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Drink and Drugs News

12 March 2007
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Diary of a dual diagnosis communications project

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Editor's letter

There's a lot to read in the RSA Drugs Commission's new report – probably what you would expect from a two-year study involving representatives whose different jobs touch the drugs field, from public health to criminal justice.

The recommendations mirror much cross-sector lobbying – for a strategy that addresses all areas of life, home and work, instead of pointing straight to jail – and asks government to acknowledge that current drugs strategy is failing.

It's a big ask. As far as the Home Office is concerned, a criminal justice led strategy is filling treatment places and helping citizens sleep more soundly at night. There's a big tick against DIP, and testing on arrest is being credited with bringing more people into contact with drug workers.

The Commission is asking government not only to lead the way in stopping the 'demonisation' of drug users; it's asking them to pass the lead for drug strategy from the Home Office to the Department for Communities and Local Government, so local areas, led by their drug action teams, can work out what's best for their own communities.

Stepping back from the detail, the Commission is suggesting a massive fundamental shift in attitude. It asks government and society to stop chasing the impossible dream of a drugless society, and to look at where support is most needed. Taking the hysteria out of the drugs debate is our only chance of basing strategy on actual harms, it suggests. We could start looking at alcohol, tobacco, solvents and prescription drugs, alongside drugs that are currently illegal. Turning the tables, we could consider consumption rooms and prescribed heroin as a regular option.

The report, boldly entitled 'Facing facts', has been released in time for the government's much anticipated drug strategy review next year. We look forward to seeing which ideas hit home.

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Radical rethink of drugs policy proposed

A radical rethink of drugs policy has been proposed by the RSA Drugs Commission, following a detailed two-year study.

The report pulls drugs policy away from criminal justice and refocuses it on health and social support. Highlighting that the Misuse of Drugs Act 1971 is 'no longer fit for purpose', the Commission calls for a new Misuse of Substances Act to include alcohol, tobacco, solvents, over-the-counter and prescription drugs.

Launching the report, the Commission's chair, Professor Anthony King, urged ministers to 'undertake the task of re-orienting drugs policy and redirect it towards a broader conception of harm prevention and reduction'.

Recommendations detail how this should be achieved by transferring the drugs policy lead from the Home Office to the Department for Communities and Local Government. A framework of local area agreements would help communities to tackle drug issues at local level, and drug action teams would be given 'enhanced status and profile' to co-ordinate cross-sector initiatives.

The Commission is adamant that current drugs policy is not working, is 'driven more by moral panic than a practical desire to reduce harm' and needs a completely new approach to transform the fortunes of Britain's 350,000 problematic drug users. By looking at substance use as a heath and social issue, rather than just a crime problem, the Commission looks to redress a situation where 'drug users are frequently depicted as evil and a threat to society' to a 'calm, rational and balanced approach'. Drug policy should no longer be 'ghettoised', but integrated with policies on all areas of life.

Evidence suggests that 'a majority of people who use drugs are able to use them without harming themselves or others', says the report – so it calls for help to be directed towards problematic drug users, found disproportionately among the poor, jobless, homeless, and socially excluded.

Better housing, harm reduction support and stronger efforts to reintegrate to society those affected by drugs or alcohol, were more effective use of resources than ploughing them into criminal justice initiatives. The Commission calls testing on arrest 'ineffective, wasteful and ultimately unsustainable', and calls for a refocus of 'futile efforts to tackle illegal drugs, to concentrate on organised criminal networks rather than the casual user'.

The fundamental overhaul had to include reaching children at a younger age. 'The "just say no" approach has not worked', says the report, which calls for children to be given drugs education younger, at primary school age, as part of 'developing general awareness of health issues and decision-making'.

The bottom line was that current policy 'at best, gives mixed messages and at worst, is dishonest'. Separating health and criminal justice approaches and 'rating substances according to the amount of harms they cause' would be a large step towards a single, logical regulatory framework, suggests the Commission. Among early reactions, DrugScope welcomed the 'watershed' report and recommended it to politicians from all parties, to take a more realistic approach to drugs; while the Transform Drug Policy Foundation said 'good, but no cigar' – good for its positive recommendations, but no cigar for flirting with the idea of prohibition 'without really ever nailing' it.

The report is at www.rsadrugscommission.org

Parent contracts to be piloted in Scotland

The Scottish Executive has pledged greater action on protecting young people from their drug using parents.

In a speech given at the Association of Chief Police Officers drug conference, justice minister Cathy Jamieson announced new plans to pilot voluntary contracts between drug-using parents and drug service providers. The contracts will be designed to ensure parents are clear about their responsibilities to their children and the consequences of their actions should they 'let their children down'. The contracts will also detail the type of service and support drug using parents can expect to receive.

But, the minister stressed this was not 'about taking children off drug users, but about being honest and recognising the real risks these young people face'. The contracts, the minister said, are intended to be part of a wider support plan for each child. Each contract would be frequently reviewed so the impact of the parent's drug habit could be carefully monitored. Detailed proposals for the contracts are being developed, and those interested in taking part will be invited to put forward a bid during the summer.

The contracts are part of a new approach toward tackling drugs, which will place greater emphasis on education and training. As part of the new approach, drug education in Scottish schools will also undergo a review, in particular to highlight the links between underage smoking and drinking, and drug use.

'I want to give higher priority to prevention and education,' Ms Jamieson said. 'Just as young people have become highly sophisticated consumers, we must be equally sophisticated in our drugs education messages – in our schools and through our Know the Score Campaign.'

Scottish drug education in line for a revamp

In a move to refocus Scotland's drugs strategy on drugs education and prevention, a revamp of Scottish drug education has been announced.

In the week that justice minister Cathy Jamieson told a conference of the Association of Chief Police Officers in Scotland that she would 'give higher priority to prevention and education' and make drugs education messages more sophisticated, education minister Hugh Henry asked health, crime and education agencies to work more closely together to give all pupils access to high quality drug education.

The multi-agency approach would target vulnerable groups and make sure teachers were adequately equipped – with both competence and resources – to teach the subject. He also called for lessons to highlight links between underage tobacco and alcohol consumption.

A range of initiatives were being explored to follow this approach, by widening training and resources, according to the Scottish Executive. Among these, a pilot scheme could involve recovered addicts visiting schools to share their experiences, and video-conferencing could allow young offenders on drug education programmes to speak with secondary pupils on the lessons they had learned.

Referring to newly published research evaluating the effectiveness of Scottish drug education, Mr Henry said the work would build on existing 'strong foundations', but acknowledged there were still challenges ahead.

'At the moment we give children and young people information but this does not necessarily change their behaviour,' he said.

'We need to adopt a more targeted approach, identifying the trigger factors that can lead youngsters into all forms of substance misuse and the miserable spiral of drug addiction and finding ways to steer them towards a safer path,' he added.

Evaluation of drug education in Scottish schools is available at www.scotland.gov.uk/publications/2006/03/14135923/0

Prescription drugs set to overtake illicit drug abuse

Prescription drug abuse is fast becoming a bigger problem than illicit drug abuse, according to the 2006 annual report of the International Narcotics Control Board.

Abuse of prescription medication had already surpassed the abuse of drugs such as heroin and cocaine in some parts of the world, with prescription medication containing narcotic or psychotropic substances becoming a drug of choice rather than a substitute. In Europe, painkillers were the most commonly abused prescription medication.

The demand for these products was so high, the report noted, that it had generated the new problem of counterfeit products. While counterfeit drugs were not a new phenomenon, there has been a surprisingly rapid growth in their availability and production in the past few years. New technology, in particular the ability to purchase prescription medication over the internet, had contributed to the problem.

INCB president, Dr Philip O. Emafo, has called on governments around the world to make greater attempts to address the problem. 'The board invites all governments to alert their law enforcement officers to the rising trafficking and abuse of pharmaceutical products containing controlled substances,' he said. 'The board also recommends providing adequate information to law enforcement and health authorities as well as to the general public on the risk and possible consequences of their abuse so as to ensure a realistic risk perception.'

Commenting on the report, Martin Barnes, chief executive of DrugScope, agreed the public needed to be made more aware of the dangers of prescription drugs. 'Whether purchasing these drugs for unsupervised treatment of a health condition, to feed an addiction or for their performance enhancing qualities, consumers should be aware that they are putting themselves at significant risk of ill effects, not least because of the increasing quantity of counterfeit products entering the market,' he said.

The report is at www.incb.org

FDAP and AC launch award to recognise experience in counselling

An award for counsellors has been launched to recognise professional knowledge, skills and experience.

The Introductory Certificate for Drug and Alcohol Counsellors has been developed by FDAP and Alcohol Concern to validate counsellors that have been trained and supervised to national standards.

Counsellors and their line managers will need to demonstrate that they have undertaken 100 hours of formal counsellor training and 60 hours of supervised practice in counselling people with drug or alcohol problems. They will also need to show competence in the four core units from DANOS, plus two further units ('counsel individuals about their substance use' and 'make use of supervision').

