29 January 2007
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DDN
Drink and Drugs News

KEEP IT IN THE FAMILY
Parents learn to talk about substance misuse

PREPARE FOR THE ICE AGE
Methamphetamine – can we afford to be complacent?

NO BARS TO PROGRESS
Improving prison drug treatment with 'Sparcle!'

COMING IN OFF THE STREET
Bringing sex workers into contact with health services

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29 January 2007

Editor's letter

'As a GP in Reading 20 years ago, I only came across one or two sex workers,' Dr Stephen Pick told me. The picture now is very different – whether we want to see it or not. With an established sex trade, the challenge is to make a connection between women and the services they desperately need but are reluctant to seek out (cover story, page 6).

Dr Pick seems to be one of those prize specimens, a GP determined to improve his patients' overall wellbeing, as well as fixing ailments while fighting with the surgery clock. At what must be a particularly difficult time for sex workers to feel comfortable about approaching services, he suggests straightforward ways through which GPs can make it easier – recommendations that echo documents from the Home Office and NTA, produced last year.

Has this research hit home? In the NTA study, 92 per cent of women said they were wasting their lives by being on drugs. Almost as many said they wanted to be able to cope with life without using drugs. Surely this points to the fact that if realistic help is offered, there's a good chance they'll take it?

Communication is a strong theme throughout this fortnight's issue. What's the best way of getting parents to discuss drug issues, and how do you equip them to tackle difficult subjects with their children? Drug, alcohol and parenting charities debated issues at a recent seminar and learnt from innovative schemes (page 12).

Gary Rees shows determination to improve communication between prisons and makes progress in healthcare and harm reduction through the innovative 'Sparcle!' network, on page 10.

Finally, amid reports of how crystal meth is devastating America, the Home Office reclassified the drug this week. How worried should we be about its impact on the UK? Two different viewpoints contribute to the national debate, on page 13.

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Website maintained by wiredupwales.com

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ
Printed on environmentally friendly paper by the Manson Group Ltd

Cover: Art Kowalsky / Alamy

In this issue

News Round-up
Pooled Treatment budget announced • Recommendations for prison drug treatment • EU drugs agency broadens scope • Bristol alcohol service's new premises • Londoners' drug and alcohol highs and lows • NICE launches policy consultation • Resource pack on sensible drinking • News in brief • Media watch 4

Features
Cover story

Coming in off the streets
DDN looks at how more can be done to help drug using sex workers into healthcare and finds out from Dr Stephen Pick how the family doctor can help. 6

No bars to progress
Gary Rees tells DDN how he created 'Sparcle!', to build better relationships with other prison drug services. 10

A day in the life
Claudia Salazar shares her experiences and enthusiasm gained from working in the NHS as a nurse consultant. 11

Keeping it in the family
How should parents communicate with their children about substance misuse? Drug, alcohol and parenting charities discuss the options. 12

Preparing for the ice age
DDN hears two different perspectives on whether we should be worried about the threat of a crystal meth invasion. 13

Regulars
Letters and comment
Alternative high; abstinence and recovery; young people; is heroin for offenders a folly? 8

Post-its from practice
Dr Chris Ford looks at pain management. 8

Q&A
Advice for Terry on how to find voluntary work after a prison sentence. 14

Background Briefing
Prof David Clark on stages and processes of change (part 2). 15

Jobs, courses, conferences tenders 16

News in brief

Meth reclassified
Methamphetamine, commonly known as crystal meth, has upgraded from class B to class A, with the 'severest penalties' for users and dealers promised by the Home Office. Home Office Minister Vernon Coaker, said the very harmful drug 'fortunately is not widespread in the UK' but said it had been reclassified because we could not be complacent about its potential to ruin lives and needed to learn from the experiences of other countries. *See page 13.*

Source of support
The Drug and Alcohol Recovery Network UK (DAARN) have launched an innovative online networking system that offers support for families and friends of substance misusers at www.familysupportnetwork.co.uk. Founder Richard Carus, said: 'My intention is to make DAARN UK the leading provider of web-based support and networking services for everyone affected by addiction.' Sister website RecoveryCafe has expanded its services to Australia and South Africa. Link from www.recoverycafe.co.uk

Contaminated cannabis
The Department of Health has warned smokers of herbal and 'skunk-type' cannabis to look out for batches contaminated with glass-like beads or ground glass. The Drugs Awareness Programme is advising anyone with tight chest pains after smoking to seek medical advice. The Legalise Cannabis Alliance berated the DH for belated warnings, pointing out website forums had been posting warnings 'for some time'.

Booze-free 40 days
Thirst for Life is repeating its campaign to urge the public to go for 40 days without alcohol. Project officer, Colleen Hunter said that last year's campaign had positive responses from the public and turned out to be a great success. She said: 'We all know someone that is affected by alcohol. Please help us begin to tackle the binge drinking epidemic in our nation. Help us help others.' Thirst for Life's 40 days will start from 21 February. www.thirstforlife.org to sign up.

Injection of resources
The International Harm Reduction Association (IHRA) has created the '50 Best' literature collection to provide professionals in the field, free and accessible resources on HIV prevention and care for Injecting Drug Users. They include research papers, advocacy guides and UN documents on the website. Visit www.ihra.net

This year's Pooled Treatment Budget announced

An overall increase in the Pooled Drug Treatment has just been announced by Public Health Minister Caroline Flint.

The government has pledged an increase from £375m to £388m for 2007/8, with an additional £10m to be distributed in capital funding.

The extra funding has been earmarked for areas that currently spend less than £2,198 per head on drug treatment, and is designed to narrow the gap between lowest and highest spend per person.

Areas that received 'significantly more in recent years', including a 28 per cent funding increase for 2006/7, will have 'a small reduction' in funding, according to a Department of Health statement. The NTA and strategic health authorities are to work with these areas to make sure their service delivery is not jeopardised, using Audit Commission research to show where savings can be made.

Talking of 'record investment' drug treatment, Ms Flint acknowledged room for improvement in improving treatment effectiveness. 'Today's announcement demonstrates drug treatment remains a key priority for funding for government,' she said.

Among drug action teams to benefit from the announcement, Bristol DAT welcomed £1.3m extra funding for drug services in the city, which would include enabling more offenders to enter treatment.

Head of community safety and drugs strategy, Alison Comley, commented: 'Without this significant growth in funding we would not be able to continue to increase the numbers of drug misusers accessing treatment and the quality of treatment they receive.'

Recommendations for intervention in prison

Vulnerability of drug using prisoners and risk of overdose on release are among the issues tackled in a new document looking at management of drugs in prisons.

The recommendations, designed to be introduced over a two-year timeframe, aim to bring clinical interventions and healthcare up to NTA standards and in line with best practice in the community.

As part of a strategy responding to the risk of prisoners self-harming or committing suicide, the document recommends that prisons offer a broader range of clinical responses, such as extended opiate detoxification (for at least 14 days) and maintenance programmes. It notes that fewer incidents of drug smuggling and violent aggression have been recorded in prisons that adopt this more responsive regime. Individual treatment would be drawn up according to a risk management programme understood by clinical teams and residential staff.

Health screening of new inmates would not only establish their level of drug and alcohol use, but would determine immediate healthcare needs, including withdrawal. More consistent clinical recording, accurate drug screening tests and assistance from healthcare workers trained in substance misuse were seen as essential to improving the support system for doctors, nurses or pharmacists conducting these assessments, to make sure a full and accurate picture was compiled of each patient's needs.

The document also gives guidance on managing opiate overdose and administering naloxone in an emergency, advises on a detailed regimen for methadone maintenance and gives guidance on detoxification and withdrawal.

Specific advice is given on dual diagnosis, clinical management during pregnancy and prescribing naltrexone to support abstinence. The need for adequate support and training for clinicians surfaces throughout the document, which acknowledges that clinical services have been slow to develop in comparison to other drug interventions in prisons.

It also calls for stronger support for black and minority ethnic prisoners in accessing drug services, through more active BME staff recruitment and better links with BME community services.

Recommendations are the result of consultation with government, the Prison Service, psychiatrists, GPs and addiction agencies.

Clinical management of drug dependence in the adult prison setting. Available at www.dh.gov.uk

Drugs agency modernises role and broadens scope

More active monitoring of drug use trends is promised as a result of revising the role of the EU drugs agency.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has been given a new mission statement by the European Parliament and the Council of the EU, to update the remit set in 1993 and broaden the centre's scope.

The drugs agency will now be allowed to collect and analyse information relating to trends in polydrug use, including licit and illicit psychoactive substances.

EMCDDA director, Wolfgang Gotz, called the new regulation 'a timely development when multiple drug use is becoming more visible within the European drug culture' and said it was 'an important instrument which launches us on a new path and enables us to provide a full picture of today's drug problem'.

EMCDDA's purpose is to provide EU member states with reliable information on drugs and drug addiction at European level.

Bristol Alcohol Misuse Service celebrate the opening of their new premises with a reminder of the safe drinking levels for men and women. Jules Risk and Tilasmi Smith of the Addiction Recovery Agency wear the sweatshirts as Bristol PCT chief executive Deborah Evans congratulates the team after cutting the ceremonial ribbon.

Londoners show highs and lows of drug use

Londoners are less likely to drink alcohol than the rest of England, and young Londoners are less likely to use drugs than those in other regions, according to a report from the Greater London Alcohol and Drug Alliance (GLADA), whose partners include police, probation, councils, the NTA and the London Drug Policy Forum.

