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DDN
Drink and Drugs News

24 April 2006
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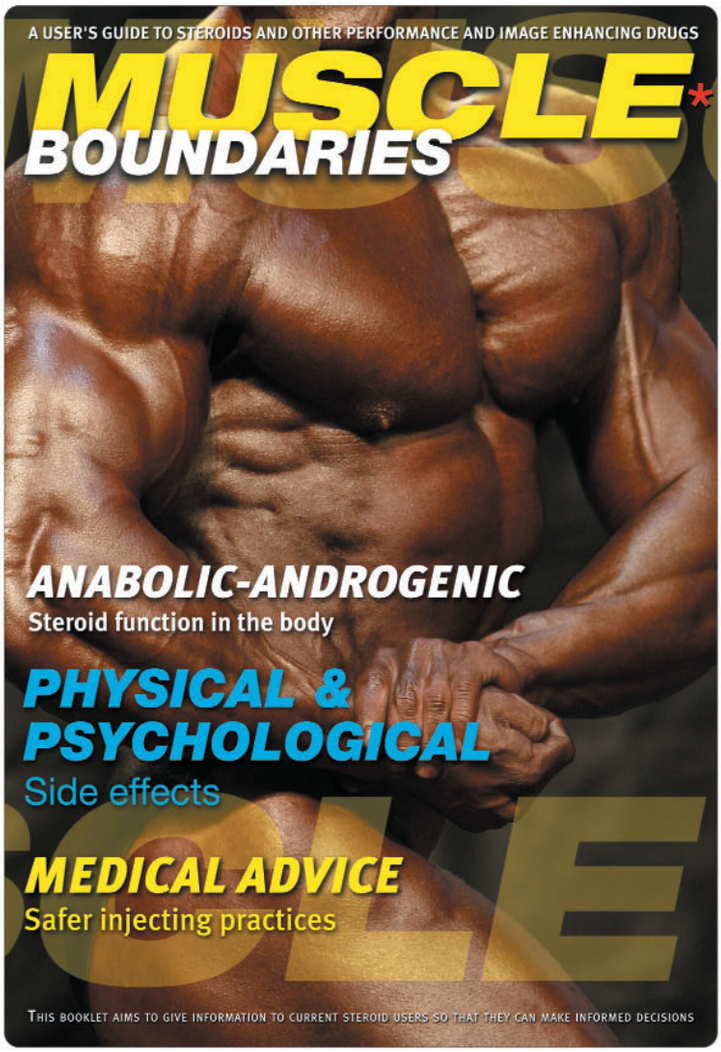

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24 April 2006

Editor's letter

Imagine being categorised as a chocolate eater or a jeans wearer in relation to everything you do – just because that's one thing you do regularly. More peculiar still, suppose your jeans wearing put you at the bottom of the queue for housing or healthcare.

Daft as this example is, it demonstrates in a simplistic way what it can be like to be categorised for one aspect of your behaviour. Just after receiving two letters about the dangers of making assumptions about 'typical' heroin users, I visited the Unhooked Thinking conference in Bath.

The counsellor leading a session I attended described how she discussed the issue of identity with a heroin user. He used heroin, but of course that was not all he did. He was a heroin user – sometimes. As a group we were led to consider how, if any one of us told our story in 20 minutes, it would be a snapshot of us and our behaviour. It wouldn't say everything about us – and would be a different 20 minute slice the next time around, adding some things, omitting others.

It was an interesting discussion, particularly after spending a day at Cocaine Anonymous's conference (page 12), where coming face to face with the phrase 'I am an addict', and repeating it long after you have severed your relationship with substances is part of a process of unflinching self-appraisal. Being welcomed to an occasion like this, which included meetings and 'shares' from members, was an illuminating insight to the world of 12-step recovery – which seems to work very effectively for some people.

I am constantly reminded to keep an open mind by the views on our letters pages, by people with diverse experiences and a very clear idea of what works for them. One thing that's clear to me is that identity is so sacredly individual that it's a mistake to make assumptions about anyone else's.

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
Website maintained by wiredupwales.com

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In this issue

News in brief

Belmarsh on the run

Staff from the substance misuse team at Belmarsh Prison are gearing up to run round the perimeter wall to raise funds for a children's hospice. Demelza House, which provides services for life-limited children and their families across Kent, Sussex and South London, will benefit from the 24-hour run by six members of staff, who will have to run a lap every hour. To sponsor this fine effort send cheques, made payable to Demelza Spartans, to: Beccy Hayden, Detox Department, House Block 3, Belmarsh Prison, Western Way, Thamesmead SE28 0E3 or donate via the website at www.justgiving.com/Thespartans

Top therapy for alcoholism

This year's Occupational Therapist of the Year, Michael Sharkey, was nominated for his award by a patient who was treated for alcoholism at Withington Hospital in Manchester. Angela Bennett, who had felt suicidal from family pressures, said he had helped her by teaching her about the effects of drink, anxiety management techniques and communication skills, without using 'patronising language or magical thinking'. He will receive his award at the College of Occupational Therapists' annual conference in June.

Probation changes ahead

The government has published responses to its consultation on restructuring the Probation Service. According to the document, next steps will be restructuring the service as soon as parliamentary time allows; introducing an enhanced performance regime as a matter of urgency; and carrying out a rigorous performance assessment to identify and rectify failings. Baroness Scotland QC, Minister of State for Criminal Justice and Offender Management said that 'far-reaching action must be taken'.

Tracking the traffickers

A new law enforcement agency has been launched to fight serious and organised crime. The Serious Organised Crime Agency (SOCA) will use intelligence to tackle drug trafficking within its brief, and will aim to disrupt criminal markets. SOCA officers will strike deals with informants and use enhanced powers of confiscation for proceed for crime. Home Secretary Charles Clarke said: 'I am sending the organised criminal underworld a clear message: be afraid.'

Potent cocktail

Many methadone patients use cannabis on a regular basis, according to an Irish survey of polydrug use. The study of 851 methadone treated patients by the Health Service Executive North Dublin found that 83 per cent used cannabis. There was also a high incidence of cocaine use, with many patients using both drugs alongside their methadone script. Researchers warned that despite its perception as a 'safe drug', cannabis has 'both acute and chronic health effects and does produce dependence'.

Link between alcohol and mental health being ignored, says Foundation

Many adults in the UK are using alcohol to cope with the stresses of modern life – which is increasing their vulnerability to mental health problems, according to the Mental Health Foundation.

In a research report launched to coincide with Mental Health Action week, from 16 to 22 April, the charity highlights that alcohol consumption has doubled over the last 50 years, mirroring the increase in people experiencing mental ill health.

While the government had acknowledged physical health concerns relating to alcohol consumption, there had been little policy debate about the links between mental health and alcohol – in particular, the reasons why people turn to drink.

'The research confirms our worries that people are drinking to cope with emotions and situations they can't otherwise manage, to deal with feelings of anxiety and depression,' said Dr Andrew McCulloch, chief executive of the Mental Health Foundation.

The report highlights significant connections between heavy alcohol use and depressive symptoms, but 88 per cent of those polled said they would find it difficult to give up alcohol completely. The Foundation is calling for the public to be better informed about the hazardous effects that alcohol can have on mental as well as physical health, and has made policy recommendations to government, which include incorporating mental health messages in all alcohol-related public health, training and teaching materials and clearer pathways from alcohol treatment to mental health services.

'The need for mental health to be demystified is urgent,' says Dr McCullogh. 'Mental health is a crucial factor that is omitted from virtually every national debate.'

The *Cheers* report can be downloaded from the Mental Health Foundation's website at www.mentalhealth.org.uk

Glasgow alcohol deaths 'set to double in next 20 years' reveals report data

A report on Glasgow and West Central Scotland's health, published as 'the most comprehensive description of health and its determinants ever created' for the area, demonstrates the link between disadvantage and health – but also challenges some stereotypes.

There was good news in some areas, but not relating to alcohol. The *Let Glasgow Flourish* report projects that alcohol related deaths could double in the next 20 years, based on recent trends. There was better news on smoking: rates in Glasgow had 'fallen considerably' during the last 30 years.

Data collected by the Glasgow Centre for Population Health covered life expectancy, economic factors, social and physical environment and behaviour, among other factors. Health inequalities were apparent in many contexts – but alcohol related harm was found to be among problems that were not so clearly linked to poverty, but linked to the population as a whole.

Prof Phil Hanlon of the University of Glasgow, who led the multi-agency report team, said the report indicated that there were no simple solutions to Glasgow's problems, and 'no single initiative that would turn around such a complex set of problems with such deep roots in history', but that a large number of determinants of health had to be changed.

Sir John Arbuthnott, chairman of NHS Greater Glasgow and Clyde, said trends of alcohol consumption and obesity were 'frightening', and looked to the recent more integrated approach through Community Health and Care Partnerships to provide 'tools and common purpose' to bring about health improvements.

Let Glasgow Flourish is available at www.gcph.co.uk/strength1.htm

Treatment room dedicated to memory of Cass

Cyswllt Ceredigion Contact, a day treatment service for people with drug or alcohol problems and others affected by their using, has dedicated its new treatment room to Frank Cassidy, senior addiction counsellor, who died last November.

Cass, as he was known to colleagues and clients, had played a key role in the agency's treatment programmes, offering education, day treatment and aftercare support to chronic substance misusers, as well as help and advice to family members. He regularly visited the wards at the local NHS hospital to assess potential clients and acted as a mentor for trainee counsellors.

