From FDAP in association with WIRED

DDN

Drink and Drugs News

30 January 2006
www.drinkanddrugs.net

CAREER PORTFOLIO
How to get started on creating yours

ALCOHOL CHALLENGE
NERAF becomes service users' champion

TOBACCO SMOKING
Q&A tackles the subject we all avoid

BLACK HOLE SERVICES

Are we getting value for money from Tier 3?

societyguardian

TURNING POINT
turning lives around

drugs and alcohol today

Pavilion

drugs and alcohol today

London

Date: Wednesday 5 April 2006 **Venue:** Business Design Centre, London

Launched in 2005, Drugs and Alcohol Today London was hailed a tremendous success, with 50 organisations exhibiting and over 1,500 visitors attending.

This one-day event, comprising a full and comprehensive conference programme and a large exhibition, will provide a valuable opportunity for everyone involved in the sector to come together to debate the big issues, share best practice and network.

Seminar topics to include:

- anti-social behaviour
- young people
- local alcohol strategies
- testing – how to use results and understanding results
- preserving relationships and protecting children
- social work – drugs and alcohol
- treatment effectiveness.

Tickets:

£20 inc VAT in advance

£25 inc VAT on the day

Group discount:
5 tickets for the price of 4 – that's just £80

"The exhibition was an extremely lively event and was a great chance to meet people from all areas of the field.
It'll certainly be on our calendar for next year."

Claire Brown *Editor*, *Drink and Drugs News*

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30 January 2006

Editor's letter

There's a great deal you can't do without money – but there's a lot to be said for a 'can do' attitude. Kevan Martin (page 12) went further with a 'must do' approach to setting up NERAF, a forum for alcohol service users in the North East.

Kevan's determination to go out and find service users before they leave treatment and spend years wrestling with the lonely reality of alcoholism – as he did – has given him the basis for an active and responsive network. The individuals and services who have helped him along the way, with ideas, support, use of a room – and all the small things that make a huge difference when you're trying to turn an idea into practice – are testament to those who listen and respond to what's needed by service users.

Alongside the inevitable frustrations about the lack of funding for alcohol services and refusal to recognise the escalating scale of damage to the nation's health, there is a rallying cry to unite in influencing future planning. To be heard above the constant noise of the criminal justice system is going to take a clear and united message from alcohol services and service users throughout the country.

Why shouldn't alcohol service users have a strong and co-ordinated voice representing groups around the country, in the same way that drug service users are participating in dialogue and contributing to the future direction of services?

Alcohol Concern are, of course, right up there in the front line – supporting Kevan and other groups around the country and lobbying government for the crucial underpinning finance. With the deadline due now for responses to their 'Spend £1, get £5 free' campaign, to make spending on alcohol treatment a priority, there's a reminder on page 6 to add your support while you still can.

Editor:
Claire Brown
t: 020 7463 2164
e: claire@cjwellings.com

Advertising Manager:
Ian Ralph
t: 020 7463 2081
e: ian@cjwellings.com

Designer:
Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

Website:
www.drinkanddrugs.net
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In this issue

Our drug strategy works – but what next, asks Hogg

Lowest ever waiting times for treatments, lowest rate of drug-related deaths and 89 per cent more users in treatment than in 1998, and stabilisation of class A drug use in young people were some of the successes of the government's drug strategy according to Vic Hogg, Head of the Home Office's Drug Strategy Directorate.

Mr Hogg had been asked to tell delegates at Release's Fifth Drugs University whether the government's drug strategy was working. Progress was being made, he said, and Drug Intervention Programmes were bringing acquisitive crime down. The Proceeds of Crime Act was 'hitting the big criminals in their pockets'.

The effect of interventions on supply was more difficult to gauge, said Mr Hogg, as 'when you take an organised gang out, another steps in'.

Mr Hogg was keen to face challenges of the future, through more effective partnership working between agencies, government departments and countries.

'Much is lost by not operating properly,' he said. 'There's a lot of good practice out there, but we're not very good at communicating.' The media did not like celebrating good news, said Mr Hogg, 'but we have a duty to communicate it'.

More work needed to be done on growing the workforce and skills training, such as the recent Home Office campaign to expand the workforce.

Making sure wraparound services were available was equally important, and government departments such as the Office of the Deputy Prime Minister and Department for Education and Skills must do their part in making sure services were in place, according to Mr Hogg. Vulnerable young people were 'at the very top of the government's agenda', he said.

With the current drug strategy running out in 2008, government was gearing up to a comprehensive spending review. 'We need to evaluate effectiveness, refine best practice, and know what works,' said Mr Hogg. Money for drug treatment would plateau after this time, he warned, 'so there is a need to prove that money till then has been used for maximum benefit'.

What should the strategy post 2008 look like?, he asked delegates. 'Do we want radical change? Do we want a radical new drug strategy?' Should delivery and funding be mainstreamed where possible, through the NHS instead of the NTA for example, he wanted to know. Should there be individual strategies relating to different groups such as young people, or would it be better to channel drug strategies into other mainstream departments?, he asked.

The existing strategy was effective, Mr Hogg concluded, with data showing that it was moving in the right direction. 'But it's a long and difficult journey,' he acknowledged. 'There's more to do, and we need to do it together. I am confident progress is taking us in the right direction.'

Addaction appoints new chief executive

Deborah Cameron has been appointed as the new chief executive of drug and alcohol treatment charity Addaction.

With a background of senior roles in both public and voluntary sectors, Ms Cameron was most recently director of The Alcohol Recovery Project (ARP), which recently established the alcohol treatment project 'Choices' in Brixton, for minority ethnic communities. Other roles include ten years as director of social services at the London borough of Newham.

Her first task on joining Addaction is to get on the road and meet the charity's 700 staff and as many clients as possible, said Ms Cameron.

'Empowering users to become more involved in their treatment, and supporting and motivating the people we employ, will be among my first priorities,' she added.

Awards seek drugs field's unsung heroes

An awards scheme to find the drug worker and team of the year has been launched by the Home Office, to find 'workers who are making a real difference in the local community'.

Part of the Tackling Drugs Changing Lives campaign, the awards are open to public and voluntary sector workers in the UK, who can be nominated by colleagues, friends, family, current or ex-service users.

Prize money of £10,000 will be awarded to both the winning individual and the winning team who, the Home Office suggests, might be drug treatment providers, police teams, prison officers, social workers, housing officers or youth workers, or from criminal justice interventions teams and DATs.

DrugScope chief executive, Martin Barnes, one of the judges, said that the awards would 'recognise the outstanding work that is happening around the country, as well as the range ans diversity of local projects'.

To make a nomination for either category, visit www.drugs.gov.uk/awards2006 before the end of March. Winners will be announced on 23 May.

FDAP membership continues to grow

As of the beginning of the year FDAP's membership stood at 2,700 individual practitioners, and 64 affiliate agencies, with a total of 3,800 drug and alcohol specialist staff. For more information see under 'membership' at www.fdap.org.uk.

New Chair for FDAP

After two years at the helm, Chris Hannaby (chief executive of Vale House) has stepped down as Chair of FDAP, to be replaced by Noreen Oliver (Director of BAC). Simon Shepherd, FDAP's Chief Executive, told DDN - 'We are extremely grateful to Chris for her commitment and support over the last two years – which have seen a period of rapid growth in the organisation's membership and profile.'

ANSA is new DDN partner

DDN welcomes The Association of Nurses in Substance Abuse (ANSA) as a new partner organisation.

Formed in 1983, the association has influenced and responded to changes in the drug and alcohol field that relate to nursing, and the nurse's role in the caring for service users and their families.

We look forward to benefiting from ANSA's expertise in enhancing our editorial coverage of nursing issues.

IHRA to block change in drug status

A rushed decision by the World Health Organisation to reschedule buprenorphine is being contested by the International Harm Reduction Association (IHRA).

WHO's Expert Committee on Drug Dependence (ECDD) has included a 'final decision' on rescheduling the drug on the agenda of its meeting on 28-31 March in Geneva.

What this means in practice is that buprenorphine, which is used to treat pain and reduce dependence on opiates, is likely to be moved to a stricter UN drug convention, which will mean tighter controls, more reporting requirements, and possible changes in law.

The move could represent a significant backward step for countries that rely on the drug as a tool to reduce HIV transmission – particularly those where availability of methadone is restricted, according to IHRA.

Executive director of IHRA, Professor Gerry Stimson, has written to WHO's director general, Dr Lee Jong-Wook, to request that the decision is postponed to allow a proper review of the scientific, public health and social implications of the proposal.

A hasty decision to reschedule was far more than a technical issue, said Prof Stimson. It could mean 'increased HIV infections, greatly limited access to opiate dependence and antiretroviral treatment, and more lives lost in violation of drug users' fundamental rights to health and life', he told WHO.