'The award recognises the effort and dedication of those new to the field who wish to demonstrate their knowledge, skills and experience,' said Alcohol Concern chief executive, Don Shenker. 'We want to support alcohol and drug services to demonstrate the professionalism of their staff and to recognise their achievements.'

It is also intended to plug the vacuum left by the demise of funding for the Volunteer Alcohol Counsellor Training Scheme (VACTS), he explained, and was being introduced as inexpensively as possible 'to encourage many new counsellors to obtain certificates'.

Applying for the certificate costs £50 for FDAP members or affiliates, and AC members; £75 for others. Download the forms at www.fdap.org.uk/certification/intro_cert.html

Random breath testing considered

Random breath testing will be considered as one measure to reduce drink driving, according to the Department for Transport's second review of the road safety strategy. Currently police officers must provide a legitimate reason for stopping a motorist for a breath test, for example, erratic driving. Under such proposals, such requirements would be waived and police would be free to stop all motorists.

The government has also not ruled out the lowering of the current legal blood alcohol limit from 80mg to 50mg.

The review notes that over the past decade there has been a marked – 25 per cent – drop in drink-driving deaths, however, drink driving remains a top priority.

Media Watch

More than 60 per cent of women admit to drinking while pregnant, according to an Irish study. The 120,000 women in Ireland who participated in the survey, were asked questions relating to their alcohol, tobacco and illegal drug use during pregnancy. The findings revealed that the 18 to 24-year-olds were drinking over 10 units of alcohol a week and over two-thirds of expectant under 18 year olds were boozing throughout pregnancy. It also highlighted that over 45 per cent of smokers did not give up during pregnancy and almost five per cent had used some form of drug.
The Irish Times, 2 March

Crystal meth is becoming more widely available in London, according to a judge. Mixed with cocaine and skunk many people are unaware that they are taking it, which may be an attempt to get people hooked, says District Judge, Justin Phillips. Sitting in one of the two drug courts set up in a pilot scheme by ministers, he added that the class A drug is often used by people attending court. 'I know it's being taken because everyone on a drug order is tested,' he said. People who use the drug could face up to seven years in jail and those dealing could get life in prison.
BBC, 1 March

Since the introduction of the 24-hour Licensing Act a Merseyside borough has seen a drop in alcohol-related crime. According to a report, the total number of crimes between 2004 and 2005 was 2,798, whereas during the same period in 2005 and 2006, it had fallen to 2,611. The biggest reduction in offences was during the hours of 10pm to 5am, with figures dropping by 11 per cent. Describing the reduction in crime as 'encouraging' sergeant Nick Cowell of Merseyside Police's Licensing Unit added:'It is still early days and there is still a lot to do'.
The Bootle Times, 8 March

Bars, nightclubs and music festivals are banned from selling nitrous oxide (laughing gas) following two related deaths in the UK. The Medicines and Healthcare products Regulatory Agency (MHRA) and the Local Authorities Coordinators of Regulatory Services (LACORS), are warning all venues that they face prosecution if they are found supplying the gas to the public. In recent years, nitrous oxide was seen as a legal and cheap way to get 'high' with the substance sold in balloons for recreational purposes. However, if it is inhaled directly it can lead to fatal asphyxiation and regular long-term use can lead to depression and poisoning of the central nervous system.
The Times, 5 March

Researchers have found a treatment which, they say, could help alcoholics kick their addiction. A study on animals, carried out by the Scripps Research Institute and the Eli Lilly drug company, used a synthetic compound known as MTIP to block a hormone in the brain, corticotropin-releasing factor (CRF), which is responsible for people relapsing. When the MTIP was injected into the animals that were dependent on alcohol, their susceptibility to relapse was eliminated. Scientists believe that the MTIP can be given orally and can block more than 90 per cent of CRF levels in the brain. Bob Patton, a health psychologist at the National Addiction Centre, King's College London, said: 'This could be a useful addition to our existing treatment.'
BBC, 7 March

The recent Hidden Harm review revealed patchy progress in working with drug using parents and their children. We have to do better, says Addaction's Clare McNeil.

Why is the harm still hidden?

Drugs were always part of family life for Kelly. 'My dad's like a kid, I can't figure him out. He smokes weed and does coke. I remember showing off to my mates when I was in year four that I knew how to roll a spliff. In year four, though!'

Now drugs are part of her life, too. 'I smoke five spliffs a day', she says. 'It really takes your mind off things and gets you out of it. The thing is though, when it wears off it's like, boom! All your problems are right there.'

Kelly, 15, is typical of many children of drug or alcohol using parents Addaction sees at its Breaking the Cycle project, who adopt their parents' behaviour from an early age. Kelly began smoking cannabis aged 12 and is now getting specialist support for her own drug problems.

Breaking the Cycle, a pilot scheme working with substance misusing parents and their families, was set up as a direct response to recommendations made in the Advisory Council on the Misuse of Drugs (ACMD)'s 2003 'Hidden Harm' inquiry with funding from the Zurich Community Trust. The inquiry uncovered the suffering of children from parental drug misuse and for the first time put a figure on the number of children affected – 300,000 children in England and Wales and between 48 and 51,000 children in Scotland (4-6 per cent of all children under 16 in Scotland overall). Such was the influence of the report that 'hidden harm' widely became the term used to describe the issues affecting children of drug users.

Now, three years on, the ACMD has published a review assessing the impact of that inquiry. Just how far were its calls for drug treatment agencies and government to bear more responsibility for children at risk from parental drug misuse taken up?

The inconsistent picture painted by the report overall doesn't take away from some encouraging findings. Of the treatment services originally questioned, 45 per cent say there is improved working around drug-using parents or their children and a similar number say joint working on pregnant drug users has got better. All hospitals surveyed in the report now routinely screen for drug and alcohol use and almost 20 per cent more maternity services have special arrangements in place to work with pregnant drug users than in 2003. Some impressive facts stand out. Almost 7,000 practitioners have been trained on 'hidden harm' issues by Scottish Training on Drugs and Alcohol and over 4,000 health care professionals have been trained in England by the Royal College of GPs in the last few years. Isolated examples of innovation are praised, including a 'hidden harm network' in the North East of England and local authorities such as Nottinghamshire, which have estimated the scale of the 'hidden harm' locally and pulled together the resources to tackle it.

And yet there remain some major stumbling blocks to making real progress. We are no closer to understanding the extent of parental substance misuse in the UK. The original figures from the 2003

inquiry, based on figures now many years out of date, are still the best estimates available. Opportunities to capture more accurate information through new data collection systems, such as the much hyped electronic Integrated Children's Systems, have so far been missed.

Pushing forward the Every Child Matters agenda brought rapid changes in children's services and presented an ideal opportunity to make sure that the needs of children of drug users were being addressed. But disappointingly, only a third of three-year children and young people's plans have specifically addressed their needs, and of these only 8 per cent identified the group as a priority and set targets to meet their needs.

The effective joint working between agencies, which is so crucial to preventing children from remaining hidden from view, is still largely in its infancy. Local authorities are now charged with developing the blueprints for more integrated working, but the ACMD calls for a stronger lead from the Department for Education and Skills to ensure this happens – perhaps wisely so, as not even half of the 47 drug action teams surveyed had protocols in place for joint working with this group of children.

Contrast this with the picture emerging from Scotland. Even before Hidden Harm was published, work was underway in the Scottish Executive to guide professionals making difficult decisions about the welfare of children of drug users, recognising that no single worker could solve problems of these families alone and that co-ordination of services was vital to getting the best results for families. Now smooth joint agency working is the norm in most, if not all, areas and the children of drug users are a high priority in Integrated Children's Services plans.

Another jewel in the crown for Scotland is its data collection. Changes in the light of Hidden Harm mean that workers in Scotland are required to collect information on any child they are sharing a household with – not simply their own – allowing for a much better understanding of the problem. It is also the only system in the UK that records what efforts are being made to support drug users in their parenting and can therefore trigger support if needed.

Even allowing for a difference in scale and ways of working, there are clearly lessons to be learned from north of the border. Much of the uncertainty and tension felt by professionals working in this field in England is down to the lack of general guidance and inter-agency protocols. Developing these should be the first of four clear priorities to be taken from the report. Next is the need for frontline workers to be better equipped – training on parental substance misuse should be compulsory for social workers, as it is in Scotland. Thirdly, the needs of the estimated 1.3 million children in the UK affected by parental substance misuse must be equally prioritised, both locally and nationally.

And finally, there must be guaranteed ongoing funding at a local level for services working with families affected by parental substance misuse. These are still few in number, many are run by non-statutory organisations and competing for limited resources. What happens to these vital services if they are not absorbed into the mainstream or able to find alternative sources of income once the funding runs out?

