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DDN
Drink and Drugs News

9 October 2006
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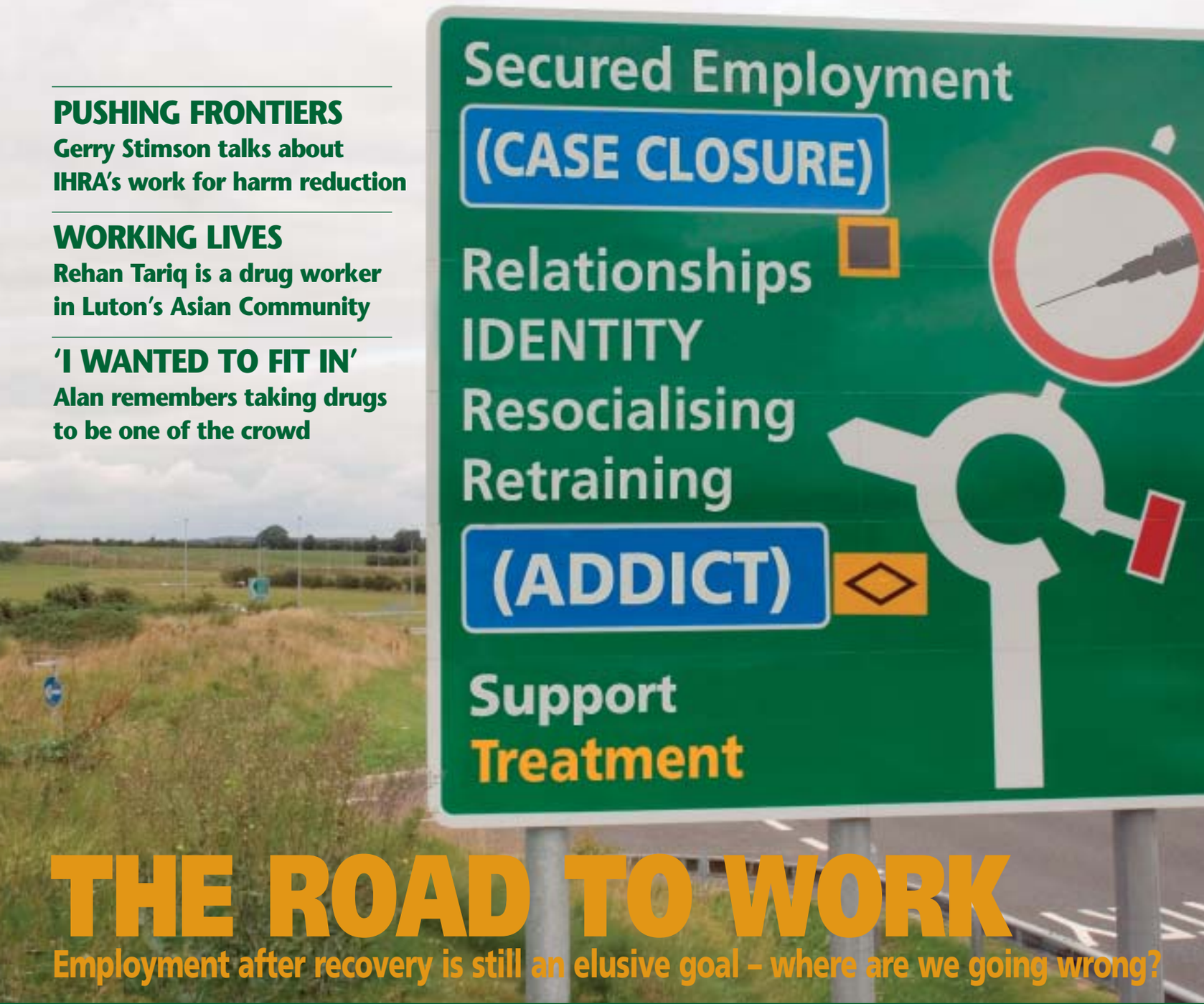

PUSHING FRONTIERS
Gerry Stimson talks about IHRA's work for harm reduction

WORKING LIVES
Rehan Tariq is a drug worker in Luton's Asian Community

'I WANTED TO FIT IN'
Alan remembers taking drugs to be one of the crowd

THE ROAD TO WORK
Employment after recovery is still an elusive goal – where are we going wrong?

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9 October 2006

Editor's letter

Once again this country's prisons have been declared at bursting point this week, to the point where we're looking at shipping prisoners abroad or extending the experiment of holding them in police custody suites, in a desperate bid to reduce overcrowding. It seems as appropriate as ever then, to look at how we help people out of the system and hold them in society – whether they've been in the criminal justice system or in residential treatment.

It makes sense that having a job improves chances of long-term recovery, and research backs this up solidly. It may come as a surprise then to take stock of the situation with Neil McKeganey and James McIntosh in our cover feature.

Only a tiny minority of people in recovery are finding jobs and keeping them. Why? The authors suggest that they are leaving treatment ill-prepared for working life – and that many services are not equipping them with essential life skills – or the means to learn them. There are schemes out there to help bridge the almighty gulf between treatment and work, and Andy Wright shares some ideas from his casebook at the Shaw Trust (page 7).

Once again empowerment wins the day. Give the service user the confidence to feel like they can hold down a full-time job and they're half way there. Let them grow in the job and feel valued in the workplace and they may find they are too busy and motivated to pay the same amount of attention to their old substance misuse problem.

For another demonstration of life changing intervention, read Alan's story on page 12. Before discovering Cocaine Anonymous he dedicated his life to trying (and failing) to fit in, which led him round the prison system as if he deserved no better. It's amazing what a bit of care and mentoring did for his outlook.

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In this issue

News in brief

BADSUF for Bournemouth
Bournemouth service user forum BADSUF have launched a new website with news, services, links, a forum, and an introduction to the team. The site includes details of the open day on 15 November, where service users can share views and find out more about treatment in the area. Visit *www.badsuf.com*

No confidence
A poll of doctors by Pulse magazine has shown 89 per cent have little faith in the country's 8,500 independent extended nurse prescribers, believing that they endanger patients. Dr Olly O'Toole, a GP trainer for the RCGP, added: 'The potential for harm is enormous. I pity the patients and the doctors are going to have a field day.'

Want more now
Motivation and choice are important issues for people seeking treatment for heroin dependency, according to market research carried out for pharmaceutical company Schering-Plough. Most respondents said they were not happy with the process they followed when entering treatment; desired changes included 'speeding up the whole process' and wanting more education and information.

Moving Clouds families
Clouds Families Plus, the charity working with families and significant others affected by addiction, has moved from Salisbury to Jill Cunningham House in East Knoyle, Wiltshire. The new location is convenient for residential treatment centre Clouds House, which is visited by hundreds of family members each year. Families Plus has developed its services to include brief residential family programmes and carer support groups.

Transform history
A historical timeline is being produced by Transform Drug Policy Foundation, tracing drug policy from 1800 to the present and beyond. Legislative and cultural events, including the develop-ment of the 'drug war', lead beyond the present day, with 20 years of crystal ball gazing into the future. TDPF welcomes contributions, corrections or suggestions for the timeline – visit *www.tdpf.org.uk/policy_timeline*

Treatment targets met 'two years early'

The government has announced that it has met its target to double the number of drug users in treatment, two years ahead of schedule.

Figures published by the NTA show that 181,390 people have been in contact with specialist structured treatment programmes over the past year – an increase of 113 per cent since 1998/99. The statistics were collated by Manchester University from the National Drug Treatment Monitoring System.

More than 141,500 people (78 per cent of those in treatment) had successfully completed or continued treatment at the end of March 2006 – an increase of 20,800 since March 2005.

Fifty-seven per cent of those in treatment during the year had entered treatment for the first time, or had relapsed and were re-entering services. Seventy-seven per cent were shown to have stayed in structured treatment for the recommended 12 weeks or more.

This showed that more people were staying the course of treatment, increasing the chance of it being more effective, commented NTA chief executive Paul Hayes.

He said the figures showed 'a considerable achievement by all involved in the drug treatment field'. Public Health Minister Caroline Flint added that she 'would like to congratulate the NTA, local drugs partnerships and treatment services around the country for their hard work and commitment in bringing about this extraordinary achievement'.

Heroin topped the league table of drugs misused by adults, at 66 per cent. Cannabis (75 per cent) was the most frequently misused drug by under-18s.

For detailed statistics visit the NTA's website, www.nta.nhs.uk

Izzy was among young people to perform rap, beat box, poetry and comedy at the first Drugs Rap 'n' Mix event in Birmingham. Right Start Foundation International organised the event in partnership with Birmingham DAT's Crack Strategy Department with the aim of attracting young people from Black and Minority Ethnic backgrounds, to express their views on the danger of drugs. Crack strategy manager Grantley Haynes said the event had proved 'innovative and powerful' in getting the right messages across to young people. 'The evening gave youngsters the chance to perform in front of their peers in a style which fits, while sending out positive information about the harm drugs cause and how to get help,' he added.

Professional training update

Two new units have been approved for Drugs and Alcohol National Occupational Standards, to cover retention and risk management.

Approved by the DANOS steering group, the units have been developed and tested to fill gaps identified in advanced practitioners' training. Key stakeholders, expert groups and focus groups have given their input to the consultation process on developing new units.

Standard AG4 stipulates that candidates must show evidence of retaining individuals in contact with substance misuse services. Standard AG5 states that they must implement policies to manage risk to individuals and third parties.

For more information on DANOS developments, including revisions to existing units, visit *www.skillsforhealth.org.uk*

A searchable DANOS-training database is now available on our website, www.drinkanddrugs.net. You can find a specific course or qualification, find the latest on professional training, and look for information in your area.

Go to the 'training and development' section of *www.drinkanddrugs.net*

FDAP's annual Drug and Alcohol Professionals Conference is on 8 November, and includes key updates and lively issues for debate. Speakers will look at the topics of the moment, including the future for rehab, harm reduction and alcohol services and workforce development and *DDN* will be on hand to report your views.

Register now at *www.fdap.org.uk* while there are still places.

Drug deaths down

A six per cent drop in drug deaths has been reported by the National Programme on Substance Abuse Deaths (np-SAD).

The programme, based at the International Centre for Drug Policy at St Georges, University of London, records a decline in deaths from 1,472 in 2004 to 1,382 in 2005. Three quarters of deaths were male, and most under the age of 45.

More than half of cases died from accidental poisoning, and opiates/opioids – either alone or combined with other drugs – were blamed for three quarters of deaths.