On the downside, of London residents who did drink, more were dependent on alcohol. Heroin and crack cocaine use also gave cause for concern: 1 per cent of London's population were problematic users, representing more than 74,000 people.

The 195 London treatment agencies offering specialist alcohol interventions represented a significantly higher number than elsewhere, and the number of clients entering drug treatment through the criminal justice system increased by around 19 per cent between 2004/5 and 2005/6.

Launching the report, London's mayor Ken Livingstone said it demonstrated that the drugs and alcohol situation in London was unique.

He added: 'It reveals the scale and complexity of the challenges that we face, re-emphasising the necessity for partnership working to reduce the harm caused by drug and alcohol use.'

Chair of GLADA John Grieve said the inclusion of alcohol in the report had allowed a much fuller analysis of substance misuse in the capital, building on the last report in 2003.

'The collection and sharing of reliable evidence enables us to respond to these changes effectively and at all levels – prevention, enforcement, treatment and rehabilitation,' he said.

'London: the highs and lows 2' is available at www.london.gov.uk

NICE launches policy 'milestone' consultation

A consultation has been launched on drug treatment, by the National Institute of Health and Clinical Excellence (NICE).

Treatment services have welcomed the initiative, including Phoenix Futures' chief executive Richard Phillips, who says: 'It is a milestone of UK drug policy for NICE to have brought together this vast body of research evidence showing that treatment works and is cost effective.'

The draft includes many recommendations in its 264 pages, including the suggestion of shopping vouchers as an incentive to come off a drug habit – a line of the document that has already found its way into debate on the BBC website and discussion on Radio 4's *Today* programme. The condoc is at www.nice.org.uk/page.aspx?o=256691

A review of treatment using methadone and buprenorphine for opioid dependence has also been launched by NICE this month, presenting clinical evidence available on each drug and the research benefits from the expertise of clinical specialists and advising on effective treatment using flexible dosing regimens.

Available at www.nice.org.uk/guidance/TA114/niceguidance/pdf/English

A resource pack on sensible drinking has been launched as part of the Department of Health and Home Office's 'Know your limits' campaign, aimed at 18 to 24-year-olds. Campaign posters and leaflets are available free of charge to stakeholders to give information on binge drinking and unit consumption, sensible drinking tips and ideas for action in the community.

Media Watch

Norfolk and Norwich University Hospital A&E department has adopted a new screening policy for people who are suspected of misusing alcohol, developed from the The Paddington Alcohol Test (PAT). Julia France, who helped develop the system, said it was not about making judgements, but about offering support.
BBC News, 22 January

More than a dozen drug boxes have been placed in Exeter's pubs and clubs in a new scheme aimed at getting illegal substances off the streets. Part of the force's Pubs Against Drugs campaign, the boxes provide a secure method of holding confiscated drugs until the police come to collect them. Exeter licensing officer, Lesley Carlo, said: 'The message to pub-goers is that taking drugs into licensed premises will not be tolerated.'
Express & Echo, Devon, 20 January

An 87-year-old man was bemused when he was asked to prove he was over 18 when trying to buy a bottle of sherry at a Morrisons supermarket in York. Jack Archer, a former Lord Mayor of York, said: 'I don't think I look my age but they must know I'm not under 18.' A spokesperson said the supermarket took their responsibility on selling alcohol very seriously, and required staff to ask anyone buying alcohol to confirm that they are over 21 'to eliminate any doubt'.
Sky News, 25 January

Criminal gangs are using children as young as nine to distribute drugs in schools. Pupils in London, Birmingham and Manchester were being used as 'mules' for drug dealers, and then rewarded with class B drugs, which they can sell for themselves. According to the Department for Education and Skills, around 100 to 200 organised criminal gangs are active in London.
The Times, 25 January

Cholesterol supplements during pregnancy might protect human foetuses against alcohol related damage, a study of zebrafish revealed. Humans and zebrafish share the same group of proteins that control the early developments of the nervous system – heart, head, face and limbs, which need cholesterol to become active. Researchers at the Duke University School of Medicine, USA, exposed zebrafish embryos to alcohol and found that giving them cholestrol supplements prevented birth defects resembling foetal alcohol syndrome.
New Science, 22 January

Coming in off the street

Recent coverage of the dangers of sex working have made it even less likely that women in this isolated trade will come forward for help. DDN looks at how we could do more to bring drug using sex workers into contact with health services.

The Home Office's *Coordinated Prostitution Strategy*, published a year ago, highlighted the common interdependency of sex work and drug addiction. Taking consultation responses from 861 organisations, individuals, agencies and the public – many working directly with this client group, others representing their communities – the document explored ways of tackling the problems associated with this stigmatised group.

Inevitably there is strong emphasis on community safety, and the Home Office declares from the outset that its strategy aims to reduce prostitution and challenge the view that the 'oldest profession' has to be accepted.

But the strategy also faces up to the reality that tackling prostitution can not be about arresting sex workers without offering life-changing support.

It would be rare to come across the story of a sex worker who had entered the trade by choice. Most are forced into the trade by dire circumstances, and more often than not, these include funding a drug habit. The Home Office reports that, according to its survey: 'a high proportion – in many areas, practically all – of those involved in street prostitution are class A drug users'.

The Drug Intervention Programme (DIP) has put many sex workers in contact with drug services, via a positive drugs test. But the real issue is around tackling the reasons for their lifestyle and offering viable alternatives to resorting to prostitution.

Routes out of prostitution depend on the interest of local services, and Drug Action Teams need to play an active role when carrying out needs assessments for their local communities.

To have any meaningful impact, services need to be flexible and offered on a long-term basis, with a keyworker. Breaking the cycle of drugs and prostitution can mean that the woman has to face up to homelessness, childcare issues, and the threat of violence. It is likely that she will need psychological as well as physical support, and might be experiencing mental health problems from years of abuse or fear.

The Home Office strategy benefits from the experience of those who work closely with women in this situation. They recommend that sex workers are fast tracked into assessment and treatment, and point out that providing treatment by female only staff might improve chances of engagement. They also suggest that the women's pimps and partners could be targeted for treatment, to make sure the experience is indeed life-changing.

The London charity St Mungo's offers a stepped approach, giving crack-dependent women who are involved in prostitution a safe place to live. In the first of their two hostels, clients receive an intensive needs assessment, are allocated a key worker and drugs worker, and are helped to access healthcare and claim benefits. When they are stable, they are moved to the second hostel, and helped to live independently.

In April last year a study carried out for the NTA by the Academic Psychiatry Unit at Keele University Medical School

‘Most of my drug using female patients have sex worked at some stage, I would guess. If you’ve got a largish habit, you’ve got to get £700 a week and you can’t steal it all. As a lady you’ve got a means, that’s the tragic reality.’

and a women’s project in Stoke-on-Trent, looked at the impact of treatment on female drug-using sex workers through a sample of 89 patients who attended a fast track clinic.

During the 15-month study period, most of the women stayed in contact with services for more than six months. They were offered testing for HIV and hepatitis B and C, treatment for sexually transmitted infections, and care for infected injection sites, abscesses and deep vein thrombosis.

Most of the women had begun working in prostitution at a young age and had not been in regular contact with the healthcare services they needed. When they did, they would not disclose their prostitution, so were unlikely to get care related to the risks of their job.

The study concluded that the women’s project had a useful role to play in making it easier for women to get into treatment, by helping them cross barriers of waiting times, transport difficulties and financial problems. Linking with primary healthcare and maternity services made it easier for the women to get back into mainstream healthcare.

The challenge for the many services dealing with the welfare of women caught in this trade, is to make sure they offer easy to access health care. The NTA research was published last April, and the Home Office strategy was published a year ago – have their implications and recommendations made their way into service planning in your area? **DDN**

...into the surgery

Sex workers can do very well in general practice, says Dr Stephen Pick – the challenge is to get them into the surgery and establish a dialogue. DDN asks how.

Most of my drug using female patients have sex worked at some stage, I would guess. If you’ve got a largish habit, you’ve got to get £700 a week and you can’t steal it all. As a lady you’ve got a means, that’s the tragic reality.

It hasn’t been dealt with very well in general practice. The patients are shy or ashamed of saying to their GP that they’re sex working. Some of them may have known their GP for a long time and found it very difficult to talk to them – I’ve been a GP for 30 years and so I’ve seen people from birth.

But how do you ask women if they’re sex working? It’s different from being in a sexually transmitted infections clinic where you can have assumptions about what people are going in there for.

It’s up to us GPs not to be afraid of this group of people. It could do a huge amount of good. Sex workers and drug addicts are so marginalised, we can help get them back into society and give them their dignity back.

You can’t put notices in the surgery because other patients start kicking up. GPs should be more aware that if patients are using drugs, female and male as well, they might well be involved in the sex trade. And they may really welcome someone just asking about their welfare.

Certainly some of the patients I’ve talked to have said ‘if only somebody had asked me some time ago, it really would have helped. I wish I’d been asked’.

It helps to know local agencies that you can point them to. It can be difficult because GPs get so much post and tend to chuck most of it. It helps for the local services to keep on advertising themselves. I’ll keep a pinboard, and put leaflets in a file. I know many of the services now, so I can just phone them up and say, ‘help, what do I do?’

In the past I’ve been very bad at asking my drug users, but I am slowly becoming more aware that I actually need to be quite upfront. We have patient questionnaires when they come and register. You’ve got to be careful how you ask the questions: ‘I see you smoke, what medication are you on, are you taking any drugs... sex working...?’ It’s down to your tone of voice.