The government, with its eye on reducing drug related crime, has not taken up the gauntlet thrown down for it by the ACMD to make the children of drug users a priority in the drugs strategy. Do we really have to wait for a few high profile cases of neglect of children of drug users in the media in England as there have been in Scotland for much-needed political action to be generated? This would be tragic. With the current drugs strategy almost at an end, now is the time to ensure the focus is widened.

For its own part, Addaction is shifting the focus of its 70 plus services to include needs of the children and wider families of their clients. Changing structures, mindsets and ways of recording information which are all geared up to working with the adult user is a long and often difficult process, but it can be done. Valuable learning and knowledge is emerging from this new and challenging work on the frontline and Addaction intends to use it to build the case that working in a broader, more family based way can bear fruit both in the short term and in reducing the burden for future generations.

Kelly wants to cut down her cannabis use and eventually stop. She's already managed to cut down by half. Perhaps Kelly didn't receive this support soon enough – but if it becomes more widely available, as it must, thousands of others like her may be grateful they did.

Clare McNeil is press and policy officer at Addaction.

Into the open

James and Paul Rogers aged two and three are running excitedly around the bare, uncarpeted floors of their new home, while their parents Scott and Lisa are downstairs helping electricians make last minute adjustments to the lighting. The scene couldn't be more different from Breaking the Cycle family worker Donna Cardell's first meeting with the family just six months before.

'Syringes and needles were lying on the floor of their property which was in a serious state of disrepair. Drug users known to local services were seen entering the property and there were real concerns for the safety of the children,' says Donna.

The family had been the subject of an anonymous tip-off from neighbours who were concerned about the impact Scott and Lisa's heroin use was having on their children. Over the next few months Donna visited the family as often as she was able to get access to the family home. She contacted the local housing service to express concerns about the property and to arrange a joint visit. On several occasions they were unable to get access to the property and at one point a court order had to be obtained by housing services on health and safety grounds.

Donna gave advice to Lisa and Scott about how to minimise harm around their drug use and they were given sharps bins for discarded syringes and needles. The family had been lacking contact with health services so an appointment with a health visitor was arranged for Lisa and her sons. When she was put forward for a Drug Rehabilitation Requirement (DRR) Donna helped Lisa to obtain funds available for child care and for transport to and from treatment appointments. Lisa is now receiving regular drugs treatment and is on a methadone prescription.

After a long struggle, today's move to a home in better condition, with more space and a garden marks a new start for the family. Donna explains: 'Scott and Lisa continue to need intensive support from myself and the range of agencies that are now working with them. But they have made real improvements in their parenting in the last few months. Now I'm helping them to arrange for James and Paul to attend a pre-school scheme so they have the chance to interact and play with other children.'

Sharon Carson became EATA's new chief executive in June last year. With her feet now firmly under the table, **DDN** finds her busy drawing up plans for the future

Carson drives in change

'Ten months into the job I'm still passionate!' declares Sharon Carson, chief executive of the European Association for the Treatment of Addiction, better known as EATA.

As she starts to talk about her role – apart from grumbling that this is all a bit much for a Monday morning – you get the impression that it will take a lot to dent Carson's enthusiasm. She is lively and talkative, and has plenty of ideas on where she would like to take a membership organisation that represents treatment centres 'right across the board', from day centres to residential rehabs.

Leaving a commissioning post with a primary care trust to join EATA, Carson has a useful range of experience under her belt. Before commissioning sexual health and HIV services, she set up a tier 2 drug and alcohol service, and worked in a residential setting before that.

Her NHS job not only taught her how commissioning works; it helped her understand what working for a statutory sector organisation entails.

'It gave me more understanding about how decisions are made at central and regional level,' she says. 'I started to appreciate the rationale, rather than always being on the delivery side and blaming decisions that are made through statutory sector organisations... I could see why decisions are made, and why they might not always be popular.'

Combined with a good dose of diplomacy, her past experiences have prepared her well for the balancing act of representing the treatment sector to government departments, and vice versa. An important part of her remit now is to negotiate with the Department of Health, Home Office and National Treatment Agency to keep treatment services high on the agenda – and to bid for all-important funding to supplement income from membership fees.

'I suppose I'm in a unique position,' she reflects. 'I've got an understanding of each side, which could be to the advantage of both.' She's joined EATA at a time of competing priorities for all treatment providers, against a backdrop of uncertainty for the entire field, and acknowledges that her organisation has a very practical role in helping members deal with the uncertainty of looming changes in drug strategy.

In the meantime, she is focusing on getting on with the job in hand – and that means growing EATA into a force to be reckoned with. Since taking up her post, the organisation has grown its membership by 20 per cent to 90 organisations, she says, which include many more regional services for the larger players such as Turning Point and Addaction.

While acutely aware that EATA has to keep a realistic workload for a staff of just two people, Carson explains that her business development manager, Ghada Osman, monitors and responds to the day-to-day concerns of individual services, a role that complements her own more strategic remit. To a great extent their agenda has to be shaped by the immediate concerns and crises of their members – which, most recently, has meant focusing on the capital allocation to tier 4 services.

Carson declares that she would rather be operating in a climate of full choice for every person with a drug or alcohol problem.

'I want to shift towards getting an even focus with tiers 2 and 3, as much as tier 4,' she says.

'We need to redress how individuals have access to the treatment system. We need to make sure people have access to treatment when they need it.... And to do that we have to look at what's going on in every tier, including changes happening on the criminal justice side.'

Small organisation, big remit – so how will Carson begin to make the impact she wants? By advising on systems and practice; by consulting with members; and by contributing to national groups and panels representing the sector, she says.

Carson has more to say about what should happen in drug and alcohol treatment, based on her previous incarnations.

'There's a whole debate going on at the moment around whether services are fit for purpose... I think we have to turn it on its head and look at whether commissioning is fit for purpose.'

She warms to her subject. 'We need to really sort out what's going on in commissioning... commissioning isn't just about purchasing, it's about strategic development and whether we're convinced there's the right governance or the right structures in place.'

Then just as quickly she backs off the subject, as if to remind herself that she has enough on her plate.

'It's really difficult at central level to influence local commissioning behaviour... you can produce guidelines till they come out of your ears, but they're only as good as the local area where they need to implement them.'

Future horizons are wide, as far as Carson is concerned. She is bouncing along at the moment, buoyed by substantial section 64 funding, trust funding from Esme Fairburn and other bids in the pipeline.

She has ambitious plans to develop links with European services, to share best practice and encourage more research over here she says, in answer to a question about the European element of EATA.

But for the short term she is aware that she needs to make a strong impression at home.

Immediate plans include launching an accreditation scheme for treatment centres, which will link with FDAP's individual practitioners' accreditation to drive up competency throughout the field.

It's an important initiative that will examine the quality of what's being delivered 'as opposed to numbers', she says. It also follows her strategy of prioritising close to base at this early stage.

'What I need to do is really be very clear about what our direction is in the UK,' she says. 'I'm very clear on what we can deliver and where we can really add benefit. It's about now having the opportunity to do that.'

And with that, she gets up and ever-so-politely ushers me to the door, so she can get on with it. **DDN**

'I am dismayed by the way the job I used to love doing has changed. My skill is working with people, not sitting at a desk, shuffling mountains of paperwork and endlessly recording, collating, analysing and reporting data, which I then send off into the ether. I am sick of auditors coming in like vultures to pick over the bones of my work and criticising my team of skilled, dedicated workers for forgetting to tick some box on some bloody form. Proving I am working has become my job and I feel de-skilled, demotivated and unappreciated.'

Who watches the watchmen?

I imagine thousands of practitioners across the country agreed with the points your correspondent made regarding Paul Hayes and the bureaucracy that controls our lives (*DDN*, 26 February, page 9). I think it's about time that the people who actually do the work, turned the tables and started putting under intense scrutiny the ever-growing army of those whose nice jobs, salaries and pensions depend on us being at the coal face.

Who is monitoring them? How many audits are they subjected to every year? What are their targets? What specialist qualifications do they hold?

I am dismayed by the way the job I used to love doing has changed. My skill is working with people, not sitting at a desk, shuffling mountains of paperwork and endlessly recording, collating, analysing and reporting data, which I then send off into the ether. I am sick of auditors coming in like vultures to pick over the bones of my work and criticising my team of skilled, dedicated workers for forgetting to tick some box on some bloody form. Proving I am working has become my job and I feel de-skilled, demotivated and unappreciated. I am incensed that I am told I must do more and more without any increase in resources while seeing the bottomless pit of money available for yet more tiers of bureaucracy and more cushy jobs for people who wouldn't know a drug using offender if they woke up next to one.

Let's start applying the same pressure to our pen-pushing masters and see how they respond. Let's demand that they are accountable to us and make them prove they are fit for purpose. Let's hear some voices!