Brighton and Hove recorded the highest annual drug-related deaths per 100,000 population (24.2), followed by Dunbarton, Blackpool and the Fylde, the Isle of Man, East Lancashire, Liverpool, Southampton and New Forest, and Neath Port Talbot.

In some areas, including Liverpool and Jersey, deaths had reduced for 16 and overs. For others – Torbay and South Devon, Ceredigion, Cheltenham, the Black Country, Surrey, Exeter and Greater Devon – numbers had increased.

Professor Hamid Ghodse, director of np-SAD said the overall decrease in drug deaths was 'excellent news' that 'could well be the result of both the drug misuse monitoring and prevention initiatives promoted and carried out in the last few years'.

He also called for continued vigilance and constant monitoring of the situation to make sure the trend continues.

Mentor competition entrants Rebecca Skyrme and Adam Westbury, aged 12 from Hook County Primary School in Pembrokeshire, meet Blue Peter presenters Zoe Salmon (left) and Konnie Huq, on winning the 'young people's involvement' category of the charity's first Alcohol Misuse Prevention Awards. Their winning project started when their sports day was nearly cancelled because of broken bottles on the playing field and demonstrated how alcohol can impact on people's lives.

Pregnant women targeted in the washroom

Pubs and clubs in Manchester are joining in a campaign to target pregnant women on the risks of drinking.

Manchester Pub and Club Network, in partnership with Manchester Specialist Midwifery Service and NHS Drinking Responsibly Project, are displaying posters and wallets sized cards in women's washrooms. They warn against drinking when pregnant or trying to conceive, and give contact details for Manchester Specialist Midwifery Service for support and advice.

The campaign has been prompted by warnings about Foetal Alcohol Syndrome, a condition that affects the baby's intellectual abilities – and by research that shows that 18 to 25-year-olds in the North West drink on average four times their safe limit.

Faye Macrory, consultant midwife, said the campaign aimed to reach women who may not realise how many units they were actually drinking.

'One of the key messages we are trying to get across is that no alcohol equals no risk of alcohol-related harm to the baby,' she said. 'Education around alcohol and pregnancy with the support of a midwife is effective and can be all the support that is needed.'

Funding partnership gets cash to the front line

A funding partnership for projects in Scotland has been evaluated as having significant impact on services.

The Partnership Drugs Initiative, a partnership between the Scottish Executive, Lloyds TSB Foundation for Scotland, the Laidlaw Youth Project and Atlantic Philanthropies, had helped to develop nearly 100 new projects in the last five years, delivering £18.5m to work with the voluntary sector.

Helen Chambers, PDI programme manager, said the partnership was a way of 'getting cash to the front line with minimum bureaucracy'. The PDI targets children and young people with substance misuse problems, those at risk, and those with parents who misuse drugs or alcohol.

Deputy Education Minister Robert Brown said tackling drug and alcohol abuse was one of the biggest challenges of our age, and commented: 'it's great to see the difference we can make when we work in partnership to improve the day to day lives of children and young people in Scotland.'

Young people in Leicestershire are being offered clear and accurate facts about drugs through a new website and information card. The campaign is being co-ordinated by the three area DAATS in conjunction with their diverse partner organisations, including councils, police and young people's services. DAAT young persons commissioning officer Mark Aspey said it was 'an important step in providing young people with accurate information, so that they can make informed decisions about their lives'. Cards will be distributed in schools, doctors, and organisations dealing with young people's substance misuse.

From addiction to work... a road to nowhere?

Employment can be vital to recovery but is a rare and distant goal for many people leaving treatment. Where are we going wrong?, ask Neil McKeganey and James McIntosh.

On the basis of interviews with recovered drug addicts undertaken for our book *Beating the Dragon: the Recovery from Dependent Drug Use*, it would be hard to overestimate the importance of drug users finding work. Securing paid employment was beneficial for recovering drug users in a whole host of ways. For example, it provided a legitimate source of income for the drug users and meant that the individual did not have to rely on the marginal and often illegal means of securing funding that had carried them through their drug use.

Working was also helpful in a range of less tangible ways. It helped the addict develop relationships with non-drug users and lent a structure to their day that more closely resembled the rhythms of a life that was not running to the clock of their addiction. It also helped the individual move forward in the process of developing a non-addict identity – something that we found was crucial if their attempts to get off were to be successful.

Whichever way you look at it, getting recovered addicts into work is a worthwhile thing to do. It comes as rather bad news then, to report that only a tiny minority of addicts in treatment are successful in securing paid employment. Within the large scale Drug Outcome Research in Scotland study that has been following over a thousand addicts over the last three years, just over 10 per cent of drug users interviewed some 33 months after they had started a new episode of drug treatment, were in paid employment at the time of their interview. That depressingly small percentage tells us something that is all too apparent to those working in the world of drug user recovery; namely, employment is a rare and distant goal. But where may we be going wrong?

At least part of the answer to that question is likely to lie in the gulf that lies behind the world of work and the world of drug abuse treatment. Within the West of Scotland an initiative aimed at getting recovered drug users into work has stumbled for many years for a number of reasons. It has been possible to recruit staff who are expert either in the area of drug user recovery or who are expert in the area of securing and sustaining employment. Recruiting staff who are expert in both domains however, has been considerably more difficult. As a result, the project has vacillated between being an employment project for ex and recovering drug users that has an element of therapy and support added in, or a therapeutic project for drug users that contains an element of employment support for clients.

The second problem which this project faced, had to do with the fact that many of the drug users were referred to it on the basis that they were 'ready for work'. In fact they turned out to be a million miles away from that goal – they were, in a nutshell, still very much locked into the need for day-to-day support and treatment. This suggests either that many of those agencies that were referring drug users were unable to assess who was most likely to benefit from exposure to the work environment or, more worryingly, that those who they genuinely felt would benefit still had a long way to go before they could actually function in an employment situation.

There are other aspects of the gulf between the world of work and the world of drug abuse treatment that may bear upon this issue. For years, drug abuse treatment services within the UK have been encouraged to develop user-friendly relationships with their clients. While the ethic of user friendliness may be an important part of a therapeutic environment, one suspects that the world of work emphasises rather different valued goals such as reliability, conscientiousness, being committed to one's job and actually being as good at that job as the other employees who may not have had a drug problem.

The world of work is likely then to be that much harsher and more demanding than the world of drug abuse treatment. What this may mean in reality, is that a drug user in the later stages of his or her treatment may well need to undergo a degree of resocialisation or retraining into the conventions of the world of work and away from the conventions of the world of drug abuse treatment.

It sounds easy in theory but how do drug services know when is the right time to move the individual into this resocialisation or work socialisation phase? Some elements may be obvious. For example reducing the requirement on the individual to consume his or her methadone on a daily basis under close supervision is clearly something that you are going to need to do if you are going to be successful in getting a recovering addict into work. But in addition to this there is also going to be a need to place less emphasis on exploring the interior world of the addict and more emphasis in ensuring that they can turn up to work on time and in a state where they can do the tasks expected of them.

It is often difficult for drug services to decide when an individual has had enough treatment and when they can move on from treatment. In the jargon of service provision, this is called case closure.

Difficult or not, though, we are unlikely to enjoy much success in the realm of getting addicts into employment unless we are better able to spot the point at which individuals are nearing the end of their treatment and identify the different needs and skills they will have to foster to succeed in the world of work.

At the moment, what characterises the world of treatment and the world of work more than anything else is the gulf that exists between these two domains. It is a rare employer who understands the world of drug treatment and a rare drug worker who has recent experience of work in other employment sectors. If drug users are to profit from greater exposure to the world of work and if more drug users are to going to secure paid employment, we will require much closer cooperation between drug workers, clients and employers than would appear to be the case at present.

Part of that cooperation is likely to consist in a greater mutual understanding of the different demands placed on the individuals in the world of work and the world of drug treatment. Part of it will be developing a clearer understanding of the kind of support that both drug users and employers need in

'While the ethic of user friendliness may be an important part of a therapeutic environment, one suspects that the world of work emphasises rather different valued goals such as reliability, conscientiousness, being committed to one's job and actually being as good at that job as the other employees who may not have had a drug problem.'

order for the 'addiction-to-work' schemes to successfully operate. And part of it will also require a change in the mindset of those providing drug abuse treatment to bring clients to the stage where they can take on paid employment.

Over the last few years in Scotland, and elsewhere within the UK, there have been initiatives aimed at helping recovered drug users into work. While the intention of these programmes is to address some of the issues we have identified, on the basis of the Drug Outcome Research in Scotland Study (DORIS) data, the success of these projects may still be a long way short of what it needs to be if we are to see substantial numbers of recovered addicts moving from the realm of treatment to the realm of paid employment.

Neil McKeganey and James McIntosh are at the Centre for Drug Misuse Research, University of Glasgow.

Routemap to recovery

Andy Wright works at the Shaw Trust helping recovering drug users back into work. DDN asked him what, in his experience, makes the transition easier.

Employers have to take people on their merit. But if you give clients self-confidence, and they can manage it, they'll go away and they'll do well. Sometimes work can help in their treatment.

I see my role as an advocate – a guiding person, rather than making them do it. They take a job out of their own will, and that helps them to stay on the road.

We put one client on a programme called InBiz at the job centre – an initiative that helps people on benefits get back into work, by allowing them to work while they're on benefits. It's been a positive experience for him. He said to me yesterday, 'I've been so busy, I haven't had time to think about my addiction.'

We all have our difficult times, and some of them have been quite bad for my clients. But you have to convince employers to give them a try. It mainly revolves around clients' self-confidence. If I can boost their self-confidence, they can go off and do their own thing.

Giving employers an understanding of what addiction is, and making sure they have some awareness of the problem, can actually alleviate some of the hassles they will have. Clients can have problems getting up in the morning, if they've been using the evening before. They turn up late for work and get sacked – and there's no understanding about why.

Clients might start off in that frame of mind, but through working with me for a little while they want to go to work, they want to get up in the morning, they want to overcome these issues. When they get the job, they can become even more enthusiastic. They might start off initially not being able to give up their drug use, but when they've got the job and they work, they find it very easy to overcome.

Part of the problem of going to work is physically getting there, particularly if you're in a rural area and don't have very good transport links. Most people in this situation can't drive; they can't afford to have a car. There are schemes out there that will help. One scheme I have used actually lends people a bike – a little moped to get around, which they can borrow for six months. It gives people time to save up some money to buy their own. That's all people need – a chance.