Highly knowledgeable in the fields of substance misuse and criminal justice, Cass was known as supportive, compassionate and enthusiastic. Contact's director, Maureen Fyffe, said 'his colleagues learnt from him and his clients respected him. He is sorely missed'.

RAPt calls for closer analysis of treatment outcomes in future

'We've had a good year thanks to RAPt frontline staff. We've been subject to some pretty rigorous target setting, which shows real progress' chief executive Mike Trace told the Rehabilitation of Addicted Prisoners Trust spring reception at the House of Lords.

With a wide portfolio of services, RAPt's challenges ahead were about maintaining and refining delivery, he said, demonstrating staff competence through DANOS and being more creative in the way RAPt delivered services – particularly in developing services outside prisons.

'We have some good practice and models, but we're not doing enough outside release,' said Mr Trace. Understanding outcomes better was now a key priority he said. From expanding treatment models since the 1990s, to the point where we spend £700 million a year on addiction treatment, the field now needed to move from just counting outputs to understanding the outcomes of treatment.

'We know lots about the quality of services, but less about how services affect life improvement,' he commented. Rapt's 'obsession' would be to ensure programmes were analysed and outcomes assessed.

Annette Dale-Perera, director of quality at the National Treatment Agency, added that the NTA wanted to improve engagement, retention and care planning, 'and bring the poorest drug treatment up to the quality of the best'.

Mike Trace: 'We know lots about the quality of services, but less about how services affect life improvement.'

Unhooked thinking gives food for thought

Does stigma contribute to revolving door syndrome? Is there an interest by the drug treatment industry in keeping people addicted? Do we romanticise addiction as a heroic part of being human?

These and many more questions were taken on by the Unhooked Thinking conference in Bath, which used a chat-show format and informal conversational sessions to encourage an interactive conference.

'We're all dependent on some things, but most of us aren't addicted to something devastating,' said Birmingham University's Prof Jim Orford, in response to being 'interviewed' by Prof Stanton Peele of New York University.

'It's bad because it's about getting committed to something – and not something that society values,' said Prof Orford. 'Why have we been conspicuously ineffective in treating addiction?' he asked. His own answer was that we underestimate how susceptible human beings are.

William Pryor described how 'addicts practice being an outsider' and described addiction therapy as 'teaching us to be human'.

'There are 30,000 people working with addiction in this country. Is this a symptom of being human in the twenty-first century that we need these people to teach us how to live?' he asked.

These and many more questions were debated enthusiastically by delegates from diverse backgrounds.

Look out for the logo!
The DDN book logo means that the book mentioned is available from the DDN bookshop at a reduced rate for our readers. Visit www.drinkanddrugs.net/drinkanddrugsnews.html to search a diverse library of books on drugs and alcohol – all available at less that the publishers' recommended retail price.

Media Watch

A woman has been unconscious for over a week after taking heroin contaminated with the flesh-eating bug, streptococcus, a bacteria that consumes sufferers from inside. The microbe has already killed two people one of whom was known to have taken heroin with the woman. Detective Sergeant John Crichton said: 'The young lady is still on the edge but we are more hopeful that she will pull through.'
The Preston And Leyland Citizen, 20 April

Two cemeteries in Edinburgh have been fitted with boxes for the safe disposal of needles in an effort to reduce the amount discarded in the grounds. Drug users often use the churchyards because they are open 24 hours a day and have crypts where they can shelter. The pilot was initiated by Action on Alcohol and Drugs in Edinburgh who insist it is part of a wider campaign dealing with drug use in the Scottish capital. Tom Wood, chairman of Action on Alcohol and Drugs, said: 'We put bins there for public safety alone. The bins are an experiment to see how they work. I don't want Edinburgh to be full of needle disposal bins – I want Edinburgh to not have needles disposed of in the first place.'
The Scotsman, 19 April

Newcomers to the Sheffield drugs scene are turning their backs on heroin because of negative publicity, police say. Detective Constable Steve Duce, who monitors drug trends for South Yorkshire Police and co-ordinates strategies for dealing with them, said: 'Heroin will never die out completely. Some hard-core drug users will continue to use it, but for people just starting out with drugs there is some evidence that they are turning their backs on it and appear to prefer stimulants such as cocaine, ecstasy and amphetamines instead because they see them as the safer option'.
The Sheffield Telegraph, 18 April

Health alerts like those currently on cigarettes will be placed on bottles, cans and beer mats next year the government hopes. The warnings have been labelled 'nanny state meddling' by some. Tory MP Laurence Robertson, a member of the All Party Commons Beer Group, said: 'People are getting pretty sick of this government trying to ban everything. All most drinkers want to do is go and have a pint in peace and quiet and not have their senses assaulted by huge warnings. They'll be banning laughter soon.' The warnings could be in place next year and are likely to contain information on alcohol units, and slogans such as 'don't do drunk'.
The Sun, 20 April

A Church group in Renfrewshire has launched a course to help parents give guidance on drugs to their children. The project titled 'How to Drug Proof Your Kids' offers advice on how parents can help their children make informed choices about drug use. The course is sponsored by The Church of Nazarene and supported by Strathclyde Police, it is hoped that, through the course, parents can learn how to communicate effectively with their children about drugs.
The Paisley Daily Express, 20 April

Tough questions for tough choices

Drug testing on arrest, with required assessments for those testing positive, has just been extended to new areas by the Home Office – which has presented the roll-out as a logical extension of a pilot scheme which doubled the number of offenders in treatment. But beneath the figures there are serious concerns, which threaten to undermine the programme's integrity and viability, says Kevin Flemen.

The Home Office rolled out drug testing on arrest in April under the name 'Tough Choices'. Powers and requirements, introduced as part of the Drugs Act 2005, had been trialled in pilot areas and have now been rolled out to 'Wave 2' areas.

But beneath the fanfare and the Home Office press releases, some serious concerns have emerged concerning the viability of the programme, and how effective the much-vaunted initiative can really be.

Under the Drugs Act 2005, people who have been arrested for a 'trigger offence' are required to submit to a drugs test and, if this is positive, the person can be required to attend a Required Assessment (RA). Attendance at the RA is mandatory, and failure to attend is an offence.

In the original Regulatory Impact Assessment for the Drugs Bill, the Home Office envisaged that 'refusal and breaches will be kept to a maximum of no more than 5 per cent'.

But in practice, the level of attendance for Required Assessments in the first wave areas did not always meet this high level. In Yorkshire, the drop out rate for people with Required Assessments was as high as 50 per cent where RAs took place out of custody. In Nottinghamshire, 39 per cent of people with RAs out of custody failed to attend.

The clear lesson from these outcomes is that the dropout rate for people given appointments for RAs out of custody is unworkably high. Unless RAs take place on site, the odds are almost half of people will fail to attend, and in doing so commit an offence.

This is a lesson for the Home Office, with the message coming out from the 'Lessons Learnt' presentations (online at www.drugs.gov.uk) being that the 'ideal situation is that the assessment takes place whilst person in custody'.

Where assessments have taken place in

custody, assessment levels of almost 100 per cent have been achieved. But such an approach presents some logistical challenges not envisaged within the original bill or the Regulatory Impact Assessment.

In order for an assessment to take place while the person is in custody, it needs to happen within the detention period authorised by PACE; a person cannot be detained solely for the purpose of a Required Assessment. Drugs workers therefore need to be located within police stations, and they need to be available on a flexible basis. In Sheffield for example, coverage was provided by teams of workers covering shifts from 7am to 2am, seven days a week, across four custody suites. Cover was provided by 16 new staff.

However this highly intensive worker coverage was dedicated to seeing a throughput on average of 45 clients who had tested positive per week – or the equivalent of two workers on shift assessing one client every six hours.

These findings from the pilot areas also throw up some serious questions for smaller police stations, and those without such large custody suites. It is likely that, in such areas, Required Assessments outside of custody will prove the only viable option, with the accompanying low attendance rates. This means that in smaller towns and rural areas, the Tough Choices programme will result in a higher rate of criminalisation for failure to attend than in large urban areas.

The fact that a Required Assessment is likely to take place in custody settings is discouraging enough. But there are some extra perils to trip up the unfortunate service users, which stem from guidance issued by the Home Office, or interpretation from Home Office-commissioned training.

The Home Office FAQs on Tough Choices say that 'if an individual is deemed unfit to attend a Required Assessment (without good cause) then they have failed to attend and remain and this failure should be acted upon'.

This is widened elsewhere in the FAQs to the still-vaguer 'displaying behaviour which places individuals at risk of harm or distress', which could include offensive language.

But, while the police are obliged to instruct the person orally and in writing of their obligation to attend and remain at an assessment, and the potential legal ramifications of failing to do so, there is no obligation to warn the person that presenting in an 'unfit' state would similarly render them liable for prosecution.

This interpretation falls outside the strict requirements of the Drugs Act that simply requires that the person attends and remains at the assessment, and such an interpretation would need to be tested in court.

Of similar concern is confusion relating to the rights to confidentiality, to which the person being assessed is entitled. Eliesha Training, contracted by the Home Office to deliver training on the Tough Choices programme, suggests that confidentiality should be waived whenever the client makes reference to a specific offence for which they have not been charged. They say 'at the start of the assessment, the drugs worker would make it clear that if [the client] revealed that she had committed a specific crime for which she had not been charged, this would be reported to the police'.