A lot of the questionnaires are done by our nurses, and they can be very sensitive and good at asking. It’s important to get the practice nurse tuned into this, and to realise that people are probably sex working a lot more than we think.

Initially we need to help them rather than getting them out of sex work. Some sex workers are where they want to be at that time – it’s their job, it’s what they want to do. But sometimes people get into a state where they think ‘how the heck do I get out of this awful trap?’ So you have to be sensitive and leave it open: ‘If you want me to do anything to help in the future, come and ask me’.

It’s about seeing the whole person not just seeing them as a sex worker, a drug user, an opiate user or whatever. As a man, I also have to be very aware of my manner. Many of the girls are used to being abused and taken advantage of by men, and somebody who isn’t going to do that is going to be quite scary and strange. So forming a relationship can be tricky – you have to hang in there.

GPs can offer incredibly basic information around not getting hurt, while asking ‘are you making sure you’re safe? Are you using condoms? Girls get paid more if the guy doesn’t have a condom – but they need to know they’re earning the money riskily. A lot of the younger girls are taking more risks than some of the other girls who are more experienced. People don’t think about HIV so much now – the panic’s gone out of it. But it’s actually on the rise.

Ultimately, we’re not having to do anything majorly difficult, just be empathetic, and try to give help when that person wants it. Professional services all need to be more geared up to this.


Alternative high

'I was on a 24-hour expedition climbing the three highest peaks in Britain – Ben Nevis, Scafell Pyke and Mount Snowdon – all through Merseyside Probation, Fresh Start programme. I was a recovering substance misuser and found that attempting this challenge and completing it became one of my biggest accomplishments of my life... It turned my life around.'

Harm reduction on film

I am holding a film festival in Leicestershire this June, to reach groups that do not have much contact with local services and to enable people to have a greater understanding of what constitutes harm reduction. We hope it may ultimately save lives.

I'm writing to ask if any readers would be happy to give or lend films that we can show. We are looking for any movies that can be classed as harm reduction, and can be in any format. So please dust off those old videos and send them along.

The event is supported by our local DAAT and will be open to everyone. Invites are going out to hostels and housing staff in Leicestershire, drug workers, service users, parents and carers – anyone who might be interested. Representatives from local agencies will be available to chat to people on the day.

Please help me to make this a fabulous day – it will only be a success with your support. We are looking to gather all films together by March 2007.

Please contact me as soon as possible at Alyson.Taylor@leicester.gov.uk.

Alyson Taylor, substance use policy and development officer, Leicester City Council.

And then I got high

I was interested to read 'Alternative high' (*DDN*, 15 January, page 6).

I was on a 24-hour expedition climbing the three highest peaks in Britain – Ben Nevis, Scafell Pyke and Mount Snowdon – all through Merseyside Probation, Fresh Start programme. I was a recovering substance misuser and found that attempting this challenge and completing it became one of my biggest accomplishments of my life.

I became higher than any point in the country (Ben Nevis) and have pictures to prove it, this giving me a high no drug could ever give me. It turned my life around.

I am now volunteering as a client support worker within the Lighthouse Project (Alternatives) Liverpool.

David Ashley, by email

Small reward – high price

I recently heard on the news that a chief of police suggested that it would be a good idea to give heroin to prolific offenders to try and stop them committing offences. As a recovering heroin addict myself, I could not believe what I was hearing. Surely the message that needs to be addressed is that if you repeatedly commit offences you will get punished for it through the justice system, not given free drugs as a kind of reward.

I think more money should be invested in helping people get off the drugs – this will surely reduce the crime rates and perhaps agencies should be more available as the waiting list can be up to three months. I also think there should be more funding for courses like the Offender Substance Abuse Programme (OSAP), which I am currently on through probation.

When users are clean or are being medicated, boredom is a big factor that triggers people back into crime or drug use. Perhaps then, we should be focusing on what aftercare can be offered – like gym passes at a discounted price or something that can keep the people who genuinely want to stay clean the help and support they need to become a better member of society.

I currently have a job two hours a night, but my daytimes are empty and I do not have the money to keep myself busy. However, if I was given a gym pass or something to do during the day I would feel a lot better about myself and be able to meet people who are not involved with crime or drugs. This would give me more fulfilment than drugs could ever give.

Also, what happens when the crime rate goes up because of people using crack-cocaine? Do you then start giving them free drugs?

I would be very interested in comments on this.

Jodie Nind, High Wycombe

Going through changes

There is nothing new or surprising in Alex Stevens and Tim McSweeney's comments about the difficulties people experience in adapting to the concept of abstinence and recovery (*DDN*, 15 January, page 9). Resistance to change is part of the human condition.

What does disturb me is the implication that they were asked to do just that 'quickly'. To even consider that it is possible, shows a remarkable lack of understanding of the complex nature of addiction, therefore that such attempts met with resistance and failed is hardly surprising. But it is alarming to be made aware that those who attempted such a clumsy approach not only appear to be unaware of the complexities of addiction, they also appear to be unfamiliar with the psychological and emotional processes described in the 'Cycle of Change'.

The journey of recovery is slow and unpredictable; attempts to rush it are predisposed to failure. People do not become 'ready' for abstinence by accident, or just the passing of time. They become ready following patient, determined, enthusiastic, and not infrequently, repetitive application of time tested and successful principles.

I am in complete agreement that treatment can be a successful alternative to imprisonment – as long as there is a willingness to engage in an individual's life, with a view to establishing what might motivate them, rather than seeking to engage him/her in some predetermined box ticking format within a specific period of time.

I also agree 'insisting on abstinence' would not in itself reduce the number who reoffend; it is also true that those who achieve abstinence are far less likely to offend than those who are still using and therefore pursuing activities to fund that use.

But I have to regard the suggestion by the contributors that abstinence focused interventions would 'lead to an increase in imprisonment', as a very large 'red herring'. We know that in the real world the revoking of court orders does not automatically lead to transgressors being incarcerated. On the contrary, recent highly publicised cases show only too clearly that even those on parole have to commit horrendous crimes before action is taken, and in almost every case we learn that they have breached their parole orders over and over again, without action being taken.

Peter O'Loughlin, The Eden Lodge Practice

Suffer the children

I have recently read the NICE guidance on psychosocial interventions and note that it includes people from the age of 16 years up. As a specialist in young people's drug treatment I was keen to see how young people's psychosocial treatment issues were differentiated from those of adults. On reading the document it is clear that they are not, in fact the adolescent literature does not appear to have been specifically included.

I would like to highlight this issue to readers to encourage people to contact stakeholder organisations and submit comments. I am concerned that otherwise they may slip by without anyone noticing and soon become adult based evidence for young people's policy. It is a very important document and has big implications and changes in practice for adult service users too.

Jill Britton, Outcome Consultancy, London

Timely intervention

Thank you for an opportunity to vote on whether DIP has been a worthwhile initiative (*DDN*, 15 January, page 8).

When people are arrested, charged, tried or sentenced for a crime, an opportunity presents itself to identify whether the individuals need help to resolve a substance misuse problem related to their offending.

In that context, a programme that seeks to ensure that such people promptly receive an appropriate assessment and are referred to suitable treatment under a coordinated care plan must be viewed as welcome, when compared with the deficiencies in providing such services in many areas prior to the introduction of the DIP. Carrying out the DIP scheme has resulted in more cases receiving treatment, and improved communications between agencies about individuals' treatment.

However, I do not think that achieving these objectives by using the DIP scheme has been all 'worthwhile' as it has involved massive administrative waste and duplication of effort. The same results could have been achieved at a fraction of the price, by creating a nationally accessible database in a standard format with links to templates for a properly qualified assessment and care plan and an inter-agency referral and information transfer form, with a further template for recording contact and work done.

The current DIP scheme suffers because the Drug Interventions Record (DIR) system is not a suitable assessment tool nor a suitable communications tool, and the discrepancies between area borders in the different agencies (health, prison, probation, police, drug agencies, council and social services) require inordinate efforts to track down individuals.

In my view these problems have resulted from a lack of consultation and could be repaired with some effort to consult further, which would no doubt improve the 'worthwhileness' of the system.

Eleanor Levy, Substance Misuse Officer

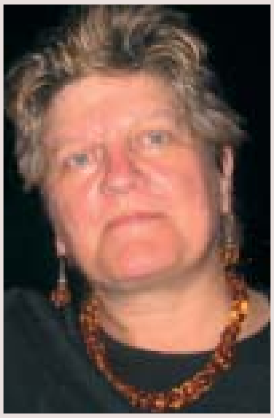
Has DIP (Drug Intervention Programme) been worthwhile?

Consultation is still open on our website: visit www.drinkanddrugs.net to vote.

Post-its from Practice

No pain, all gain

Dr Chris Ford looks at the need to manage pain in people who use drugs



Nicky is 42 years old and has been registered with the practice for a couple of years. Until recently she received her drug treatment from the local specialist drug service and was on 200mg injectable methadone. She used to be a national cross-country runner and also suffered from anorexia as a teenager. She started opiates in her late 20s for severe knee pain. For pain relief, she first bought heroin but quickly transferred to methadone, firstly from a private prescriber and more recently from the drug service. She uses no illicit drugs and does not drink alcohol.

She came to see me to explain that her knee pain was getting worse and that the methadone was no longer helping. About a year ago her orthopaedic surgeon had decided the best solution was bilateral knee replacements. The first one was done about eight months ago and had failed, causing more pain. Over the years she has seen a number of pain teams who have prescribed a number of medications, most recently gabapentin and amitriptyline, but never opioids and none of the drugs tried have helped.