Those coming out of drug treatment could get involved a bit earlier with people like me, rather than them coming back onto the streets and having nothing to do, then getting referred by somebody else later on. Having an intervention earlier gives that little bit more advantage.

We've just started to go into prisons to see what we can do for people with custodial sentences before they come out, so they've got something in place. When they leave they can go on A B and C... and their life is back to normal. **DDN**

The Shaw Trust is a charity that provides training and work opportunities for people who are disadvantaged. Their website is at www.shaw-trust.org.uk

'At the same time as service providers are telling us they have disastrously low occupancy rates, others are reporting healthy take-up. Even some of the organisations whose senior managers are talking about a 'crisis' have at the same time been reporting 90 per cent occupancy to Bedvacs.'

Neither 'bizarre' nor 'ill-judged'

The NTA has acknowledged, since its inception, that the funding regime for residential rehabilitation providers is inadequate and needs reform. The residential rehabilitation sector has been funded primarily from a community care system designed for the needs of the elderly. Furthermore, most provision is spot-purchased, not commissioned within a managed market.

This can cause problems for residential services serving regional or national catchments, giving rise to regular concerns about the under use of residential provision and the consequent impact on the financial viability of providers.

In this context, the Department of Health/National Treatment Agency initiative to expand residential provision is neither 'bizarre' nor 'ill-judged', as suggested by Brian Arbery in his article (*DDN*, 25 September, page 9) but the best opportunity we have had since 2001 to consolidate and double residential capacity in order to maximise service users' opportunities to complete treatment, and also to ensure that those who are commissioned to provide residential treatment in the new environment have access to an adequate and reliable revenue stream.

Whatever the improved prospects for the future, Brian paints a picture of 'crisis' about the present and demands immediate 'action' from the NTA.

Unfortunately it is difficult for us to act until we know whether we are dealing with a new crisis or a recurrence of the problems we have all been living with for years. At the same time as service providers are telling us they have disastrously low occupancy rates, others are reporting healthy take up. Even some of the organisations whose senior managers are talking about a 'crisis' have at the same time been reporting 90 per cent occupancy to Bedvacs.

The NTA needs to understand where we are on the continuum of explanations – from a widespread system failure to invest in residential services to the normal operation of market forces, which can create winners and losers – before we can plan an appropriate response. In developing this we are fully involving EATA as the umbrella body for many of the affected providers and have held meetings directly with representatives of the providers.

The NTA remains committed to the consolidation and expansion of the residential treatment sector as part of the treatment effectiveness strategy. If our current investigations identify a systemic problem which is jeopardising this strategic aim, we will act to remedy it. However, if what we identify is the appropriate operation of market forces causing a 'crisis' not for the sector but for individual providers, then it would be inappropriate for us to act.

In any event, action in advance of understanding the issues is clearly not going to help anyone.

Paul Hayes, chief executive, National Treatment Agency for Substance Misuse

Scared of commitment?

I sympathise with the frustration expressed by Brian Arbery at the large-scale under-utilisation of residential rehabilitation as a treatment modality (*DDN*, 25 September, page 9). He locates a central responsibility for this failure with the NTA and worries that a lack of financial commitment from local authorities may be preventing placements. To be fair to NTA, their strategic and operational responses may not be the primary or only forces influencing this particular agenda, and likewise there may be more than just resource issues at play.

I used to work in a locality from which a lot of rehab placements were made. There were usually one or two people about to be assessed or waiting to go in; a couple doing their placements; and someone coming out. This is in contrast to the area in which I work currently where, to my knowledge, there have been no drug rehab placements in the last two and a half to three years, and not because of lack of access to beds or a lack of financial resources.

Rather, it is as if there has been a gradual decline in the knowledge and skills in the practitioner workforce around rehab, which in turn has perpetuated a vicious circle of under-placement. How does one, for example, meaningfully talk to a patient about rehab if one has never actually seen it used, successfully or unsuccessfully?

In my view, the explanation for the stark contrast in uptake between these two authorities is the extent to which rehab is a real and live treatment option within the provider agencies of the respective areas. And moreover, the extent to which it may be similarly real and alive for the friends, families, and drug using peers of all those service users who have experienced both the challenging and positive aspects of rehab: who have come back home because it hasn't quite worked out right this time, or in this particular rehab, but who have been able to reflect on and – crucially – share their experiences; or who, conversely, have successfully achieved and maintained abstinence, and who are living proof of the power of rehab for their former peers. In other words, the difference is a critical mass of informed and aware service providers and service users.

There is a national educational task around residential rehabilitation that needs to be undertaken, and while the NTA is charged with the overall performance management of the sector, it would be wrong to place the burden of this educational and training responsibility onto the NTA. It should be squarely on the DAATs themselves, and their Tier 2 and 3 provider agencies.

Name and address supplied

Extreme lengths

Thank you Professor David Clark, for your invaluable series of 'Background Briefings'. The current series which examines the theories of addiction (*DDN*, 25 September, page 15) has the hallmark of your normal succinct style.

I am sometimes amused at the extreme lengths that opponents of the disease model seem prepared to go to in order to discredit this model which is rooted in factual experience, scientific and medical research.

To argue that there is no 'constellation of alcohol related problems that could be described as alcoholism' is disingenuous when, in fact the criteria for it is so clearly documented in both DSM-1V and ICD-10. The proposition that 'there is no evidence that addiction is irreversible', ignores the evidence that has accumulated over many years. I acknowledge that much of this evidence is anecdotal and self reported, but for anyone who has taken the time and trouble, to attend a few hundred 'open' meetings of groups such as AA and NA, the similarity in the history of literally thousands of those who have made countless and diverse efforts to moderate, or control their consumption of their drugs of choice, and subsequently failed, is hard to ignore.

When one then considers that such fellowships are based on the concept of self, rather than expert help, are not motivated, or influenced by political, or funding considerations and consist of people from differing cultures, race and background, I suggest that the evidence becomes compelling. In marked contrast, the opponents struggle to produce any significant evidence of a thousand or more people, who having been independently assessed as meeting either DSM-1V or ICD-10 criteria for addiction, successfully reversed their condition over any meaningful period of time, this being defined as a minimum of 12 months.

The suggestion by the opponents that the disease model can lead to people avoiding self responsibility is a gross distortion of the underlying principles of 12-step recovery, as indeed is the implication that the necessary inner (spiritual) changes essential to recovery are thus avoided. Those who seek to advance such a specious argument have either failed to understand the six principles underlying the 12 steps – *ie* acceptance, faith, personal inventory, change, restitution and helping others – or choose to ignore them; principles that are alien to those whose addiction is active, if only because the pursuit and consumption of their drug(s) of choice is their overriding priority.

What the disease model does suggest is that no-one sets out to become addicted, but that having done so, recovery is very much the responsibility of the individual, whilst ongoing support is offered simultaneously for as long and as frequently as the individual desires it.

The equally baseless hypothesis that

being 'labelled as an alcoholic or addict' whilst spending time in the company of others who have also experienced the terror of addiction is not conducive to a balanced lifestyle or 're-integration into society', is a further distortion of the principles of the 12 steps of recovery. First, all of the self-help fellowships stress that the only person who decides whether or not to consider themselves as addicted is the individual, and that no other member has the right to 'label' another as such. Second, those who have bothered to seek the evidence of the efficacy of self-help groups by attending a few hundred or so 'open' meetings, rather than just looking at the title of each step, soon become aware that many of those who attend these groups have been through the Criminal Justice System, and that a not inconsiderable number are initially homeless.

Further, it soon becomes apparent that many of the members have experienced, or are experiencing, severe psychological, medical, or behavioural problems, yet through the help, support and encouragement of other members, many of these seem to find gainful employment (a strange concept to those on DTOs and purportedly 'engaged' in 'treatment'), become self-supporting to the point of finding rented accommodation, and are encouraged to seek appropriate professional help for problems other than alcohol or other drugs.

Given the abject failure of the current government strategy, as documented in the research and report published by John Moores University, rather than the selectively edited recent report that has emerged from the Healthcare Commission and is published on the NTA's website, such a 'lifestyle' is far more normal and responsible, than those engaged in the revolving doors of 'harm minimisation'.

Insofar as other therapeutic interventions are considered, anyone who has studied and become skilled in implementing the transtheoretical model of change will be very conscious of how compatible the 12 steps of recovery are with the various stages in the 'Cycle of Change.'

Peter O'Loughlin, Eden Lodge Practice

Unhooked Thinking

I found William Prior's article Love and Baggage (*DDN*, 25 September, page 8) surprising and refreshing. While writing within the framework of addiction he says 'we get confused about love, so badly do we want it'. Obsessive 'love' is a drug and, as with other addictions, can be seriously damaging to mental and physical health. Where powerful emotions are involved, we are all slow to learn.

Anthony De Mello in his spiritually wise book *Walking on Water* tells us love is not attraction or desire ('I love the way you make me feel') although it is eternally confused with these. He questions our thinking: 'I love you, I can't live without you'; the verdict here being this isn't love, it's hunger. We are told that when we get rid of our fear, attachments and illusions enough to see a person clearly, then we can love in the true non-addictive sense. Popular culture, lyrics *etc* lead us anywhere but here, however. They continue to brainwash and confuse.

With its theme of Love and Baggage, Unhooked Thinking 2007 sounds set to explore the myths and complexities of human relationship and promises a broad look at addiction and that most fascinating area, the frailties of the human heart.

Angela Bott, Bromsgrove

User group advice wanted!

We are setting up a new service user venture in Medway Kent, and would appreciate readers' advice.

A group of us who have suffered from drink and drug addiction and met through attending AA and NA meetings have been discussing the ongoing effects of depression. (I am still taking antidepressants and have been for about six years).

So often we have heard people say 'go out and join a club', that will cure you. This is not an easy thing to do in an area where the majority of social activities are based around pubs, which is not a very good idea for those of us in recovery.

A few of us who have shown an interest in doing something to raise the profile of our lives are starting a coffee get together to put our heads together on activities that we can participate in, and the formation of a drop-in centre for people in the same situation, who don't want to be talking about the drink and drug 'war stories' all the time, but need relief from the drudgery of depression.

If any readers have experience of similar activities, their suggestions would be most welcome.

Trevor, by email

Email Trevor at ts006q4169@blueyonder.co.uk if you can offer suggestions. The group's meetings will begin on Friday 13 October, 1-4pm at 55 Green Street, Gillingham. All welcome.

Comment

Learning the hard way

The independent inquiry into the care and treatment of Michael Stone has outlined lessons on dual diagnosis that we cannot ignore, says Mike Ward.