This creates a substantial risk that the client will incriminate themselves during the assessment, or at the least reduce the chance that the person will engage in an open and honest dialogue with their assessor.

The interpretation placed on confidentiality in the training is at odds with the interpretation in the Home Office's Tough Choices FAQs, which in turn exceeds the requirements of the Drugs Act 2005.

The FAQs restrict themselves to saying:

- 'There is no absolute standard, as employers set their own, other than the legal requirement around Child Protection issues and serious harm to clients or others. Normal practice is that:
- General references to offending behaviour are not usually disclosed.
- Details of specific offences committed or about to be committed are usually disclosed to police.
- Whatever the position, it is made clear to the client at the beginning of each meeting what the boundaries of confidentiality are.'

In preparing this article, Eliesha Training were asked about the issue of confidentiality; they referred the question to the Home Office. The Home Office worker named in the FAQs referred the question to the DIP Project Manager. And this person has, to date, declined to answer this question.

Given the risks of self-incrimination, it would perhaps be reasonable for a person being assessed to have a solicitor present during the assessment. However, the person being assessed has no right to have a solicitor present during the assessment, according to the FAQs. This says: 'If both the individual and drug worker agree, a solicitor can be present. However, a required assessment should not be delayed or rescheduled in order for this to happen.'

Given the lack of clarity and the risks surrounding the process of Required Assessments, one course of non-incriminatory action remains open to people being assessed – remaining silent. Failing to attend, leaving during the assessment, presenting in a way that could cause harm or distress, or disclosing specific offences would all expose the person to risk of prosecution.

But as the FAQs make clear: 'The individual must attend and remain and although it is hoped that they engage, this is not necessary. Therefore it is possible for an individual to arrive at the assessment, remain silent for the duration and still comply with the requirement.'

So attending, remaining silent throughout and then leaving, would, though an utter waste of time and resources, leave the person facing no risk of prosecution.

Kevin Flemen runs the independent drugs training and information service KFx. The website is at www.ixion.demon.co.uk

Notes from the Alliance

Tough choices should never mean compromising basic human rights, says The Alliance's Daren Garratt.

It's April 2006 and Tough Choices have officially arrived. But just how tough should a user's choices be, and why should the increasing criminalisation of drug users result in a complete erosion of basic human rights?

I raise this because I've been informed of two incidents in a West Midlands Police Occupational Command Unit (OCU) where a suspect's legally prescribed medication has been withheld from them.

In the first instance, a suspect was being held in custody and his wife took his methadone in for him, as she knew he'd soon start to rattle. The custody officer decided it should be admissible 'as evidence' and so confiscated his legitimate medication and refused to give it to him.

In the second instance, an arrested user simply had his methadone taken from him and poured down the drain, when he was taken into custody.

How can this be allowed to happen? Actions like this strike me as not only unethical and possibly even unlawful, but also send out shockwaves regarding how users can be treated in an environment whose traditional and cultural role has been to punish, as opposed to care for, illegal drug users.

Oddly enough, despite doing a number of policy searches, I can find no specific guidance that supports these actions.

Instead, I discovered that:

- 'A detainee needing or dependent on certain drugs, including alcohol, may experience harmful effects within a short time of being deprived of their supply. In these circumstances, when there is any doubt, police should always act urgently to call an appropriate healthcare professional or ambulance.'
  (from PACE Codes Of Conduct Code C Section 9Ca)

and that

'Where it is known that a detainee requires medication, the custody officer is responsible for:

- The safekeeping of the medication which should be held in a locked receptacle to prevent unauthorised access.
- Providing the detainee with the opportunity to take the medication at the prescribed intervals.
- Ensuring that the correct medication is given and at the right dosage.
- Recording the information in the custody record.'

(from Guidance on The Safer Detention & Handling of Persons in Police Custody, ACPO 2006*)*

But I found nothing on arbitrarily withholding a potentially life-saving intervention.

I'm confused. And angry. And scared.

In *Substance Misuse Detainees in Police Custody* (2001 – under review) the Royal College Of Psychiatrists states that:

- 'Individuals in police stations are entitled to the same standard of medical care as any other member of the public. The forensic physician needs to give careful attention to the issue of consent of the detainee to any examination. Detainees have the right to have prescribed medication continued while in custody, as long as it is clinically safe to do so.'

That's all very well in theory, but what can we activists, practitioners and users do when we know it's not happening in practice?

'Clearly there is a way out from the inevitability of heroin addiction 'rock bottom'. Perhaps Professor Clark will even find space to talk about those heroin users who do not fit within his model: the controlled, recreational heroin users who do in fact hold down regular jobs, and who do not match the prevailing stereotype he presents to us in such an uncritical way. In fact, as an increasing number of studies have shown, there are even heroin users out there who do not 'neglect to pay attention to their appearance and personal hygiene'.'

Coercion not needed

I must reply to 'name and address withheld' who, in your letters page recently criticised RAPT as 'a worrying step towards US-style religious-coercion-as-drug-treatment' (*DDN*, 27 March, page 8).

He (or she) was responding to the DDN article on our day programme in Tower Hamlets – I would like to invite him (or her) to visit this project, or any other of our projects, to search for the religious coercion that seems to be of concern. I've worked at RAPT for four years, and managed 12-step treatment programmes for a further 10 years and I've never come across it.

The fact is that RAPt is a large provider of a range of treatment services to offenders with drug problems. In some of our projects, we operate 12-step programmes on a total abstinence basis. We also offer advice, throughcare and referral services. We are like any other provider in this field – we seek to deliver client-focused services professionally and cost-effectively.

Yes, we are proud of the achievements in our programmes – 'name and address withheld' casts doubt on the research behind the claim of a 50 per cent success rate. This figure comes both from the independent research conducted into our programmes (by Kings College, Player and Martin 1996), and the rigorous monitoring of our prison-based programmes by the Home Office National Drug Programme Development Unit, and refers to the proportion of prisoners starting a programme who stay drug free, and graduate 20 weeks later. We are happy to see that the rate across our nine programmes will this year be nearer to 60 per cent.

There remains the question of how these completion rates translate into long-term behaviour changes. We have some evidence of positive impact but, like all providers in this sector, have not produced a large-scale longitudinal study to prove this. We are currently developing such a study, and invite other providers to join us in this work to gain a greater understanding of what works.

Dave Mulvaney, Director of Services, RAPt.

Uncritical stereotypes

Professor David Clark is to be congratulated on reducing the complex matter of heroin use into such a short article ('The drug experience: heroin', *DDN*, 10 April, page 15).

Perhaps, however, it could be even shorter, as Professor Clark's argument could be summed up thus: heroin is bad, because it is bad. On the rare occasions he seems about to stray into related issues such as underlying psychological problems, the role of environmental factors, the repertoire of lifestyle choices available to the user, he hauls himself back to a truly pharmacocentric position.

But it was heartening to read that in the next instalment we will be informed of the process of recovery. Clearly there is a way out from the inevitability of heroin addiction 'rock bottom'. Perhaps Professor Clark will even find space to talk about those heroin users who do not fit within his model: the controlled, recreational heroin users who do in fact hold down regular jobs, and who do not match the prevailing stereotype he presents to us in such an uncritical way.

In fact, as an increasing number of studies have shown, there are even heroin users out there who do not 'neglect to pay attention to their appearance and personal hygiene'. In other words, people who use heroin yet still manage to have a shower in the morning.

Dr David Shewan, Research Director, Glasgow Centre for the Study of Violence, Glasgow Caledonian University

Ridiculously simplistic...

The latest part of Professor David Clark's Background Briefing on the drug experience of heroin (*DDN*, 10 April, page 15) seems to reinforce the 'addicts will do anything' line – unfortunately by including a quote from an [ex?] addict.

I agree *some* might do 'anything', but the majority of my mates who became addicts, and many more I've met since we started M.O.R.P.H. (a user activist/advocacy organisation) most certainly *do* have limits to what they'll do... loads of them.

It might be that they won't steal anything (I was one of these; I worked, busked or took methadone) or they'll only steal from shops or factories and certainly wouldn't mug someone, do a street robbery or a burglary. Many dealers – or people who score for other addicts and get a bit for doing it, there is a subtle difference – have made a conscious decision not to rob people, but supply other addicts who want gear. ('A victimless crime', to quote a judge commenting on my case while I was up for a DTTO.)

Some dealers would never 'cut/bash' their wares before selling them on – others do it every time. Some addicts won't sell their possessions; won't use in front of kids; won't inject; won't use other people's works; *etc etc*. Some steal from their families, many won't. We all have our own personal limits – just like everyone else! It's also the reason some people would rather beg for their next bag than rob someone.

This also covers grassing: while it's true that some addicts 'cave in' and give information to the cops when they're nicked (as many of us know all about when they turn up 'wired' and get us scoring for them, then nicked for supply!) – many won't. That 'all junkies fall to pieces when they get in the cells' is another of these junkies-will-do-anything 'truisms' that gets bandied about and is simply not true.

Addicts are individuals with their own sets of values, morals and principles – not automata with

no control over their actions. You rarely hear the 'junkies" side so it's easy for people to trip out this mantra and before you know it a 'fact' is born.

Until these 'facts' about 'all addicts' are exposed for the ridiculously simplistic bollocks they are, we'll continue to be referred to in these blanket generalisations – which really don't help when we come for treatment wanting to be seen and treated as individuals. When we are 'all' this, that or the other it becomes easier for workers to think of us 'all' as a problem waiting to happen; or giving us 'one size fits all' treatment because we're 'all the same'.