Deferring the item to a later meeting would allow an adequate review of data and time for essential canvassing of opinion of NGOs and others whose work would be affected by the decision.

As well as pressure on the WHO Executive Board, IHRA has contacted affected UN agencies and key UN staff to alert them to the situation, ahead of the Geneva meeting.

Make your voice heard now – Alcohol Concern extends deadline for DDN readers

Alcohol Concern has extended the deadline to return postcards for their 'Spend £1, get £5 free' campaign to allow readers of this issue of *DDN* to catch it in time.

A portion of the card, supplied by Alcohol Concern should be signed and returned to them, so they can send the cards to the Department of Health. AC is co-ordinating representations from treatment providers, service users and activists, to call on government and primary care trusts to make alcohol treatment a priority.

'Every single postcard can make a difference, so please take this opportunity to make your voice heard to government about the vital importance of investing in alcohol treatment services,' says the charity.

Email campaign@alcoholconcern.org.uk to have postcards posted to you immediately. Please sign and return them by the extended deadline of Friday 3 February.

(For background to AC's campaign, see DDN 14 November, page 14, or visit www.alcoholconcern.org.uk

Karl from Broadreach will be sorely missed

Karl Branston, treatment team manager at Broadreach, died of cancer on 19 January 2006, aged 48.

Karl worked in the field of drug and alcohol treatment for over 12 years, including 10 years at Broadreach as a Counsellor, always well-liked and respected by both clients and staff, and making a profound difference to the lives of a countless number of people.

He had a particular interest in developing new treatment approaches, and brought a wealth of experience and understanding to implementing these at Broadreach, making an immense contribution to the high quality and effectiveness of treatment.

Throughout his 20 month struggle with cancer, Karl continued to work whenever possible. His dedication to his work and his absolute commitment to the highest standards of care will be a great loss to Broadreach House. His compelling enthusiasm, intelligence, warmth and wonderful sense of humour will be sorely missed by all of us who work here.

Staff at Broadreach House.

Latest Findings

Get effective!

The NTA's new emphasis on effectiveness and corresponding developments in Scotland means UK policy is now aligned to the mission of the *Drug and Alcohol Findings* magazine, writes its editor, Mike Ashton.

Produced by a partnership of national charities (National Addiction Centre, Alcohol Concern and DrugScope), the magazine translates latest research on the effectiveness of drug and alcohol interventions into the practical implications for UK practitioners.

Highlights in the new issue include American research that shows how treatment services can implement the national push to link clients to housing, training, medical, and other services, building a stable platform for recovery. What the Philadelphia researchers found is probably familiar to many in Britain: comprehensive assessments of these needs were done using the system mandated by the regulators (the Addiction Severity Index – an international standard) – and then filed rather than prompting referral to services.

A simple system within the reach of any local network of services transformed this redundant paperwork into a practical route to the 'wrap-around' care now being advocated in Britain. The secret was to create a tailored, computerised directory of local services keyed to the needs identified in the assessments, making it easy for counsellors to identify how to respond. As intended, clients assessed through this system received more of the services they needed, but the clincher for managers with an eye on performance targets could be a remarkable 'side-effect' – over twice as many completed the core addiction treatment programme.

At the more subtle end of counselling practice, we found confirmation that the directiveness of the therapist is a major factor in how clients respond. It came from a new video-based analysis drilling down to what actually happened during therapy sessions in Project MATCH, the blockbuster US alcohol treatment trial. It confirmed findings from very different settings and caseloads, all converging on the proposition that clients prone to react against direction do best when allowed to take the lead, while those more welcoming of direction lose out when therapists fail to provide direction and structure.

It seems common sense, but the research goes further than most of us could simply intuit, identifying which particular elements of being directive make the difference and providing ways to identify in advance what is most likely to suit which client. It seems a fair bet that the ability to make such judgements and adjust accordingly is one way empathic therapists with good social skills improve outcomes.

These 'X factor' qualities are explored further in part four of the 'Manners Matter' series, focusing on whether motivational interviewing can help legally coerced clients engage with treatment. It can, but only when the conditions are right – and often they are not.

***Drug and Alcohol Findings* issue 14 is now available – more information and free downloads at www.drugandalcoholfindings.org.uk or phone the National Addiction Centre on 0207 848 0437 and ask for *Findings*.**

Notes from the Alliance – Methadone and beyond

Keeping it dirty

Tackling prejudice and unfair treatment is about more than just turning a blind eye to it. Come on! Let's look at options for long-term maintenance as well as abstinence as part of the Treatment Effectiveness Strategy, says Daren Garratt.

Last December I attended the 'Making It Clean' conference in Manchester. Organised by the North West NTA Regional Office and aimed specifically at commissioners and providers, the aim of the day was to promote abstinence as a viable treatment outcome, which actually supports the Alliance's core philosophy that service users have a fundamental right to develop a care package that is tailored to their own individual needs and aspirations – including abstinence.

This may surprise some people whom, I suspect, have our organisation marked as blinkered, unquestioning methadone evangelists. We know, though, that methadone is inappropriate and unsuitable for a lot of users, and sadly, society's continued prejudicial stance against the drug can result in some users being denied full citizenship.

However, evidence also shows that when it is appropriately administered as part of an effective treatment package, it is the gold standard in maintenance prescribing; it helps users achieve stability and it saves lives. These qualities should never be dismissed or underestimated.

Unfortunately, not everyone seems prepared to strike that pragmatic balance and accept that being methadone maintained is not somehow inferior to being drug free.

Take Stuart Honor's keynote speech on 'the social reality of drug treatment' and his 'outing' of the accepted practice of blind reductions as perpetrated by a DAT in the North East. Blind reductions are when a key worker – not the GP – can decide to reduce scripts involuntarily after a failed urine test but 'top up' the remaining methadone with water so that users don't become suspicious. If users then complain that their script isn't holding them, the notion's dismissed – and if they do finally get an admission, they're informed of a waiver they signed whilst rattling and desperate at their first appointment.

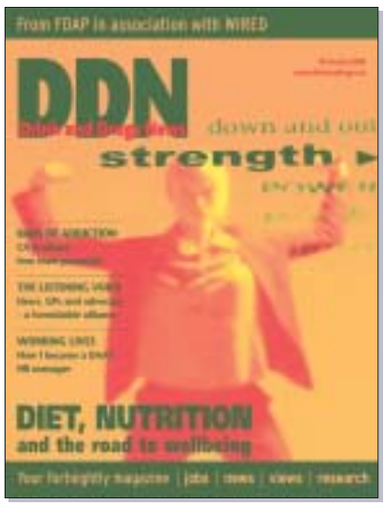
Stuart then went on to imply that it is somehow methadone that should be outlawed and not the inadequate care planning and dehumanised treatment systems that fail and endanger those they are designed to support and protect by summarising the 'options' of methadone maintained users as: 'a life on benefits, the incapacity book (I'm sick – Hallelujah), underemployment (shootin' chickens), a life on methadone, a life of crime, a mixture of the above'; and stating that 'poverty is not soluble in methadone hydrochloride'.

Amazingly, these distortions and examples of gross medical malpractice were greeted with a number of wry smiles from some delegates and zero public response from the NTA ('More treatment, better treatment, fairer treatment'), which undoubtedly led some delegates to assume that this is a philosophy increasingly endorsed, shared and promoted by the organisation.

So, come on NTA! Let's redress the balance and host a joint conference that focuses solely on promoting long-term maintenance options and controlled drug use as effective, viable components of the Treatment Effectiveness Strategy.

And let's give it a title that sums up the prejudices, attitudes and treatment that many users experience if they're not interested in 'Making It Clean'; let's remind them how they're 'Keeping It Dirty'.

The power of words. Don't take it for granted.



'Three years ago I injected my 120mg methadone takeaways, IV Ritalin two or three times a week, took 40mg valium a day, pot all day if possible, opium twice weekly, coke or speed if possible. Now, after three years on supplements and no real willpower, effort or pain, I am on 80mg methadone, and reducing.'

Living proof that fuel can help recovery

I am a 47-year-old worker for the Hepatitis C Resource Centre, Otago in New Zealand. I found the 'Fuel for Recovery' article very interesting (*DDN*, 16 January).

The evidence that essential fatty acid (EFA) levels predict future cocaine use better than past cocaine use (in other words, nutritional status has more influence on drug taking compulsions than behaviour does) confirms my experience from treating my Hep C with L-methionine and selenium.

I inadvertently corrected some underlying chemical imbalance, and as a result gradually lost all my compulsions to abuse drugs – just lost interest. I'll still use if I think it will make me feel good (in the longer term as well as immediately), but there just aren't many options like that, so I'm becoming drug free.