Name and address withheld

Let me down easy

It was good to see the difficulties associated with benzodiazepine use being highlighted by Dr Chris Ford in 'Good Drug, bad drug?' (*DDN*, 26 February, page 13), as well as her sympathetic approach to the problem. In the case she cites, monitored maintenance prescribing was the way forward for her patient and a positive outcome was achieved by prescribing benzodiazepines to someone dependent on them.

At Mind in Camden's Minor Tranquilliser Project, we all too often hear of clients being threatened with an abrupt or too quick cessation of a benzodiazepine prescription. Our way of working is recommending a slow reduction at the user's own pace, because in our experience this is the most successful way to withdraw from benzodiazepines. We have come across cases of inadequately treated clients who then try and relieve persisting distress with alcohol, other drugs and or obtaining benzodiazepines by illicit means. Residents of Camden who would like to receive a range of services for any difficulties they may be having are welcome to contact us.

Whether good drugs or bad, the chief medical officer sent a statement to doctors in 2004 reminding them that benzodiazepines should only be prescribed for short-term treatment (two to four weeks) before reviewing the situation. The unfortunate consequence of the CMO's statement is that we have heard from clients whose GPs are pressurising them to come off without discussion with their patient. This has caused great distress to our long-term prescribed benzodiazepine users, and increasing concerns about withdrawal symptoms.

For some clients, general health advice, supportive counselling, and information on sleep, relaxation, and behavioural strategies may suffice for coming off. However, for many of our clients addicted to these pills, whether in combination with other drugs or not, these techniques alone are not enough. What users of the project do tell us is helpful, is that they are allowed to be a prime mover in their treatment and to taper the dose gradually at their own pace, with our service's encouragement and support.

Melanie Davis, service manager, Mind in Camden's Minor Tranquilliser Project, (tel: 0207 241 8980)

Ball of confusion

I fully agree with Dr Ford's decision to reinstate Imran's prescription of benzodiazepine (*DDN*, 26 February, page 13). In my opinion it is both unfortunate and dangerous that some drug services refuse to prescribe benzodiazepines beyond a few weeks to dependent individuals.

The two to four week guidelines are aimed at new patients or non-dependent individuals. The guidelines from the vast majority of medical authorities, including prodigy clinical guidance, committee on safety of medicines and the Department of Health, state that withdrawal of benzodiazepines should be carried out over a lengthy timeframe. It is unfortunate and worrying that many drug services seem to confuse the guidelines for prescribing benzodiazepines to new patients or non-dependent patients with the guidelines for withdrawing dependent individuals from benzodiazepines.

From the description of Imran's behaviour it sounds like he was suffering an acute withdrawal syndrome. Abruptly or rapidly discontinuing benzodiazepines can be hazardous and has been associated in clinical studies with suicide, psychosis and epileptic seizures. Also, it would be expected that Imran's alcohol usage would increase during acute benzodiazepine withdrawal as alcohol and benzodiazepines are cross-tolerant and one will relieve to a degree the withdrawal of the other.

The 1999 Department of Health guidelines, referenced in the article, advised against rapid detoxification of patients who are physically dependent on benzodiazepines. The DoH 1999 guidelines state that: 'A benzodiazepine can be withdrawn in proportions of about one-eighth (range one-tenth to one-quarter) of daily dose every fortnight', but the rate of withdrawal can be slower as they state in the same guidelines that: 'The rate of withdrawal is often determined by an individual's capacity to tolerate symptoms'.

The Department of Health does, however, recommend against long-term maintenance prescribing of benzodiazepines. This is because long-term use can be associated with harm, including cognitive deficits, agoraphobia, social isolation, and increasing anxiety problems as well as a lack of continued efficacy. Of course not everyone is negatively affected by taking long-term benzodiazepines and many can function reasonably well on them.

It was reported that Imran had suffered depression since early childhood and had been using benzodiazepines to deal with this. Benzodiazepines may also impose a learning defect which impairs an individual from learning or forming new coping strategies to overcome mental health problems.

I personally believe that an individual already dependent on benzodiazepines should be encouraged (but not forced) to withdraw gradually from them, and long-term prescribing should not be initiated for non-dependent individuals – the distinction is important. The 'bad guy' in this article seems to be the drug service who abruptly stopped Imran's supply of benzodiazepines after 20 years of use and the 'good guy' was Dr Chris Ford who recognised the dangers in doing this. A better understanding of benzodiazepine dependency management among drug services is called for!

Ross J. M.

Out of Your Head

Diary of a dual diagnosis communications project

How do you communicate harm reduction to drug and alcohol clients with severe mental illness? Mark Holland, consultant nurse for dual diagnosis at Manchester Mental Health and Social Care Trust and Michael Linnell, Lifeline's director of communications decided to pool their expertise to produce a series of guides. But getting the project right was much more difficult than they had anticipated…

Mark: Ten years or so ago, as a community psychiatric nurse, I found myself searching for information and education materials to give clients (and their carers) who experienced concurrent serious mental illness and who also used street drugs or alcohol – often called a dual diagnosis. I found very little, and what existed was pretty weak. The reason my clients used drink or drugs was not very clear, the effect drink or drugs had on them was varied and almost always detrimental, and the response from substance misuse and mental health services was often counterproductive; they tended to pass the client on to other services claiming either the mental illness was the cause of drug use or drug use was the cause of mental illness. Clients got passed from pillar to post, to quote MIND.

As a result of these observations I put together research proposals examining the responses by services to this client group, what types of intervention might work and what information might help them, their carers and practitioners involved in their care.

Eventually, the University of Salford, my local mental health trust and Lifeline agreed to collaborate over a project that would examine all the issues outlined above from a user perspective using a qualitative methodology. Academic and medical ethical approval for the project was received in September 2004. The core of the project was to develop accessible information for service users; a secondary goal was that the information (booklets) would also be read and used by carers and practitioners. The rationale for this was that as practitioners and carers were often at a loss as to what was going on anyway, any little would help.

Michael: Eighteen months ago, I found myself sitting in the smoking room of the intensive care unit of a psychiatric hospital, about to interview a group of patients. Although one man spent the entire session whispering in my ear in an attempt to persuade me to eat some of the cheese he had in his pockets and another dropped to his knees mid-sentence whenever God spoke to him, it was when an extremely articulate man, in the context of a discussion about the positive aspects of his illness, said, 'Do you know how good it feels burning down a £300,000 house?' that I realised, producing harm reduction guides for people with severe mental illness was going to be 'challenging'.

'People who have experienced mental illness should avoid using drugs.' This is the standard line inserted into drug information products, and although this statement is undoubtedly true, it is also true that people who have never experienced mental illness should avoid whacking up a groin full of smack or snorting a line of Charlie the length of the District and Circle line. And yet within the drugs industry, with the exception of the most rabid abstentionist, harm reduction is seen as the most effective, pragmatic and humane approach while people are still using. So, why is our approach to people who use drugs and have experienced severe mental illness any different? Are we saying that only sane people should use illegal drugs?

Mark: Anyone caring for a person experiencing 'madness', be it a 'moment of' or sustained, wants to help. You see a patient in hospital, they're hearing voices that abuse them, they think they are under mortal threat by some entity or other; they're overwhelmed by distress. If they use drugs you conclude that the episode has been made far worse than usual because they've smoked cannabis or used something or other that's psychoactive in nature, including alcohol. What option is there? One obvious one: 'just stop using'! It's clear: stop using and your medication will be more effective and you won't trigger or worsen episodes of your mental illness.

Fine, but in reality (just like someone who is habitually cutting themselves) abstinence is only feasible after they have worked their way through the alternatives to using (or cutting). Working through the alternatives takes time for a lot of people. For nurses in hospital, and mental health or substance misuse practitioners in community settings, that time can be used to good effect to provide useful information that promotes safer (not safe) substance use. Keeping someone healthy until they stop using is probably the most viable option.

By producing harm reduction booklets for dual diagnosis clients we thought: one, clients would be more aware of the mental illness-substance interaction and two, practitioners and carers would be exposed to an approach that offered an alternative to the unrealistic demand of immediate abstinence.

Opposite: excerpts from the 'Out of your head' guides, illustrated by Michael Linnell. From top to bottom: No.3 Jason – the Psychonaut; No.1 David – the man with the transparent head; No.2 'Raving Mad' Martha.

Michael: As an outsider to the psychiatric profession, I was initially very disturbed by the side effects of anti-psychotic medication (which can cause long term Tardive Dyskinesia). However, after listening to people's experiences and seeing the risks in context, I changed my mind. Although I approached this project from a harm reduction user-centred focus, I was also very clear that we were trying to tell a story from both sides. After speaking to the patients' advocate service and as many of the patients had been compulsorily detained, I made some efforts to distance myself from the nursing staff on the ward to maintain an independent perspective. A number of things surprised me – a number didn't. Some of the drug use was controlled, logical and familiar (to me), some of it far less so – *ie* getting 'the voices' stoned; deciding to drop a trip when you are in the middle of a psychotic hallucination; smoking rock to chase those 'big black hairy spiders' from out of your mouth. That there was a stigma about being a 'druggie', even among people compulsorily detained in a psychiatric hospital, was no real surprise.