She requested an increase in methadone and/or alternative analgesia from the drug team, but they said they had reached their maximum dose and that she should discuss pain relief with her GP.

It was a difficult problem for me to address. However, I felt the first thing to do was take over her methadone and ask her to try splitting the dose four times a day. Dose splitting can be more effective as pain relief, and this did help a little, but she continued to experience severe pain. Her sleeping and mobility decreased and she began to get depressed.

Having tried most analgesias other than opioids, we decided together that we needed a new approach to try and get the pain under control. We started with a small dose of long-acting morphine, which required increases until the pain was more under control. The only remaining problem was breakthrough pain, especially after any mobility and sometimes at night, so we added quick acting morphine, which she takes very occasionally.

Nicky is now on 200mg of methadone, which she splits into two, as she feels this works the most effectively for her, 100mg long-acting morphine twice daily and 50mg of short acting morphine as required and she is almost pain-free. Her mood has improved, as has her mobility and sleeping. She does not feel chemically affected by these doses and she feels that she is 'living again' (her words). She is thinking about returning to college and has recently started as a volunteer in a charity shop.

Nicky's pain management proved difficult and daunting for me as this was the first time prescribing these doses and this combination, but seeing the excellent results for her has made the risk worthwhile. In my experience (and the evidence supports this) people on long-term substitution therapy often need higher doses of pain relief – don't forget they also do feel pain!

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

No bars to progress

When Gary Rees saw the opportunity to build better links with colleagues in other prisons, he seized it. **DDN** hears about the creation of 'Sparcle!'

'Seeing the same old faces coming back through the doors can be demoralising,' says Gary Rees, detox manager at Exeter Prison. 'You go through detox and maintenance with them again and again... I've known a guy who's been inside eight times. It gets quite soul destroying – you think, I'm not actually doing anything to help.'

While contending with these frustrations, Rees was invited to an international prison health conference, where he met others from the prison service who worked with substance misuse and detox. There were nursing staff and some who had worked in voluntary agencies before being employed in CARAT (Counselling, Assessment, Referral, Advice and Throughcare) teams. The mixed group of staff realised they all lacked peer support and a framework of standards. Detox regimes in Exeter were different from Cardiff or Bristol.

'So we met up in the evening and had a lot of discussion around what we felt was missing from our jobs and what we would like to see happening,' says Rees. The outcome was a pledge to meet up every three months through a group they called 'Sparcle'. The acronym came from Swansea, Park, Ashfield, Cardiff, Leyhill and Exeter prisons – 'with an extra "r" because we couldn't really call ourselves Spacle!'

True to their decision, the group met three months later with a guest speaker, Dave Marteau from Prison Health. Around this format, the group began to share effective practice, shining the spotlight on a different prison each time and looking at how they could share ideas to do things better.

Rees' own situation at Exeter Prison illustrated that of many other colleagues. 'Within the prison estate there are lots of us in different rooms doing the same job and none of us knows exactly what the others are doing,' he says. 'So this is about linking in with each other and fine-tuning ideas.'

The issues are wide-ranging, from staffing problems to prisoners' medication. One prison might have brought in methadone maintenance and be able to guide another on where to start. Another might give an informative talk on alternative therapies, sharing insight on acupuncture, yoga, Indian head massage. Knowing how to help detoxing prisoners relax and sleep better can be an important aid to their recovery and future wellbeing that might otherwise have not passed into a particular prison's dialogue.

'You mention to people outside prisons about drugs getting inside and they'll say that's disgusting, you've got to crack down on that. You'll mention that prisoners manufacture illegal hooch and they laugh.'

Record keeping also stands a better chance of improving with peer support. Rees talks about prisoners with alcohol problems, which illustrates how the system is not always tuned to actual needs.

'We never used to record people having an alcohol problem,' he explains. 'But if they come in on drugs we record it for our key performance targets.' Talking about the illogicality of this prompted a new record system.

'Now we break it down. We have a list of those who are on drug detox, methadone or subutex maintenance, and those that are on alcohol detox.' Of course it's been a funding issue with alcohol, he sighs, admitting that he'd previously had to capitalise on a prisoner's minor drug problem compared to their major alcohol problem, in the paperwork, to get them into prison treatment programmes.

It's part of the uphill struggle to have alcohol problems taken seriously. 'You mention to people outside prisons about drugs getting inside and they'll say that's disgusting, you've got to crack down on that. You'll mention that prisoners manufacture illegal hooch and they laugh.'

Linking with colleagues through Sparcle has given a productive outlet to these frustrations. Meetings have hosted constructive debate and a better understanding of controversial initiatives such as needle exchange in prison. Staff from some prisons who were opposed to the idea began thinking differently when they heard colleagues from elsewhere explaining how it was working well for them.

Better communication with prisoners has been important to the group from the outset. Sparcle's handbook, called *A user's guide to coming off opiates*, was launched last May, with support from an educational grant from Britannia Pharmaceuticals. It's aimed directly at prisoners, and gives clear information on how to cope with coming into prison with a substance misuse problem. The text and illustrations are clear and unpatronising, with an emphasis on staying safe and detoxing at a manageable pace. Rees says the reaction from prisoners has been very positive, responding to their commitment to support them.

Such feedback has added to the group's momentum and Rees is spurred on by the thought that they are sowing seeds of change among colleagues within the prison system.

'If we don't do anything proactive and just wait to react, we're going to miss so many people,' he says. 'Even if there's only a handful of people who say "yes, it made me stop and think", it's worth it.' **DDN**

For copies of the Sparcle handbook, or for more information on Sparcle, email Gary Rees at gary.rees01@hmps.gsi.gov.uk

A day in the life
of a nurse consultant

Claudia Salazar was appointed nurse consultant for Central and North West London (CNWL) Mental Health Trust four years ago. Initially trained as a psychiatric nurse she started her journey in alcohol treatment after a training placement at a detox unit. With 20 years in the field she has seen her share of violent clients and staff shortages, yet, as she tells DDN, she still feels passionate about her vocation.

I usually aim for a nine o'clock start and divide my work in the mornings. Between nine and half nine I am preparing notes and making phone calls. I mainly have clinical duties but it can vary as I might teach or have a meeting to attend.

Primarily I work with clients dependent on alcohol, which involves carrying out assessments, one-to-one work and group work. However, I can also work with drug misusers. I find that there is a difference between clients presenting for drug abuse and those presenting with alcohol problems. People using drugs are generally coming with a focus on prescribing rather than other changes that they also need to make, so we have to introduce all round safe management of their medication.

We have to look at different factors, to find where people are at in their alcohol abuse. We use motivational interviewing, group work and doing some one-to-one to look at helping people change. The point at which someone decides they have a problem with alcohol is more complicated than drug misuse; being a legal substance and much more readily available can make it more difficult for people to come to terms with their addiction. So the emphasis of the work is slightly different depending on which model of treatment we are focusing on.

Some of the more challenging clients are the ones who have fallen through the net of services. I had a client who was discharged from hospital after taking a severe overdose. He was then put on a train back to London and he came to us homeless, quite suicidal, disorientated and with severe health problems. After we got him admitted and dealt with the crisis, I then had to negotiate and find out which borough he belonged to, who would pay for his community care and ensure that there was a package of treatment for him. This took about three to six months to sort out and the client was left in limbo.

We had to keep him as an inpatient for much longer than necessary as people were not willing to put a package together, because of his transient status in London.

Fortunately he is very well and in rehab now, but sometimes people do fall through the system through no fault of their own. It isn't a usual thing as most clients are residents, but the ones who have a transient status have difficulty in terms of where they belong, whether they are eligible and who's going to pick up the bill.

CNWL Mental Health NHS Trust is one of the largest NHS Mental Health Trusts in London that specialise in substance misuse services for residents. The nurse consultant position is quite new within the NHS structure, certainly in terms of substance misuse, and it is something I have had to develop. It is an interesting role and I feel privileged, as there aren't many opportunities for nurses to progress to in this type of work.

My afternoons can be a mixture of clinical supervision for nurses and other staff, and attending meetings, which usually involves me moving to different sites and areas.

Currently we are looking into a policy on how to manage the risk of people drinking heavily while being prescribed opiates, benzodiazepines and various other medications. It had started off as a pragmatic local policy but has actually become a huge project and we're still in the first draft a year later because people have come and gone, the organisation has grown, we've merged with other areas that have different practices, and there are no national guidelines for it. It suddenly became a much bigger nut to crack.

My days normally finish at around six so I can tie things up. I like to leave having ticked all my boxes and as I'm moving from site to site I try to finish whatever work I have at each location. I'm usually fairly driven to the last minute of the day.

I enjoy my job. I think it is stressful working in the NHS and it has become more stressful as time goes on, but I don't have any illusions that anywhere else is any different. My dream job would be one where we didn't having to face uncertainties around finances every six months. I wish the NHS could stop changing for a minute just to give us breathing space. **DDN**

Talking to families in a language they understand can cut corners in delivering meaningful drug and alcohol education. **DDN** listens to drug, alcohol and parenting charities discuss ways to get parents on board.

Keep it in the family

Professionals are so used to dealing with the sharp end of substance misuse, they often don't think about the role families can play in drug and alcohol, says Eva Geser of Adfam.

Co-ordinating the 'Bouncing Back!' project for the past 18 months has given new insight on how families can help their kids to develop resilience to the harmful influence of drugs and alcohol, with clear boundaries to damaging behaviour.