Michael Stone's killing of Lin and Megan Russell ten years ago is entrenched in the public consciousness. The fact that he had a severe anti-social personality disorder sparked a public debate and led almost directly to attempts to re-draft the Mental Health Act.

Unfortunately various legal appeals and challenges to the inquiry process have meant that the report could not be published until September 2006. As a result some of the lessons are less striking now than they would have been when the report was completed in 2000.

Nonetheless, Michael Stone belongs to a group who are still among the most challenging to deal with: those with a severe antisocial personality disorder, drug and alcohol abuse, and occasionally, psychotic symptoms.

Stone came from a disrupted family background. He spent his adolescence either in care or in custody. He was using heroin by age 17 and was still using at the time of the killings.

He was 36 at the time of the killing and had had regular contact with mental health, substance misuse, prison and probation services. The inquiry found no evidence that the killings were directly due to failings in the provision of services; indeed in some areas services in Kent were to be commended. Nonetheless there are failings which provide important lessons.

The key message is familiar from other inquiries. From 1993 to 1997 Stone was in contact with the mental health and drug teams in Medway. The initial work of the drug service is praised: it was responsive and there were joint care management meetings between mental health, substance misuse and probation services. However, later in his care there are criticisms of inadequate care planning, *ie* poor implementation and review of a care package, poor coordination with other agencies, and inadequate sharing of information. These familiar themes run across all the main agencies working with Stone.

However, the most powerful passage of the report is that which talks about the challenge of working with drug using personality disordered clients. The report challenges those who take a defeatist attitude to this client group:

...there is no simple remedy, but that is not a reason for doing nothing. What has to be done is patiently to take all reasonable steps to reduce or remove the negative influences on the individual's life, build up the positive ones, and assist... in a return to a style of life and behaviour more consistent with survival in the community... There will be many reverses, failures and disappointments, but that is so of many conditions, physical, mental and social, which confront the caring agencies... The cancer patient is not abandoned because there is no cure.'

The report is almost 400 pages long and contains many other useful insights, such as a section on the application of the law on confidentiality. However, the greatest tribute to the Russells would be the application of its demands for a better response to those with a dual diagnosis of substance misuse and a personality disorder.

Mike Ward has been a member of both homicide inquiry and drug death review teams and provides training. He can be contacted at Michaeljohnward@btitnernet.com

As IHRA gathers steam for the next international conference on harm reduction, DDN talks to Gerry Stimson about the bigger picture.

Pushing frontiers of harm reduction

We want to create an environment where harm reduction is accepted and implemented, says Professor Gerry Stimson, IHRA's executive director for the last two years.

The International Harm Reduction Association is best known for its work on behalf of illicit drug users, but its remit includes all psychoactive drugs and the organisation is having to stretch itself to cover a burgeoning agenda on alcohol and tobacco harm reduction.

Stimson is not daunted. Heading towards IHRA's eighteenth conference next year in Warsaw, he describes an expanding network that supports the small but energetic executive council of 12, that covers most global regions.

The annual conference has a particularly important role in sharing practice and inspiration. 'It's where people can exchange ideas, new practice and research,' says Stimson. 'It's also a breath of fresh air once a year – a supportive environment.'

Follow-up action demonstrates the event's influence. One delegate from Taiwan had been attending conference for about eight years, learning about harm reduction. When his country uncovered a major problem with injecting drug users and HIV infection a couple of years ago, he was able to open doors for an IHRA delegation to visit Taiwan to speak to ministers, doctors and conferences.

'Last year Taiwan adopted harm reduction and now has methadone and needle exchanges,' explains Stimson. 'That's the way we like to see our influence.'

Part of IHRA's bigger picture comes through promoting harm reduction with international organisations. Work over the years with the World Health Organisation, United Nations Association and the United Nations Office on Drugs and Crime has brought significant policy changes in different countries.

This might not seem important for the UK – 'which doesn't take much notice of the UN!' Stimson acknowledges. 'But it's incredibly important for many countries that there's a UN document that says substitution treatment and harm reduction are OK,' he adds. 'It helps them to push forward.'

While the steady work supporting other countries goes on, IHRA is frequently called to the front line. When the US put pressure on the European Community to 'back off' on harm reduction, IHRA joined with others to form a coalition of drugs policy, human rights and HIV/Aids organisations that worked behind the scenes to brief governments who were sending delegations to the Commission on Narcotic Drugs.

Similarly, when UNA was reviewing prevention and the US insisted that syringe exchange shouldn't be mentioned, 'we organised delegations from other countries to make sure good sense prevailed,' says Stimson.

Earlier in the year IHRA lobbied against the International Narcotics Control Board's proposal to WHO that they move buprenorphine into the more stringent Single Convention. Had the INCB succeeded, WHO would have put the drug under tighter control and made it harder for doctors in different countries to prescribe it, but a campaign involving 160 organisations in 40 countries convinced them not to reschedule the drug.

Such co-ordinated action underlines Stimson's statement that 'we're not just IHRA, but IHRA and others'. But the handful of organisations that IHRA works with regularly, adds to the association's dynamic culture and makes it nimble in responding to smaller organisations' needs. Many small but sincere bodies that don't really know where to start in tackling harm reduction in their areas are given a route to engage in advocacy – with the spin-off that IHRA receives valuable offers of volunteer support.

Funding – 'always a struggle, but getting better' – comes from a mixture of conference, the association's membership, donations and some grants for project work. It helps that every opportunity is maximised: many people use the international conference as a stage for their own meetings, 'which keeps the spin-off groups ticking over until next time', says Stimson.

He reflects that progress in harm reduction has been tremendous over the last 20 years, from the movement's humble beginnings in a few agencies in the UK, Holland and Australia. Now there are needle exchanges in 65 countries and methadone and buprenorphine in about 60 countries – but in other areas the challenges are only just beginning. IHRA is fully involved in applying the harm reduction agenda to alcohol and tobacco, and with the EU alcohol policy about to be released, have been listening to the many arguments around increasing taxation to reduce consumption.

'But there are an awful lot of things that can be done to make the environment safer for drinkers and those affected by drinkers,' Stimson points out, applying the harm reduction philosophy that hasn't always been considered in the alcohol debate. Alcohol harm reduction can be very like drugs harm reduction, he says. 'You can change the drinking environment, the management of the pub, transport, bar staff training – a lot of harm reduction activities are relevant to public order.'

Similarly, discussions with the campaigning group Action on Smoking and Health (ASH) are bringing a harm reduction perspective to the table in dealing with smokers' nicotine addiction, which will be echoed in ASH's future policy.

Unfazed by needing to be everywhere at once, Stimson is preparing to fly to Iran, having just returned from Barcelona. IHRA's mission is to animate and harness help, and his commitment to engaging with like-minded others makes him a determined ambassador. **DDN**

'There are needle exchanges in 65 countries and methadone and buprenorphine in about 60 countries – but in other areas the challenges are only just beginning.'

Recognising that not everyone interested in harm reduction could be in Vancouver, IHRA held a London event to share the content of this year's conference. IHRA's Jamie Bridge reports.

Lessons for local practice

Last month, 130 people from various backgrounds gathered in London to gain feedback from the 17th International Conference on the Reduction of Drug Related Harm – an 'international harm reduction circus' held in Vancouver in May, that was attended by over 1,300 people from around the world. Inevitably, many people were unable to travel to Canada, so this event provided an important forum to make the key lessons as accessible as possible.

Tim Rhodes, director of the Centre for Research on Drugs and Health Behaviour, opened by stressing that harm reduction services must be flexible, proactive and innovative to address the current challenges, such as rising HIV prevalence, high hepatitis C prevalence and increasing rates of crack injecting. Gerry Stimson then presented the key themes from Vancouver – such as user involvement, human rights, alcohol harm reduction and young people – and emphasised that 'conferences are only as good as what comes before and what comes after', so harm reduction around the world must apply the lessons from Vancouver in order to advance.

Andria Efthimiou, Grant McNally and Daren Garratt spoke about user advocacy, 'the means to honestly facilitate the empowerment of users', which has been developing internationally since the eighth International Conference in Paris, in 1997. There were groundbreaking international and national user group meetings in Vancouver as well as scholarships, facilities and support for drug users. The conference represented true involvement of drug users, as opposed to tokenistic 'user representation'. Post-Vancouver, the international drug user group released their declaration statement and the national user group published a guide on user involvement – *Nothing About Us Without Us*.

Jo Kimber from the CRDHB presented the latest information on bacterial infections, which are overlooked by most harm reduction services, despite affecting one in three drug injectors in Europe. These problems are often compounded by poor hygiene, hurried injecting techniques, delays in seeking help and barriers to accessing primary health care. The concluding lesson for harm reduction services was that early diagnosis and treatment must be a priority, alongside on-site education and advice in harm reduction services and low-threshold primary health care.

Neil Carey presented research on harm reduction, young people and 'heavy' cannabis users. The sample were using 'skunk' daily and were vulnerable (although none had been diagnosed with chronic mental health problems). Heavy cannabis use was regarded as a need to smoke first thing in the morning and last thing at night, and the enjoyment of cannabis above anything else. To effectively tackle this, harm reduction services must engage young people, consider their own perceptions of their use, understand the function that cannabis plays and offer alternative coping mechanisms.

Danny Kushlick of the Transform Drug Policy Foundation presented his 'alternative view' of Vancouver, where areas that 'exuded health' sat alongside poor areas, and he praised the city's drug strategy as 'the best on Earth'. (Vancouver has North America's only drug consumption room). Next year's international conference will embrace the debate about drug prohibition and he closed by looking ahead to a 'long embrace' between the harm reduction and legalisation fields.

Paul Turnbull of the Institute for Criminal Policy Research opened a session on heroin use by focusing on how non-problematic users challenge how we view the drug. The key factors were individual circumstances and characteristics, environments and external commitments ('a life beyond drug use'). Most non-problematic heroin users 'were not immersed in heroin subculture' and did not inject, so harm reduction services must dispute the socially constructed 'junkie stereotype'.

Nicola Metrebian of the National Addiction Centre then presented the latest news from the UK's prescribed heroin trial, which is comparing injectable diamorphine, injectable methadone and 'optimised oral methadone' treatments. The final report is due for publication in July 2008 and will add to the international evidence, hopefully advancing harm reduction in the UK.

'Harm reduction services must be flexible, proactive and innovative to address the current challenges, such as rising HIV prevalence, high hepatitis C prevalence and increasing rates of crack injecting.'