Mark: Embarking on this project with an experienced researcher from a reputable (or is that infamous) drugs agency, I was anticipating challenges. Healthcare is fairly conservative; the NHS today feels more risk averse than ever. Introducing Lifeline into mainstream psychiatry was going to be exciting. The fact that the first focus group's participants all put their tenner payment each into a kitty for the only patient with unescorted leave to go and score with, demonstrated a lot. It showed how organised the most 'mad' people can be. (These focus groups took place in wards for acutely disturbed patients.) It showed how naïve I was, and it confirmed what we suspected; patients would not stop using automatically, so a harm reduction approach was definitely the way to go.

Therefore, working with a drugs agency was essential. We needed their expertise on the subject itself, substance use – but also we needed their expertise in reaching particular audiences. This was the first time I had seen a combination of imagery and storylines used as a research tool to reflect research participants' experiences. This was clearly an appealing method for the patients who participated in the project too. It generated a lot of engagement with staff and patients. It was evident that patients and staff in mainstream psychiatry were, and will remain, receptive to substance use approaches; it's simply a case of providing them with some resources. In this modest case, that amounts to four dual diagnosis information booklets.

Michael: A variety of styles of pencil drawings were used to test style, humour, understanding and interpretation of visual messages.

I eventually (and confidently) came up with the idea of a character called 'Ghost Weed', a Rastafarian spirit who appeared on the ward every time a group of four patients smoked 'the magic weed' (at least half of the respondents in the intensive care unit were black males, hence the black hero/storyteller). After several months' work, the prototypes were tested on some patients... they didn't work.

Ghost Weed was too confusing for some people and too simplistic for others. This, to put it mildly, was disheartening. However, the part of the story in which the patients told their histories or stories did seem to work well. After struggling with the stories' structure for another couple of months (the horror of the blank sheet of paper), a pilot was tested and seemed to work.

Mark: The data was collected through numerous focus groups and interviews in day treatment, but mainly in inpatient psychiatry. Mike produced pictures and story lines for four fictitious characters and integrated the vast amount of the participants' experiences into the characters' lives. The themes in the storylines had to match separate thematic analysis carried out by me. Failure to match them would compromise the validity of the content of the booklets. The experiences had to resonate for participants and therefore later focus groups were used as part of the storyline or themes verification. Amendments in content and format were made as we constantly refined the booklets. Each substantive subject, such as relapse prevention in psychosis, homelessness and mental illness, schizophrenia and cannabis use, medication, and pharmacological action of street drugs, had to be reviewed. The content needed to be accurate from an established evidence base point of view, as well as reflecting our participants' views and experiences.

Once we had satisfied ourselves that the content was sound and true we sought approval from opinion leaders in the field including the Care Services Improvement Partnership (CSIP), particularly the National Institute for Mental Health in England (NIMHE). It was critical that mainstream NHS mental health agencies approved of the booklets because our target audience was dually-diagnosed clients, most of whom are in the care of specialist mental health NHS trusts and services. It was important also to demonstrate academic rigour and sponsorship.

The booklets ultimately need to reach practitioners who are scratching their heads in the same way I did ten years ago. In trying to find information for a troubled client group that will be of therapeutic value to clients and culturally enlightening to services, I feel optimistic that the Out of Your Head series could be very beneficial.

See downloads and web clips from the project at www.lifeline.org.uk

Building foundations for a counselling career

Clouds' new foundation degree has opened doors to an addictions counselling career for some who might otherwise have considered themselves unlikely candidates. DDN finds out more from tutor and students.

'People in the drugs field often have good academic qualifications and very little experiential knowledge. Or they are trained on an apprentice model – they know all about addiction only because they've been there,' says Tim Leighton.

As head of professional education, training and research at Clouds, Leighton is pleased to celebrate with the first year of students to graduate from the Clouds foundation degree in addiction counselling.

'The foundation degree is designed to create practitioners,' he says. 'They're trained to be good practitioners, but they also understand something about the models they're using and the research that supports them.'

Training is thorough and begins with the first half of the year in the classroom, learning about all aspects of addiction treatment, including harm reduction, 12-step, cognitive behavioural therapy, motivational interviewing, as well as about diagnosis and assessment.

Theory becomes practice through a placement for the second half, which might be in an intensive residential treatment programme, or could be with a harm reduction agency.

Leighton prefers to settle students into one placement, so they can become part of a team, rather than moving them on when they start to become useful. They develop a portfolio of work-based learning, assessed by a supervisor, to complement the traditional essay writing.

The course is structured to bring the best out of its students. But what kind of person makes a good addictions counsellor?

A selection day helps them find their most likely candidates, Leighton explains. The course leaders want access to be as wide as possible, to include those applicants who might not have formal education or qualifications, as well as the more academically able. Many students want to change career to come into the field – in fact all the recent foundation graduates were mature students.

Shortlisted candidates are invited down to Wiltshire for a day, to see how they interact with others.

'They're invited to do a number of activities, and to talk and give their opinion in small groups,' says Leighton. 'We can assess whether people can co-operate, whether they're too much of a shrinking violet, or whether

So you want to be an addictions counsellor

Rachel Walters thought she would never be considered for the course with her background in banking. Now she has gone on from the foundation course to the BSc Hons.

I came to the course by accident really. My nephew died aged 21 and I also had two fairly violent alcoholic partners. I wanted to know why.

I came across Clouds House on the internet and saw they did a course. It wasn't the degree course then, it was the diploma.

I phoned up thinking I wouldn't stand a chance of getting on the course because of my background. I had an interview and they told me to go and do a couple of free courses with Wiltshire County Council, find out more, and keep them informed. When I came back to them, they suggested I might be interested in the foundation degree. I went on the selection day and got onto the course.

I'm now seeing addiction from the other side. It helped me understand my own processes as well, and taught me how to deal with different situations. It was a good grounding for interacting with people and watching my own reactions. Within a year I came across somebody within treatment who reminded me exactly of my nephew. So had I not had intensive training at the beginning of my course it might have been quite difficult to handle, even with supervision and support.

I think you need to know yourself very well and not react to people, to be a good counsellor. You are under quite a lot of pressure at certain times and patients do shout. You can't let it affect you or react – you need to keep not exactly detached, but calm about it. Some people can be intimidating and quite manipulative.

I've found that clients fall into two camps: some think you have a magic wand, which you can wave to make everything fall into place. Others see you as an authority figure, and kick against that sometimes.

There's quite a managerial element to the BSc, and we go into therapies – cognitive behavioural therapy and motivational interviewing in particular – in much greater detail. Once I've done the BSc I want to work in a counselling role for a while; my ultimate goal would be to be a team leader, then a manager.

But I need to get more experience first. The foundation degree gave me a brilliant chance to work on the job and learn at the same time – it prepares you completely for the job.

they'd be dominating.

'We stick them in groups of three, so one person plays the counsellor, another plays the client, and another one plays the observer. Some of these people have already got diplomas and certificates in counselling and we expect these people to demonstrate pretty good skills. But we also see people who've got none of that, who show a talent for it by doing the right thing. We observe that and score it.'

A subtle part of the intake process is assessing candidates' motivation for doing the course. Personal experience is no bar to joining, Leighton explains: 'We're less judgemental about this than we used to be. If someone says they want to do it we say OK then, this is what it involves and these are the kind of qualities you're likely to need.'

Once places have been confirmed, the course needs everybody to start in the same place.

'They need to more or less suspend what they think they know about the issue and open their mind to different angles.'

Their reward will be a good chance of employment – the diploma from which the foundation degree was developed had a record of nearly 100 per cent employment afterwards, according to Leighton – and those who have completed it have tended to stay in the field.

'We did a survey of the first 100 people who had gone through my course a few years ago,' he says. 'Nearly all of them had not only got jobs within the field – they were still in those jobs.' Other foundation graduates go on to the BSc honours degree in addiction counselling.

While candidates are lining up for the foundation course, Leighton is surprised that there are not more applicants for the part-time version, and contemplates that employers might need more help in supporting people who have been in the field for some time and have not had the chance of professional development.

'We want to help employers see the benefits of sending staff on the foundation degree part time while they're employing them,' he says – and hopes that a forthcoming move from the depths of the Wiltshire countryside to mainline Warminster, where they will open the Clouds Centre for Addiction Treatment Studies, might help to make the whole idea more accessible. **DDN**

Adrian Edwards joined the course when he was in desperate need of a career change – propelled by personal circumstances. Having graduated from the foundation degree, he is now partway through the honours degree.

A number of things made me interested in working in the field, but probably the most important factor was that I lost quite a close friend to drugs.

I was working in the defence industry, very unhappy, and looking to get out. I was interested in doing drug work, so thought I would approach some organisations to do voluntary work. But they weren't interested, so I thought, 'if this is something I want to do, I'm going to have to get the skills to break into it'.