Three years ago I injected my 120mg methadone takeaways, IV Ritalin two or three times a week, took 40mg valium a day, pot all day if possible, opium twice weekly, coke or speed if possible. Now, after three years on supplements and no real willpower, effort or pain, I am on 80mg methadone, and reducing. I haven't used IV or ritalin for six months (speed, orally, once in that time), no valium for a year, opium only very occasionally, and no more than one joint a day.

Most of those were compulsions, not true addictions, and those are the habits that went. When you do a drug, or an action like injecting, even though you know you don't need it or won't enjoy it, that's a compulsion that becomes vulnerable when you find your chemical balance.

What interested me about your article is, separate from the effect on HCV – and I went from having next to no life, hadn't been happy for decades, to being happy most days – was the delayed effect on my drug taking.

It has become obvious to me that my attitude to drugs (not that I enjoy them, not that I want to take them – but I was compelled to take them when I didn't expect to enjoy them, or want to take them) was the result of a chemical imbalance. Thus, the reference to EFAs and cocaine made perfect sense.

This attitude wasn't so strong to start with. Bad diet, alcoholism and malnutrition caused it perhaps more than the effects of the drugs (I was still a polydrug used when I started to improve). It doesn't follow that every compulsive drug-taker has the same imbalance (probably histadelia, or high brain histamine, which L-methionine helps correct) or will respond to the same nutrients (though everyone here with HCV, especially autoimmune hepatitis, seems to respond to them).

Eating fish and seeds has been a big part of my diet for the last three years, so the EFAs are there too. I don't intend to avoid taking drugs if I feel I'll enjoy them – that's just hardly ever the case – or if I need them because of my habit. But now I feel better on a reducing dose of methadone, where I used to need gradual increases to feel secure.

I suppose the difference is, I really do feel 'high on life', and love, and I resent drugs if they interfere with that. Also, I do believe that methadone and HCV don't mix; I've seen people get very sick and don't believe reassurances that it's not hepatotoxic. Maybe it won't cause cirrhosis, but with HCV there are many ways liver function can be adversely affected.

But it's not as if I'm on natrexone, antabuse, or something that stops me getting high – it's just that highs don't compare with an average normal day. And things that don't interfere with that – like good speed – don't entrap me either, perhaps because they wear off so slowly (and without depression) that I'm never tempted to repeat doses. Also I'm not tempted to spend money I don't have any more.

So much for the 'addictive personality'. I was never able to get addicted to nicotine however much I smoked when I did.

My personality may have improved, but I think people I used to know still recognise me. Some people instinctively reject what I'm saying because it insults their sense of free will, but to me it's the opposite; I have more free will now than I had before, I've undone one of the ties that predestined me to certain unwanted behaviours.

I'm sure others will be offended because I seem to have found a shortcut to a place others

have suffered to reach. But I've suffered to get drug-free before, and it's not the same thing at all – not for me anyway.

I'm quite happy to admit that, without supplements (and the right ones – I've often used vitamins to ameliorate withdrawals or comedowns, without more success than that), my willpower alone would never have achieved anything.

George D Henderson, Hepatitis C Resource Centre, Otago, New Zealand (who can be emailed with any questions at hepcotago@gmail.com)

East-West Massive

I read the letters in your last issue (*DDN*, 16 January) and felt the need to add further support for the East-West Detox alternative detox and rehab programme, which I was fortunate to have taken part in over two years ago. This enabled me to deal with my demons once and for all. I was a chronic heroin, methadone, subutex and crack user for six years.

I met Mike Sarson when I was sleeping rough on the streets, leading a very chaotic lifestyle and felt very drawn to the spiritual element of the process and taking a journey to a safe place away from familiar territory. Over the years I have tried many different conventional detox/rehab programmes in the UK, which never worked for me, as I always relapsed.

I have now been clean for over two years and leading a productive life, working in the caring profession supporting others.

In the West we tend to over medicalise and just deal with symptoms, which does not deal with the underlying reasons for becoming dependent on substances. My experience at the monastery gave me the time and space to deal with my issues and go through a healing process by reconnecting with my spirit and finding stillness within. The East deals with the problem of addiction in a very different way, which we in the West could learn a lot from by working together and supporting charities like East-West Detox who have so much to offer.

I am also aware of others who were fortunate to have gone through the East-West Detox programme and remain clean. Please support this charity's important work, which produces positive results.

Sarah Sowinska

Entitled to a choice... and facts

In response to Wendy Gregory's letter 'An alternative way' (DDN, 16 January) I would like to inform your readers that there are a number of different options available to obtain treatment at Thamkrabok other than through East-West Detox.

Although it might not be advisable in every case, it is possible for addicts to travel to Thailand independently. The Thamkrabok Monastery gives its services free.

Addicts must let the monastery know by email when they will be arriving at Thamkrabok. It should be noted that the monastery is closed to new admissions each year from 15 March until 5 May. It is recommended that addicts stay for a minimum of 10 days but the longer they can stay the better (up to a maximum of 28 days).

Full details, and lots more besides, can be found on the Thamkrabok Independent Information Network website at http://www.thamkrabok.net.

Professionals and the public alike should have the facts available to them upon which to make informed choices. The higher the claimed success rate of a particular treatment model, the more likely it is to be perceived as a catch-all miracle cure. Unfortunately, Wendy Gregory does not reveal East-West Detox's success rate but draws our attention to a figure of '70 per cent over the past 58 years'.

I think Wendy has been misinformed on two counts. Firstly, the monastery has only been in existence for 48 years and secondly the Thamkrabok Monastery has never claimed nor published such statistics. Thamkrabok does not offer miracle cures. The monastery simply provides a rapid herbal detox and the opportunity for addicts to view the world differently, from a Buddhist perspective, allowing them to reassess their life and their place in the world.

The only 'recent' official figures are from an independent report to the World Health Organisation in 1993, which sets success rates at between 20 and 30 per cent, depending upon certain criteria.

Addicts should understand that undertaking treatment at Thamkrabok is not an easy option. However, success rates and relapse prevention can usually be enhanced by ongoing support. So I'm pleased to say that there is an online support group for ex-addicts who have completed treatment at Thamkrabok (or anyone considering treatment at the Monastery in Thailand) at http://groups.google.com/group/Friends-of-Thamkrabok-Monastery.

Of course sometimes it is not possible, or indeed desirable, for individuals to travel alone and unprepared to Thailand. There are a number of private organisations, such as the Alba-Thai group in Dundee (http://www.alba-thai.org) or TARA Detox in West Berkshire (http://www.tara-detox.org), who can facilitate treatment at Thamkrabok. These organisations are independent from the monastery and provide varying levels of service to addicts usually at a cost.

Some organisations will provide basic unescorted travel arrangements to the monastery, while others will provide fully escorted detoxification trips to Thailand, including before and after services. Obviously, the Thamkrabok Monastery cannot, and will not, enter into disputes between individuals and their chosen independent service organisation.

I very much agree with Wendy Gregory when she says 'surely everyone seeking recovery is entitled to a choice'.

As the provider of an 'alternative' detox service, I too feel disappointed by the present recommendation from the NTA, but hope that funding for treatment at the Thamkrabok Monastery will be reviewed favourably in the future.

Vince Cullen, TARA Detox Organisation, www.tara-detox.org

Better standards in drug testing: part four

Effective screening

Carrying out a screening test can indicate what drugs have been taken, but a back-up procedure must follow. In the fourth of his six-part series, Phil Houldsworth tells you how to read the result and what to do next.

Once a sample is collected, the next step is of course to test what's in it. The level of testing depends on what you will be doing with the final result. The evidential value is important. If all you need is a presumptive look at what's in the sample, then all you have to do is carry out a screening test. The evidential value is low, as the screening test can't conclusively prove the presence of a drug. For instance, a screen can tell you that an individual has taken an opiate but it won't be able to tell which one. If you need to pinpoint which opiate has been taken then you will need to carry out a confirmation test to confirm the findings of the screen and identify the opiate. The evidential value of a confirmation test is therefore very high.

At one time screening tests could only be carried out in a laboratory, but now it is possible to carry them out at the point of collection of the sample as well. The following describes screening tests in general and can be applied to both laboratory based and point of collection screening.

The drug in the sample binds to an antibody, which either starts a reaction or prevents a reaction from happening. This is called an immunoassay and the vast majority of screening tests are based on this principle. This can be done either within minutes at the point of collection, or by a laboratory.

However, the problem with any screen test is that it is only an indicative test and all positives should be confirmed. You can confirm the screen test in one of two ways. You can either have a laboratory carry out a test to confirm the screen result, or you can simply ask the donor. If the sample donor agrees with the screen, then they have confirmed the screen; if they disagree, then send it to the laboratory.

