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DDN
Drink and Drugs News

GIRLS' TALK
Empowering young Asian women and celebrating identity

FIGHTING ADDICTION
A journey from alcohol-fuelled violence to service user rep

'Nobody's addressing the root cause of why someone's using drugs... aren't we just throwing money out the window?'

UNSPOKEN TRUTHS
HOW CAN FRONTLINE WORKERS DEAL WITH THE LEGACY OF CHILDHOOD ABUSE?

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DDN Drink and Drugs News

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Editorial – Claire Brown

Unhealed wounds

When to call for more than a sticking plaster

The statistics relating to frequency of sexual abuse are horrifying in their own right. But as our cover story highlights (page 6), while the legacy of abuse is widespread for many drug and alcohol clients, there is a total mismatch with the attention this difficult issue receives.

When we've written about the subject of childhood abuse before, we've been contacted by readers who wanted us to know how long it's taken them to peel back the layers of drug and alcohol problems from the unhealed scars of abuse from their formative years. Considering how common this seems to be, how strange it is that so few agencies incorporate specific skills to help their staff recognise and address their clients' past trauma. Everyone's trimming their budgets, but this surely is the starkest example of a false economy. Treating the substance problem by whatever means does not negate the need to dig deeper and unearth the strands that have firmly rooted the client for years in drug, alcohol and mental health services.

The 'sticking plaster' approach highlighted by the Southmead Project does nothing to safeguard against relapse and promote any chance of long-term recovery. So why are we ignoring the massive influence of abuse throughout policy documents? Why are frontline workers reporting that their agencies can't address this issue because they don't get the dedicated funding for it?

Everyone's noticing the recovery agenda at the moment (see letters, page 10) to the extent that it's been officially recognised in national strategy for the drugs field. But why are the small but vital local support projects for victims of abuse struggling on with little or no funding? Working with clients at this level could offer vital new direction for victims of abuse and give them chance to experience the recovery agenda – and save miles of sticking plaster later on.

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Cutting cravings

A cocaine vaccine that uses the immune system to help block the drug's effects worked in 38 per cent of subjects, according to researchers at the Baylor College of Medicine in Houston, Texas. Further research will be conducted into the vaccine, which is designed to help prevent relapse by diminishing cravings for the drug. 'The results of this study represent a promising step toward an effective medical treatment for cocaine addiction,' said director of the US National Institute on Drug Abuse, Dr Nora Volkow. 'Provided that larger follow-up studies confirm its safety and efficacy, this vaccine would offer a valuable new approach.' www.bcm.edu

Hard times

Alcohol misuse, anti-social behaviour and domestic violence are all on the rise, according to research published by the Local Government Association (LGA), with more than three quarters of respondents to a survey of town halls in England and Wales blaming the economic climate. 'The recession is clearly causing an increase in certain types of crime,' said chair of the LGA's safer communities board, Les Lawrence. 'Many parts of the country are witnessing a rise in burglary, vehicle crime, domestic violence and anti-social behaviour.' www.lga.gov.uk

Chair challenge

Stephen Burgess, national director of children's charity Coram Life Education, has become the new chair of the Drug Education Forum (DEF), replacing Eric Carlin after his recent resignation (*DDN*, 7 September, page 5). A member of the forum since 2001, Mr Burgess has been vice chair since 2006. 'I am looking forward to working with my colleagues in the forum to make sure that the positive case for improving drug education is understood and acted on,' he said.

Relentless approach

Agencies across Derbyshire have joined forces to tackle anti-social behaviour with activities including drug and alcohol awareness weeks, licensing checks and enforcement of underage street drinking rules. The six-week Operation Relentless involves the police, Derbyshire DAAT, trading standards departments and youth service teams and includes information for several non-English speaking communities.

'Dramatic' fall in young heroin users

The number of young adults presenting with heroin and crack problems has fallen by nearly a third over the last four years, according to figures published in the NTA's annual report. However, the proportion of over-35s newly presenting for treatment jumped by 20 per cent, and there has also been a sharp rise in the number of young adults seeking treatment for cocaine powder.

The number of 18 to 24-year-olds presenting for treatment for heroin and crack fell from 12,320 to 8,603 between 2005/06 and 2008/09 says the report, while those presenting for cocaine rose from 1,591 to 2,998. It also shows that young people are entering treatment faster than before, and that 97 per cent of clients are able to access treatment within three weeks.