I remember feeling quite nervous about the selection day, wondering what the correct terminology was for talking about drugs and alcohol. Do you call them an addict? Or someone with a problem? I had absolutely no idea.

The course gave me exposure to different areas of addiction. I'm now in the second year of a placement with Broadway Lodge, which is abstinence based. Over the summer I worked in Exeter Prison. They are two very different environments, but I now feel equipped to work in either.

Having experienced both, I personally feel more comfortable with harm reduction. Dual diagnosis is an area I'm particularly interested in.

This is the only adult education thing that I've started and finished – or even come close to. That's down to support really – at Clouds and from other professionals along the way in placement agencies.

I did all right at school, but not fantastic. This has given me a completely new opportunity.

Q&A

Someone I know has been included on the shortlist for a job at my agency. We have a strict 'clean' policy here, but I know this person socially, and he is well-known for his drug-taking. Should I advise my manager of the situation, or keep my nose out?
Rose, Birmingham

Popularity vs professionalism

Rose
The person you know has clearly put you in a difficult position. Your organisation has developed a policy to protect the vulnerable people in your care and, as a paid professional, you have a responsibility to preserve this.

I was in a similar position some years ago and had to chose between my professional integrity and my popularity with others. Personally, I would contact the person and ask them if they were aware of the organisation's policy concerning the use of drugs by staff members. I would then gently ask them to take some responsibility within this, with the expectation that they would withdraw their application. If they were unwilling to do so, I would let them know that I am required to inform my line manager, and how I felt about this.

I know how difficult it can be to follow through with this, but it's worth reminding yourself why this policy was put in situ in the first place and the responsibility we have as professionals to preserve the wellbeing of vulnerable people in our care. Equally, we need to ensure that we don't parallel and collude with the common rules often found in our client population, about 'grassing'. The cost is too great. I hope this goes well and the very best of luck.
Nick Gully, director of addiction services, The Priory Hospital Roehampton

No choice for a friend

Dear Rose
My heart goes out to you, yet there are two issues here: firstly, this person is a user; secondly, he's a social friend.

So on the first point, I would feel I had no choice but to whistle-blow. Just think of the problems this person could bring to the agency – and more importantly, the harm he could bring to clients seeking help.

On the second aspect, you state that you know him socially; so if this is the case, you as a professional will be doing your friend a caring favour for himself and keeping to the 'clean' policy the agency holds. I am sure this can be done confidentially to your manager without everyone knowing – and if this is the case, then your friend will never know that you have done him a favour. Being a professional is not easy when situations like this arise. Good luck in your chosen decision.
Sean Rendell

Reader's question

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

Email your suggested answers to the editor by Tuesday 20 March for inclusion in the 26 March issue.

A day in the life

Neil Bolton-Heaton has been service development manager at the Alcohol Recovery Project (ARP) for the past 18 months. He tells **DDN** about the challenges of uniting service users' needs with the planning and developing process.

My brief at ARP is wide-ranging. I arrive at work around nine in the morning and start working on the Links Case Management System – a software programme we've been developing for a year and a half. Presently, one-third of our client cases are electronic, but we want to expand our system to incorporate all of our services. This will benefit us on a number of levels and will mean a more seamless care and support for clients moving across our services.

We are now at the end of the financial year, and our performance reviews and appraisals have been completed. So I am working on our training needs analysis and workforce development – which is scheduled for next year. Most of our training is geared around supporting staff to achieve qualifications.

The Alcohol Recovery Programme runs 25 residential projects for homeless or insecurely housed people with alcohol and drug misuse problems within London. We offer a wide range of services including floating support, six direct access day services offering community-based care, and counselling. We are one of the only agencies that deal solely with alcohol.

Many people are referred to us by word of mouth and some of our clients have gone on to be involved in either the management or other parts of the organisation. Our Advisors 2 Board (A2B) is a service user led group, which comprises current or recent users of ARP services, who advise the board and the operations director on arising issues and where they want to see improvements.

This year ARP is 40 years old so some parts of the organisation will benefit from a continuing internal modernisation programme.

My afternoon is spent finalising policies and procedures and getting them out to referring agencies and our own services – this will take up the rest of the day. At the moment we are just coming to the end of a policy review that focuses on service delivery. All the revised information on our procedures have come from our staff and service users rather than the management sitting in their offices writing them, so we have something that reflects what people do on the ground. This has been a fairly intensive piece of work and there is still more to do.

I like my role at ARP. It's good because the pace of change is so fast at the moment, that there's no time to be bored. I also find it motivating because we're working on some innovative and challenging projects.

Originally I am from the North of England where I trained as a nurse specialising in AIDS and HIV. About 13 years ago, I came to London and was shocked to see the number of people sleeping rough on the streets with obvious health needs as well as substance misuse problems. During my time in the sector I have worked across the board, from direct service delivery to performance management of local authorities in relation to substance misuse. I think that this range of experience is important as you have an idea of the limitations local authorities are up against and it broadens your understanding of the structure surrounding social care.

My day finishes around five so I make a list and take notes to remind me of what needs to be done for tomorrow on top of my ongoing pieces of work.

I think the best part of my job is listening to the staff and service users on what's needed to make services work more effectively for clients – and the key to that is delivering on those recommendations. Seeing the impact of that change can be highly motivating for staff, as they are aware that they are being listened to and that the organisation is responding to them. That to me always seems like a job well done. **DDN**

If you would like to be interviewed for 'A day in the life', contact Ruth Raymond by emailing ruth@cjwellings.com

Theories of craving and urges

Professor David Clark describes craving and urges for drugs and alcohol, and briefly outlines some of the underlying theories.

The terms craving and urges have enjoyed wide popularity in both subjective reports of people misusing substances and in the clinical literature of addiction.

Craving occurs for substances that cause problematic behaviour and addiction, including opiates, stimulants, alcohol and nicotine. Moreover, craving has been suggested as a prominent feature maintaining drug and alcohol use and precipitating relapse after a period of abstinence.

Craving is regarded as a subjective motivational state in which an individual experiences an intense or overpowering desire to engage in drug-taking or alcohol consumption. It can vary in intensity, sometimes reaching a level that can overwhelm the individual, dominating their thoughts, feelings and actions to the exclusion of all else.

There has been some confusion in the field related to the terms craving and urges. While some people use the terms interchangeably, others consider a distinction between the two phenomena.

For example, Tom Horvarth describes craving as a desire to achieve the psychological state induced by the substance that one has given up – the 'I want it badly' feeling. Cravings serve as a cue for urges.

An urge is considered to be the impulse or intention to get the substance and use it – it is the 'I have to do it now' feeling. Some therapeutic strategies focus on managing the response to urges because they cue the addictive behaviour.

Cravings and urges have been intimately linked to classical conditioning processes. Over a long history of drinking or drug-taking, stimuli that have been repeatedly associated with consumption of alcohol or drugs (*eg* sight of the pub, or the syringe) become conditioned stimuli.

These conditioned stimuli become capable of eliciting the same responses that are produced by alcohol or drugs themselves. They activate conditioned motivational states that produce craving and urges, physiological reactions, and drug or alcohol seeking behaviour.

Craving and urges can be linked to both positive and negative reinforcement systems. One model proposes that these states arise from the anticipation of the positive reinforcing or pleasurable effects of drugs or alcohol. Watching someone smoke a cigarette and the smell of the tobacco can remind an ex-smoker of the relaxing effect of smoking and trigger an intense desire to experience this again.

Another model proposes that craving and urges arise from the need to relieve withdrawal or conditioned withdrawal symptoms. Thus, a person returning to an area where they have experienced withdrawal on many occasions in the past may experience conditioned withdrawal symptoms, which in turn can generate craving.

'Craving can vary in intensity, sometimes reaching a level that can overwhelm the individual, dominating their thoughts, feelings and actions to the exclusion of all else.'

In contrast, Terry Robinson and Kent Berridge argue that drug or alcohol craving is a psychological process that is distinct from conditioned withdrawal and the anticipation of pleasurable drug or alcohol effects.

They propose that repeated use of these substances can lead to neuroadaptations (increased sensitivity) in brain dopamine systems that are involved in attributing incentive salience to stimuli. Incentive salience is a psychological process that 'transforms the perception of stimuli, imbuing them with salience, making them attractive, "wanted", incentive stimuli'.

The sensitisation of these brain dopamine systems causes excessive incentive salience to be attributed to the act of drug-taking and to stimuli associated with drug-taking, transforming ordinary wanting into excessive drug craving.

Importantly, these researchers make a distinction between 'wanting' and 'liking'; although a person may want a drug, they may not necessarily like it.

While some models assume a tight link between drug or alcohol misuse and craving, the cognitive model of Steve Tiffany proposes that drug and alcohol use in addicts can function independently of the processes that control craving.