You have to be careful when looking at the result. If you get a negative response from your screen test this does not mean that there is no drug in the sample; it means that there was either no drug present or not enough drug present to get above the cut off level of the test. Remember the screen test indicates the presence of a drug above a certain level, which is called the cut off level. They may have taken the drug you are looking for, but the level is now too low for the screening test to see. Negative does not mean nothing; it means we maybe cannot see it.

The other problem with any screen test is that it sometimes shows up positive for a drug when there is actually no drug there. This is called a false positive. What's happened is that a compound that is in some way similar to the drug has bound to the antibody and produced a positive result; for instance, Sustiva, an anti-retroviral drug, can cause false positive result for cannabis. This is not because Sustiva is made of cannabis, but the antibody used in the screen test sometimes gets confused. This is why sometimes, when you send a positive screen sample to the laboratory for confirmation testing, it comes back negative. The next article will describe the process of confirmation testing.

Phil Houldsworth is managing director of Tackler Analytical Ltd, which sets up and administers drug testing quality assurance programmes.

Trouble at Tier 3

Too many tier 3 services are stuck in a rut – low in quality, high in cost, and failing service users. Why are we turning a blind eye to this dismal date of affairs, asks Sebastian Saville

Tier 3 services represent the key element in the present government's reconfigured and reinvigorated strategy for the provision of treatment to the estimated 300,000 regular users of heroin and cocaine/crack in England and Wales who want it. The services' vital ingredient is substitute prescribing – including methadone, which a powerful and growing evidence base supports as indispensable. While counselling, social support facilities and preventative discourses all have undoubted value, no treatment strategy can be expected to work without substitute subscribing services.

It is with considerable alarm, therefore, that I note the precarious state of current tier 3 provision. Much of it remains low in quality and high in cost; its financial and contractual arrangements are opaque and obscure. Telephone help and advice lines run by drug user organisations report the continued existence of geographically patchy and often substandard services, which, by failing to meet the clinical benchmarks laid down in the Department of Health guidelines, leave clients unsatisfied and their real health needs unmet.

This dismal picture arises against a background of substantial and ongoing increases in the financial resources directed toward drug treatment. Some £417 million of taxpayers' money was spent in 2004/5, with the figure set to climb to £700 million by 2008. In view of these levels of expenditure, it must surely be a matter of urgent concern that so much of the tier 3 service delivery remains unsatisfactory. How then have these circumstances come about, and – the most important question – why are they allowed to persist?

The late 1990s saw expanded resources brought to bear upon the entire drug treatment sector. A sharpened policy focus and new forms of expertise accompanied them. Beneath the resultant policy spotlight, it quickly became apparent that, despite absorbing significant sums of public finance, many existing treatment services were of dubious quality, had unacceptably long waiting lists, and were lacking a fundamental transparency in their contractual and financial practices. These problems were at their most acute in the tier 3 prescribing sector.

Composed largely of specialist substitute prescribing clinics, these services were in the near-exclusive grip of NHS Mental Health Trusts. It is estimated that, in the year 2000, 60 per cent of total drug treatment expenditure was allocated to this group of providers, to whom service delivery was contracted out by local commissioners. The newly formed National Treatment Agency regarded the modernisation and improvement of these services as a core component in its brief, which was to raise treatment standards in accordance with the objectives of the government's national drug strategy.

Initially, the NTA proposed that service commissioners would work in partnership with their existing NHS providers. The primary objectives were to reduce waiting lists, to improve clinical practice by bringing it in line with a specified evidence base, to eradicate postcode prescribing, and to develop more transparent commissioning. While this process of 'modernisation' has clearly had some positive and enduring impact on the commissioning process, it soon became apparent that large numbers of Mental Health Trusts were either unable or unwilling to implement the required improvements. In spite of the best of intentions, the upshot was a continuation of the same old bleak pattern of inadequate and exorbitant service provision.

Recent years have witnessed a gradual but undoubted transformation in the attitudes of some commissioners, and an attendant desire to open up the field to genuinely competitive tender. However, while various commissioners are expressing an aspiration to radically improve their local tier 3 services, there remains in place a set of forces that keep the doors to new players seeking to enter the field firmly shut; forces that seem determined to obstruct any movement away from the effective monopolisation of the sector by Mental Health Trusts.

The stock responses to calls for a freeing up of the sector to allow the entry of new providers are customarily twofold. Firstly, it is argued that putting tier 3 services out to tender will jeopardise and disrupt broader relations between the commissioners and the Mental Health Trusts. The additional contention is that there are no alternative providers out there anyway, so the question is merely an academic one.

The former point was perhaps understandable in the early years of the strategy, when there existed an implicit faith in long-established models – a faith underpinned by NHS domination. In 2005, following six years of massively increased investment in services and commissioning systems – and limited signs of improvement – such a stance becomes indefensible. If, despite these enhanced resources, service providers continue to demonstrate a failure to meet NTA waiting-time targets; to comply with the standards of clinical governance set forth in the Department of Health guidelines, Models of Care and the NTA's best-practice protocols; or to present clear activity and expenditure data that displays an accurate 'unit-cost', then an alternative provider should be found.

Under these circumstances, it is difficult

to avoid the conclusion that there are other factors at work underpinning the continued faith of commissioners in the failed relationships of the past. It would appear that local NHS politics, and social networks in which individuals from both sides of the contractual relation mix together, are taking precedence over quality of care and value for money.

It has already been demonstrated beyond doubt that specialist prescribing based in a user-friendly environment can provide services that are both cheaper and more effective than the traditional Drug Dependency Unit model that typifies the Mental Health Trust approach. Kaleidoscope has been providing accessible, user-friendly prescribing in South London for many years, and the Junction Project, a service I managed with Dr Chris Ford in the London Borough of Brent from 1997 to 2000, are both examples of services that completely replaced and dramatically improved on existing NHS provision. Such opportunities, however, remain strictly limited, with the majority of commissioners apparently committed to struggling along with their existing providers through repeated cycles of 'improvement plans' and 'last chances'. Still the impasse persists.

Fed up with trying to get things moving through traditional pathways, I started DTL (Drug Treatment Limited). Yes, a private sector company. It seemed the only way to operate in the flexible and responsive manner needed so desperately in the field. I find laughable the almost hysterical knee jerk reaction to the thought of good drug services being delivered by the private sector – free at the point of delivery to users of course. I have worked in both the voluntary and public sectors and have witnessed the waste of vast amounts of resources.

So yes, I could be accused of being an interested party, with a stake in this debate. This might appear less so when looking at the group of respected names in the UK drugs field, all with proven track records in the public sector, who have become involved with DTL over the last year. Mike Trace, Professor Gerry Stimson, Monique Tomlinson, Dr Gordon Morse, Gill Bradbury and Martin Blakebrough are among those who have come together with a stated objective of stimulating this much talked about 'modernisation' of treatment – particularly in the area of tier 3 prescribing. All of us can testify to the existence of an urgent and unmet need in this arena, and believe we are well positioned to meet it.

But the point is that this is not rocket science. In principle, any NHS or independent sector provider can, with the necessary will, knowledge and creativity, provide tier 3 services to a much higher standard and at a lower cost, than those with which commissioners and users alike have been forced to make do in recent years. An estimate, derived from discussions with a variety of key stakeholders across England and Wales' drug treatment sector, would look as follows: of the Mental Health Trusts contracted to deliver tier 3 services, 25 per cent are good, 25 per cent are acceptable, and 50 per cent are of unambiguously poor quality. Many people appear to be fully aware of this state of affairs.