'Problem drug use associated with heroin and crack appears to be declining among 18-24 year olds coming into treatment,' said chief executive Paul Hayes. 'This means we may have passed the high water mark for heroin addiction in this country. Treatment is the first step on the road to recovery, and while there are increasing numbers of the older 'Trainspotting' generation still entering treatment, more are also coming out the other side, free of their dependency.'

DrugScope said falling numbers of young people presenting for heroin and crack was encouraging but warned that claims of having reached a high water mark were 'premature' – 'not least at a time of recession when a growing number of young people are not in employment or training and overall unemployment is rising,' said chief executive Martin Barnes. He also said the increase in those presenting for cocaine represented a challenge. 'It is vital that drug services are given the resources to meet emerging problems with drugs like cocaine.'

Turning Point called for more integrated services to tackle issues like housing, employment and mental health, as the report found that more than a quarter of clients who reported their accommodation status said they had a housing problem. 'It is essential in this time of tightening public spending that preventive services like these are seen as a top priority to avoid massive extra expenditure in the long run,' said director of substance misuse, John Mallalieu.

The NTA also published its *National statistics on drug treatment for 2008/09*, showing a 35 per cent increase in adults successfully completing treatment compared with the previous year. Of 125,000 adults in treatment at the start of the year, 76 per cent were still in treatment at the end, 'indicating for the majority it takes more than one year for recovery to become established,' said the agency. EATA chief executive Peter Martin said the figures showed that treatment worked but its members were 'reporting closures of detox units and difficulties in filling bed spaces, which is something that needs to be addressed'.

Meanwhile, data from the National Drug Treatment Monitoring System (NDTMS) analysed for a study published in *The Lancet* that found that 42 per cent of heroin users in treatment had stopped using – and 29 per cent reduced their use – within the first six months, with similar figures for crack.

Tellingly, the findings were reported in the *Daily Mail* as 'just one third of drug addicts manage to kick the habit after receiving treatment' while *The Guardian* wrote 'Two-thirds of heroin and crack cocaine addicts on drug treatment programmes either abstain or substantially reduce their use of street drugs during the first six months.' The American news agency Associated Press, meanwhile, reported that 'A senior White House official said the results validated England's approach to treating drug addicts and called for similar efforts to evaluate American drug addiction programmes'.

Annual report and national statistics available at www.nta.nhs.uk

Tories set out plans for benefits and booze

A conservative government would 'simplify Labour's numerous and piecemeal programmes into one back-to-work programme' for people on benefits, leader David Cameron told the party's conference in Manchester. Their work programme, he said, was a 'big, bold and radical scheme' and would include 'support back into work for the 2.6m people claiming incapacity benefits currently excluded by Labour'.

The Department of Work and Pensions' (DWP) plans to withhold benefits from drug users who fail to seek treatment were dismissed by the drugs sector as unworkable and discriminatory (*DDN*, 3 November 2008, page 4). Release responded to the Conservatives' announcement by saying 'It seems the two main parties are doing battle to be seen to be doing the right thing by jobseekers, tax payers and the public's finances, but their simplistic attitude to moving dependent drug users from benefits into treatment and then into work is worrying. The genuine need to reduce the burden of the welfare state should not be translated into unfair and discriminatory practices that are unlikely to save money in the long-run.'

Shadow home secretary Chris Grayling also announced that his party would introduce 'significant tax increases' on alcopops and strong beer and cider – with a 4-pack of high strength beer costing up to £1.30 more – as these were the drinks that 'contribute to violence and disorder on our streets'. There would also be a ban on supermarkets selling alcohol at below cost price and a 'much tougher licensing regime', he said, including police and local authority powers to restrict numbers of late licenses. 'We are sending a clear signal that a Conservative government will take real action to tackle binge drinking.'

'Strong cider, strong beer and alcopops are some of the most irresponsibly priced and problematic drinks available in Britain,' said Alcohol Concern chief executive Don Shenker. 'Measures of this kind would be a positive step towards making them much less attractive to teenagers. It may also encourage production of low alcohol products, increasing consumer choice for responsible drinkers. But it's limiting to target teenagers when alcohol misuse occurs among all age groups.'

NICE consults on alcohol minimum price

The National Institute for Health and Clinical Excellence (NICE) has become the latest health body to back the call for a minimum price per unit of alcohol. The recommendation forms part of its new draft 'public health programme guidance' on alcohol, which has been launched for consultation. The organisation is inviting comments on the practical value of the recommendations, areas not covered and any inconsistencies.