Simon Parry, M.O.R.P.H. co-ordinator

Prof David Clark is on holiday this month, but will resume his series on heroin in the next issue of DDN on 8 May.

Psychotic demand

For those who still believe that cannabis is a 'relatively safe' substance, I suggest that you take a look at 'Psychosis among Substance Users'; Current Opinion, in *Psychiatry* 2006;19(3):239-245 (posted on 4 April at www.medscape.com).

I must say that in view of the references, the government's decision to downgrade this drug, and then to subsequently insist that there was no need to reclassify it on the basis that of its 'relative harms', seems to defy the body of medical and scientific evidence and research.

I can only conclude that the evidence and research quoted was not brought to the attention of successive Home Secretaries, or that it was ignored, or worse still suppressed. Perhaps those responsible for seeking to persuade us that cannabis is 'relatively harmless' would care to comment.

Peter O'Loughlin, The Eden Lodge Practice

Concession becomes confusion

The two direct responses (*DDN*, 10 April, page 9) to my letter in the previous issue gave me cause to look into Hazeldon's official success rate, and I must concede that I had the official numbers incorrect. The figure quoted on their website is indeed 53 per cent.

However, I should mention that, after about half an hour of searching the net, the details of this research seems to be unavailable anywhere. When this is the case, one should consider the quality of it. Is it randomised, or are the candidates 'cherry picked'? Was there a group receiving equivalent non-12-step treatment? Was there a 'control group'? How many candidates were considered? If certain conditions, such as these, are not fulfilled, then any statistician would call into question the quality of the research carried out.

It was also stated that there has been published literature which proves that 12-step treatment does work, yet the papers that I have seen suggest otherwise. One of the most comprehensive studies into AA effectiveness, carried out by Prof George Vaillant, a non alcoholic member of the AA World Service Board, which compared AA treatment to various other methods as well as an untreated control group, showed that 12-step treatment was completely ineffective.

In all, 95 per cent of his AA subjects relapsed over the course of the eight-year study, which is similar to the spontaneous remission rate for alcoholism. Dr Vaillant himself admitted: 'Not only had we failed to alter the natural history of alcoholism, but our death rate of three per cent a year was appalling.'

Project MATCH was also mentioned, which seems bizarre considering that both writers were proponents of Twelve Step Facilitation (TSF). This $27million study effectively failed to prove that 12-step treatment is any more effective than other type of treatment. Not much good for a program that claims its the only way, as demonstrated by the following quote from the *Big Book* (third edition): 'At first some of us tried to avoid the issue, hoping against hope we were not true alcoholics. But after a while we had to face the fact that we must find a spiritual basis of life — or else.'

ScienceNOW Magazine, after analysing the results of Project MATCH, concluded that: 'You can toss out the window any convictions about the best form of psychotherapy to get alcoholics to quit drinking. Contrary to a leading theory, it doesn't seem to matter which kind of technique you use. That's the bottom line of a six-year, $27 million study whose findings were announced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).'

One of the writers also mentioned that RAPt shows 'no evidence of religion'. However, this was not the New York Supreme Court's view when, commenting on a prison program similar to RAPt and an inmate who claimed he was denied certain privileges for not engaging in it, they stated that 'adherence to the AA fellowship entails engagement in religious activity and religious proselytization. Followers are urged to accept the existence of God as a Supreme Being, Creator, Father of Light and Spirit of the Universe.' The US Supreme Court upheld this ruling.

The problem with TSFs is that their 'powerless' doctrine flies directly in the face of current harm minimisation strategies. These self-fulfilling prophecies can undo months of hard work carried out by the more conventional drug agencies.

Abstinence based therapy has its place, but it should be realistic and develop contingency strategies for the event of a relapse. The 12 steps, by their very nature, cannot do this. As an ex-member, I should know.

Name and address withheld

Reference: The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery, George E. Vaillant

Email your letters to claire@cjwellings.com or write to: Claire Brown, Editor, Drink and Drugs News, CJ Wellings Ltd, Southbank House, Black Prince Road, London Se1 7SJ.

Letters may be edited for reasons of clarity or space.

NTORS and the mystery of £3 savings for £1 of treatment

***DDN* continues its trawl through the back issues of Drug and Alcohol Findings. For the full article referred to in this extract and more free content visit via www.drugandalcoholfindings.org.uk.**

If you (and government ministers) know nothing more about drug dependence treatment in Britain, you know that for every £1 it costs, society reaps £3 in cost savings, mainly from reduced crime. This was the headline finding from the National Treatment Outcome Research Study, better known as NTORS.

The study arose from a review of the effectiveness of treatment ordered in the mid-90s by a health minister who was distinctly sceptical about the ethics and effectiveness of methadone. 'People should not be taking drugs' was Brian Mawhinney's straightforward take on the issue. But ironically, the study which would make or break treatment – and methadone prescribing in particular – was put in the hands not of sceptics like Mawhinney, but of researchers at the National Addiction Centre, closely allied with one of Britain's biggest and best established addiction treatment and methadone prescribing services.

Issue 2 of Findings analysed the results. By one leading NTORS researcher, the issue was judged 'great, superb... You've done NTORS proud', but the analysis had uncovered a puzzling anomaly at the heart of the £3 for £1 calculation. The commonsense understanding (and one most people still believe) is that the £3 was the savings which accrued to society for each £1 spent on the treatments studied in NTORS. In fact, the £1 represented not the full cost of that treatment, but the extra cost compared to what was spent the year before. Puzzled? So were *Findings*.

It worked like this. In the year after entering the NTORS study, treatment costs for the sample totalled £3 million. The year before, treatment costs for the same patients had totalled £1.4 million. The difference – £1.6 million – was less than a third of the £5.2 million cost savings estimate, leading to the £3 for £1 estimate.

The underlying assumption is that having spent £1.4 million on treatment the year before, simply spending this same sum again would have had no further impact on crime: all the cost savings are attributed to the extra £1.6 million. Why this assumption was made remains unclear. Similar studies from elsewhere have costed in the full cost of treatment, regardless of how much was spent before.

Had this been done in NTORS, the estimated return to society would have fallen to under £2 for each £1 spent. Take this further and assume (not implausibly) that the NTORS treatments built on what went before – that successive treatment episodes have a cumulative impact – then the £4.4 million cost of treatment in the NTORS year plus the year before would need to be set against the savings. We get uncomfortably close to a one-for-one ratio.

This was not the only question mark over the study nor even the main one, but it is the one few people even today appreciate. As the *Findings* analysis commented, none of the study's limitations seriously diminish faith in the cost-benefits of addiction treatment because so much more could have been heaped on the benefits side such as saved lives, improved health, and mended families, and because we have other studies.

But did these early results from NTORS really show that addiction treatment saves money? Whatever the answer, the £3 for £1 mantra embedded itself in the field's collective consciousness and served an important purpose – to deflect the threatened decimation of treatment services.

Safe as houses?

If we're serious about giving recovering drug and alcohol users a stable place in society, we need to do much more to keep them in accommodation, says Michelle Duffin.

For some of the more vulnerable groups in our society, finding suitable housing is immensely difficult, particularly if they have histories of anti-social behaviour, rent arrears, offending behaviour and drug and alcohol dependencies.

We must recognise that drug and alcohol users and offenders are a vulnerable group whose housing needs must be addressed as part of a package of interventions to control and prevent relapse into substance misuse, offending and homelessness.

In 2005 Perpetuity Research and Consultancy International (PRCI) undertook a study to assess the housing needs of a sample of drug and alcohol users and drug using offenders, to explore some of the barriers and gaps in current housing provision. Consultation with users and offenders and input from service providers offered an insight into the level of need for housing support, and stimulated discussion around the types of housing support considered essential to the effective rehabilitation and resettlement of users and offenders.

All of those consulted were receiving some form of treatment and had a history of problematic drug and alcohol use; some drug using offenders had extensive offending histories and in some cases had served lengthy prison sentences.

Some interviewees had concerns about hostel accommodation because users and non users were housed together; this made it very difficult for those who were trying to abstain from drugs or were on court orders such as Drug Rehabilitation Requirements (DRRs). Temporary accommodation was also criticised for the level of drug and alcohol use evident in some provision.

A lack of suitable emergency accommodation when drug using offenders (who were often clean) were released from prison, often left them with nowhere to go. Service providers in this study were aware of people sleeping in people's sheds, other people's houses, camping, sleeping in cars, sleeping on the streets or squatting. This places them at considerable risk of using drugs and alcohol and re-offending.

There was a shortfall of accommodation for people with multiple needs including dual diagnosis, depression, self harm and suicidal tendencies. Similar difficulties were highlighted in relation to housing women – refuges were reluctant to house women who had mental health issues and/ or drug issues. Similar difficulties were experienced when seeking accommodation for offenders particularly arsonists, armed robbers, and violent offenders.

If people have drug or alcohol dependencies, landlords are often reluctant to accept them in rented properties, and findings from this study confirmed that having a drug or alcohol dependency makes it very difficult to access mainstream housing. Poor credit rating or rent arrears and a history of anti-social behaviour were all barriers to accessing social housing.

The local authority did not perceive drug and alcohol users as in priority need of housing and therefore accommodation was not available to them. Single men in particular were not given sufficient points for housing association accommodation.