'Resilience is what helps young people get through difficult situations to thrive,' says Geser. 'They need to develop the happy knack of being able to bungee jump through the pitfalls of life.'

With Department of Health funding to develop six pilot parenting projects around the country, Geser has looked for diversity from the applications submitted, as well as areas that could most benefit from dedicated support from the programme. Those that made it through a robust selection process include an Afro Caribbean project in London; an isolated community project in Cumbria; a Portuguese crime prevention project; working with a prison; a failing comprehensive school; and with children in foster care.

With £10,000 allocated to each project, ideas were piloted over a year to involve families in prevention projects. The aim was to involve parents and children together, which needed creative and resourceful planning to interest all participants.

One of the projects, 'Boys2Men', explored how fathers could play a more active role in drug prevention and highlighted many of the problems of communicating with fathers and male carers about substance misuse.

David Bartlett, of the information centre Fathers Direct, uncovered specific issues relating to fathers, while working on a recent two-year project with Adfam, in partnership with The Baby Father Alliance who focus on engaging African Caribbean fathers, and the An-nisa Society who work with Muslim fathers.

'Fathers and mothers respond differently to substance misuse in kids,' says Bartlett. 'Fathers have a tendency to take a back seat and let mum deal with it.' At the same time they are likely to show their child anger and frustration without communicating effectively which, considering that harsh father parenting has been shown to have a strong effect on children's aggression, can create further problems.

The project, with money from the Parenting Fund, looked systematically at how to make contact with fathers and give them better support. Were existing publicity materials effective in engaging them? Did they use 'the language of help' which could be off-putting? Such research led to recommendations to try activity-based gatherings such as football matches, which were found to be a non-threatening, engaging way of creating a forum to talk about issues including drugs.

'We found very little research about fathers and substance misuse and realised fathers were not generally being catered for,' adds Nicolay Sorensen of Adfam. A training course aimed at those working in family support, youth services, drug and alcohol services, and child and adolescent mental health teams, aimed to redress that by looking at attitudes to fathers, their influence in the family, and how they could be better supported to play a positive role in their children's lives.

Fathers' overall caution in seeking support demanded a different approach to engaging them. Positive, often sporty initiatives that required little commitment at the outset and allowed them to socialise with other fathers, were found to be an effective way of hooking men in, rather than using the sometimes feminised environments and publicity material frequently on offer.

Dads Against Drugs (DADs), a project in Hull, is an example of a community-based programme that set up a football team as a forum for educating fathers about drugs. The initiative began as a means of sharing information about drugs to help them talk to their children with authority about the subject, and has since gained respect as a dynamic influence on drug awareness and healthy lifestyle within the community.

A common deficiency with education initiatives is that they rarely target alcohol awareness, says Mike Eden, a former teacher who now works at Alcohol Concern. Getting involved in AC's parenting project, also funded by the Parenting Fund, he realised that there was little crossover between parenting professionals and alcohol workers.

Free training for both sets of professionals across nine regions tackled bringing the two issues together, showing the potential of multi-agency working and looking at good practice. AC has also developed a toolkit with the help of professionals including school nurses, health visitors, social workers, alcohol workers and teachers, which is proving to be a popular resource on the charity's website.

Eden called for targets and key performance indicators to be introduced to make commissioners take alcohol issues seriously – and to reflect the statistic of 1.5 million children being affected by their parents' drinking. At the very least, he said, 'we need a national strategy on the harm parental drinking causes to children'.

DDN attended a good practice seminar on working with families affected by substance misuse, hosted by Adfam. View or download Alcohol Concern's training resources and toolkit at their dedicated website www.alcoholandfamilies.org.uk. For further information on working with fathers, visit Adfam at www.adfam.org.uk and Fathers Direct at www.fatherdirect.com

Preparing for the ice age

Methamphetamine, commonly known as crystal meth, was reclassified from class B to a class A drug on 18 January, meaning the 'severest penalties' for users and dealers. Home Office minister Vernon Coaker said that while the drug is not widespread in the UK, 'we cannot afford to be complacent'. **DDN** hears two different perspectives.

'Off the shelf and highly addictive'

'People are saying crystal meth is not taking hold in the UK,' says Jonathan, a recovered addict.

'What they don't understand is how addictive the drug is. A hit of crystal meth can have the same effect as a hit of crack; but the production method of crystal meth is so much cheaper and more readily available. It's off the shelf, almost like alcohol.

'I can go to my local hardware shop and buy everything I need to make crystal meth, the same as I can go to an off licence and buy everything I need to be an alcoholic. It really is as easy as that.

'People are buying crystal meth thinking that it's crack. My experience of good crack is that the rocks are clear, so if someone hands you a £20 stone of crystal meth that's completely clear you're going to think 'wow, what fantastic gear'. When you burn it, you get oil that's exactly the right constitution.

'Drugs workers should be educating, speaking to active addicts and saying 'do you realise you could have been smoking crystal meth?' Most will probably say no.

'Some people have said there's little hope of recovery from crystal meth addiction, but you can use the same 12-step programme as for other drugs. You can become a recovering addict one day at a time.

'It doesn't matter if you smoke crystal meth, drink three bottles of vodka, or jack up three bags of brown – you're an addict. Crystal meth's biggest threat is that it's readily available and cheap.'

'No evidence we're on the verge of an epidemic'

'It's very hard to say categorically that there's an increase in the drug. A lot of the stories associated with its use seem to be anecdotal,' says David Mackintosh, London Drug Policy Forum.

'There does seem to be some increase in its use – a lot of it on the club scene. But there isn't hard statistical evidence to say we're on the verge of a meth epidemic. There have been factories identified within the UK, and some police forces have dismantled labs. But it's not on a huge scale. They have raided a number of addresses and found kit. Hampshire are very switched onto methamphetamine and have done a lot of work. Some other forces haven't really encountered it yet.

'A lot of dealers would have a strong interest in preventing ice from taking over from crack because as a dealer there's no way you could make as much money with it. You'd probably lose about 75 per cent of your profits.

'We need to be very clear what form of methamphetamine we're talking about. Are we talking about pills, known as yabba, or powder which has turned up in some cocaine samples as a bulking agent or whatever, or are we talking about ice (rocks).

'The argument that swung the ACMD on reclassification was that it's a precautionary measure. Resources and activity only really flow towards class A drug problems.

'There's no reason to suppose the UK is immune, but it's quite odd the way the argument's been polarised by some people. I haven't heard many police officers say that there's going to be a big problem. Very small numbers of users are actually turning up for treatment – but we're not awfully good at attracting stimulant users in general.

'Also, it might take five years before anyone decides it's a problem worth doing something about and that there's a need to access services. We have to accept that drug treatment figures lag considerably behind usage, and you wouldn't use them as an indication of current usage.

'There has been some advice that's gone out from ACPO. Obviously one of the big issues from a police perspective is that a meth lab is a hazardous chemical environment. You don't want to send people into an environment where there could be a hazard of exploding chemicals. It's not just a drugs issue, it's a heath and safety – and a public safety – issue. In the States where there are a lot of small-scale DIY meth labs, every now and again a lab goes bang. An explosion in a residential tower block in London would cause a great deal of excitement.

'It's an awkward situation for the police to deal with, and ACPO have done their best to be sensible and pragmatic. They haven't gone out and done a mass scare campaign. They've held events in London for service providers to ask questions and repeat what they're picking up from the street and their clients. If the Home Office had waited for evidence of a problem before they'd reclassified the drug, they would have been in trouble.

For a detailed look behind the hype of crystal meth, see 'The ice age is coming' (DDN, 17 July 2006, p10), by 'Delia Venus Wynn' who has first-hand experience of producers, suppliers and users. Available on our website archive of DDN back issues at www.drinkanddrugs.net.

I am nearing the end of a mandatory life sentence, having spent the best part of 18 years in and out of detention centres, borstals, prisons and institutions. During my time in prison I have learned to read and write and educated myself to GCSE level. I completed every course the education department had to offer and have over 50 certificates. I am about to do a diploma course on counselling children and adolescents, after which I would like to do some voluntary work. I really want to put something back into the community: please can anyone point me in the direction of any contacts, a company or organisation that might be willing to give me some voluntary work?
Terry, Parkhurst Prison

Smart candidate

Hi Terry
Provided that you will be living in London on your release, you sound like a good candidate for Addaction's Next Project or SMART scheme. The Next project is for ex drug or alcohol users who are looking to work in the substance misuse or social care field. We provide two days training a week for 12 weeks and after six weeks we can provide an administrative placement at a treatment organisation for one day a week.

The SMART scheme runs in partnership with Rugby House and is for anyone – ex substance misuser or not. Participants work towards a Health and Social Care qualification, which includes four units from the Drug and Alcohol Occupational Standards. From here you will be ideally placed to apply for jobs within the substance misuse field or alternatively, you may decide to transfer your skills to related fields such as housing or mental health.

Depending on which is most suitable for you, you can get further details and an application form from our website at www.addaction.org.uk

Good luck – the opportunities for you are out there.
Francis Sikes, Addaction

Act local

Dear Terry
The best place to go if you want to volunteer is your local volunteer bureau. They will know about all sorts of opportunities in the local area, and they can talk to you about what you want to do and put you in touch with the right people. When you are out of prison, you can find out where your local volunteer bureau is by ringing Volunteering England on 0845 305 6979.