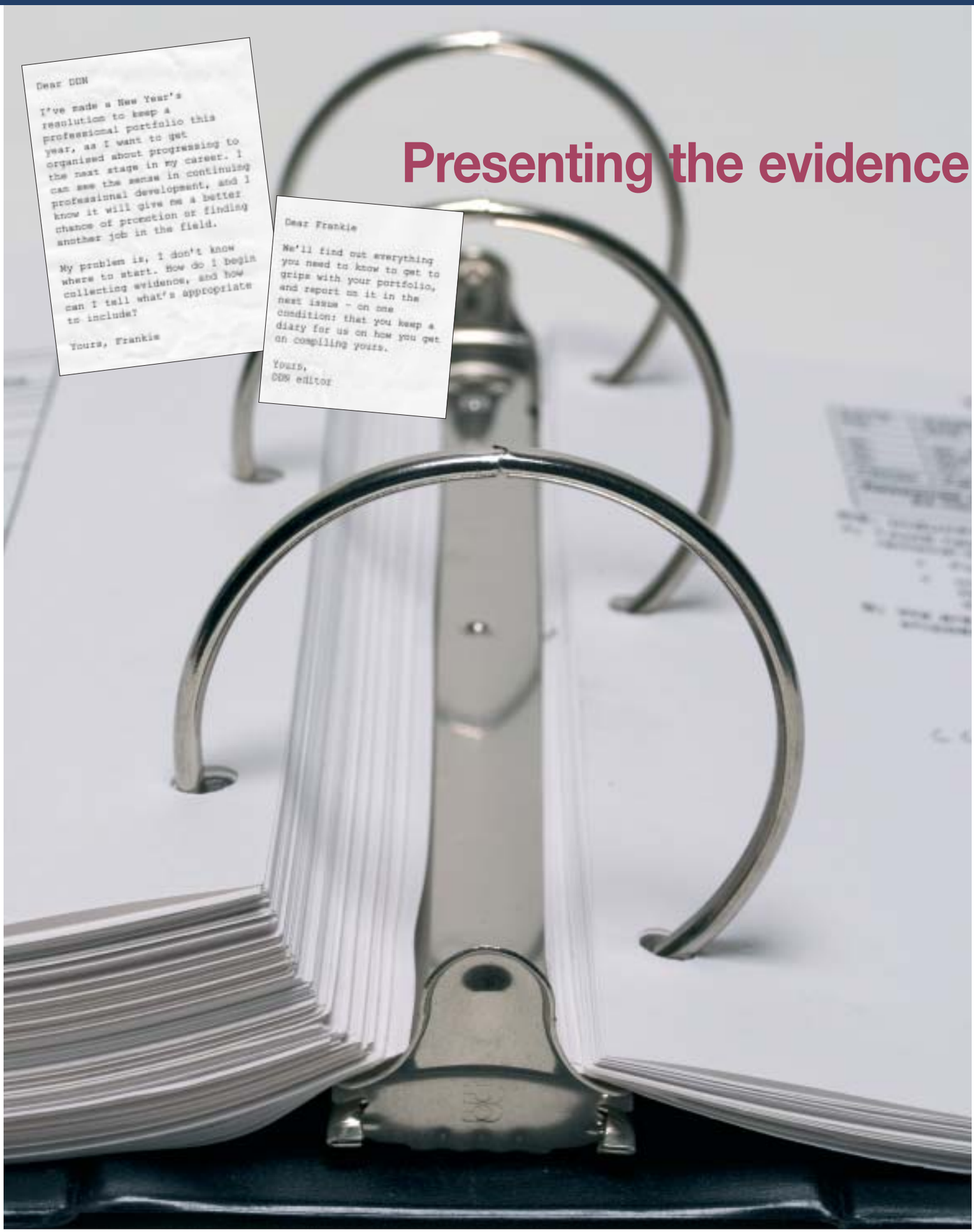
'While various commissioners are expressing an aspiration to radically improve their local tier 3 services, there remains in place a set of forces that keep the doors to new players seeking to enter the field firmly shut; forces that seem determined to obstruct any movement away from the effective monopolisation of the sector by Mental Health Trusts.'

And yet there remains a stubborn resistance among some commissioners to properly open out tier 3 services to competition. We hear on the one hand an alleged desire for innovation and modernisation, yet unless you can show that you have been delivering services (however effective) for many years, it is almost impossible to be considered. Furthermore, some of the commissioning structures have become bedevilled with procurement processes so enwrapped with red tape that they appear to have been specifically designed to stifle innovation; a catch 22 situation which impacts on the public, the service user, their family and the NTA themselves.

It represents a truly extraordinary state of affairs when a large, publicly funded organisation is unable even to supply an accurate number of clients treated and, consequently, to put a figure on its unit costs. Superimposed on this is the further problem of disaggregating the actual cost of drug treatment from the overall package of services supplied by the Mental Health Trust. These circumstances render large numbers of Trusts effectively unaccountable for the immense fiscal sums they spend, year on year.

It will be apparent to the reader that there are no winners in such a scenario – certainly not the service users, who are forced to accept inadequate services or return to the illicit market. It is high time that some senior figures within the government began to ask why the return on their investment in drug treatment has been so small.

Presenting the evidence



Keeping a portfolio sounds as if it could be a useful move for career development. So what's involved, how straightforward will it be – and is it worth it? DDN finds out.

So you've made a resolution to keep a professional portfolio. But first things first: why bother? Aren't we all resistant to extra paperwork?

According to the Chartered Institute for Personnel and Development, employability in today's market largely depends on 'self-directed development'. In other words, employers are increasingly looking for evidence that job applicants have kept themselves up to date and constantly looked for chances to improve knowledge and increase their experience. Continuing Professional Development is about 'consciously' updating professional knowledge, and is 'a state of mind, more than a set of rules of a programme of study', says the Institute.

So think of the portfolio as a career passport, to move around the field. It's not just a formal record of qualifications and a listed employment history; done properly it will show evidence of your achievements to give future employers a fuller picture of your ability. The investment will be long term: your portfolio should be a living project that grows alongside your career. As well as resulting in a record of what you have done, the exercise of planning and compiling a portfolio is also meant to be developmental. It's aimed at making you consider your future aspirations – and how to get there through planning your next move.

There is no rigid format for a portfolio – but it must be structured systematically, so it is easy for someone else to navigate and understand. Essentially you are telling your career story, using examples from your daily work, so you need to plan the evidence to best reflect your competence. The golden rule here seems to be 'quality over quantity'. Vast amounts of items, haphazardly presented will not impress. Worse than that, they will be counterproductive and detract from your nuggets of experience.

Presentation is important, so first of all, think how you will organise your evidence. Most people use a lever arch file, divided into sections. You can consider compiling an e-portfolio – a digital record of achievements, which can be easier to store and send – but most people still opt for the paper format, which is easier to pick up and look through.

Next, think about the items you will need to collect to show your competence in a range of situations. You can look for examples in your recent past, but try not to use evidence that is more than two years old as your aim is to demonstrate current competence and show you have up-to-date skills. You can draw on your experience of activities outside the workplace, such as voluntary work, if you need to supplement examples from your current job.

To compile evidence from documents produced at work, have a look at care plans, records of meetings and assessments, action plans, reports, letters and emails. Select examples of these documents, if you think they demonstrate your competence in a particular area or record relevant experiences. If you need to use documents that are confidential and cannot be removed from the workplace, provide a written statement describing your involvement and achievements, and state where the document can be found. You should also remember to remove references to any personal information when you use case studies in your personal history.

Another useful approach is to collect statements and testimonials from people who have witnessed you performance at work. You could ask managers or colleagues to sign and date work, and ask service users for feedback whenever it seems appropriate. Get into the habit of collecting evidence about different pieces to work to demonstrate your competence in different situations.

Organising your portfolio is quite straightforward, but it is worth planning the structure before you begin. Start with the title page – your name, job title, organisation, contact address, phone and email and the purpose of the portfolio (such as any qualification you are working towards). Follow it with the contents page, listing sections of your portfolio that will be separated by the file dividers.

Next comes your personal profile. Give a brief summary of your job, and include a job description or role profile. An organisation or department chart should also go here, if you have one, along with a copy of your up-to-date CV.

A 'professional development' section should then give evidence of your personal development plans. These could include documents relating to training and development you have done, or want to undertake, and can give an idea of your future intentions for career development. Include relevant qualification certificates in this section.

For the next section on drug and alcohol national occupational standards (DANOS), copy the key units that are relevant to your job. You can take these from your current job description or role profile, or from a qualification or award that you are working towards.

Then comes the section with your evidence records. For each DANOS unit, you need to provide a written statement that shows that you have met its requirements, referenced to the sheets demonstrating your evidence. A clear way of doing this is to include a grid or matrix, listing the items of evidence and showing how they cross reference to each unit's requirements.

At the end of your portfolio, compile all the evidence you have collected in one section. This works better than distributing evidence throughout different sections, as good pieces of evidence can be relevant to more than one unit. Number each item of evidence for easy reference, in the order that you have placed it in the portfolio, and make the section even clearer by including an 'evidence index' at the front of it.

So that's all there is to it! It goes without saying that the evidence must be your own work – or if you include examples from team work, make it obvious what your own contribution was. Include each piece of evidence in your portfolio for a clear reason – to prove your competence. If you're not sure what an item proves, don't include it. Volume is not the purpose of this exercise; you won't get brownie points for extra stationery.

Remember to keep your evidence clear and to the point, without duplication. You can reference a piece of evidence as many times as you like, but include just one copy of each item, clearly referenced with a simple, consecutive numbering system. Make it easy for the person reviewing your portfolio to see easily what you are trying to demonstrate. You are trying to showcase your experience, so why make the evidence difficult to find?