'Intentionally homeless' decisions were also seen as barriers to accessing accommodation for drug and

alcohol users. One service user spoke about his experience of being labelled 'intentionally homeless' when he had moved out of his flat when it was being used as a crack house. He was left with no other choice than to access emergency accommodation in a local hostel and had since been refused access to social housing. If prisoners lost accommodation when in prison they were also regarded as 'intentionally homeless'.

For those who were fortunate enough to meet the criteria for mainstream housing, waiting lists and procedures to get points, by being in a tenancy for six months for example, considerably delayed the process. Interviewees felt very strongly about the lack of consideration given to those who were in treatment trying to abstain from drugs, who were offered housing that was often in areas rife with drugs and dealers.

Offering housing in these areas to those most vulnerable to using drugs and alcohol was considered inappropriate and a hindrance to the effective resettlement of drug using offenders. Those who declined accommodation in these areas often had to wait for a further six months for alternative housing or lose their place on the housing list altogether.

Offenders often lost accommodation when they were in prison, because they fell behind on rent payments. Those consulted highlighted the need for more qualified staff in the prison system working with prisoners to prevent them from losing accommodation while serving custodial sentences. The need for earlier links with housing providers, prior to release into the community, was highlighted as a key challenge.

Interviewees had all held tenancies at some point in their lives. One of the key findings from this study was the need to prioritise preventative measures to prevent people from becoming homeless. The need for more support before someone gets to the stage of having an accommodation crisis was strongly supported.

Users favoured floating support schemes where they could be visited in their own homes by qualified workers who could assist them with areas of difficulty, including managing budgets; paying bills; obtaining household furniture and clothing grants; forming links with other agencies – such as employment and training, and drug and alcohol services (for medication *eg* methadone and subutex, and counselling) and reminders to attend appointments.

The findings of this study clearly underlined that housing is an essential basic requirement that drug and alcohol users, those in recovery and offenders, if they are to put some stability into their lives.

There is a need to not only ensure that sufficient accommodation is accessible to these vulnerable groups, but also to ensure that they are provided with appropriate support to help them to maintain their tenancies and prevent homelessness in the first place.

For more information on this and other research undertaken by PRCI, contact Michelle Duffin, research consultant, m.duffin@perpetuitygroup.com

Further reading: *Introduction to Social Housing,* from the DDN bookshop: www.drinkanddrugs.net/drinkanddrugsnews.html

Better standards in drug testing: part six

Standards and assurance

In the final part of his series, Phil Houldsworth advises on finding the right drug testing services to ensure the operation is completed to the highest standards of dignity, accuracy and efficiency.

Now that we have a clearer idea of what drug testing is about, where should you go for your drug testing services and what should you be looking for?

If you are going to go for onsite testing – that's the presumptive screening of the sample – you need to find a supplier of dipstick or integrated kits, either urine or oral fluid (or both).

You need to ask the supplier how efficient the devices are. Efficiency is the balance between the number of samples the device misses (false negatives) and the number of the samples it incorrectly calls positive (false positives). In our opinion you should be looking at efficiencies above 95 per cent. If the sales rep does not know the efficiency of the device they are trying to sell, you then only talk to them when they do know. I would also be cautious about companies who claim they never make a mistake *ie* the service or device is 100 per cent efficient. You also need good back up in the form of advice and technical support.

One of the problems with onsite testing devices, is you cannot tell if they have given you the correct answer. You only have the word of the sample donor that the negative result is a correct result. You have to build up confidence in the use of the devices and confidence in the results they generate. Confidence building can come from efficiency data and from competent training – so always look for training from the kit suppliers, as well. Confidence also comes from use. Another way to build confidence is to participate in an external proficiency testing (PT) scheme. The providers of the scheme will send you samples to test to see if you get the correct answer. Over time this will build up your confidence in your ability to carry out testing and in the kits themselves.

If you are going to send the samples to a laboratory, it must be accredited for the purpose of drug testing. Within the Health Service many hospital labs are CPA accredited and are able to carry out screening of the samples for the presence of drugs, but not many are accredited to carry out confirmation testing. There are a few regional centres and if you are lucky to be close to one, you will get a quick response; if not, it could take some time before you get results.

There are also commercial laboratories that provide screening and confirmation services. They provide the collection kits, post and packaging, chain of custody systems and the majority of them provide a full interpretation service for the results. You should check that they hold ISO17025 accreditation with UKAS, because without this you have no assurance as to the quality of the work carried out by the laboratory. In addition, you must make sure that they participate in an external PT scheme and that their performance is as expected.

'One of the problems with onsite testing devices, is you cannot tell if they have given you the correct answer. You only have the word of the sample donor that the negative result is a correct result.'

In conclusion, and to summarise this series of articles, all collections regardless of the sample type should be dignified and respectful, and the integrity of the sample should be maintained by a well thought through collection process. Purchase your drug testing services or devices from knowledgeable and accredited providers who can offer you the relevant training and technical support. Ensure they have an effective quality system in place, and if you do the testing yourself, put your own quality system in place – *ie* join a PT scheme.

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

Further reading: *Drug Testing and the Workplace,* from the DDN bookshop: www.drinkanddrugs.net/drinkanddrugsnews.html

One step at a time

david sanger photography / Alamy

It's a sunny Saturday morning in Brighton. In the lobby of a smart hotel on the sea front, Rick is telling me about the years he spent homeless, living on the streets; drifting desperate times when he cared only about his next fix.

He is looking back as if at another lifetime. Today this engaging and articulate man has invited me to fourteenth annual UK conference of Cocaine Anonymous. He gives me a form to sign, confirming that I will respect the anonymity of all participants, a press badge to wear to give people fair warning of my approach, and explains that I will be accompanied throughout the day, to comply with CA's public relations policy. He adds that I am extremely welcome – an assurance I will hear from others throughout the day.

Welcoming is something 12-step organisations pride themselves on doing well, and CA is a baby in the family that started with Alcoholics Anonymous. Respecting the format of meetings, the structure of the organisation, and the life-changing results reported by its worldwide membership, Narcotics Anonymous borrowed AA's formula with permission, followed by Cocaine Anonymous.

Although they are careful to state that they are not affiliated with AA, the organisation is run along the same lines, with a 'World Service' headquarters, linked to countries and their individual meetings. It sounds like a hierarchical pyramid, but I am assured that those who hold the voluntary offices 'just co-ordinate – and nobody leads, nobody's in charge'. Furthermore, 'the most important person is the one who's walked into their first meeting'.

Later I am told by a very smartly dressed man representing the World Service (known as a 'delegate' in the overall structure), that CA is not driven by mandate and people can change it. 'It's very accessible and approachable. Linking local districts to the World Service is about enabling problems in local areas to be shared by the same solutions,' he says. For the new member of CA, this offers a fellowship stretching from here to the World Service office in California, via locations all over the US and Canada, Mexico, the Netherlands, Sweden, France, Spain and Hong Kong. 'I used to be six stone 12 ounces, a cocaine addict living with someone who only kept a microwave for cooking rocks,' he adds. 'My mission now is to 'pass the message on to the addict who still suffers, to encourage newcomers to embrace and celebrate recovery'.

Celebration is what this weekend conference is all about. Looking at the programme, it's hard to know what kind of culture to expect. There are early morning fun runs at 7am and marathon meetings that continue freestyle all night, with all kinds of speakers and workshops in between, with titles like 'awareness', 'gratitude' and 'forgiveness'.

As Rick leads me up to the main hospitality area to meet other participants, I am expecting something quite serious and intense. The scene that greets me takes me by surprise: pounding music, balloons, disco lights, stalls full of t-shirts and books. In the middle of this strange cross between a night club and a bazaar, people greet each other with hugs and backslapping, and there is plenty of

Does 12-step recovery work? For delegates at Cocaine Anonymous's annual UK conference the signs certainly look good, as DDN reports.

laughter. I am greeted with enthusiasm and told this is a celebration – of living life without drugs, and finding the fellowship of CA.

But behind the fun and fellowship, there is of course very serious business in hand. The traditional readings feature at each session, including the serenity prayer: 'God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.' There are 'shares', where a CA member shares their own personal experience with others in the room; and there are 'birthdays', where members are congratulated for completing another year clean. The shares are intense and personal, but are an essential part of acknowledging the past, according to CA doctrine.

Different members take turns to read CA's passages about the nature of their addiction: 'Nothing mattered more to us that the straw, the pipe, the needle. Even if it made us miserable we had to have it…

'We had to admit that cocaine was a serious problem in our lives, that we were addicts.'

The admission is just the starting point to recovery. As every 12-stepper knows, getting used to your identity as an 'addict' (or in its original context, an 'alcoholic') is an essential part of joining the fellowship.

'My name's so-and-so and I'm an addict,' with the chorused response 'hi so-and-so!' precedes everything that's said. A repetitive structure that takes some getting used to for the outsider, takes on the comfort of a mantra to those who see it as confirmation that they are accepted by the fellowship, and held securely on the path to recovery.

The parallels with religion seem very obvious to the observer, and many people see step three – 'we made a decision to turn our will and our lives over to the care of God as we understood him' – as a way of making a religious programme more palatable to those who see themselves as atheist or agnostic.