Charlie Lloyd then presented the Joseph Rowntree Foundation's report on drug consumption rooms, which found a considerable need in the UK, with its high rates of drug-related deaths, hepatitis C, homelessness and public injection. Internationally, drug consumption rooms have been shown to save lives, improve health and reduce sharing and these facilities should be piloted in the UK and integrated into existing services. National guidance is currently being written but the government has refused to support the idea.

Finally, Tim McSweeney of ICPR reviewed the criminal justice topics from Vancouver, where several presentations highlighted examples of good and bad harm reduction practice in criminal justice settings. In particular, prisons and the police represent unique opportunities to deliver harm reduction. However, these opportunities are often under-utilised and significant advances can be made through post-release services, improved attitudes, substitute treatments, and needle exchanges. European studies have found a significant reduction in drug use in both coerced and voluntary individuals – so coercive treatment can play a role in a coherent drug policy, rather than being in conflict with harm reduction.

Overall, the one-day event was a success, providing a snapshot of the Vancouver conference and allowing for open discussions that were at odds with the hot and stuffy lecture theatre. Events like this can help to ensure the continued development of harm reduction – we look forward to seeing you at the next one!

Jamie Bridge is communications and project officer at IHRA.

Adapted from the Rapporteur Report by Gill Bradbury and Jamie Bridge, available at www.conferenceconsortium.org alongside the session slides. For information on next year's international conference, visit www.harmreduction2007.org

I just wanted **to fit in**

From his early life as the kid with the funny accent, Alan had seemed destined to depend on drink and drugs as his only way of fitting in. Nobody was more surprised than he was, when Cocaine Anonymous broke his cycle of dependence and prison to offer him a new life.

We moved to Bristol from the North East when they were closing down the mines. I was five or six, with a broad Geordie accent. I felt out of place, different from the people around me.

This constant feeling followed me wherever I was. I followed the crowd thinking 'if I could just feel part of this…'. I spent my time just trying to fit in.

In secondary school I'd found that if I drank alcohol and sniffed substances, I didn't need to fit in so much. I was quite good looking, I could dance a bit. When I left school with no qualifications I drank heavier and heavier. I saw it as a solution – I could fit in.

It got to the point where it didn't seem to be working. So I decided to get married – that'd do it. That wore off, so I thought I'd have a kid. That didn't work, so I had another.

Throughout this process, whoever came near me seemed to come off worse. There was delusion in my head – I wasn't seeing things. Eventually, because of my behaviour, my wife left me, my friends left, and I lost contact with my children.

I had started committing crimes. I would shoplift – then I moved onto burgling houses. I had absolutely no consideration for the victims. All I kept thinking was me, me, me. Then a couple of things happened. My mother died and I didn't make it to her funeral. Then when I went to visit my sons aged seven and eight, I passed out under the kitchen table. I woke up with one of them looking at me in disgust and the other one crying because he thought I'd died.

When 9/11 happened I was in hospital with infection in my groin. They said they might have to take my leg off. But all I cared about was wanting to score. I even thought that if I had one leg I could beg better and get more money.

So I decided that the solution was to move area. I stayed clean for seven hours. Then I ended up on the street, playing a penny whistle. I could play two tunes and justified myself as a busker. Then I got into a fight involving a weapon and ended up in jail. I'd been in prison a couple of times before, but would walk back out into the world with my discharge grant. All I knew how to do was score – so that's what I did.

This time, because of the conditions of my parole, I had to go on a course. All my family had run from me by now. While I was going through this process in jail, someone put this information about Cocaine Anonymous in front of me. They didn't force it, so I thought I'd have a look.

From this point forward my life changed. I started looking at the Big Book [the 12-step handbook written by Alcoholics Anonymous, and adopted by CA among others]. It's been proven over many years. I did things suggested by CA. I got a sponsor to give me their experience, because that's what I could listen to.

As a result, my life is very different now. Before this programme I couldn't have a relationship with anyone, not even my dog – I had to let her go into a dog's home.

Now I'm back in touch with my kids and I go out and work for an honest living. It's totally alien to the life I had before. All my life I've been selfish and self-centred. I took from everyone for minimum effort. Now I have friends in my life who don't have to run when I come in the door.

I'm a social creature, who can interact at last. The relief and joy is incredible. In all my years of using I could never look anyone in the eye.

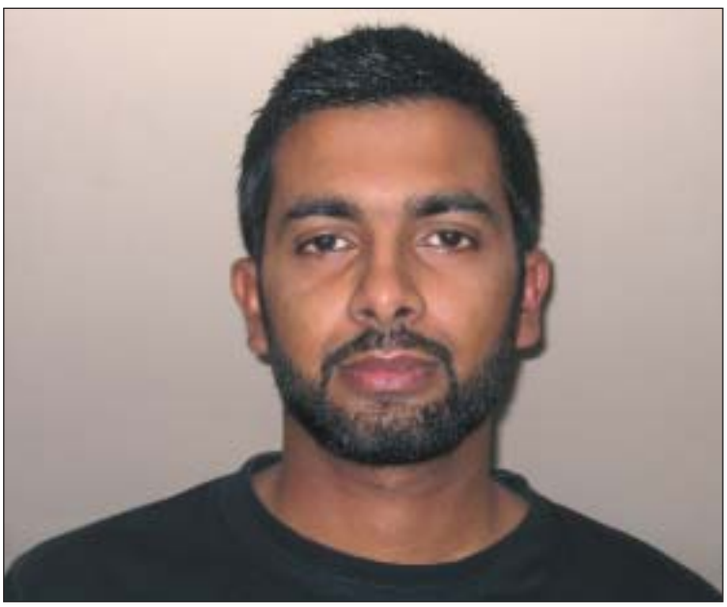
I have a nice little home that I pay for – my flat – by going through this simple programme. It's so simple I almost missed it. I wanted to intellectualise it at first; thank God I had a sponsor who told me it would save my life. It's idiot proof – and I can say that, because it worked for me.

I go through my life one day at a time. It's not all sunshine and happiness. But this programme's given me ways to deal with it by doing very simple and straightforward things – as simple as making sure I get out of bed an hour before I leave the house. I used to get up two minutes before leaving, and I wanted to kill people as I went down the road.

I had to be at the point of desperation before I would give it a try. It was hard for me to realise how straightforward the programme is.

I have my friends, my family – and my family in CA. The fellowship wipes all the clutter out of my head. **DDN**

For help with cocaine or other drugs, call Cocaine Anonymous on 0800 612 0225 or 0207 284 1123, or visit www.cauk.org.uk



Working lives:

Rehan Tariq, senior drug worker in Luton

Rehan Tariq is a senior drug worker with Luton PCT shared care drug service. As part of our occasional 'working lives' series, he shares his experience as an Asian working in the community he grew up in.

After attending university and completing my master's degree in petroleum geoscience, I worked in the Middle East as a seismologist, on a well-paid contract with a comfortable lifestyle attached. After 18 months I began feeling unfulfilled and realised that this was not the life I wanted to live.

As a practising Muslim, I felt there was more to life than financial rewards. Family life and the local community were important to me. As the first person in my family to have the opportunity to get a good education and to go to university, I wanted a job that was fulfilling and would enable me to feel I was helping my community by giving something back.

Returning to England I was shocked to discover that a number of my old friends had got involved in the drug scene, either using or selling drugs. I wanted to be able to help, but in a constructive, non-judgemental way.

Demographically, 35 per cent of Luton's population are from Black and Minority Ethnic groups. The local southern Asian population is predominantly made up people of Pakistani/Kashmiri and Bangladeshi origin. Historically they have not been willing to accept that there is a drug problem in their community. Mosques and Community leaders were not taking up the offer of education and advice from traditional mainstream drug services. They appear to have been in denial about the effect of illicit drug use on their communities.

In early 2000 I started work at ADIBOP (Asian Drug Information Befriending Outreach Project), which had recently been set up in a community partnership between organisations representing the Pakistani/Kashmiri and Bangladeshi communities. The aim was to provide a tier 1 service in schools and youth clubs and to signpost individuals to other services where appropriate. At that time there were not any Asian drug workers in the field locally.

In 2001 Luton teaching Primary Care Trust (tPCT), in response to the lack of treatment, started the Shared Care Drug Service (SCDS). As in many areas, GPs were reluctant to engage with the drug using population. Part of the remit of the SCDS was to support GPs who were willing to work with drug users. However, SCDS had also decided to employ its own doctors who continue to prescribe on behalf of GPs.

I was ready for a more challenging position and was appointed as a generic drug worker with a specific remit to engage clients from Southern Asian communities. The PCT recognised that these communities' needs were not being met and that having a representative from the community could be pivotal to successful retention of clients.

The team was initially made up of a midwife, a mental health nurse, a general nurse, an admin assistant and myself. The manager was keen that we did not use a predominantly medical model – measuring motivation and stopping scripts if people were using on top. We wanted to prioritise retaining clients in treatment, as well as removing waiting lists and barriers to treatment. Asian clients were often reluctant to access their GPs for treatment, as the client's perception was often that their family would find out. While GPs are bound by confidentiality, other members of the close-knit community may see them visiting the doctors and ask questions.

One of my first tasks was to promote the strict confidentiality of the service. The office, although in central Luton, was not particularly visible to passers by and gave a sense of privacy. Our mission statement was to offer a non-judgemental, client centred service, which was non-punitive, working with the client rather than imposing where we wanted them to be. Previous experience had shown that retaining clients in service and providing an easy-to-access service with no waiting lists was the key.

Chaotic drug users can be notoriously bad at keeping appointments and due to the conservative nature of existing services, are often viewed as 'not being motivated' or ready to change. Luton SCDS strategy was to be more flexible and meet the needs of the clients, by getting them into treatment and encouraging them to accept responsibility for their lifestyle choices.

Asian clients responded particularly well to this approach and we saw our figures for clients from the Southern Asian Communities steadily rise to 45 per cent. We compared this to other areas with a similar population spread to Luton, where the average take-up from Asian clients were about 4-6 per cent.

We also developed a more flexible approach to prescribing. The clients were encouraged to become more involved in their treatment and work in partnership with their keyworker. Having a wide cultural staff mix also helped the service to meet the needs of clients who do not have English as a first language. Ongoing education among the staff group helped to address confusion around inaccurate cultural and religious beliefs.

In the five years since Luton SCDS opened, I have seen my role change from service development, to becoming senior drug worker for the adult team. Our service is well integrated into the local community and we get most of our referrals by word of mouth. I get great satisfaction when I am seen as a positive role model by the Asian clients and have the respect of their families for the work that I do.