Above all, bear in mind that much of your portfolio is about demonstrating what you've already done and the knowledge you've gained. With a little organisation you will realise how much scope you have to make the next move in your career. **DDN**

In future issues of DDN: follow Frankie's diary as she begins her portfolio.

If you have any queries relating to professional development, email DDN Career Clinic, c/o claire@cjwellings.com (or write to the editor at the address on page 3) and we will try and find an expert answer for you.

Where to get more help

The 'management resources' section of our website gives a range of support tools from different organisations to help you with DANOS and compiling a portfolio. Links from the site will take you to the DANOS microsite from Skills for Health; DANOS implementation guides and workbooks from Pavilion; a software package from the Management Standards Consultancy (who helped to develop the DANOS standards) and MAPS; and Capacity Builder – a free software package produced by Skills for Justice.
Visit www.drinkanddrugs.net

If you are an NVQ candidate, you should work with your assessor to agree the most appropriate evidence and the best way to present it. You can keep action and assessment plans, developed with your assessor, in your portfolio.

A glass half full

With problem drinking taking its toll on the North East, Kevan Martin decided to turn his experience into action by forming the service users' forum NERAF. DDN talks to him about his mission to haul alcohol treatment up the agenda

Following intensive treatment for alcoholism, Kevan Martin was sent back home to fend for himself. That was when the safety net was cut away and he realised he was back on his own with a problem that continued to overwhelm him.

'I was going home to the same place, nothing had changed,' he explains. 'And I'd lost the skill to change things because I'd been drinking dangerously for some 20 years.'

Spurred on by the need for support, Martin got involved with the regional drug user forum. He realised that he was not the only person in his region that felt swamped by alcohol problems, and became vice chair of the forum, so he could bring alcohol issues to the table.

But his agenda was soon thwarted. 'We were told by the NTA that effectively there was no room for alcohol in that forum. I was incensed, to tell the truth; I thought if it's good enough for drugs, it's good enough for alcohol. So I set about starting a self-help group in Whitley Bay where I live.'

From these initial frustrations sprouted NERAF – the North East Regional Alcohol Forum. Realising from an early stage that he needed help to get the group up and running, Martin approached VODA, a community service agency, which gave him help with setting it up and forming a constitution. He found an invaluable ally in Peter Carlin-Page, alcohol co-ordinator for Sunderland Teaching Primary Care Trust, who 'asked what I wanted to do and has been 100 per cent behind me ever since'.

Carlin-Page shared Martin's concern for the state of alcohol services in the North East. 'We've got the fewest treatment services and the longest waiting times. Alcohol is a serious problem up here,' explains Martin. 'There were 430 people who died from liver disease last year in the region, and we're on the increase.'

There were two strands to the newly formed NERAF's strategy: getting things moving locally, and working out how to get more influence nationally to extend support to other service users around the country.

Setting up drop-in centres was an obvious point of local contact. The more difficult part of the local equation was finding people before they slipped through the net – just as Martin had. He set up links with services and the four local rehabs, intent on

'We were told by the NTA that effectively there was no room for alcohol... I was incensed, to tell the truth; I thought if it's good enough for drugs, it's good enough for alcohol. So I set about starting a self-help group in Whitley Bay where I live.'

partnership working: 'We haven't set up an opposition agency or militant group, we've set up to complement other services,' he explains. 'Where they finish, we take over. We go on to the long-term aftercare.'

Visiting the rehabs each month gave NERAF the opportunity to see people before they came out, 'with the hope they'll tap into us'. Not only did many of the service users accept ongoing support – many of them wanted to become involved with the group, 'to help others go through what we've gone through, to show them there's a way out'. Martin took the opportunity to reinforce the group's message with the help of new supporters. The message is: 'you can be turned around, and you can go on to lead a meaningful and profitable life. Just because you've had a drink problem, that doesn't mean that's life ended,' he says.

Alongside the immediate comfort of reassurance, Martin emphasises that NERAF has an important role to play in the long-term game for people with alcohol problems. His own experiences have given him a lasting memory of being treated only for addiction – 'they didn't treat anything else', explains. He now makes it his mission to help people address all areas of their life, to get back control. NERAF's long-term goal, he says, is to set up seven-day-a-week centres, 'one-stop facilities, where we look at housing, debt, therapies, arts and crafts, IT training'. They will help people re-establish contact with children, encourage them to get relationships going again and rebuild the fabric of their lives.

Local service providers are now linking into the Forum's network of contacts, referring people for ongoing counselling and care. Martin was coming into contact with people who had been five or six years into recovery but who were unable to get back into work, and he saw the opportunity to develop a peer support network. He knew he needed help with NERAF's growing workload – and that there was a demand for their skills that were borne of experience: 'Service users were saying to their counsellors, "look, I want to talk to somebody who has experienced what I'm going through now".' He set up a network of volunteers to bring the 'vitally important' peer support model to life, and is training former users in advocacy and mentoring, to become involved in a newly commissioned mentoring service in Sunderland.

He is now seeking funding to pay a salary to his four full-time volunteers. In the meantime he is encouraged: 'we have people actually coming to us with contracts now, which is very very good.'

Tapping into a national framework has been an ambitious project. Undaunted – and grateful for Carlin-Page's help in opening doors – Martin has gained support and inspiration from Alcohol Concern and a seat at meetings of the North East government office's alcohol forum. Not content with being a self-help group for Whitley Bay, Martin wants NERAF to galvanise the alcohol support network throughout the country.

'We've got the blueprint now, which anyone else can follow,' he says. And making things happen is not about waiting for the money: 'A lot of people are waiting till funding is actually available. But if you dig deep there's some funding available,' is his message. 'OK, it might not be through health services or DATs – but there is funding to get this going now.' He urges colleagues in other parts of the country to get organised with whatever resources they can find – 'so when the mainstream funding comes in, you know what to do with it.'

Political uncertainty (will there ever be more money to turn DATs into DAATs?) should not choke the potential for local initiatives, according to Martin. Visiting liver units in hospitals, going into A&E departments, finding opportunities to intervene with problematic drinkers can make a lot of difference, he says – particularly if you can then involve service users in influencing commissioning.

'Commissioners are in their own world,' he says. 'But we're breaking through now by showing the success we're having.' To get the message across, NERAF is sending questionnaires to areas throughout the North East – 'and 99 per cent of the 202 questionnaires we got back want a peer-led support service.'

Martin has respect for different methods of tackling alcoholism, but a key goal is promoting choice. While AA is 'a fantastic organisation', it didn't work for him. 'We don't care how a person achieves or maintains sobriety,' he says. 'What matters is they get there.' NERAF aims to be holistic – and encouraging, particularly when the going gets tough.

'If somebody lapses, they give themselves such a hard time – and we say don't,' Martin explains. 'A baby when it's born doesn't get up and walk straightaway, it keeps falling down. And that's what happens with alcohol. You've got to stand up, brush yourself down, and carry on. You learn from it.'

He used to give himself a hard time whenever he lapsed – 'I remember going 18 months without a drink and then went back. I felt so disappointed.' But now he knows that's the nature of the condition and wants to help others persist.

Six years on from his last drink, Martin has a fist full of plans and a determination that alcoholics should no longer languish at the bottom of the priority list. But he knows he has a fight on his hands.

He's afraid that the extra £15 million to be spent on alcohol treatment in the next year is not only a drop in the ocean, compared to the scale of the country's alcohol problem, but that government targets are all heading for the criminal justice agenda to tackle binge drinking.

'The people needing treatment very rarely break the law,' he points out. 'They're solitary people, they go to the off-licence and back home. They don't commit crime.' To issue funding on these grounds is to miss the main issue, he says, and missing the main people that want treatment.

His purpose and his passion through NERAF then is to galvanise movement throughout the country, to unite with other groups and give a strong voice to alcohol service users, whatever kind of treatment they are involved in.

Martin has already had vague promises of involvement, but is determined that NERAF is in it for the long haul. From wanting to get better alcohol treatment for one of the worst served areas in the country, he is now driven by conviction that this is the time for alcohol services to be heard: 'Service users have got to get united behind each other, it doesn't matter if they're AA or what. People with drink problems have got to be saying look, this isn't on.'

'I would like other groups in the country to get in touch with us,' he says. Let's get something going nationally. Now's the time.' **DDN**

NERAF's newly launched website is at www.neraf.org.uk. You can get in touch with the forum by emailing neraf@hotmail.co.uk.