If you want to volunteer with children and young people, the organisations will want to know about your conviction and your time in prison, as they have to make sure that you are suitable to work with children. Some organisations may have serious concerns about your record because you have served a life sentence, and they would need to be reassured that you are not a risk to young people. With this in mind, it might be a good idea to consider alternative options as well, such as working with adults. It is great that you want to put something back into the community but it would be best to consider all options.

At the Resettlement Plus Helpline, we have some advice guides on how to disclose your criminal record when applying for volunteering opportunities. If you would like a copy, or want to ask any other questions about employment and volunteering, you can ring us on 0800 0181 259, or write to us at Nacro, 169 Clapham Road, London, SW9 0PU.
Ruth Parker, manager,
Resettlement Plus Helpline

Supervisor assistance

Dear Terry
I noted your request for advice on voluntary work following release from a mandatory Life Sentence.

It is clear from your description that you have used your time well, and taken advantage of the many training and learning opportunities available during your lengthy time in prison.

There are clearly some limited opportunities for voluntary work whilst still serving (depending on each prison) such as Listener and Insider schemes, and opportunities for Restorative Justice in some establishments.

In terms of planning for release, and post-release voluntary work, anything planned should be done alongside the supervising lifer/probation officer, who can review realistic options in the planned/intended home area. Although undertaking 'references' can be problematic (in terms of disclosure/ confidentiality) the supervising case-manager (probation officer) may be in a position to plan and maintain oversight of any voluntary placement, and offer advice on what is appropriate, and in keeping with the Sentence Plan.
Peter Mate,
Area Offender Risk Manager,
Yorkshire and Humberside Area Office

Voluntary beginning

Dear Terry
I am delighted to hear that you are interested in doing voluntary work. Organisations may vary hugely in their response to your criminal record, but there has been a campaign organised by Volunteering England to promote opportunities for ex offenders.

As your sentence was over five years, you will always be obliged to disclose your record (under the Rehabilitation of Offenders Act 1974), however this won't be a barrier to all voluntary roles.

The chances of working with vulnerable people will depend upon the nature of your crime, not the length of sentence. Voluntary organisations will conduct individual interviews, where they will ask about your criminal record.

The main point to bear in mind is your skills and experience that you can offer. It often takes time to find the best volunteer opportunity and there are organisations that are keen to offer volunteering as part of the resettlement process, and a way to contribute to the community.

To find your nearest volunteer centre, contact Volunteering England – their website is www.volunteering.org.uk.

You can also contact the NACRO resettlement Plus helpline.

Good Luck with your volunteering!
Elizabeth Eves,
Volunteer Coordinator, Rehabilitation for Addicted Prisoners Trust (RAPt)

Mentor

Dear Terry
While I am based in Cork, Ireland, I am aware of NACRO's adult peer mentoring project for those who are or have recently been incarcerated.

I am currently trying to design a quality training and preparation program for those who have experience of incarceration and who wish to use this experience to positively assist others towards and into society. Visit www.youreequal.com for information.
Larry O'Reilly, You're Equal Ltd

Reader's question

There's a group of kids on my estate who I'm convinced are trying to deal drugs to my son. Who should I go to for help? They're very intimidating and I'm frightened of the repercussions, but more than anything I'm worried for my son.
Kathy, by email

Email your suggested answers to the editor by Tuesday 6 February 2007 for inclusion in the 12 February issue of DDN. New questions are welcome from readers.

Stages and processes of change: Part 2

Professor David Clark continues his description of the Transtheoretical Model of Change, focusing in this article on processes of change.

In my first article describing the Transtheoretical Model of Change, I focused on the various stages of change that are thought to occur when people change a problematic behaviour, such as drug or alcohol misuse.

In this Briefing, I consider the Processes of Change, the cognitive and behavioural activities that facilitate change. The extent to which each of these processes is used depends on what state of change the person who has a problematic behaviour has reached.

These processes occur in people who change their problem behaviour without professional assistance (self-changers) and in people who work with counsellors or other forms of practitioner.

The following is a summary of the ten processes of change suggested by James Prochaska and colleagues in the book Changing for Good (see below) and other publications.

Consciousness raising involves increasing the awareness of a person about the causes, consequences, forms of help and cures for a particular substance use problem. By increasing the amount of information available, we increase the likelihood of sensible decisions being made.

Interventions that increase awareness include education, media campaigns, information about key resources, and feedback.

Social liberation involves new opportunities or alternatives that the external environment provides for a person to begin or continue their efforts to change.

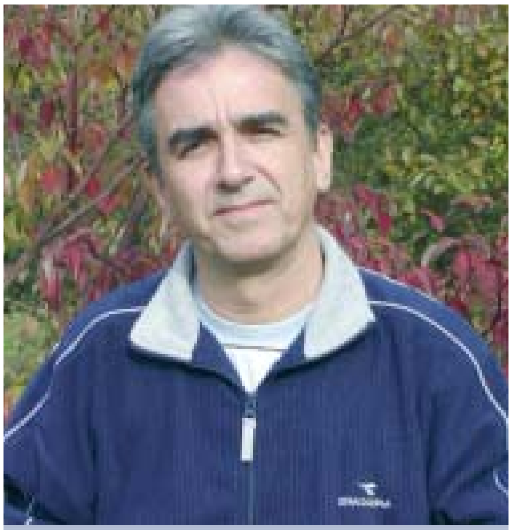
Examples of social liberation are no-smoking areas and easy access to clean syringes and needles. Advocacy organisations and empowerment procedures provide opportunities for people trying to change.

Emotional arousal is a significant, often sudden, emotional experience related to the problem at hand. It parallels consciousness-raising but works at a deeper psychological level. For example, a person with a drinking problem may be deeply affected by learning of a drinking buddy's serious motor accident under the influence.

Psychodrama, role playing, grieving and personal stories can move people emotionally.

Self re-evaluation requires a thoughtful and emotional reappraisal of a person's problem, and an assessment of the person they would be if they overcame it.

Self re-evaluation allows the person to see how and when their substance use problem conflicts with their personal values. As a result, they can



'However, punishment is rarely used by people who change themselves or by therapists, since it neither leads to lasting change nor is ethical.'

come to really believe that life would be better without their problem.

Commitment (or self-liberation) is both the belief that one can change and the commitment and recommitment to act on that belief.

The first step of commitment is private, telling oneself that I am choosing to change. The second step is going private, announcing to others that a firm decision to change has been made. Public commitments are more powerful that private ones.

Countering (or counter conditioning) involves the learning of new healthier behaviours to replace the problem behaviours. These healthier behaviours replace the problem substance use itself, as well the factors that lead to the substance use.

Examples of countering include going for a jog when the urge to get high occurs, using relaxation to counter stress, or doing something with a friend rather than drinking alone at home. People need to find the countering activities that best suit them.

Environmental (or stimulus) control involves restructuring one's environment so that the problem of a problem-causing event is reduced. Cues for unhealthy behaviours are removed and prompts for healthier alternatives are added.

Environmental control techniques can be as simple as removing alcohol or cigarettes from the home, or objects that have been frequently associated with the use of drugs, *eg* needles and syringes. No-smoking signs may be placed around the house.

Environmental Re-evaluation combines both affective and cognitive assessments of how the presence or absence of a personal behavioural problem affects one's social environment.

This includes considering the effect of one's smoking on others, *ie* the impact of passive smoking. A heroin user may become concerned about how the acquisitive crime used to support their habit is impacting on the victims of this crime.

Environmental re-evaluation also includes the awareness that one can serve as a positive or negative role model for others.

Rewards (or reinforcement management) provide(s) consequences for taking steps in the right direction. This may involve punishing problem behaviours or rewarding desirable behaviours.

However, punishment is rarely used by people who change themselves or by therapists, since it neither leads to lasting change nor is ethical. Rewards are often used successfully to change behaviour.

Self-praise or praise from family and friends, buying a present with money one would otherwise used on drugs, and group recognition are examples of rewards that can facilitate change.

Helping relationships take a variety of forms, including help from family members or friends, peer support groups, and professionals (either specialist or generalist workers).

It is important that these helping relationships combine empathy, trust, openness and acceptance, as well as support for the healthy behaviour change.

It is important not to make the mistake of confusing these processes with techniques of change. Each of the outlined processes involves a broad strategy that may employ any number of techniques.

For example, countering can involve the techniques of relaxation, desensitisation, assertion or positive self-statements.

In the next Background Briefing, I will look at how people use different processes of change at different stages of change.

James O. Prochaska, John C. Norcross and Carlo C DiClemente (1994). Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad habits and Moving Your Life Positively Forward. Harper Collins. (Available from Amazon.)

The Priory Hospital Chelmsford is an independent hospital that specialises in the treatment and management of mental health problems for both Adults and Adolescents. The hospital incorporates a Grade II listed building that has been extensively restored and situated in 3.5 acres of landscaped grounds.

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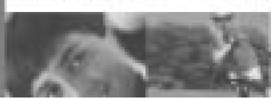

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1. *Young People's Early Intervention Substance Misuse Service: Havant Borough, Hampshire.*
2. *Targeted Youth Support Early Intervention Substance Misuse Service: Test Valley Borough, Hampshire.*

These services will form part of the network of pan Hampshire, Tier 2 early intervention services for young people. The services will be required to start week beginning 4th June 2007.