We have just advertised a job with the service and were inundated with applications from BME groups. Not only are we recruiting more workers from the communities we serve – it is now being seen as a career choice to be proud of!

How did you get into the field? Email the editor, claire@cjwellings.com

Alliance poster this issue

As you will have noticed, this issue of DDN carries a poster advertising the Alliance's helpline, *writes Daren Garratt.* This is because we have recently made some major changes to the service, including moving the helpline to an 0845 number attached to a virtual call centre.

By transferring our helpline to an 0845 number we have ensured that all calls to our helpline are only charged at a local rate when users call from a landline. The virtual call centre allows us to have an unlimited number of operators staffing the helpline at any one time, which means that we are less likely to be unable to take a call because operators are tied up. It also allows call queuing, which again will minimise lost calls.

If you are a user, carer, treatment provider, GP, DAT worker or manager please take a minute to ensure that the poster is displayed in all your local treatment agencies.

The helpline is the lifeblood of the Alliance; all our advocacy cases are generated from calls we receive. All calls are treated in the strictest confidence, and are answered by people with direct experience of drug treatment. People who understand the difficulties that users can face when trying to access appropriate, effective treatment. People who help by supplying callers with balanced, honest information or transferring their case to one of our regional advocates for more in-depth support. So if anyone you know is experiencing difficulties with drug treatment, please feel confident in accessing this service.

The NTA Treatment Planning Guidance for 2006/07 expects local partnerships to develop:

- Networks of advocacy and support services aimed at drug users which involve, where appropriate, PALS (NHS), local authority and the independent sector.
- Service level agreements which require services to display a service user charter, include user consultation in service reviews, and promote access to advocacy for users.

Putting up these posters in waiting rooms is a simple, effective way of ensuring that local users have access to the range of services they need, and that services are operating in line with local and national planning requirements. And if local services aren't willing to put these posters up, gently remind them of the NTA requirements and that it's treatment planning six-month review time...

If you would like any more posters delivered to you for distribution around local services, please contact Ursula Brown at malliance@btconnect.org.uk and she will arrange for their delivery.

We are a small Tier 3 team who support young people aged up to 19 years with comorbid substance use and mental health needs. I am currently undertaking a project to examine how we can involve our service users fully in both their own care plans and in the planning of future services. Here, we include them in all meetings and share written records with them, heeding their wishes with regard to confidentiality, (apart from the usual exceptions). We have an exit questionnaire and also seek and record young people's views as we work with them. It still sometimes seems not enough however: can readers give me any other ideas?
Barbara, Cambridgeshire

Box ticking exercises

Dear Barbara

It sounds to me that you are doing more than most to engage with your service users and to get meaningful input from them. Far too many people treat this as a box ticking exercise to demonstrate that they are following NTA guidelines; the fact that you are doing a lot to get genuine involvement and want to do more is to your credit.

One of the questions I would ask is; do the service users feel involved in the meetings?

Speaking from personal experience I know that it can be intimidating sitting in on professional meetings when you have no previous experience of a work environment. Too often the meeting can be dominated by senior people who may use jargon or terms that you are unfamiliar within these situations the service user can feel unable to challenge or question decisions and may feel swept along into agreeing with the drugs workers running the meeting. Some of whom (and of course I don't know if this is the case in your organisation) can be a little domineering and have an 'I've been doing this for years, I have seen it all attitude'.

The same can be said for the writing of care plans. Too often I was asked very closed questions and presented options in a way that led me to agree with decisions that had already been made. A bit like a 'magician's choice' you always end up with the card they are holding.

The fact that you are conducting exit questionnaires is great, but of course it is how the answers are used and the changes that are made as a result of them that makes them worthwhile, if they are just filed away they may as well not have been filled out in the first place.

I'm sorry if this all sounds like doom and gloom – as I said at the start you sound like you are genuinely trying to engage and want real participation. I have been in the position of a service user feeling part of a tokenistic engagement process (although usually very well meaning). Now I am on the other side of the fence having been a drugs worker for the past six years and the thing that I always make sure I do is really listen. As they say you have one mouth and two ears – use them.

Good luck with your plans, it sounds as if you are genuinely trying to make a difference.
Brendan, via email

Going through the motions

Dear Barbara

I just wanted to write to say how impressed I am with your efforts to involve your service users in their treatment pathways. I have attended services very recently where the so-called 'care plan' is nothing more than going through the motions.

It is great to hear that you are striving to do more. Tackling drug dependence is an extremely personal process, which is why it is essential that clients' views are taken into account.

Please carry on the good work – we need more people like you in the field who care about the clients rather than the paperwork.

One suggestion if you're stuck for more ideas: just ask your clients what they want and what helps. No two people are the same and I'm sure they'll tell you what works for them, whatever their age.
Roger, South Glamorgan

Regular Reviews

Dear Barbara

You're going through the right routine to get your service users' input. What you must do now is make sure you incorporate regular reviews.

A care plan is only useful if it is a living, breathing document and is regularly reviewed. Make space in your diary for regular feedback, as nothing will demonstrate your commitment to listening to your young people better than being proactive and responsive.

Also particularly important for this age group – be as flexible and approachable as you can, leaving a contact number for out of office hours if possible.

Seek their feedback on what doesn't work and what you could do better as well, however difficult this may be. It will work wonders for you in tailoring your service to their needs. I wish you well with your research – it will be worth it.
Teresa, Carlisle

Reader's question

I read your article about tackling addiction alone last month, prompting this request. I'm 25 and I've been using base amphetamines and alcohol in increasing quantities for nearly two years. I want to give up now, so much. I'm sleeping badly, getting chest pains and losing my ability to keep a grip on my life. I'm also starting to experience paranoia which I never have before. I can't go to my doctor or attend a clinic. I would lose my (well-paid and respectable) job if they ever got a sniff of my drug use. I need to do this myself and I need to do it quickly. Is there, or has anyone, any specific amphetamine-oriented advice that can help me give up alone?
Sarah, London

Email your suggested answers to the editor by Tuesday 17 October for inclusion in the 23 October issue of DDN. New questions are welcome from readers.

Conditioning models of addiction: Part 1

In his next Background Briefings, Professor David Clark describes the processes of operant and classical conditioning, as well as positive and negative reinforcement. He looks at how these processes are involved in problematic substance use and addiction.

There is a substantial body of research that shows that the ingestion of psychoactive substances and the development of problematic substance use or addiction involve psychological processes similar to those involved in normal appetitive behaviours such as eating, drinking and sex.

Research in laboratory animals has provided many insights into the role of reinforcement, learning and conditioning in normal appetitive behaviours, as well as in the misuse of psychoactive substances. In this regard, it is important to note that when given the opportunity, laboratory animals, such as the rat, learn to self-administer psychoactive drugs (except LSD).

Over millions of years, the brains of animals have evolved a motivational system that helps animals survive and reproduce. Behavioural responses that lead to positive consequences, such as the reduction of hunger, are likely to be repeated. Moreover, animals learn to escape from or avoid painful or noxious stimuli.

Operant conditioning, or instrumental learning, refers to the way in which the consequences of behaviour influence the likelihood of that behaviour being repeated. One class of consequence which can affect behaviour, positive reinforcement, is illustrated by a laboratory rat learning to press a lever to obtain food, or a dog sitting up to beg for a biscuit.

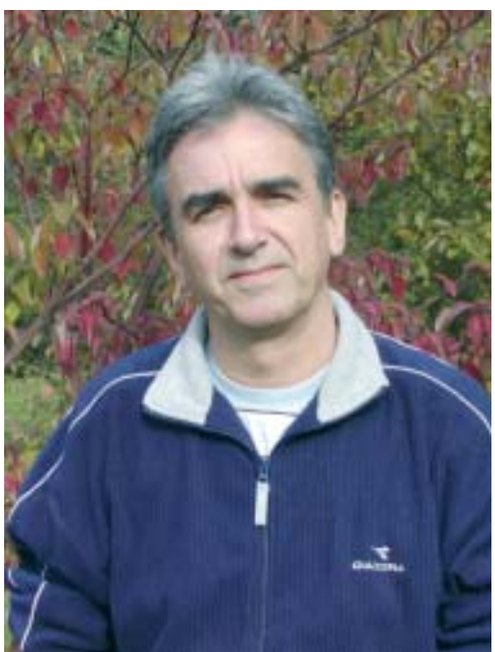
Drugs of dependence tap into the motivational system underlying this behavioural change. The drug acts as a reward, or positive reinforcer, and with repetition the association between cue, response and reward becomes stronger and stronger.

Another important principle here for understanding problematic substance use is the immediacy of reinforcement. It is well-established that the sooner a reinforcer follows a behaviour, the more powerful its effect will be on that behaviour and the more likely the behaviour is to be repeated.

A second class of consequence that can affect behaviour (negative reinforcement) can be demonstrated in the laboratory by training a rat to press a lever to avoid being punished by, for example, a small electric shock to the feet. Each time the animal receives the cue (*eg* a light predicting impending shock), it will perform an operant response to avoid the shock being delivered.

Similarly, the dependent heroin user may take the drug (perform an operant response) to avoid impending withdrawal symptoms and the associated physical and psychological discomfort.

It is important to emphasise that these instrumental learning mechanisms can operate outside conscious awareness and not involve a decision-making process.



'...in this model, addiction can be viewed as involving the "development of a habitual behaviour pattern that is independent of any conscious evaluation that might be taking place about the costs and benefits of the behaviour".'

Robert West (2006) points out that in this model, addiction can be viewed as involving the 'development of a habitual behaviour pattern that is independent of any conscious evaluation that might be taking place about the costs and benefits of the behaviour. The impulses to engage in addictive behaviour that are generated by this mechanism can be so strong that they overwhelm the desire of the addicts to restrain themselves'.

Classical (or Pavlovian) conditioning is a process that involves a neutral stimulus (such as a red light) becoming rewarding and influencing behaviour because it has reliably preceded a reward such as food.

In Ivan Pavlov's seminal experiments at the turn of the 20th century, salivation was demonstrated in dogs presented with food. After a neutral stimulus (bell) was presented in combination with the food on a number of occasions, the bell became capable of eliciting salivation in the absence of the food. Thus, the bell had become a conditioned stimulus capable of influencing behaviour, *ie* producing a conditioned response.

Conditioned stimuli play an important part in our daily life, and they have played a significant role in evolutionary terms, in respect of the survival of the species. They allow us to react to threatening situations and alert us to such necessities as food and sexual partners; they shape behaviour.

As discussed earlier for operant conditioning, classical conditioning processes can become automatic. Behaviour can be influenced without conscious, decision-making processes.

