appoint the following:

### SUBSTANCE MISUSE PRACTITIONER

We are looking for a dynamic, creative and flexible practitioner with extensive knowledge of harm reduction and the ability to develop therapeutic alliances with clients. You will be skilled and experienced in delivering assessments, satellite services, care planning and advice, brief and extended interventions, group work and needle exchange.

You will have two years experience within the substance misuse field and a relevant professional qualification, or be working towards one.

**This is a full time post at 35 hours per week.**

**Salary: NJC Point 26 – 31 (£25,263 – £29,277) including LW.**

**The closing date for all applications is Friday, 2nd October 2009.**

*For more information and to request an application pack, please email: [jobs@foundation66.org.uk](mailto:jobs@foundation66.org.uk)*

*All advertised posts are subject to Criminal Records Bureau enhanced disclosure. Foundation66 is an equal opportunities employer and welcomes application from all qualified candidates.*

**WWW.FOUNDATION66.ORG.UK**



## Commissioning Officer – Alcohol Misuse

**Department of Community Services**

**Grade I, £23,405 – £25,940 p.a.**

**Wiltshire**

This is an opportunity to join our new Substance Misuse Commissioning Team to contribute to the development and implementation of a commissioning strategy under the leadership of the Joint Commissioning Board for Substance Misuse and in partnership with key stakeholders including service users and carers, that is evidence based, represents value for money and meets the Partnership's priorities.

In this key partnership role your responsibilities will include: supporting the process of the joint commissioning of services in partnership with key stakeholders; contribute to the planning, management and monitoring of resources and performance management of services; and researching and understanding national and local policies in substance misuse and to give leadership with managing their implementation at a local level.

Suitable candidates will have experience of working in or with substance misuse services, and will have a sound understanding of service development, commissioning and working in partnership.

You will be expected to have access to transport as part of your daily work.

**Ref: DCS09/54.**

For informal enquiries please contact: Eleanor Stirling, Joint Commissioning Manager for Substance Misuse on: 07780 954398, or email [Eleanor.stirling@wiltshire.nhs.uk](mailto:Eleanor.stirling@wiltshire.nhs.uk).

If successful, you'll be required apply for a Disclosure from the Criminal Records Bureau.

Our preferred method of application is on-line at [www.wiltshire.gov.uk/jobsandcareers](http://www.wiltshire.gov.uk/jobsandcareers) If this is not possible application packs can be obtained by contacting the Recruitment Team, Human Resources, Trowbridge, Wiltshire BA14 8JN. Tel: 01225 713295 (24 hour answerphone) quoting the relevant reference.

**Closing date: Tuesday 6 October 2009.**

**Interviews will be held: Thursday 29 October 2009.**

Committed to equality of opportunity. All applicants will be selected on their merits. We promote flexible working patterns and will consider job sharing.

[www.wiltshire.gov.uk/jobsandcareers](http://www.wiltshire.gov.uk/jobsandcareers)



## Alcohol needs analysis and development of strategy

The Safer Middlesbrough Partnership are seeking an organisation or individual to carry out an alcohol needs analysis and to develop and implement a new Alcohol strategy across Middlesbrough.

The specification will include:

- Carry out an alcohol needs analysis that covers all key areas that would be included in the final strategy document
- Develop an alcohol strategy for Middlesbrough based on the above, with recommendations and an agreed action plan
- Run a strategy launch event in Middlesbrough
- Develop the structures and processes that will need to be in place to support the strategy, ensuring that the relevant strategic groups are started and have clear terms of reference etc.
- Coordinate the delivery of the strategy for at least 6 months locally
- Produce at least 4 areas of local good practice documents that are included on HubCAPP (an alcohol evidence base site)

It is expected that the successful applicant will develop the specification themselves rather than it be provided by the SMP. The quality and breadth of this specification will be the primary factor in awarding the contract.

**Closing date for Tenders: 12th October 2009**

**To receive full details please contact David Jackson via email on [d.jackson@middlesbrough.gov.uk](mailto:d.jackson@middlesbrough.gov.uk) by no later than Friday 2nd October 2009.**

### WARRINGTON BOROUGH COUNCIL

#### Drug and/or Alcohol Residential Rehabilitation Programme Invitation to Tender

Warrington Borough Council invites applications from established and experienced organisations/providers who wish to be considered to be included on our approved provider list within a framework agreement for the provision of a Drug and/or Alcohol Residential Rehabilitation Programme. Organisations/providers must be within a 100 mile radius of Warrington however, we will consider organisations/providers for the framework agreement who can offer a specialist service i.e. single sex, dual diagnosis, younger people under 25 years, mother and child.

The contract will initially be for three years from March 2010 with an option to extend up to 2 x 12 months thereafter.

Organisations tendering should note that TUPE may apply to this Service.

Interested applicants will be required to complete and pass a pre-qualification questionnaire. Shortlisted organisations/providers will be included on our approved provider list/framework agreement. Thereafter organisation/providers will be invited to submit a tender for each care package offered. The tender response will need to include a Treatment and Discharge Plan which will outline how you will meet the needs of each individual and a pricing structure as a minimum.