Talking to CA members, it seemed to be quite usual to be sceptical about 12 stepping at the outset. But each had found a connection with the fellowship that tuned in to their very strong needs. Fitting in with the 12 steps came later; what they responded to was an organisation that was diverse, non-judgmental, and run by people they could identify with. Working towards 'clean' happened at their own pace, and they were not kicked out for relapsing. All that was required of them was an admission that they had lost control over mind-altering substances and needed 'a power greater than [them]selves' to restore them to sanity.

Sally remembers sitting in a crack house in St Paul's when her friend started 'lecturing' her about the Minnesota 12-step model (on which CA's steps are based).

'I thought "no way am I doing anything like that – it's for loons!",' she says. 'I didn't identify anything that was of use to me at all. I was quite closed minded and my field of vision was narrow.

'When my friend started the 12 steps I thought it was quite desperate. I thought she was a deflated version of her former self – she wasn't even abstinent.'

But as Sally's crack use led her to feeling 'desperately lonely, questioning my own existence', she eventually went to a 12-step meeting.

'I saw that people came together for a very positive reason,' she says. She was surprised how this affected her: 'I got to talk about myself and I loved it, I felt the centre of attention. Lots of people reached out to me.'

Tony also remembers feeling initially that 12-stepping was not for him. Fifteen years ago he was a 'functional addict', always working, but frequently depressed. 'At 21 years old I was banned for drink driving,' he says. 'I looked in the door of an AA meeting and thought "no way!".'

'The parallels with religion seem very obvious to the observer, and many people see step three – 'we made a decision to turn our will and our lives over to the care of God as we understood him' – as a way of making a religious programme more palatable to those who see themselves as atheist or agnostic.'

Heroin and cocaine use meant family and finances slipping out of his grip. 'My wife had the house signed over to her name, she filed for divorce. But I never clicked that the problem was with me.'

When his brother, a year older, died from a cocaine induced heart attack, Tony realised he needed help, but couldn't identify with AA. When he was sacked from his job 'after so many chances', he stopped using in shock and followed a suggestion from someone at AA to try Cocaine Anonymous.

'I watched people who did the 12 steps. There was a look in their eyes – something different,' he says. 'When this guy explained about the physical reaction and the mental obsession with the drug, for the first time in my life I realised I was an addict. I was told it was a spiritual disease… to find that out in step one was a revelation.

'I thought it wouldn't work for me – I don't believe in God,' says Tony. But one step led to another, and my whole perception of life changed. I got back my wife, my kids, my job. I thought I'd smashed everything in my life to pieces, but everything is rebuilt – and more.'

In their public information officer's words, 'it's all started happening over the last nine months' for Cocaine Anonymous. 'CA used to stand for "can't attend", he says. Now we're getting letters and we're on the prisons website.'

Contact with prisons is an important part of CA's hospitals and institution (known as H&I) programme, alongside contact with recovery projects, hostels, and treatment centres – in fact 'anywhere people can't access usual meetings', explains Maria, whose role is to liaise with these organisations in the hope of arranging regular CA meetings with them, as a bridge to their support in the outside world.

'We offer a collaboration of what the institution wants, and what we can do,' she says. 'We have to mind their criteria. They have certain traditions we have to abide with – as long as they're respectful of ours.'

Bursting with enthusiasm for her work, Maria explains that she is 'passionate about CA because it saved my life, taught me the tools of recovery. I'd used drugs for 20 years and wanted to die.'

She now takes very seriously her mission to carry the message to other addicts – the basis of CA's sponsorship programme, where members are encouraged to offer their support as a sponsor to newer members.

It becomes clear throughout the day that many people tap into CA because of its culture of enjoyment as much as its non judgmental nature, and the organisation attracts many members who use substances other than cocaine. 'People who use cocaine tend to enjoy life,' says one. 'Why should it be any different in recovery?'

In an attempt to dig deeper, I asked Sally if replacing drugs with CA and the 12 steps was replacing one addiction with another – but there is no denial of this. 'I was a black hole of energy before,' she says. Now there's pleasure giving back.'

For others, including Rick, CA is simply about getting the support to live again – and they want to pass it on to others.

'I'm so grateful for the fellowship,' he says. 'I came here because I was going to die. Now I want the same love I received to be given to the next user.' **DDN**

All names in this article have been changed to respect anonymity. For more information on Cocaine Anonymous email pi@cauk.org.uk, phone 020 7284 1123 or visit the website, www.caukorg.uk. Anyone wishing to find a meeting for themselves or a loved one can call the CA helpline, 0800 612 0225.

Further reading: Integrating the 12 steps into Addiction; and How to work with others in 12 Step Recovery, from the DDN bookshop: www.drinkanddrugs.net/drinkanddrugsnews.html

I've been in my job as a drug and alcohol worker for four years now, and want to move into management. Could you suggest what sort of training and qualifications I should look at doing?
Caroline, Sheffield

False hope

Dear Caroline
Are you sure you want to get into management? You may not find it all it's cracked up to be. Instead of working with clients and helping people on a daily basis you will soon find your days involve filling out reports, dealing with staff problems and attending meetings, meetings and more meetings. It won't be long before you wont even be able to remember what helping a client is like. Is that what you really want?
Name and address supplied

It's all responsibility

Dear Caroline
Moving into management is not just about having the right qualifications but is all about demonstrating that you are ready to take on the extra responsibility that goes with managing people and projects. The first thing that you could do is volunteer for extra responsibility in your current position: you could take the lead on a new project or offer to help induct new members of staff, anything that shows initiative and a willingness to take responsibility. Doing this will definitely be a benefit to your career, as either it will impress your present managers if you apply for any vacancies arising in your current organisation or you can document it on your career portfolio for future interviews. While training and qualifications are extremely useful there's no substitute for experience.

Good luck,
Bernie, by email

Portfolio now!

Hi Caroline
Begin your professional portfolio if you haven't already – it's a great way of realising the skills and experience you already have. I bet you have more management skills than you realise!

Yours,
Frankie

Negotiate

Dear Caroline
I was in the same position as you a couple of years ago. I was extremely busy at home as well as in my job, so found it hard to schedule training courses, but was very keen to move on.

I explained my career ambitions to my manager, and we worked out ways in which I could gain new experience and build management skills. I was able to mentor a new member of staff and was given control of a departmental project, which was a huge learning curve in terms of managing and motivating people from different teams to work together.

You may need specialist training in different areas – and my suggestion is not a replacement for this. I still plan to top up my skills in some areas with professional training when I can. But my communication skills and time management have improved considerably, and I feel much more confident to apply for a management role in the near future.

I would urge you not to wait any longer for your opportunity to progress – but to find it.
Sheila Wheeler, Lancashire

Get qualified

There is a range of options for managers – it partly depends on where you work and at what level of management.

If you wanted to be able to run a residential service covered by the Care Standards, you will need a Level 4 NVQ or equivalent covering both management and care. The NVQ for Registered Managers is one option here, and with the focus on demonstrating competence within the Care Standards, may be the most appropriate one. Contact your local college for more details.

For most other roles you don't have to have a particular management qualification - but the NTA has set a target that by 2008, 90 per cent of people in management positions should have received at least some management training. Your local college should be able to advise on training courses available locally. It might also be worth looking at the training section on the www.drinkanddrugs.net site.

In addition, there is a range of generic NVQs in management – again, speak to your local college to find out what is available locally. And there is the Open University/FDAP competence award in management and supervision of drug and alcohol professionals – see www.fdap.org.uk for more details.
Simon Shepherd,
chief executive, FDAP

Solid guidance

Guidance on training and qualifications for workers in the drugs and alcohol field can be found on www.skillsforhealth.org.uk/danos/getuserfile.php?id=108. This guidance focuses on training and qualifcations for practitioners, but it does list a number of higher level qualifications that might be appropriate for managers in substance misuse services.

If you are considering moving into a management role, I would recommend you consider a generic management certificate or diploma offered by one of the professional bodies. The Chartered Management Institute's qualifications can be found on www.managers.org.uk/content_3.aspx?id=3:157&id=3:152 and the Institute of Management and Leadership's qualifications can be found on www.i-l-m.com/qualifications/ qualifications.ilm. These Vocationally Related Qualifications (VRQs) are offered by local centres across the UK and provide a broad foundation of the knowledge and skills required for first line management positions.

If you already have management experience, I would recommend you consider a National Vocational Qualification (NVQ) in Management and Leadership, available from CMI, ILM and a wide number of other awarding bodies with centres across the UK – Scottish Vocational Qualifications (SVQs) are available in Scotland. The NVQ has two major advantages:

1. It proves that you are competent as a manager – *ie* that you apply the necessary knowledge and skills to perform consistently to the standards required.

2. It recognises your existing knowledge, skills and competence – you only need to develop new knowledge and skills to fill gaps in your repertoire as a manager.

If you hold either a VRQ or an NVQ/SVQ from CMI or ILM you will be entitled to become a member of these professional bodies. CMI also has a continuing professional development scheme by which you can maintain and continue to develop your managerial competence and use the title 'Chartered Manager'.

I hope this helps. For further information contact me at www.themsc.org

Regards,
Trevor Boutall

Reader's question

My friend is a persistent drug and alcohol user. I have offered to get him help from the treatment agency where I work, but he has threatened to break off our friendship if I interfere and betray his confidence. Should I break his trust to save his life?
Joanna, Leicester

Email your suggested answers to the editor by Tuesday 2 May for inclusion in the 8 May issue of DDN.

New questions are welcome from readers.