An open tendering procedure will be followed with the criteria for award of the contract to be:

- *Organisation economic and financial standing.*
- *Organisation track record of and commitment to the provision of substance misuse early intervention services for young people.*
- *Service User Involvement.*
- *Organisation capacity & capability to deliver young people's early intervention services.*
- *Price & Best Value.*

For the Test Valley Service further criteria will be:

- *A commitment to work as part of a multi-agency Youth Matters Targeted Youth Support Team.*

Process for application:

1. *All interested parties should contact Hampshire DAAT for a tender application pack using the address below indicating if you wish a tender pack for Havant, Test Valley or both areas.*
2. *All tender packs must be received by 12 noon on Friday 16th February 2007.*

To receive a tender application pack please contact **Anthony Andrews**, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL or email Anthony.andrews@hants.gov.uk

Lead a new drug service in Essex

Drug Interventions Programme County Manager
Essex • Salary £34K to £37K

Westminster Drug Project is a leading drug treatment provider, currently delivering a variety of Tier 2 and 3 services across twelve London boroughs. We are a major provider of Drug Interventions Programme (DIP) services and our expansion in this area is set to continue, having successfully tendered for the DIP services for the county of Essex starting 1st April 2007.

We are looking for a talented individual to take the role of County Manager and lead the service operating at a variety of sites across Essex. You will be at the forefront of establishing this exciting new service and pivotal to its success in delivering the highest possible services to its clients.

You will be able to demonstrate an impressive track record of leadership, working in partnership and problem solving. You'll have extensive knowledge of the drugs field, the criminal justice system and Drug Interventions Programme, and what works for the drug users who enter them.

If you have a commitment to making positive changes to communities, are full of creative flair and innovative new approaches and have a passion to inspire a team of drug workers, then we're the right organisation for you. Join Us.

WDP is a warm, supportive and diverse organisation which values its people and supports professional development, offering rewarding career paths and learning opportunities. To discuss the role informally, please call David Bamford on 020 7421 3103 or Stuart Campbell on 020 7421 3102.

Closing date: 21st February 2007.

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

To learn more about this opportunity and to apply, please visit our website www.wdp-drugs.org.uk

WDP

Westminster Drug Project Ltd.

The Alliance

Taking treatment forward

Regional Advocate (North East)
Regional Advocate (South West)
Regional Advocate (London)

Part time: 21 hours (three days) per week
Salary: £24,708 pro rata (NJC scale SO2 32)

The Alliance is a user led organisation providing helpline and advocacy services to drug users. We are looking for three advocates to provide services to drug users in the North East, London and the South West as part of a National Model of Advocacy funded by the Department of Health.

The North East and South West regional advocates will work from home, and the London advocate will be based in the Alliance's office. Each advocate will be expected to travel within their region. They will be expected to work as part of a national team while successfully managing all aspects of regional advocacy delivery. Excellent interpersonal and communication skills are essential, as is an understanding of treatment options for drug users.

The successful candidate will need to have direct experience of drug treatment and a commitment to improving the quality and availability of treatment in the UK.

The Alliance operates an equal opportunities policy and welcomes applications from all sections of the community. We are particularly interested in receiving applications from current drug service users.

For a job description and application form (CVs not accepted) please contact the Alliance on 020 7089 6334 or by emailing malliance@btconnect.com.

Closing date for completed applications is 5th February 2007. Interviews to be held on 22nd February 2007.

The Methadone Alliance is a Registered Charity (No. 1081554) and a Limited Company (No. 3934379)

DDN/FDAP workshops

Healthy eating for a better life

14 February – Central London

Helen Sandwell, Nutritionist, MSc NutMed

This workshop is aimed at all those who work with substance misusers. It will explore why diet is so important to their physical and mental health, as well as their long term drug/ alcohol outcomes. The workshop will focus on healthy eating related to the particular problems experienced by the individuals who come into contact with drug and alcohol workers. Re-run due to popular demand.

£110 + Vat per delegate

Qualifications, competence and government targets – making it work

26 February – Central London

Carole Sharma, Former NTA work-force development lead

This one-day workshop will assist those responsible for workforce development in creating local systems for the development of the substance misuse workforce. Using experience from her time at the NTA, Carole will demonstrate how to work towards a competent workforce and achieve government targets. This workshop provides essential information for anyone responsible for managing staff.

£145 + Vat per delegate

All workshops are located between London Waterloo and Vauxhall and run between 10.00am and 4pm. They include morning coffee and a light lunch. A 15% discount is available to FDAP members. Place numbers are limited on all of the workshops, so early booking is recommended.

DDN Drink and Drugs News

fdap

For more information or to book your space please contact Ruth Raymond, e: ruth@cjwellings.com t: 020 7463 2085

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Email: SamRecruitment@btconnect.com Or register online

www.SamRecruitment.org.uk

London Borough of Redbridge

REDBRIDGE DRUG AND ALCOHOL ACTION TEAM PARTNERSHIP
CONTRACTS FOR:
(A) TRAINING AND EMPOWERMENT SERVICE
(B) STRUCTURED COUNSELLING SERVICE
(C) WRAP AROUND SUPPORT SERVICE
(D) TIER 2 OPEN ACCESS SERVICE
RESTRICTED TENDER PROCEDURE

Notice is hereby given of the London Borough of Redbridge that:
The Council invites expressions of interest from suitably experienced and recognised service providers for each of the following FOUR new services. This is in response to gaps in the current treatment system, and identifying needs in consultation with local service users.
Each of the contracts individually will comprise the development, planning and delivery of a new service for a 12-month contract:

- **(A) Training and Empowerment Service**
  This contract will involve the development and delivery of a range of needs-led training courses for current/ex-service users, parents/carers/family members, community members and Tier 1-4 professionals. The service provider must be an accredited training organisation that provides nationally recognised qualifications. In order to deliver the Service the successful Service Provider will need to acquire premises within Redbridge that comply with the specified requirements of the Council. The contract budget available is up to £150,000 for the 12-month period.
- **(B) Structured Counselling Service**
  This contract will be for clients with drug and alcohol problems, who are assessed as in need of structured counselling interventions. The Service Provider is required to ensure that interventions are client-led and in line with national guidance / best practice. A potential site for the delivery of this service has been identified. The contract budget available is up to £150,000 for the 12-month period. If the service operates from the suggested premises rental costs will be covered separately for this contract.
- **(C) Wraparound Support Service**
  This contract will support clients who are accessing drug and alcohol treatment services with a range of issues that may impact on their ability to be engaged and retained in treatment services. This should be a multi-disciplinary service, which includes advocacy and support for housing and related support, debt management, legal issues, and support with access to education, training and employment. A potential site for the delivery of this service has been identified. The contract budget available is up to £150,000 for the 12-month period. If the service operates from the suggested premises rental costs will be covered separately for this contract.
- **(D) Tier 2 Open Access Service**
  The contract comprises the development of a tier 2 service within the borough of Redbridge for clients who are currently engaged in drug use. The service will be provided for drug using individuals and their families who are seeking advice, information and easy access services. The service must be made up of diverse multi-disciplinary input, and offer a broad range of interventions to support harm reduction and access to treatment. In order to deliver the service the successful provider will need to acquire premises within Redbridge that comply with the specified requirements of the council. The contract will also include delivery of a mobile harm reduction service. The contract budget available is up to £300,000 for the 12-month period.

Those expressing interest will be asked to complete a Pre-Qualification Questionnaire; this will be used for the short-listing of applicants using the criteria of; financial standing, previous experience, the provision of satisfactory references and compliance with the Councils standards on Equalities and Health & Safety. It is envisaged that in the region of 5 will be invited to tender for each of the above contracts.
At the second stage, those short-listed and invited to tender may be called for interview and asked to present detailed project plans and answer questions related to the service.
The Award criteria for contracts (A) and (D) will be based on the most economically advantageous tender having regard to the following, in percentage terms and in descending order of priority: Technical ability (35%); Quality (25%); Ability to Find Premises (20%); Price (20%). The Award criteria for contracts (B) and (C) will be based on the most economically advantageous tender having regard to the following, in percentage terms and in descending order of priority: Technical ability (40%); Quality (40%); Price (20%).
It is envisaged that the contracts will commence in April 2007.
Pre-qualification questionnaires will need to be returned by 12.00 noon on Wednesday 14th February 2007 and are available from Mr John Harrington, London Borough of Redbridge, Strategic Services Town Hall P.O. Box 2 High Road, Ilford, Essex IG1 1DD
(Tel 020 8708 2374, Fax 020 8708 2976) E-mail: john.harrington@redbridge.gov.uk
Further information may be obtained from: Lisa Sturrock, Commissioner, Redbridge DAAT, Station Road Centre, Station Road, Barkingside, Essex IG6 1NB (Tel 020 8708 7829, Fax 020 8708 7802) E-mail: Lisa.Sturrock@redbridge.gov.uk

www.surreycc.gov.uk

SURREY COUNTY COUNCIL

Making Surrey a better place

Agreement for the Provision of a Structured Alcohol Brief Intervention Programme (ABIP) for people within Surrey

Commissioning organisation: Surrey County Council (Family Division)

NOTICE OF CALL FOR EXPRESSIONS OF INTEREST FOR THE PROVISION OF AN ALCOHOL BRIEF INTERVENTION PROGRAMME (ABIP).

You must be able to deliver a structured alcohol intervention service for Adults over the age of eighteen (18) years who have committed offences which are related to the use of alcohol.

The Service Provider will be expected to have recruited a team manager who will be involved in the service development and the recruitment of four staff to deliver interventions at each of the four Surrey Police divisions by 1st April 2007.