Tiffany argues that over a long history of drinking (or drug use), many of the actions involved in acquiring and consuming alcohol become automatic for people with an alcohol problem. Stimulus triggers (*eg* clock reaching 17.00) activate automatic cognitive processes that result in automatic drinking, with craving playing no controlling role.

However, when the automated alcohol use sequences in a drinker are blocked by an environmental obstacle, *eg* favourite pub is closed for renovation, the person must activate non-automatic processes to cope with the problem. These non-automated processes, when activated simultaneously with automated alcohol use sequences, generate craving.

People with a drink problem who are abstaining from alcohol face a continuous barrage of cues and situations that trigger their automated alcohol use sequences. By trying to abstain they are using non-automated cognitive processes, which in turn generate craving.

This model can account for the fact that addicts often do not identify craving as a major, immediate cause of their relapse.

Tiffany points out that relapses that occur where craving is not identified as a major cause might be the result of automatic alcohol or drug use sequences being activated without concurrent mobilisation of non-automatic processes directed towards impeding these automated sequences.

Craving and urges for drugs and alcohol cause a repeated, short-term discomfort to a person, which they need to learn to deal with if they are to overcome their substance use problem. While they are a natural part of addiction, they do disappear over time. Strategies have been developed that help people deal with craving and urges; use of these can facilitate behavioural change and the path to recovery.

"It's essential to provide a warm and supportive environment, but without rules and regulations it's a waste of time. Addicts come to us from a life which has no boundaries, into an atmosphere where they must respond to time tables and meet our standards."

Tough Love

PCP Treatment Director Darren Rolfe talks to *Heather Jan Brunt* about the importance of keeping clients on track.

ADDICTS need a firm but loving environment when they reach out for recovery and at PCP they find such an atmosphere.

The business started just two years ago but continuing success has seen early expansion in both England and Spain.

With both the STAT and private sector sending clients for help, what is the secret of PCP's success?

Tough love

Treatment Director Darren Rolfe says: "We believe in tough love. It's essential to provide a warm and supportive environment, but without rules and regulations it's a waste of time. Addicts come to us from a life which has no boundaries, into an atmosphere where they must respond to time tables and meet our standards."

Mr Rolfe says addicts who truly want to move into recovery embrace this regime.

"These are people who have often disregarded the chaos and pain their addiction has caused to others; who have stolen to fund their habit, or have lived rough," he explains. "At PCP they face up to those things and learn to accept their past mistakes. Children need and respond to boundaries and it is the same with addicts, many of whom have suffered difficult childhoods where perhaps those boundaries were not in place."

No second chances

Rules at PCP go from the minor, aimed at improving the environment of addicts, such as cleaning bedrooms and eating well; to the more serious, such as no second chances for anyone found to be in possession of drugs or alcohol or actively using them.

"The reason our clients are here is to move into recovery," says Mr Rolfe. "If they cannot remain clean here, where they are supported by counsellors and fellow clients, then they stand little chance outside in the real world.

"It is essential that they are in the right frame of mind. We cannot tolerate clients who try to sneak in drugs or alcohol, because not only are they putting there own recovery at risk, but that of the people around them. If we allow them a second chance it sends out the wrong message to everyone else. So there are no second chances and we have random weekly saliva and urine tests to ensure everyone is clean. Clients know when they come here what the rules are, and we stick to them rigidly."

STAT and private clients

Mr Rolfe says PCP's uncompromising stance is particularly welcomed by DATs who require weekly reports on their clients. "Drug action teams need to see results so they won't waste their time with units that don't deliver the goods. We have a computerised system that ensures reporting is up to date, and have excellent relationships with the teams we work with."

Finances play a particularly important part with STAT clients, and PCP offers one of the most cost effective packages to be found in this country, with fees of only £350 a week at its English centre, based in Luton, Bedfordshire.

Sober Living Houses, within a one mile radius of the centre, offer comfortable accommodation in single sex properties, and PCP staff assist clients with applying for Housing Benefit.

Spain

A sister clinic in Spain, The Perry Clayman Project, is fully residential, set in the remote, beautiful and discreet La Alpujarra region of Granada. Six weeks of treatment costs £995 per week.

Family Intervention

PCP is one of the few clinics offering this very effective service. Mr Rolfe explains: "Although it can be time consuming, it is a very powerful tool, and we want to help as many people as possible so it is a service we are willing to commit to."

New look

The England and Spain centres recently expanded into new, larger premises and brought out redesigned websites at the same time, with clearer sharper text and images.

In addition a 24 hour freephone helpline 08000 380480 ensures assistance is available at any time for addicts who decide to move into recovery.

PCP
a new beginning

Contact:

Treatment Director Darren Rolfe

www.pcpluton.com
Tel: 01582 730113
Email: info@pcpluton.com

www.pcpspain.com
Tel: 0034 951 191 115
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*Average sample collection observed during clinical trials. Data available upon request from Cozart.

Drug & alcohol courses

Professional development training

the TRAINING exchange

One day courses (£110 + VAT)

Women & drugs	*23 May*
Difficult & aggressive behaviour	*18 June*
Introduction to drugs work	*18 Sept*
Effective communication	*20 Sept*
Alcohol & poly drug use	*24 Sept*
Working with Diversity	*2 Oct*
Engaging and assessing drug and alcohol users	*4 Oct*
Trainer's toolkit	*15 Oct*
Presentation & public speaking skills	*1 Nov*
Monitoring & evaluation	*8 Nov*
Mental health awareness	*13 Nov*
Bins & needles – safer injecting & harm reduction	*14 Nov*
Steroids	*tbc.*
Service user involvement	*16 Jan 2008*
Appraisals	*24 Jan 2008*

Two day courses (£195 + VAT)

Young people – mental health & emotional support needs	*21 & 22 March or 9 & 10 Oct*
Relapse prevention	*28 & 29 March or 10 & 11 July*
Introduction to management (£235)	*30 April & 1 May*
Groupwork skills	*4 & 11 May*
Dual diagnosis	*15 & 16 May*
At risk young people – the essentials	*5 & 6 June*
Project management (£285)	*4, 5 & 29 June*
Motivational interviewing	*11 & 12 June*
Key working & support planning	*20 & 21 June*
Brief solution focussed therapy	*28 & 29 June*
Supervision skills	*3 & 4 July*
Loss & change	*6 & 13 July*
Training for trainers	*26 & 27 Sept*
Bullying in the workplace	*29 & 30 Nov*

All courses take place in Bristol

All courses mapped to DANOS

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Accredited drug & alcohol training programme

Evidence Based Approaches to counselling substance users (EBA)

Now on its 10th run, the programme constantly evolves to reflect changes in the field

Tutor/assessor – Phil Harris

Phil has worked in the drug misuse field for many years as a practitioner, trainer and manager. He is a visiting lecturer at Bristol University, advisor to the US BICEP programme and the World Health Organisation. He has written over 20 scholarly articles on effective practice and published two books, Drug Induced (2005) and Empathy for the Devil (2007). Currently he is working on a number of innovative pilot programmes in natural remission and in working with concerned others.

Who is it for?

People new to the field of substance misuse work.
Experienced practitioners seeking recognition of professional practice.
Those working with substance misuse in related fields.

What is involved?

The course is divided into 4 units; students attend 13 days of formal training that take place over 8 months.

What do I get?

An Open College Network award at level 2 or 3.
Ongoing tutorial and resource support
A portfolio of evidence mapped to the knowledge and understanding that underpins DANOS units AA1, AA2, AB2, AH3, AH10, AI1

"The EBA course is a remarkable combination of explorations of meanings in addiction and treatment, exercises in competencies for both clients and counsellors, and programmed learning goals and their assessments. It is as complete and thorough a guide to dealing with addictions as exists."
Dr Stanton Peele, Social/Clinical Psychologist and specialist in addiction.

Course Fees £1600 + VAT, Maximum group size is 16

Programme Dates

Unit One:	**Critical Issues in Dependency and Treatment**	
	Orientation (afternoon)	17 September
	Drugs and Society	18 September
	Models of Change	25 September
	Attribution and Self-Efficacy	2 October
Unit Two:	**Counselling Pre-Decisional Change Drug Users**	
	Therapeutic Alliance	13 November
	Motivational Interviewing Part 1	20 November
	Motivational Interviewing Part 2	27 November
Unit Three:	**Counselling Post-Decisional Change Drug Users**	
	Behavioural Change	15 January 2008
	Solution Focused Therapy	22 January 2008
	Relapse Prevention	29 January 2008
Unit Four:	**Dependency Counselling in Context**	
	Working with Young Drug Users	4 March 2008
	Dual Diagnosis	11 March 2008
	Ethics and Practice	18 March 2008
	Debriefing (morning)	19 March 2008

TOGETHER WE CAN MAKE A DIFFERENCE

TACKLING DRUGS CHANGING LIVES

Oldham Drugs and Alcohol Action Team (DAAT) is a strategic partnership which co-ordinates the work of local authorities, Social Services, Education, Police, Probation, Health and voluntary organisations to implement the National Drugs Strategy in Oldham.