I know this well from lighting the gas ring above an oven that had been left on for many hours: I was blown across the room, fortunately with only hairs singed. But I was left with a strong conditioned response, such that every time I heard a sound near a gas stove, I literally jumped out of my skin. The response took years to extinguish.

These stimuli, such as Pavlov's bell, are known as secondary reinforcers because they derive their ability to influence behaviour by association. Secondary reinforcers can generalise in the sense that stimuli with similar characteristics (*eg* similar colour light) will produce a similar, but not necessarily identical, impact on behaviour.

The impact of the conditioned response can also extinguish, in that if presentation of the bell is not followed by food on a number of occasions, salivation in the dog will disappear.

In the next Briefing, we will look at the role of classical conditioning in substance use and addiction, considering conditioned withdrawal, conditioned drug-opposite responses and conditioned tolerance, and conditioned drug-like responses.

Recommended reading:
Robert West (2006) Theory of Addiction. Blackwell Publishing. (Available at discounted rate from the DDN bookshop at www.drinkanddrugs.net.)
Nick Heather and Ian Robertson (2001) Problem Drinking. Oxford Medical Publications.

Squaring the Circle?

Getting the most out of drug and alcohol rehab.

Date: 2nd November 2006
Venue: Ramada Leicester
Cost: €165 + VAT

For more information and booking details email events@feelgoodevents.com or telephone: 07940 722 288

NTA research indicates a need for more residential treatment for people with drug and alcohol problems. But at the same time, existing services often operate well below capacity, with some likely to close soon and others in danger of following suit.

This intensive one day event will bring together commissioners, their procurement teams, providers in the NHS, the voluntary and independent sectors, policy makers and strategic planners and thinkers to produce intelligent and jointly owned solutions to current issues on residential services' capacity and utilisation.

Delegates will:

- Share state of the art thinking and new ways of working
- Clarify the funding arrangements and identify new investment models
- Explore the commissioning arrangements at national, regional and local levels
- Present solutions that can be tested to improve results for the sector

The day is divided into two parts:

AM: Framing the challenges and expert thinking

PM: Finding practical solutions to move forward exploring national, regional and local solutions. Some of the questions we will be tackling are:

"What can providers do? What can commissioners do? What can policy makers do?"

This one day conference is supported by the National Treatment Agency and the Centre for Public Innovation and organised by feelgoodevents.

the centre for Public Innovation

NHS National Treatment Agency for Substance Misuse

feel good events

Ceredigion Cyswllt Contact

National Drug Team of the Year

SUBSTANCE MISUSE COUNSELLOR

An exciting opportunity has arisen to join our expanding substance misuse agency, based in Aberystwyth, covering Ceredigion and parts of West Wales.

Salary:
- *£18,000 up to £20,000 depending on qualifications and experience*
- *Up to £2000 towards re-location costs*
- *Full-time position, 30 days per annum annual leave*

Essential:
- *Professional counselling qualification*
- *Minimum of one year's experience within the drug and alcohol field including the Minnesota Model*

Desirable:
- *Reality Therapy training*
- *Fluent in the Welsh language*

If you are in recovery you will have had three years of abstinence.
Ongoing training will be offered for the appointed person.

For an informal discussion please telephone Maureen Fyffe on 01970 626470.
For an application pack please contact 01970 626470 or enquiries@recovery.org.uk, write to Contact Ceredigion, 49 North Parade, Aberystwyth, SY23 2JN or download the application pack from recovery.org.uk.

The closing date for applications is Monday 30th October.

PCP
a new beginning

ADDICTION COUNSELLOR c£24,000 – Spain

PCP Spain is based in the mountain region close to Granda, and opened in November 2005. Due to continued growth and success of the clinic we have an immediate requirement to recruit an experienced counsellor with a minimum of two years working experience and knowledge of 12 step treatment. Ideally you will possess a recognised qualification within the addiction treatment field. Our treatment centre is located in one of the most beautiful parts of Spain and offers excellent quality treatment and accommodation to it's clients. Excellent salary, relocation.

For further information please contact Darren Rolfe
Tel: 01582 730 113
Email: darren@pcpluton.com

Essex County Council

A FAST TRACK PRESCRIBING SERVICE FOR DIP CLIENTS IN ESSEX

Essex DAAT would like to invite you to submit an expression of interest to deliver a Rapid Prescribing Service for Essex clients entering treatment via the DIP Pathway.

This service will need to be able to deliver on the objectives of providing substitute prescribing to DIP clients within 48 hours of accessing treatment. Once stable, clients will be referred to mainstream substance misuse services.

You are invited to propose a model of delivery in line with Treatment Pathways identified in the National Treatment Agency Models of Care 2, which will deliver on provision of substitute prescribing (maintenance/slow reduction based on individual client need), using methadone/buprenorphine/naltrexone as the primary drugs for opiate substitution.

Essex DIP is primarily a Tier Two service which aims to provide improved pathways into treatment and continuity of support whilst the client is waiting for Tier 3 or Tier 4 services.

Providers will need to outline their exit strategy for clients demonstrating continuity of care.

The prescribing regime is expected to be in line with Drug Misuse and Dependence - Guidelines on Clinical Management (DOH, 1999) and more recent guidance from the RCGP on the use of buprenorphine (2004) and methadone (2005). Clients of this service will be expected to receive their medication under supervision (this could either be via services delivered by your agency or through the Essex DAAT area Shared Care and Pharmacies services). Prescribing will be in line with the Department of Health's Clinical guidelines and will take into account the recommendations for the reduction of drug related deaths identified in the report of the Advisory Council on the Misuse of Drugs Act (ACMD) (2000).

This contract has a proposed commencement date of 1st April 2007. Expressions of interest must be made in writing to the address below and received no later than 31st October 2006. Pre Qualification Questionnaires will be issued to all providers who have expressed an interest. Contact: Maria Warren at Procurement Services, P.O. Box 4, County Hall, Chelmsford, Essex CM1 1JZ or maria.warren@essexcc.gov.uk The contracting authority undertake to use reasonable endeavours to hold confidential any information provided in the proposal submitted, subject to the contracting authority's obligations under law, including the Freedom of Information Act 2000. If the applicant considers that any of the information submitted in the proposal should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The contracting authority will then consider the sensitivity statement before replying to any request received under the Freedom of Information Act 2000. Tender documents or notice of non-acceptance, as appropriate, will be sent to all applicants.

TACKLING DRUGS CHANGING LIVES
ESSEX DRUG & ALCOHOL ACTION TEAM

Annual Drug & Alcohol Professionals Conference 2006

8 November

London

fdap.org.uk

fdap

DDN Drink and Drugs News

BUCKINGHAMSHIRE COUNTY COUNCIL

We have significant benefits available to our employees including generous annual leave entitlement, final salary pension scheme, childcare vouchers, flexible working where operationally practicable, discounts on rail/bus travel and discounted memberships at local Sports and Leisure Centres.






BUCKINGHAMSHIRE DRUG AND ALCOHOL ACTION TEAM

The Buckinghamshire Drug and Alcohol Action Team (DAAT) is hosted by Buckinghamshire County Council and has been in operation since 1995. Since 1 April 2006, alcohol has been included in our remit. The DAAT brings together a range of statutory and voluntary partners to plan and commission substance misuse prevention, education, and treatment services.

DAAT Alcohol Commissioner/ Co-ordinator

£25,302 - £27,867 pa
Fixed Term for 18 months
Hampden Hall, Aylesbury
Ref: CSTS057a/DDN

In this new role, you will develop an alcohol strategy for Buckinghamshire, taking the lead on assessing need and determining local priorities. At the same time as driving the implementation of the strategy through the careful co-ordination of all DAAT partners, you will commission, contract, and manage the performance of alcohol services.

Fully conversant with the National Alcohol Harm Reduction Strategy and recognised best practice, you will have the ability to act as the principal advisor to the team and its partners. You'll also have the presence and credibility to represent the team locally, regionally, and nationally. A flair for finance and performance management will also be essential.

For an informal discussion please contact Susie Yapp, DAAT General Manager, on 01296 37920.
Please visit our website at www.buckscc.gov.uk/vacancies
Alternatively call 01296 383366 or email: recruitment@buckscc.gov.uk for an application pack.
Closing date: 12 noon, 23 October 2006.
Interview date: 7 November 2006.

BUCKINGHAMSHIRE COUNTY COUNCIL

www.buckscc.gov.uk/vacancies
Positively welcoming applications from all parts of the community

NORTH YORKSHIRE POLICE AUTHORITY

2006/17 SUBSTANCE MISUSE TESTING

Police Authorities in the North East Region are seeking expressions of interest from parties with proven experience in the provision of Substance Misuse Testing services. Interested parties should be capable of testing for alcohol and controlled drugs through a sample of hair, saliva, urine or breath as appropriate. The successful supplier will provide scheduled random testing to satisfy each Authorities testing schedule and be capable of providing a 24 hour call out service at any Authority location as required. UKAS Accreditation to ISO 17025 or equivalent is required.

The exercise will result in standing offers being open to Police Forces forming the North East Region of Police Forces and other organisations listed in the Hazell & Co Almanac. The agreement will run from February 2007 for a period of 2 years with an optional extension of up to 2 years.

North Yorkshire Police

This will be a restricted procedure and short listing will be based on the responses to the questionnaire which can be requested in writing, or e-mail from Sandy Campbell, Procurement Dept, Police HQ, Newby Wiske Hall, Newby Wiske, Northallerton DL7 9HA, email procurement@northyorkshire.pnn.police.uk

Completed questionnaires must be received no later than 12 noon on 15th November 2006 together with all other information requested.

reducing crime and the fear of crime

Department of Finance and Personnel
www.dfpni.gov.uk

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

S14928/06 **Development of a Regional Support Mechanism for Service Users In Respect Of Problem Drug Use**

Supplies and Services Division, Central Procurement Directorate (CPD), on behalf of its client, the Department of Health, Social Services and Public Safety (DHSSPS), invites tenders from suitably experienced organisations to provide the above service.

In support of the New Strategic Direction for Alcohol and Drugs in Northern Ireland 2006-2011 the CPD, on behalf of the Alcohol and Drugs Policy Branch of the DHSSPS is seeking to appoint a service provider to:

- **develop and support a regional network in respect of service users, their families and carers across Northern Ireland; and**
- **support individuals and groups within the target group in respect of capacity building and skill development.**

The New Strategic Direction for Alcohol and Drugs in Northern Ireland can be downloaded from the DHSSPS website: *www.dhsspsni.gov.uk/show_publications?txtid=17069*

Tender documents can be downloaded from CPD's electronic tendering system (ProCon). If you wish to download documents and are not registered for ProCon access, you can gain access via the relevant website: *http://procon.cpdni.gov.uk/procon/*

If you have any problems registering on the website please phone (028) (ROI 004428) 9052 6713, quoting the above reference and contract title. Under no circumstances will late tenders be considered, nor is CPD obliged to accept the lowest or any bid.