Show 'em what you can do

You'll all have heard about DANOS by now I am sure. It is not the most interesting of subjects, and there appears to be quite a lot of anxiety about DANOS (in particular about the NTA Workforce Targets – see the box below for more details). But actually DANOS is not something to be scared of and can really be helpful to your career development, *writes Simon Shepherd*.

National occupational standards like Drug and Alcohol National Occupational Standards (DANOS) can provide a framework to help identify the particular range of competences (skills and knowledge) required in particular jobs, and provide a checklist to support effective appraisal and training needs analysis.

They can also provide a framework to help practitioners show what they can actually do, without having to go to college (in fact, many college and university qualifications say more about what someone knows, and how good they are at writing essays, than on what they can actually do).

We all know that being an effective drug and alcohol professional requires a whole range of highly developed knowledge and skills – but before DANOS there was no real way of recognising them. DANOS may be boring, but it can be good for your career, and the way other people look at you.

There are a number of ways in which people can use DANOS to show what they can do.

Professional Portfolios

It is good practice for anyone working in the field to keep a 'professional portfolio', including information on training and qualifications, previous experience and evidence of competence. The competence section of a portfolio might include a range of different types of evidence – including extracts from case notes and reports, testimonials from peers, appraisal reports from line managers / supervisors, and any externally validated competence-based qualifications.

Drug and Alcohol Professional Certification

FDAP's Drug and Alcohol Professional Certification is based on a demonstration of DANOS competence. To be certified, practitioners must provide evidence of competence in a total of ten DANOS units. Registration as a Drug and Alcohol Professional is based on an internal workplace assessment of competence only. Accreditation provides externally validated evidence of competence and is based on a workplace assessment plus qualifications providing 'complementary evidence of competence' against the DANOS units.

OU/FDAP Competence Awards for Practitioners

OU/FDAP competence awards are Open University accredited qualifications based on an independent assessment of competence against the DANOS national occupational standards. Practitioners can apply for awards based around individual units or around particular clusters of units – such as a ten-unit 'competences for drug & alcohol professionals', and a three-unit award in 'assessment and care planning'.

NVQ in Health & Social Care

NVQs are 'National Vocational Qualifications' accredited by the Qualifications & Curriculum Authority (QCA). To be awarded an NVQ in Health and Social Care at either Level 2 or Level 3 (roughly equivalent to GCSE and A level respectively) workers have to satisfy an independent assessor of their competence in four core generic health and social care units, plus four others from the Health and Social Care suite of units, into which the DANOS standards have been incorporated.

Development Awards

Like NVQs, Development Awards (DAs) are QCA accredited qualifications based on an assessment of competence against national occupational standards. A number of Development Awards based around identified clusters of the DANOS and related YJ-NOS occupational standards are currently under development.

For more information on any of the above – and for background guidance on the competence framework – see the 'Training and Development' section on our website www.drinkanddrugs.net

Health & Social Care Professionals and DANOS:

The NTA workforce targets do not require 'professionally qualified' workers to gain particular qualifications in relation to DANOS, though they are expected have training relevant to their roles in the field. And many 'professionals' will still want to be able to demonstrate their competence in relation to substance misuse – both through their professional portfolios, and through qualifications such as the OU/FDAP competence awards and NVQ-related Development Awards, and accreditation as a Drug and Alcohol Professional.

The NTA Workforce Targets:

NTA has set a target requiring that by 2008, 75 per cent of 'non professionally qualified' workers in the adult treatment sector (*ie* those not qualified to practise within regulated health and social care professions) have, or are working towards, qualifications providing externally validated evidence of competence against a core set of DANOS units plus at least four other units, 'at Level 3' or above.

FDAP Accreditation (but not Registration) as a Drug and Alcohol Professional, and the Level 3 NVQ in Health and Social Care (but not the Level 2 qualification) meet this requirement. The ten-unit OU/FDAP competence award also provides externally validated evidence at the required level. Development Awards and the smaller OU/FDAP awards can provide 'top up' evidence of competence towards FDAP Accreditation.

Demonstrating DANOS competence

fdap

Drug & Alcohol Professional Accreditation

Accreditation under FDAP's Drug & Alcohol Professional Certification scheme is recognised as an alternative to the NVQ framework in providing externally-validated evidence of DANOS competence.

To be Accredited practitioners need to provide independent evidence of competence in a total of 10 DANOS units.

Unlike an NVQ, FDAP Accreditation takes account of people's existing qualifications, where they provide complementary evidence of competence against the DANOS units.

OU / FDAP Competence awards

OU/FDAP competence awards are Open University qualifications based on an assessment of DANOS competence.

Practitioners can apply for awards based around individual DANOS units, or around clusters, such as the 3-unit award in 'assessment & care planning' and the 10-unit 'competences for drug & alcohol professionals' award.

The 10-unit award provides all the evidence required for FDAP Accreditation as a Drug & Alcohol Professional - and may also be accepted as an alternative to the NVQ in its own right. The smaller cluster awards and individual unit awards can be used as 'top ups' towards FDAP Accreditation.

For more information on both of these schemes, visit www.fdap.org.uk.

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DipHE/BSc (Hons) Substance Use and Misuse Studies

Starting June and October 2006, and February 2007

Programme structure

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

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

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

Modules

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

Who can apply

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

Tel 0800 036 8888

health.tvu.ac.uk/sums
healthenqs@tvu.ac.uk

TVU Thames Valley University

Help us realise our beliefs

Rainer Surrey Drug And Alcohol Youth Support Service (Days)

Rainer is a national charity that has been working with disadvantaged and under-supported young people for over 200 years. We offer a range of tailored services that enables them to lead emotionally and physically secure and fulfilled lives.

The Rainer 'DAYS' Service is a specialist drug and alcohol youth support service for vulnerable and under supported young people in Surrey.

SPECIALIST SUPPORT WORKER: ALCOHOL

Location: Initially at Rainer Surrey 16plus Epsom Office

Salary: from £20,825-£25,725 per annum + £790 Roseland Allowance + £633.00 High Mileage allowance

With Comic Relief funding we are recruiting for a new Specialist Alcohol Support Worker to focus on developing and delivering effective brief intervention work with at risk and vulnerable young people, especially young women, who are hazardous drinking or binge drinking. In addition the worker will be required to assist in the delivery of effective training to professionals and in the recruitment and support of mentors for young people.

Key tasks will be to:

- Develop and provide specialist brief interventions for young people aged 12 – 19 who are binge drinking or hazardous drinking.
- Provide early intervention and sustained support for young people who are referred by means of affective assessment, care planning and targeted learning.
- Provide alcohol education advice, support, information, sign posting and transition support for young people referred.
- Deliver tailored training on alcohol to professional working directly with young people.
- Assist in the recruitment, training and deployment of peer and adult mentors for young people.

We will offer you training and development opportunities and high quality supervision within a supportive, friendly and stimulating environment. Rainer offers a contributory pension scheme, mileage allowances and an attractive annual leave entitlement. Work bases are co-located within Rainer Surrey 16plus Service in Epsom and Woking. Additional DAAT funded service locations will be utilised as required.

For details about this post and other vacancies with Rainer, please go to **www.raineronline.org** clicking on **'Work with us'** where you can download a full application pack and information. Alternatively email **rs16plusrecruitment@surreycc.gov.uk**

If you would prefer an application pack and information to be sent to you by post, please contact Audrey Hayes on 01483 517070.

Closing date for applications: Friday 28th April 2005.

Provisional interview date: Wednesday 10th May 2006.

The successful candidates will be required to consent to relevant checks with the Criminal Records Bureau.

The Royal Philanthropic Society incorporating The Rainer Foundation.
Registered Charity Number 229132.

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

Rainer
BELIEVING IN YOUNG PEOPLE

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London Borough of SE4

Lewisham DIP – Drug Interventions Programme

Lewisham Drug Interventions Programme is an innovative project designed to increase the numbers of problem drug-using offenders entering and succeeding in drug treatment. The Team works across a range of agencies to identify and support offenders within custody, courts, prisons and the community, into and through treatment.

The following posts are temporary to March 2008

Team Manager

£35,592 - £38,088 pa Ref: COM124

Dynamic and highly motivated with imagination, leadership skills and excellent knowledge of the drugs and/or criminal justice fields, you will lead a multi-disciplinary assessment team. You will have a strong interest in improving the lives of the offenders and their families and ultimately reducing crime in the community. As well as managing the team, you will manage an annual budget and contribute to delivering a high-quality DIP service in Lewisham.

Drugs Worker

£29,292 - £31,320 pa Ref: COM122

Working with individual DIP clients to design and implement care plans, facilitate solutions to housing problems, family issues, employment/skills issues etc, you will have experience in the drugs and/or criminal justice fields, and have a commitment to the challenging goals of the DIP programme. You will also provide an assessment service within the police station and attend court to advise on clients' treatment packages.

Housing Link Worker

£29,292 - £31,320 pa Ref: COM123

Committed, energetic individuals with experience in the housing field are required to provide expert advice and support to DIP clients and other members of the DIP team. This post will be critical to advocating on behalf of problem drug users within the social housing system, and building capacity within the wider market for housing these high-need individuals. You will have experience in housing issues including casework, and an interest in the drugs and criminal justice fields.

If you want to work at the leading edge and make a difference to our local community then visit www.lewisham.gov.uk quoting the appropriate reference number.

These posts are exempt from the Rehabilitation of Offenders Act 1974 and subject to a police check.