Tobacco smoking is one of the deadliest addictions, yet seems to be largely ignored by the substance misuse field. Do any treatment providers give advice on stopping smoking while treating other addictions?
Jodie, smoking cessation co-ordinator

Hypocrisy is the greatest luxury

Dear Jodie
I am currently training at a Treatment centre in Dorset that is abstinence based. As I am doing a degree in Addictions Counselling, I was surprised that the agency has no guidance or support for the 75 per cent of service users that smoke excessively and drink copious amounts of coffee, both highly addictive and providing triggers to other addictive substances.

I have currently given up smoking as I felt hypocritical smoking tobacco whilst helping support clients through their addiction. I think treatment centres should find a process of change that helps smokers cut down or give up while in treatment. This would in turn help recovery as client would have to find an alternative to smoking and change behaviour to reduce cravings.
Angela Earley

Life Works when you give up

Dear Jodie

I was very interested to read your question on tobacco smoking and whether any treatment providers offer options on stopping smoking while treating other addictions.

Life Works is a private treatment centre with both day care and residential facilities in Surrey and London W1. We have joined forces with The Third Space gym to develop a Holistic Smoking Cessation Programme. This will be the first UK programme that will offer real clinical support and treatment to its participants within a treatment setting. It will be a combination of proven methodology alongside cutting edge therapeutic support, incorporating a relapse prevention element.

The programme will include a medical assessment, 1.5 days counselling group, 0.5 days group work, 6 week gym membership at The Third Space Soho, Acupuncture, and Hypnotherapy.

We would be delighted to provide full details of this forthcoming programme: 0800 081 0700, www.lifeworkscommunity.com
Beth Bacchus, sales & marketing director, Life Works

Tackling dual dependence

Dear Jodie
I am a qualified and experienced smoking cessation advisor now working in the substance misuse field at APAS (Alcohol Problems Advisory Service) in Nottingham. I give advice and support on smoking cessation alongside alcohol treatment on a daily basis. I believe this should be routine throughout substance misuse services and am, myself, surprised that this is not already the case.

It is estimated that around 90 per cent of people with alcohol problems smoke and 70 per cent are heavy smokers. Alcohol problems are 10 times more prevalent among smokers than among non-smokers.

We know that dual dependence of alcohol and nicotine can bear up to a shocking 15-fold risk of certain cancers such as brain, mouth, throat, oesophageal, stomach, pancreatic, liver, bowel, bladder, breast and cervical cancers.

Historically, it has been recommended that clients should not attempt to quit smoking at the same time as undergoing treatment for alcohol problems. However, latest research shows that treatment of tobacco dependence amongst dependent drinkers who smoke does not seem to cause excessive relapse to drinking, and, in fact, stopping smoking may enhance abstinence from drinking.

Smokers with alcohol problems, as a rule, are more dependent on nicotine than those without, and may need more intensive pharmacological and behavioural therapy.
Debi Wood
Alcoline co-ordinator/advice worker

Patient awareness key

Hi Jodie
I have recently set up a smoking cessation service within a Mental Health Trust which includes a Substance Misuse Directorate.

It is very hard for people to stop smoking whilst receiving treatment for other addictions, but it is not impossible! Smoking cessation can be provided without necessarily risking a relapse with other substances. Patient awareness of the benefits of treating both addictions can increase abstinence rates.

In my experience many patients want to quit smoking and often feel that they are more motivated to quit whilst receiving treatment for other addictions. Others want advice on stopping smoking and will than plan to give up smoking as their next goal.

Where I work, recording a patient's smoking status and encouraging smoking cessation is now routine with all patients on admission. Patients are referred to me if they choose to quit smoking and I provide one-to-one and group support, which is maintained until they have quit for a year. The service I provide is flexible and I try to meet the needs and choices of the individual.

Smoking rates are much higher among people receiving treatment for addictions than among the general population, but as you suggested, tobacco smoking is largely ignored by the substance misuse field. This is concurrent with mental health, and has to change. Not providing advice on stopping smoking for people receiving treatment for other addictions is discriminatory and will continue the risk of smoking-related illnesses in this field. All health care professionals should discuss smoking and advise smokers to stop in all areas of health care.
Helen, Help 2 Quit liaison nurse – mental health, Shropshire

Smoking relapse connection

Dear Jodie
At Clouds we certainly do take smoking seriously. Nicotine is a powerful drug and the negative consequences of smoking are established. So how do we reconcile having Clouds House as a treatment centre that promotes 'abstinent recovery' with the issue of continued smoking?

Our view of abstinence is focused on the addictive or dependent nature of the relationship that people form with both substances and behaviours. In this context it is clear that nicotine as a drug and smoking as a behaviour need to be addressed. We are particularly interested in any connection that might exist between continued smoking and vulnerability to relapse into other drug use and would welcome any feedback regarding existing evidence, or interest in researching this issue further.

It is of course ultimately up to the client to decide if they need to abstain. We want their decision to be an informed one and we will do everything we can to support them in gathering the information they need. However, we are pragmatic and realise that the process of this decision-making may not be the top priority for those in an intensive and relatively short treatment episode. I guess that you could say that smoking doesn't present the immediate or short term risks that continued drug and alcohol use might present to our clients, although the long-term effects could be life threatening.

Clouds House is a non-smoking environment but provision is made for clients to smoke outside of the house if they wish. If our clients want to abstain from smoking we will assist them with nicotine withdrawal (with nicotine patches) and they will be able to utilise the 12 Step programme to maintain abstinence. If not they will have at least begun a process of evaluating what they need to do and thinking about when they might be ready to do it.
Kirby Gregory, head of client services, Clouds.

Addiction in all its guises

Dear Jodie
Far from being ignored, smoking is an issue very much on our agenda at Broadway Lodge. Whilst the main focus of our work is with alcoholism, drug addiction and eating disorders, we also consider it important to raise awareness of addiction manifesting in all its guises.

In the primary care setting at Broadway Lodge, smoking opportunities are restricted – both in time by treatment activities and in space by having only one room in the building where it is permitted. More proactively, all patients are provided with information and education about healthier lifestyles including smoking habits within a lecture programme routinely delivered by staff. We hope that as patients grow in awareness along with improving levels of self-worth and self-efficacy, a healthier and more productive future is considered both desirable and possible.

In early treatment, with all the adjustments required by this, any patient wishing to stop smoking will be advised to settle in first before embarking on a non-smoking regime. However patients sufficiently motivated to do so will be supported in giving up smoking at whatever stage in their treatment. Support comes particularly from staff trained by the local PCT to become Support to Stop Advisors. These staff members provide specialist help for patients, including where appropriate, the use of nicotine replacement patches, stress management and relaxation sessions.

In the secondary care setting, patients are much more actively encouraged to address their smoking habit. As part of their weekly workshop programme patients will be given specific information and help with addressing their smoking. It is at this stage that patients are also encouraged to be more conscious of financial matters and the need for budgeting and this often proves to be the additional incentive required for them to cut down or even to stop smoking.

Finally, the needs of non-smokers have to be taken into account as well. As an organisation we are continually exploring the ways in which we respond to the varying needs of the whole community. In this case, we are currently considering how we might move smoking from the main body of our buildings and into designated, well-ventilated smoking areas and in so doing minimise the impact of passive smoking for everyone.
Peter Smith, head of counselling, Broadway Lodge

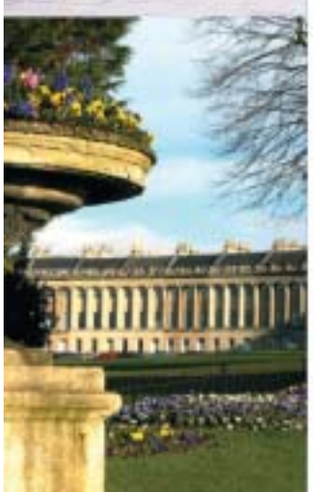
Reader's question

A question keeps coming up in our rehab about the drug naltraxone, which is prescribed to a lot of clients through the criminal justice system. Should rehabs accept people who are on naltraxone? While it is not a mood altering chemical, do we know enough about the dangers – and if someone overdosed in rehab, would it be our responsibility?
Anna, Derbyshire

Email your suggested answers to the editor by Tuesday 7 February for inclusion in the 13 February issue of DDN.

New questions are welcome from readers.

unhooked thinking



The Unhooked Programme

An unusual, international and multi-disciplinary conference enquiring into the nature of addiction

Professors
Bruce Alexander from Vancouver,
David T. Courtwright from Florida,
John B Davies from Strathclyde,
Stanton Peele from New Jersey and
Richard Velleman from Bath
will be joining film-makers, doctors, service users, writers, policy makers, psychologists and others to ask the unaskable:

- just what is addiction?
- Why do the billions governments throw at the problem just seem to make it worse?
- How can we make a difference?