The contract holder will:

- Contribute to Surrey's overall target of a 13.2% reduction in crime by 31st March 2008 by working to reduce alcohol related crime in the county.
- Provide an intervention service to work with adult offenders (18 years and over) committing offences of;
- Criminal damage,
- BCS 10 crime categories which include common assault, wounding and personal robbery, which are related to the use of alcohol.
- Domestic violence and drink driving where the offence is seen as an indicator of an ongoing alcohol problem.
- The Service will offer access to a range of interventions aimed at changing the offenders drinking and, thereby, their offending. The interventions on offer will range from brief motivational sessions to access to intensive alcohol treatment.
- Be able to demonstrate experience and specialist knowledge and skills in the support and management of people who commit offences as a result of alcohol.
- Be monitored on the delivery of stated outcomes and will have to provide satisfactory qualitative monitoring information on a quarterly and annual basis.
- The contract offered is for one year with a further two year extension clause subject to the satisfactory performance by the Provider, current demand for the Service, together with continued Government Funding.

This is an exciting opportunity, which will enable us to work towards Surrey's overall target of a 13.2% reduction in crime by 31st March 2008. We are keen to encourage Providers who are willing and able to work closely in partnership with the County Council, other Key Stakeholders and Service Users. If you feel you are up to the challenge and wish to be considered for inclusion in our tendering process, please respond to this Notice by expressing your interest in writing and including an email address for further communication.

Our tender process will be conducted under a sealed written quotes procedure; therefore we will not be bound to invite every organisation that applies. Surrey County Council will not be bound to award any contract under this tender process.

Please send your expressions of interest on a company letterhead marked ref: RM/0107/DAAT by 12 noon, Monday, 12th February 2007 at the latest to: Rachel Mawer, Procurement Officer, Families Contracts Unit (Adults), Civic Centre, High Street, Esher, Surrey KT10 9SD.

Working towards equality

DDN/FDAP workshops

Supervision, appraisal and DANOS

28 February – Central London

Tim Morrison,
Former head of training and quality at DrugScope

Performance management and supervision can sometimes be highly subjective and difficult experiences that appear like an additional burden to the normal workload. This one-day event will support managers to use DANOS as a tool to develop the skills of their staff and improve the experience of service users.

£110 + Vat per delegate

Specific services for stimulant users

29 March – Central London

Michael Bird, Community drugs services

This workshop centres on the difference between working with opiate and stimulant users, focusing on effective interventions. Interactive in nature, participation is encouraged through group work and open discussion. By the end of the workshop attendees will have a better understanding of the difficulties faced when working with this client group.

£110 + Vat per delegate

All workshops are located between London Waterloo and Vauxhall and run between 10.00am and 4pm. They include morning coffee and a light lunch. A 15% discount is available to FDAP members. Place numbers are limited on all of the workshops, so early booking is recommended.

DDN Drink and Drugs News

fdap

For more information or to book your space please contact Ruth Raymond, e: ruth@cjwellings.com t: 020 7463 2085

EXPRESSIONS OF INTEREST

WILTSHIRE DRUG AND ALCOHOL SERVICES

WILTSHIRE CHILDREN AND YOUNG PEOPLE'S TIER THREE COMMUNITY SUBSTANCE MISUSE TREATMENT SERVICE

The Safer Wiltshire Partnership is looking for a suitably experienced Service Provider to deliver the Children and Young People's Tier Three Community Substance Misuse Treatment Service for Wiltshire.

The Service will enable children and young people up to the age of eighteen with substance misuse issues and complex needs to access a comprehensive community based tier three treatment service; and to help those using the Service to overcome their problems and live healthy crime free lives. In addition, the Service will be required to provide support to tier one and tier two Service Providers.

Service delivery is required across the whole of Wiltshire (excluding Swindon) and would need to ensure appropriate accessibility to treatment for Service Users and a responsive service to the requirements of referral agencies.

Expressions of interest must be submitted in writing or e-mail by 5pm on the 9th February 2007 to: Simon Jeffery, Contracts Manager, Department of Community Services, Wiltshire County Council, County Hall, Trowbridge, Wiltshire BA14 8LE or email: simonjeffery@wiltshire.gov.uk

Wiltshire County Council

HAMPSHIRE DAAT
Drug & Alcohol Action Team

Harm Reduction & Outreach Service

The Hampshire Drug & Alcohol Action Team (DAAT) are seeking written expressions of interest from providers with proven experience in delivering drug misuse treatment services for the provision of a Harm Reduction & Outreach Service to cover the Hampshire DAAT area. The service will form part of the pan Hampshire Harm Reduction Strategy and will be a mobile service providing outreach, harm reduction support & Information including distributing injecting paraphernalia and will be required to commence in June 2007.

A restricted tendering procedure will take place following the proposed timetable below:

1. Written Submissions of interest to be received by the Hampshire DAAT by 2nd February 2007
2. Initial supporting questions supplied to interested parties 5th February 2007
3. Meeting To discuss the tender requirements with interested parties Week of the 12th February 2007
4. Supporting questions due back to Hampshire DAAT Week of the 19th February
5. Tenders packs will be sent to interested parties Friday 23rd February 2007
6. Tender packs due back to the Hampshire DAAT 16th March 2007
7. Short listed parties invited to interview and present proposed service week of 16th April 2007
8. Successful organisation awarded tender week of 16th April 2007

To register your interest please contact Pat Hall, Hampshire DAAT, Capitol House, 12-13 Bridge Street, Winchester, Hampshire SO23 0HL

Community Drug Project

Providing quality services in response to the changing needs of diverse communities

CDP continues to be a pioneer in developing services to address the wide ranging issues facing communities from problematic drug use. We run a range of high quality innovative services based on our principles of partnership working, accessibility and harm minimisation.

We offer a range of benefits including: contributory pension scheme, generous holiday entitlement, annual season ticket loan, flexible working and comprehensive training programme.

Project Manager

Hackney Crack Day Programme – E5

£29,289 - £32,112 pa

The Day Programme delivers a rolling 12 week programme for crack cocaine users resident in Hackney. The programme uses formal group work and individual skill-based interventions to support drug users through a process of change.

You will have overall responsibility for the clinical management and day-to-day running of the service and 3 permanent staff. You should have a proven track record of working with service users in the substance misuse field and of supervising and managing staff. **REF: CDP/DDN/19**

Project Worker
DIP Liaison Project Worker

Lambeth Harbour Crack Service – Brixton SW9

£24,690 - £27,810 pa

Lambeth Harbour is a unique multi-partnership project providing an extensive range of services for primary crack users. The service engages clients through the provision of formal and informal interventions including drop-ins, group work, health assessments and complementary therapies.

For either of these posts, you will need to demonstrate the ability to work as part of a team to facilitate all aspects of the crack service including receiving referrals, conducting assessments, contributing to group work programmes, key work, working within the drop-in, and liaison with the local DIP service.
REF: CDP/DDN/20

Project Worker

Quantum Direct Access Service – Forest Hill SE23

£24,690 - £27,810 pa

This open access service offers a range of support for drug users in Lewisham, specifically targeting primary heroin and crack users. The service provides a drop-in, keyworking and needle exchange and also works with local GPs to advise on substitute prescribing.

You will need a good understanding of GP shared care and be able to advise and support primary health care professionals in relation to drug use and treatment. You will be expected to work some weekends.
REF: CDP/DDN/21

For an application pack for any of the above vacancies please telephone on 020 7840 0099 or email: jobs@communitydrugproject.org.uk quoting the relevant reference no.

Closing date for completed applications: 19th February 2007.

www.communitydrugproject.org.uk

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The psychometric test which identifies substance misuse problems even in clients who are unable or unwilling to acknowledge the existence or symptoms of a problem

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www.DANOS.info

This course has been mapped to the DANOS standards and can be found on the DANOS Learning Resources Database. It helps people develop their knowledge, skills and competence in the following DANOS units: AA2, AC1, AF, AG, AI1, AI2, AJ, BA, BB1, BC, BE, BG1, BG3. BG4, BI2, BI4, CA, CB

Solihull NHS
Care Trust

The Drug Intervention Programme is a service set up to reduce drug-related crime in Solihull. Our aim is to provide a quick response to people with drug-related problems who come into contact with the criminal justice system and to move them towards treatment for their drug use.

For those who receive prison sentences we need to make sure they get the right help during their sentences, and especially on their release, to stop them returning to the cycle of drugs and crime. We need an agency to take on this challenge of establishing and delivering a Through Care Unit. The successful agency will work with all agencies within the criminal justice system and treatment services to maximise the chances of drug users engaging successfully with the help available. From assessment through to care planning and aftercare, the successful agency will work collaboratively within the current DIP service in Solihull to deliver a high quality service that meets the needs of all drug users going to prison.

To be considered the agency must demonstrate a broad range of experience of working with people with drug-related problems who come into contact with the criminal justice system and a proven track record of providing substance misuse services for this group.

If you believe your agency has the necessary experience and capability to deliver a service of this scope, we'd like to hear from you.

For an informal discussion please ring either Chris Clarke, Joint Commissioning Manager on 0121 704 6715 or Sue Moore, DIP Manager, on 0121 788 0753.

Please send formal expressions of interest by 16th February 2007 to: Mr Terry Bright, Head of Procurement, Solihull Care Trust, 6th Floor, Mell House, 46 Drury Lane, Solihull B91 3BU.
Tel: 0121 712 827. Fax: 0121 704 1879 or E-Mail: t.bright@solihull-ct.nhs.uk

The Solihull Partnership