Closing date for all posts: Noon, Wednesday 3 May 2006.

We operate a final salary pension fund.

We are an equal opportunities employer.

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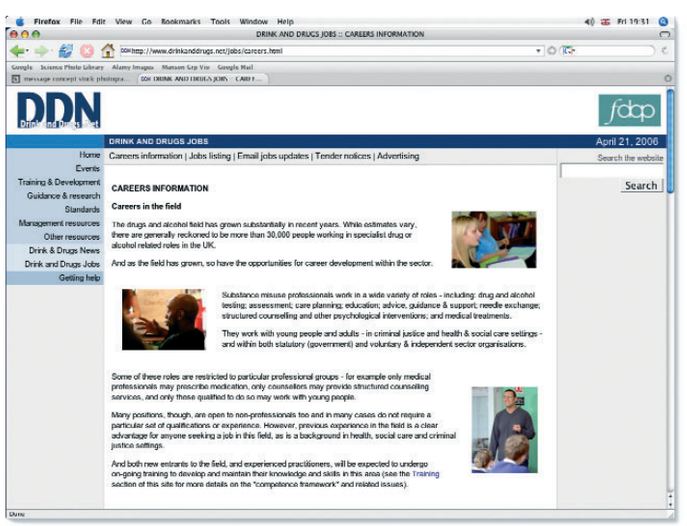
Lewisham www.lewisham.gov.uk



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TEAM MANAGER

CRIMINAL JUSTICE DRUG TEAM, LEICESTER

£27,286 - £32,603 PA

This is an opportunity to join an expanding team at a crucial point of its development. In order to provide end-to-end treatment continuity for drug using offenders in the Criminal Justice system, we are merging the treatment capacity of the Drug Interventions Programme with that provided for Drug Rehabilitation Requirements. This is a new post to work alongside an existing manager to oversee this development and ensure provision of high-quality treatment.

We have a history of successful performance and this post offers the opportunity to build on that success in a fast moving environment.

You will require some knowledge of current developments and practice in drug work.

Should you have any further queries regarding the position, please call Sean Reynolds on (0115) 242 3204.

All candidates must complete an application form a CV will not be sufficient.

Please write for an application form and personnel specification to Personnel Officer, 2 St. John Street, Leicester LE1 3BE.

You could also download the application form and job description from our website www.leicsprobation.co.uk

Closing date: 12 May 2006.

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1-1 detox

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Duties include, carrying out substance misuse assessments supervising detoxification and facilitating ongoing rehabilitation, you will work both independently and jointly where needs are identified. Successful candidates must have a minimum of 2 years experience in the substance misuse field, have excellent communication skills, presentation, initiative and sensitivity.

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Axe Street Drugs Project

Axe Street is a non-statutory, tier 2/3 community based drugs service committed to providing the highest quality care to the residents of Barking and Dagenham.

We are seeking to recruit *2 experienced, pro-active and creative people* into the following posts.

Extended Hours Worker
(part time)
Salary £13.16 per hour

2 evenings a week (8hours) + supervision, meetings, training and possibility of extra hours.

Experience required:

- Brief intervention counselling
- Needle Exchange provision
- Assessment and care planning skills
- Groups/workshops

Young Peoples Detached Worker
(full time 35hrs per week)
Salary £22,545 - £23,943 inc of London waiting

Experience required:

- Work with young people
- Knowledge and experience of working with substance misuse
- Knowledge and experience of varied models of intervention for young people
- Effective oral, written, presentation and IT skills
- Ability to engage hard to reach groups within the community
- Ability to engage with fellow professionals and the wider community

While professional qualifications are desirable Axe Street also recognises and values relevant experience gained through paid or voluntary work and personal experience.

Closing date for applications by post, fax or e-mail is Friday 5th May
Interviews will take place on Thursday 18th May

For an application pack please phone: 020 8507 8668, fax: 020 8594 3719 or e-mail info@axest.demon.co.uk. For an informal discussion about the posts please phone and ask for Dave Chapman or Martin Delaney

Axe Street is an Equal Opportunities Employer. We welcome applications from all sections of the community. We particularly welcome applications from males as they are currently under represented in the workplace.

Registered Charity 1097261

INVESTOR IN PEOPLE

AXE STREET

Lifeline Project

Helping Drug Users Since 1971

LIFELINE LONDON – YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICE

The Young People's Substance Misuse Service is an exciting new service for children and young people under the age of 19. The service is provided across the London borough of Tower Hamlets, and operates as two teams; the Early Intervention and Outreach Team and the Care Management Team from premises in South Quay. The teams provide a range of interventions including: outreach, diversionary activities, targeted prevention work, screening, comprehensive assessments and work closely with a range of statutory and voluntary agencies. We have a number of exciting positions for which we are looking for people wanting a new challenge:

TRAINING AND DEVELOPMENT CO-ORDINATOR (REF: TH 001)

Salary: £24,708 - £28,221 (SCP 31-36) inclusive of Inner London Weighting
To co-ordinate the delivery of the Early Identification and Assessment Framework to local services working with children and young people across Tower Hamlets. To work with services for young people in Tower Hamlets to ensure staff have knowledge and skills in assessment and screening for substance misuse, and are able to deliver appropriate education, advice, information and support as required.

CAPACITY BUILDING CO-ORDINATOR (REF: TH 002)

Salary: £24,708 - £28,221 (SCP 31-36) inclusive of Inner London Weighting
The postholder will be responsible for the recruitment, induction and training of key members from the local community to enable them to become Community Interacters and peer educators to help deliver seminars, advice surgeries and training sessions around substance misuse.

YOUNG PERSON'S OUTREACH DRUGS PRACTITIONER (REF: TH 003)

Salary: £24,708 - £28,221 (SCP 31-36) inclusive of Inner London Weighting and pro-rata 28 hrs
The postholder will undertake targeted outreach and deliver harm reduction information, advice and referral to treatment services. This post is for a one-year fixed term contract and then subject to further review.

TRAINING OFFICER (REF: TH 004)

Salary: £24,708 - £28,221 (SCP 31-36) inclusive of Inner London Weighting and pro-rata 21 hrs
To develop and devise a training programme for community groups and young people's organisations in relation to substance misuse and where appropriate support the Training and Development Co-ordinator post in delivering training to professionals. This post is for a one-year fixed term contract and then subject to further review.

For an informal chat about any of the posts contact; Gill Reynolds or Bernie Kastner on 0207 093 3007. For further information and an application pack, please send an A4 SAE with 2 x 1st class stamps to: Charmain Wright at; Lifeline London, Unit 59 Skylines, Limeharbour, Marsh Wall, London, E14 9TS or email charmain.wright@lifeline.org.uk (for additional packs please attach extra stamps). The closing date for receipt of completed application forms is Friday 5th May 2006, 12.00pm), applications received after this date will not be considered. **Interviews will be held Monday 15th and Tuesday 16th May 2006**

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

For further information on Lifeline see: **www.lifeline.org.uk**

DASL – Drug & Alcohol Service for London

Drug and Alcohol Service for London is an innovative agency working across London to provide a range of services to people experiencing problems with alcohol or drugs. We have the following vacancies:

CLINICAL SUPERVISOR (COUNSELLING TEAM) (Ref: 06/02)

£45 per hour for up to 18 hours p.w.

To provide group supervision, supporting workers to be aware of and to work within the parameters of DASL service specifications, agency policies and relevant legal, ethical and professional frameworks. You will have an awareness of the wider contexts for work within DASL, such as exemplified in the NTA standards and guidance on Models of Care, the DANOS standards and training, QUADS and other quality frameworks and best practice guidelines. Extensive training and experience in the fields of substance use working and clinical supervision are required along with an informed knowledge of the major models of theory and practice that inform the substance use treatment field.

PART-TIME SUBSTANCE MISUSE COUNSELLOR (Ref: 06/03)

£13,144 for 17.5 hours p.w.

To work with clients who have been referred for alcohol services including structured counselling, structured reduction and community detoxification. You will promote the service to professionals in the borough through outreach and liaison with primary and secondary care services. You must have a recognised counselling qualification, be BACP accredited or equivalent, and have some experience of care plans and key working.

These post are eligible for Enhanced Disclosure by the Criminal Records Bureau.

For an application pack (paper/email packs available), contact:
DASL, Capital House, 134-138 Romford Road, Stratford, London E15 4LD.
Tel: 020 8257 3068, email jobvacancies@dasl.org.uk quoting job title/reference number.

Closing date: 9 a.m. 5.5.06.

DASL is committed to the principles of equality of opportunity for all. Registered charity 299535

Supporting young people

Project Worker/Senior Practitioner

£20,800 - £28,200

Young People's Substance Misuse, Wokingham

This is an exciting opportunity to develop new services to young people at Tier 2 and 3 in partnership with Wokingham Council's Children's Services and Drug Action Team. You will need a relevant qualification in social work, nursing, counselling or substance misuse and experience in delivering services to Young People with substance misuse issues. An ability to develop new initiatives within a multi agency context is essential, as is the ability to engage effectively with young people on a one-to-one basis and in group settings.

This post is subject to an enhanced disclosure check via the CRB.

For an information pack please telephone 020 8498 7011 (answerphone), minicom number 020 8551 3234, or download the information pack from **www.barnardos.org.uk/work_with_us.htm** and apply online. Please quote Ref: LE5172.

Closing date: 4 May 2006.

Interviews: 18 May 2006.

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