Unhooked Thinking starts with a civic reception and dinner in Bath's historic Pump Rooms on **April 18th 2006**, then moves to the equally historic Assembly Rooms for 3 days of discussion, illumination and examination of the roots and culture of addiction. For all you need to know and bookings:

www.unhookedthinking.com

April 19th-21st, 2006,

Bath, Somerset, UK

supported by DDN Drink and Drugs News

www.unhookedthinking.com

Institute of Psychiatry

at The Maudsley

KING'S College LONDON

MSc in Clinical and Public Health Aspects of Addiction

- The course can be taken on an intensive full-time 12-month basis or part-time over two or three years
- For graduates of medicine, psychology or other related subjects, or geared to the needs of British NHS or independent care staff
- An emphasis on both clinical and public health aspects of addiction
- Wide coverage across drugs, alcohol and tobacco
- Strong research and policy component
- Interdisciplinary teaching from leading UK experts
- Clinical placements at leading specialist drug and alcohol services.

For further information and enrolment details please contact Dr Kim Wolff (Programme Leader) or Louisa Strain (Programme Administrator) Addiction Sciences Building, 4 Windsor Walk, Institute of Psychiatry (PI048), London SE5 8AF. Tel: +44 (0)20 7848 0823, fax: +44 (0)20 7708 5658, email: k.wolff@iop.kcl.ac.uk or louisa.strain@iop.kcl.ac.uk

http://www.iop.kcl.ac.uk

Closing date: 30 June 2006.

Equality of opportunity is College policy

WDAT

warwickshire drug action team

Expressions of interest for the provision of

Tier Two Drugs Services

across the county of Warwickshire

Warwickshire DAT is inviting expressions of interest for the provision of Tier Two services to the drug using populations of Warwickshire. Expressions are to be from suitably experienced organisations with a sound track record of delivering Tier Two services in other DAT areas. Our specific requirements are detailed in our Tender Pack. The contract, to be managed by Warwickshire Drug Action Team, will be for approximately £0.5 million.

All modalities must be provided within relevant local and national frameworks e.g. Models of Care. Further, providers will work in partnership with other agencies as part of an integrated system of care across Warwickshire.

Written expressions of interest should be made to Kate Harker, Joint Commissioning Manager, Warwickshire Drug Action Team, Pageant House, 2 Jury Street, Warwick, CV34 4EW, Warwickshire.

If further clarification is required you may ring Kate Harker on 01926746810 or e-mail her at kateharker@warwickshire.gov.uk

The closing date for expressions of interest is 5pm on Monday 13th February 2006 and Tender Packs will be sent out on Friday 17th February 2006.

TACKLING DRUGS CHANGING LIVES

LONDON SOUTH BANK UNIVERSITY

promis

IN ASSOCIATION WITH PROMIS, THE LEADING ADDICTION TREATMENT & RESEARCH CENTRE

MSc/PgDip/PgCert ADDICTION PSYCHOLOGY & COUNSELLING

PART-TIME PROGRAMME – SEPTEMBER 2006 ENTRY

Enhance you career prospects in Addiction Counselling. This programme, run in collaboration with leading addiction treatment and research centre, PROMIS, prepares students for work in a wide range of organisational and therapeutic environments.

Apply now to secure your place.

- Equal emphasis on addiction psychology and research, and professional counselling practice
- Units include; models of working, professional development & ethics, strategies & techniques, treatment contexts, personal development & robustness, psychological concept of addiction, development of addictive behaviours, theories of addiction, research methods
- Part-time, 1 day per week – MSc 2.5 years, PgDip 2 years, PgCert 1 year
- Successful completion of the Diploma fulfils the formal training requirement for FDAP Counsellor certification leading to UKRC registration
- Fees support for accepted students may be available via Alcohol Education Research Council

Applications from mature students without formal entry requirements but with relevant work experience are welcome.

For enquiries, information and application form, please contact the Course Enquiries Office, London South Bank University on 020 7815 7815 or enquiry@lsbu.ac.uk

Become what you want to be **www.lsbu.ac.uk**

addaction

Helping individuals and communities to manage the effects of drug and alcohol misuse.

So. Why do you want to work for Addaction?

Director of Operations (North)

Up to £54k plus benefits • location negotiable

It's the classic interview question, isn't it? And when we ask you, you'll tell us you want to work with a leading national drug and alcohol charity with a £25 million turnover and over 650 staff. You'll tell us you're excited by the challenge of providing strategic leadership as part of the Executive team, by strengthening our existing services in the north of England and by building on our success to deliver further growth.

But what will you ask us?

If you're the person we're looking for, the answer is 'plenty'. You'll want to know how diverse the challenges are going to be, how much responsibility you'll take on, and how big an impact you can make.

Charismatic, with proven leadership ability, you will have extensive management experience within the substance misuse or related field, and will be confident in your ability to build and maintain the business. Above all, you will have the vision and credibility to build relationships with our commissioners and your staff to make Addaction a model of success.

For further information and application details, please visit www.addaction.org.uk or email c.davies@addaction.org.uk

Closing date: 14 February 2006.

www.addaction.org.uk

CDC - CHANGING LIVES

Be part of a dynamic and inspiring team that is committed to improving the lives of people affected by alcohol and drug dependency.

THURSTON HOUSE, based in **LONDON** is a 22-bed residential second stage treatment centre for men.

SHARP day programme, based in **LIVERPOOL** is a new project and one that is having an important impact on drug and alcohol addiction treatment in the city of Liverpool.

SENIOR COUNSELLOR (full-time)

£26,650 + benefits p.a.

Based at Thurston House, London SW4.

We are looking for an experienced full-time Senior Counsellor to be involved in all project activities. Duties will include managerial responsibilities and group and individual counselling.

ADMISSIONS WORKER/COUNSELLOR (full-time)

£21,423 + benefits p.a.

Based in Liverpool, L1.

This role closely supports clients on our waiting list, keeping them positive, stable and committed to treatment. Duties include screening potential clients, preparing detailed files, liasing with other professional agencies and assisting the Admissions Worker/Receptionist in providing a professional, helpful and welcoming service.

Applicants for either of these positions must have relevant training in counselling to diploma level and at least two years' experience in the substance misuse field.

For an application pack, call **020 7349 5763**
email: joyletteh@thecdc.org.uk or go to our website at www.thecdc.org.uk/vacancy

Closing date: FRIDAY 17th FEBRUARY 2006
Interviews: w/c 27th FEBRUARY 2006

THE CHEMICAL DEPENDENCY CENTRE

action on drugs+alcohol

Shetland Community Drugs Team

invites applications from appropriately qualified and experienced individuals (or couples wishing to job share) for the post of

FULL-TIME RELIEF SUPPORT WORKER

37 hours/week fixed term appointment from 1 April 2006 – 31 March 2007
This is a residential post. In addition to food and board, a remuneration package worth in the region of £12k is offered

We are looking for a self-motivated and enthusiastic person able and willing to live as part of a small Christian-based therapeutic crofting community providing residential care for recovering alcohol/drug users in a remote and rural location in the Shetland Islands

For further information and to obtain an application pack (closing date 13 March) please contact: Pam Williamson, Shetland Community Drugs Team, 34 Market Street, Lerwick, Shetland, ZE1 0JP
01595 696698
pam.scdt@zetnet.co.uk

Please mention
Drink and Drugs News
when responding to advertisements

Addiction Counselling Trust

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

Counselling Supervisor (Ref: 5275)

£28,630 to £30,993 per annum pro-rata 28 hours per month

This is an opportunity to provide clinical supervision to ACT's salaried Tier 2 and Tier 3 Substance Misuse Workers. The successful candidate will have experience in integrative supervision and a good knowledge of substance misuse issues.

Counselling Supervisor (Ref: 5276)

£28,630 to £30,993 per annum pro-rata 12 hours per week

This is an opportunity to provide clinical supervision, training and co-ordination of ACT's volunteer counsellors. The ideal candidate will have experience of supervision within a substance misuse setting.

Closing date for the above posts will be 10th February 2006
For an application pack please contact Nicola on 01296 425329.
For further details on the posts contact James Sainsbury.

ihra

INTERNATIONAL HARM REDUCTION ASSOCIATION

COMMUNICATIONS AND PROJECT DEVELOPMENT OFFICER

IHRA is the leading international NGO promoting a harm reduction approach to alcohol and drugs. The post-holder will work with Prof Gerry Stimson to expand our global networks, develop information resources, support campaigns and develop new projects. Alcohol harm reduction will be a significant part of the work.

Based in London. Nine month post, salary to £25,000 pa.
Closing date: 27th February 2006

Details online at www.ihra.net, from ihra@adf.org.au or t: +61 3 9278 8104

Promoting Harm Reduction on a Global Basis