The DAAT is managed through Positive Steps Oldham, a winner of the 'Sunday Times 100 Best Small Companies to Work for 2006'. We have the following vacancy within our Oldham town centre offices:

SUBSTANCE MISUSE TREATMENT SYSTEM CO-ORDINATOR

Salary Range: £24,986- £36,809 + benefits

Working across the Drugs and Alcohol Action Teams in Rochdale, Oldham, Stockport and Tameside, you'll become an ambassador for the Models of Care and Effectiveness agenda.

As the Substance Misuse Treatment Systems Co-ordinator your mission is to build on the excellent progress in establishing the models of care framework and to drive forward an effective treatment systems approach within the four boroughs.

The successful candidate will:

- be a G-H grade nurse RMN, or a level 3 Social Worker or equivalent
- have experience of working at a strategic level across partnerships; and
- have experience of working in the substance misuse field

The appointment is fixed term until March 2008. A secondment opportunity will be considered.

We offer membership of a final salary pension scheme, annual leave from 34-39 days, flexible working arrangements, a voluntary benefits programme including childcare vouchers and learning and development opportunities. 36 hours per week for all posts unless stated otherwise.

If you are excited by this opportunity, wish to join our successful team and embrace the challenges ahead then contact our Recruitment Team for an Application Pack on 0161 621 9329 or e-mail: hr@positivestepsoldham.org.uk

Alternative application pack formats are available upon request.

If you have hearing or speech difficulties, and are a textphone user, you can call us direct in text using Typetalk on 18001 0161 621 9400.

Closing date: 27 March 2007. Please quote job reference: DAAT/SMTSC/03.

The successful candidate will be an employee of Positive Steps Oldham, who operate a Safer Recruitment process to protect vulnerable young people and adults. Positive Steps Oldham will apply for an Enhanced Disclosure with the successful candidate. For information on Disclosure please visit the Criminal Records Bureau website at www.disclosure.gov.uk

We are an equal opportunities employer who values diversity and positively encourages applications of all ages from all sections of the community.

Leicester City Council Supporting People

EXPRESSIONS OF INTEREST

Tender for a supported accommodation service for people with drug problems

Leicester City Council invites expressions of interest from suitably qualified organisations wishing to tender for a Supported Accommodation Service for People with Drug Problems. **The contract will be for 3 years**

Interested organisations are invited to apply, in writing, to request a pre-qualification questionnaire (PQQ) from:
Mel Elliott, Planning & Commissioning Manager, Supporting People Team, Leicester City Council, Adults and Housing, 1Grey Friars, Leicester, LE1 5PH.

The completed PQQ must be returned to the above address by **12 noon on Thursday 5th April 2007.**

Organisations who are successful at this first stage will be invited shortly after, to tender for the contract.

A notice was dispatched to the Official Journal of the European Union on Wednesday 28th February 2007

Telephone 0116 229 4180 / Fax 0116 225 4754

supportingpeople

Leicester City Council

Ymddiriedolaeth GIG
SIR BENFRO a DERWEN
PEMBROKESHIRE & DERWEN
NHS Trust

WEST WALES SUBSTANCE MISUSE SERVICE, CARMARTHENSHIRE

CRIMINAL JUSTICE DEVELOPMENT WORKER - BAND 6

Fixed-term contract until 31 March 2008

For an informal discussion, please contact Sue McRitchie, Locality Manager on 01267 244442.

For further information about the post and to apply online please visit www.jobs.nhs.uk. Please quote reference B223 in all correspondence.

Closing date: 28 March 2007

www.SamRecruitment.org.uk

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HMP RANBY & HMP HIGHPOINT CUSTODIAL DRUG SERVICES

HM PRISON SERVICE

CARAT Project Workers

Ref: EM-04-07-HMP Ranby
Starting Salary £19,000pa to £20,500pa

ADAPT is a national provider of drug and alcohol treatment services in custody and in the community. -The introduction of IDTS at HMP Ranby means that our CARAT Team is doubling in size, and we are recruiting six CARAT Workers, one being a Peripatetic CARAT Worker, to join our team at Ranby. Successful candidates must have good written and oral skills and be experienced in working with people from diverse backgrounds. Experience of working with addictive behaviour is a distinct advantage. Training will be given to meet DANOS standards. Some evening and weekend working will be necessary.

Closing date for receipt of completed applications is 21 March 2007

CARAT Team Manager

Ref: E-11-07
Starting salary £22,000 to £24,000pa
(dependent on experience)

ADAPT is a national provider of drug and alcohol treatment services in custody and in the community. We are looking for an enthusiastic person to lead our CARAT Team at HMP Highpoint in the delivery of CARAT's services to meet our contractual obligations to the Prison Service and to promote best practice. The role is challenging and dynamic, and the successful candidate will need to be able to evidence experience at first-line management level, or equivalent, within the substance misuse field.

Closing date for receipt of completed applications is 14 March 2007

Applications are particularly invited from male and BME groups – Section 7 of SDA 1975 applies.

For an application pack, contact ADAPT at adapt.ltd@btconnect.com or telephone 01493 854370 quoting the appropriate reference. Please submit a soft-copy of your application form if possible.

Alcohol and Drug Addiction Prevention and Treatment Reg Charity 803110

PCP
a new beginning

Secondary Care Treatment Manager
Salary: negotiable

Secondary care experience, Luton, Beds

Due to further expansion we are looking to recruit a dedicated, enthusiastic and motivated qualified Counsellor with at least 3-4 Years experience in secondary treatment.

Treatment Coordinator
Salary: negotiable

Luton, Beds

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

Please contact: Darren Rolfe (Treatment Director)
01582 730 113 darren@pcpluton.com

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

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

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

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

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

ttp alcohol and drug rehab www.ttpoc.org

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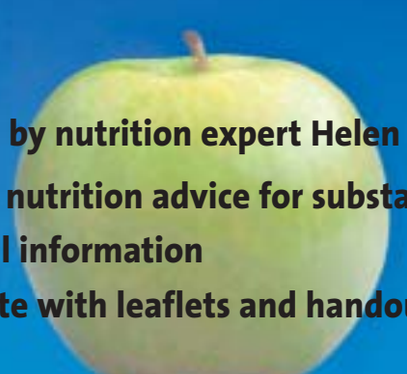

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www.drinkanddrugs.net

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

THE PRIORY HOSPITAL ROEHAMPTON

Addiction Treatment Counsellor

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

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

Sessional Addiction Treatment Counsellors

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

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

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

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

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

Closing Date: 2nd April 2007

www.prioryhealthcare.com

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Residential Substance Misuse Therapist

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

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

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

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

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

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

Charity no. 1001957

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Senior Practitioner

40 Hours P/W

We are currently looking to recruit a Senior Practitioner in order to join our expanding team at HMP Lowdham Grange. Working within the resettlement team, you will deal with the rehabilitation of all prisoners within the establishment. You will also supervise and provide support to CARAT workers on a regular basis.

Excellent communication skills are essential as you will be required to develop and deliver group work programmes, along with building relationships with both internal and external organisations. You must be committed to working in partnership with the Prison Service and the National Treatment Agency. An understanding of harm reduction approaches whilst working with drug users is an advantage as is a sound knowledge of drugs and their effects: knowledge of blood borne viruses and sexual health.

Ideally you will hold a professional qualification in Counselling, Social Work, Nursing or a similar area. As well as a minimum of three years experience working with drug users especially within a custodial environment. Knowledge of the CARAT function would be an advantage as would a clear understanding of the Integrated, Drug Treatment Services (IDTS) and other treatment options available.

Closing date 30th March 2007

CARAT Worker

40 Hours P/W

We are currently looking to recruit CARAT workers in order to join our expanding team at HMP Lowdham Grange. Working within the resettlement team, you will deal with all aspects of substance misuse relating to drugs within the establishment.

You will be required to liaise with a number of departments/organisations both internally and externally and therefore will have excellent communication skills. You will need to be able to assess the needs of prisoners who have substance misuse issues or concerns and provide one to one support to them as and when required.

Delivery of the training and drug awareness seminars will also be your responsibility; therefore you must have a good knowledge of the National Drug Strategy within Prisons. A sound knowledge of drugs, the treatment and interventions available within the prison as well as the community would also be beneficial. Ideally you will be qualified in a number of DANOS modules or have experience of working with substance misusers.

Closing date 30th March 2007

If you are interested in this role, please contact us for an application pack by emailing recruitment.lg@premier-serco.com or call our recruitment hotline (24 hour answer phone) on 01159 669 346.

HMP Lowdham Grange is committed to treat fairly all staff, prisoners, partner agencies, visitors and members of the wider community regardless of race, skin colour, ethnic or national identity, language, religion, gender, sexual orientation, disability, marital status or age.