The closing date for the receipt of completed tenders is:
15:00hrs on Monday 30th October 2006.

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www.SamRecruitment.org.uk

LOOKING FOR HIGH QUALITY, SKILLED, SUBSTANCE MISUSE STAFF?

Consultancy, Permanent, Temporary

We Talk Your Talk…

- *A comprehensive database of specialist substance misuse personnel*
- *Providing staff for Public, Private, Voluntary and Charitable organisations*

We Walk Your Walk….

- *Recruitment consultants with many years experience in the substance misuse field*
- *Meeting all your recruitment needs for the substance misuse field: Criminal Justice; Treatment; Young People; Communities; Availability*

Contact us today: Tel. 020 8987 6061
Email: SamRecruitment@btconnect.com Or register online

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drug & alcohol services

edp

EDP is well recognised as THE leading non-statutory service provider for drugs work within Devon. All Staff are fully committed to evidencing the highest standard of service provision and outcomes for service users. We are looking for skilled individuals, with excellent communication and interpersonal skills, and experience within the substance misuse or related fields. You must be committed to achieving results, possess a proactive and outcome focused approach to work, plus a commitment to delivering the highest standard of professional practice.

Senior Practitioner - Exeter, east & mid Devon adult Services – Ref No: 23.06

Salary: £25,437 rising to £28,220 (NJC Scale 32-36)
Hours: 35
Base: Exeter

We are seeking to appoint an individual who wishes to join our dynamic and expanding team of drug treatment practitioners. The successful applicant will become a key member of the Exeter, east & mid Devon Adult Services. You will play an important role in service development in line with evidence based best practice and National Standards. An important aspect of your role will be in providing supervision and performance appraisal to staff, students, trainees and volunteers in the team. We are therefore looking for an enthusiastic and highly motivated individual who has a solution-focused approach to their work.

You will be familiar with the delivery of Tier 2 and Tier 3 treatment interventions to individuals who use drugs, including their families and other carers. You will be experienced and skilled at case management and your role will involve carrying a caseload of clients, some of whom may have complex needs. You will have the ability to undertake comprehensive needs assessments, devise care plans and implement and review those plans. Your record keeping will be excellent and you will be committed to multi-agency working. You will be expected to deputise for the Head of Service. A professional qualification (e.g. social work, psychiatric nursing, counselling, teaching) or equivalent experience or training is desirable.

You will need to hold a driving licence and have access to a car.

You will receive opportunities for professional development and learning as well as having the opportunity of working for an organisation that provides an excellent employee package.

Closing date: Monday 23rd October 2006 12noon.

For an informal discussion after reading the application pack please contact:
Caroline Moore, Head of Exeter, East & Mid Devon Adult Services: 01392 666711

We would welcome applications from general or specialist drugs practitioners as vacancies arise from time to time, please send your CV to the recruitment addresses below.

Application pack available from: Georgina Burford, Human Resources Officer,
EDP Drug & Alcohol Services, Dean Clarke House, Southernhay East, Exeter,
EX1 1PQ. Or e-mail recruitment@edp.org.uk quoting the reference number.

NEED EXPERIENCED STAFF?

KINESIS Mental Health Professionals

Kinesis will provide...

- ✔ Recruitment solutions for ALL substance misuse services
- ✔ A selection of suitable CV's on request
- ✔ Excellent candidate-to-role matching - so your service finds the most appropriate project staff, nurses and consultants
- ✔ Experienced candidates for roles within...
  Drug Action Teams • Treatment Services
  Youth Services • Arrest Referral ...and more

Please call us now 0207 622 4827
www.kinesislocum.com

We are always pleased to receive CVs from experienced candidates

Kinesis Locum Ltd. are regulated by the Commission for Social Care Inspection.
We are an equal opportunities employer

LONDON AREA>

SENIOR SUBSTANCE MISUSE WORKER > HMP FELTHAM
£22,742 - £29,771 + £4,000 LOCAL PAY ALLOWANCE

This is a challenging post that will lead, manage and develop substance misuse services for juveniles. These services will be delivered to an accreditation standard that is recognised locally, nationally and internationally and the post holder will deputise in the substance managers absence.

You will provide formal case management and day to day support, management and guidance to Substance Misuse Workers regarding their case work. The successful candidate will identify and assess juvenile trainee's substance misuse needs, manage detoxification and clinical management support interventions related to Substance Misuse and develop Substance Misuse Education programmes.

PSYCHOLOGY ASSISTANTS (DRUG PROGRAMME FACILITATORS) > HMP WORMWOOD SCRUBS
£13,674 + £4,250 LOCAL PAY ALLOWANCE

Successful candidates will be responsible for facilitating short duration drugs programmes to groups of prisoners. Working as part of a multi-disciplinary team you will collate and review data as well as taking part in project reviews and plan assignments for your clients.

For further information about these posts and to apply visit our website and download an application pack at: www.hmprisonservice.gov.uk/careersandjobs/currentvacancies or alternatively email: LondonAreaRecruitment@hmps.gsi.gov.uk

Completed applications should be sent to: London Area Recruitment Centre HM Prison Service, Wormwood Scrubs, Du Cane Road, London W12 0AE

Please note that all Prison Service posts are open to part-time and job share applicants. Applicants are required to declare whether they are a member of a group or organisation which the Prison Service considers racist. The Prison Service is an equal opportunities employer. We welcome applications from candidates regardless of ethnic origin, religious belief, gender, age (subject to being within the normal minimum retirement age for the grade), sexual orientation, disability or any other irrelevant factor.

HM PRISON SERVICE
Public Sector Prisons

LONDON AREA

INVESTOR IN PEOPLE

RAPt

'Stopping Addiction, Stopping Crime'

COUNSELLORS & DRUG WORKERS WANTED

Starting salary £21,000 plus a generous benefits package

RAPt, one of the country's foremost providers of drug treatment services in the criminal justice sector are always looking for 12-step Counsellors and Drug Workers for their prison and community-based projects.

For more information, or an application pack, please send an A4 SAE and covering letter to:

Mandy Coburn, RAPt, Riverside House,
27 – 29 Vauxhall Grove, London SW8 1SY or
email mandy.coburn@rapt.org.uk

RAPT strongly encourages applicants from Black and Minority Ethnic individuals and from those in recovery from addiction.

Registered Charity No. 1001701

ACT
Together, Tackling Addiction

Substance Misuse Worker,

Aylesbury & High Wycombe, Buckinghamshire
£20,421 to £22,628 per annum
37 hours per week

ACT is the principal provider of non-statutory substance misuse services in Buckinghamshire.

This post will provide substance misuse counselling/support, as well as advice and information, group work and assessments within a multi disciplinary team. A portion of the work may be carried out in GP surgeries. Some evening work will be required. Application closing date is 25 October 2006.

For an application pack please contact Justine/Nicola on 01296 425329 or email justine@addictioncounsellingtrust.com

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

The Drugs & Homeless Initiative (DHI)

The Drugs & Homeless Initiative is an award winning charity that seeks to assist people to address problematic drug and alcohol use, with particular regard for those who are socially excluded as a result of poor housing, lack of employable skills or other means. We are currently recruiting for:

DHI

Bath based

Area Manager

Salary Scale: NJC pt 38 £29,859 to pt 42 £33,315

This is an excellent opportunity for a motivated and creative individual interested to lead and build upon DHI's activities and reputation for innovative service delivery.

The ideal candidate will possess excellent leadership, negotiation and interpersonal skills. They will have proven management experience including experience of staff recruitment, development and performance management and reporting. Ideally you will have an understanding of both Models of Care and the Supporting People framework, with experience in either the supported housing or substance misuse field. A professional qualification in management, health or social care is desirable.

As Area Manager the post holder will report directly to the Executive Director and play a key role in strategic and service development.

Benefits include 25 days annual leave, a commitment to training and optional company pension scheme.

Application Packs and further information are available from: DHI, 15/16 Milsom Street, Bath, BA1 1DE. Tel: 01225 329411 e-mail: recruitment@drugsandhomeless.org.uk

Closing date: 9am Friday 27 October

DHI is striving to be an equal opportunities employer Registered charity no. 1078154

REDCAR & CLEVELAND BOROUGH COUNCIL
TENDER FOR A YOUNG PEOPLES INTEGRATED DRUG AND ALCOHOL SERVICE

Redcar & Cleveland Borough's Young Persons Substance Misuse Partnership Board is committed to improving services for young people. The Partnership Board intends to continue to develop high quality drug and alcohol services within the Borough.

Expressions of interest are invited from suitably qualified and experienced organisations wishing to tender for the provision of a young people's integrated drug and alcohol service compliant with Every Child Matters.

The successful organisation will provide:

- An integrated and innovative approach to reducing the use of, and potential harm caused by the use of, illegal drugs and alcohol by children and young people up to 18 years of age.
- Rapid access to treatment to engage young people and reduce harm from drug and alcohol abuse.
- Assessment and clinical and non-clinical Tier 3 interventions and Tier 2 group work and one to one interventions through planned treatment.

It is anticipated that the earliest start date for the contract will be April 2007 for a period of 3 years with an option to extend for a further 2 years.

Providers wishing to receive tender documentation should apply in writing to:

Janet Power, Contracts Department, Directorate for Health and Social Well Being, Seafield House, Kirkleatham Street, Redcar TS10 1RP.

Closing dates are as follows:-

Closing date for tender pack requests: Monday, 23rd October 2006.

Return of tender: Noon on Monday, 20th November 2006.

Shortlisted organisations will be required to attend an interview week commencing 04 December 2006.

CJ Wellings

Editorial and admin assistant

Salary £16,000 – £18,000 dependent on experience

Assisting the magazine editor with chasing copy, organising news files and the production of DDN. General office admin including filing, answering phones, outgoing accounts and customer service calls.

Advertising sales person

Salary £16,000 – £18,000 basic + generous commission

We are looking for an advertising sales person to work across our publications and directories selling both display and classified recruitment advertising. You must have at least 12 months proven experience in advertising sales.

Applications via email only to **ian@cjwellings.com**
For more information visit **drinkanddrugsjobs.net**