Within the tender, organisations/providers should be able to prove that they have an excellent track record of providing a Drug and/or Alcohol Residential Rehabilitation Programme and will offer Service User led services that promote social inclusion and recovery.

Organisations/providers who wish to be considered as an approved provider should request a Pre-Qualification Questionnaire by 27th October 2009 from Ashley Chadwick via the contact details below.

**Closing Date for return of Pre-Qualification Questionnaire is: 12.00 (noon) on Friday 11th December 2009.**

#### Contact Details

**Email:** [achadwick@warrington.gov.uk](mailto:achadwick@warrington.gov.uk)

**Tel:** 01925 444055

**Post:** Commissioning & Contracting Section,  
Community Services Dept., Warrington Borough  
Council, Bewsey Old School,  
Lockton Lane, Bewsey,  
Warrington WA5 0BF.



# Lifeline Project Ltd

Lifeline has a national reputation for effective and innovative work with individuals, families and communities affected by drugs or alcohol.

## Team Leader x 3 posts

(Salary: Pts 32-37 £26,784 – £30,546) 35 hrs per week

### Team Leader – Lifeline Calderdale Young Person's Service

This is an exciting opportunity for an ambitious and highly motivated individual to set up and develop a new service for young people in Calderdale. This is a fully integrated tier 2 and tier 3 substance misuse service for young people working on a locality basis. The service will also deliver a centre based clinical treatment service for young people with GPWSI support. The service will offer advice and information, 1:1 support and therapeutic interventions, healthcare services including a regular clinic, harm reduction interventions, education, training and family support service as well as diversionary activities.

### Team Leader – Lifeline Leeds Young Person's Service

We are looking for a dynamic and self motivated Team Leader to develop and enhance our established tier 2 Young Persons Service in Leeds. The service offers both targeted / early intervention work to young people involved with or at risk of substance misuse as well as Hidden Harm interventions with children of substance misusing parents. This is a varied post and an exciting opportunity for an ambitious individual to make positive changes and enhance service development.

### Team Leader – Lifeline Rotherham Adult Alcohol Service

Following recent contractual changes, we are looking to recruit an experienced and committed Team Leader to support the development, implementation and re-launch of the Tier 2 Alcohol Service for Adults in Rotherham. The service provides 1:1 support, harm reduction, brief interventions, group work, targeted outreach to street drinkers and is establishing stronger links with partner delivery agencies such as ETE and criminal justice. You will be a quality focused and self-motivated individual with the ability to lead an established service through a new phase of delivery.

The successful candidate will be keen to achieve and deliver to a high standard. The Team Leader will focus on staff development, partnership working, service promotion and monitoring and reporting. They will work closely with the Service Manager and Commissioners, but will be able to demonstrate a high level of ability to use their own initiative and resources.

To be successful in the role of Team Leader, you will have

- A problem solving approach and initiative
- The ability to deliver high quality services to a diverse range of people
- Qualities to lead people in developing a flexible and exiting service model

For further information and an application pack download from [www.lifeline.org.uk](http://www.lifeline.org.uk) Alternatively email [ann.fleming@lifeline.org.uk](mailto:ann.fleming@lifeline.org.uk) (Rotherham and Halifax posts), or [admin.step2@lifelineleeds.org.uk](mailto:admin.step2@lifelineleeds.org.uk) (Leeds post) to request a pack.

**Closing date: 9.30am Monday 12th October 2009**

**Interviews: w/c 19th October 2009**

*Lifeline Project is an Equal opportunities Employer and invites applications from all regardless of race, colour, nationality, ethnic or national origin, religion, marital status, sex, sexual orientation, age or disability.*

## Kent Drug and Alcohol Action Team (DAAT) and the Eastern and Coastal Kent NHS invite expressions of interest to tender for the Tier 3 structured Alcohol service

Kent DAAT and the Eastern and Coastal Kent NHS are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 3 structured alcohol service within the geographical boundaries of the Eastern and Coastal Kent NHS area. The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting <https://www.businessportal.sece.gov.uk> and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

## Kent Drug and Alcohol Action Team (DAAT) and the Eastern and Coastal Kent NHS invite expressions of interest to tender for the Tier 2 Alcohol service

Kent DAAT and the Eastern and Coastal Kent NHS are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 2 alcohol service within the geographical boundaries of the Eastern and Coastal Kent NHS area. The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting <https://www.businessportal.sece.gov.uk> and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

## Kent Drug and Alcohol Action Team (DAAT) invite expressions of interest to tender for the Tier 4 Inpatient detoxification service

Kent DAAT are seeking expressions of interest from suitably experienced and qualified organisations to provide the Tier 4 Inpatient detoxification service for the people of Kent. We would welcome expressions of interest from organisations that can offer block and/or spot purchase services. The service will be delivered from the 1st April 2010 until the 31st March 2013.

Expressions of interest should be made only by visiting <https://www.businessportal.sece.gov.uk> and following the link to the South East Business Portal. The closing date for the expressions of interest is 16th October 2009. Tenders will be issued to applicants on 19th October 2009 and the closing date for receipt of tenders is 13th November 2009.

Please note the above services will be within three separate contracts, provider organisations can apply for either one or all three.

**Kent Drug & Alcohol Action Team**

## Substance Misuse Personnel

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- Prison & Community drug workers
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