The recommendation follows a call by the chief medical officer Sir Liam Donaldson, but which does not form part of the government's forthcoming mandatory code (*DDN*, 18 May, page 4). However, major health organisations have backed the call, including the British Medical Association (BMA) (*DDN*, 21 September, page 5), and the Scottish Government has included a minimum price as part of its alcohol action plan (*DDN*, 5 October, page 4).

'Making alcohol less affordable appears to be the most effective way of reducing alcohol-related harm,' says the document, which also recommends linking alcohol duty to inflation and earnings, revising licensing legislation and, 'in the longer term', banning all TV, radio and cinema alcohol advertising along with sports sponsorship.

It also calls for commissioners to make sure there is adequate provision of brief interventions for hazardous and harmful drinkers, along with provision for the likely increase in the numbers requiring referral as a result of screening. It also wants to see service managers make sure their staff are trained to provide alcohol screening and structured brief advice, and for NHS staff to routinely carry out screening as an 'integral part of practice'.

The draft recommendations have been welcomed by Alcohol Concern. 'These preliminary NICE recommendations support the call by health organisations and medical professionals who know that a minimum price for alcohol is an effective approach to tackling our rising drink problems,' said director of policy and communications Nicolay Sorensen. 'More power for councils to consider local people's health in licensing decisions, and tougher regulations to protect children from alcohol advertising are further strong but sensible recommendations which will make a difference. The consultation should ignite the debate surrounding the tough decisions government needs to take to save both lives and money and we look forward to the final publication of the NICE guidance early next year.'

Consultation available at www.nice.org.uk/guidance/index.jap?action=folder&o=45662. Consultation period ends 10 November.

Red Cross brings aid to Scotland's drug users

A new taskforce of 'community educators' to teach drug users about overdose prevention has been launched in Scotland by the Scottish Drugs Forum (SDF) and the British Red Cross (BRC).

The project, which is designed to help cut increasing rates of drug-related deaths in Scotland (*DDN*, 6 April, page 4), will run for a year and is the first time that the British Red Cross has joined forces with a national agency to deliver a community-based first aid training package across Scotland.

Up to 450 people will be trained as overdose prevention and first aid community educators, passing on the knowledge to service users, their families and community groups. They will also be able to contact Red Cross staff for telephone advice and refresher sessions.

'The British Red Cross trains people in first aid so that life-saving help is around as widely as possible when a medical emergency occurs,' said first aid development officer for the BRC in Scotland, Northern Ireland and the Isle of Man, Jane Hasler. 'We are first and foremost a humanitarian organisation and there are groups in society who are more vulnerable to finding themselves in situations where first aid is needed. People with drugs and/or alcohol problems are among this higher risk group and helping at overdose scenes should be seen as a humanitarian act.'

Breaking the cycle: 1.3m children live in a home where one or more parents have a serious drug or drink problem, according to a report on Addaction's *Breaking the cycle* campaign. The report assesses the impact of the three-year project which was set up to help children at risk and break family cycles of substance misuse. The charity is campaigning for more funds to be made available to help children living with substance misusing parents, backed by an advertising campaign on London transport. Report available at www.addaction.org

News in Brief

Get involved

Members of the public are invited to an open meeting of the Advisory Council on the Misuse of Drugs (ACMD) in London on 10 November. The meeting, which will include public feedback and a Q&A session, is free but places are issued on a first come first served basis. *To register visit drugs.homeoffice.gov.uk/news-events*

Test (tube) case

A test-tube drink called Mmwah! has been removed from sale following a complaint by Alcohol Focus Scotland to the Portman Group's independent complaints panel. The panel ruled that people were likely to drink the contents in one go as it could not easily be put down on a flat surface. Alcohol Focus Scotland has now lodged similar complaints against four other companies. 'The panel considered the design of Mmwah!'s packaging made it difficult for consumers not to down the drink,' said Portman Group chief executive David Poley. 'The industry shouldn't be encouraging this potentially harmful style of consumption. The panel will therefore clarify the position on these other test-tube produces as soon as possible.'

Lifetime's work

Swanswell staff are offering drug and alcohol advice to members of the Netmums community during an online clinic for Alcohol Awareness Week. Previous posts on the forum were viewed more than 16,000 times – 'more people than you could see in several lifetimes' said specialist practitioner Carly Smith, interviewed in our last issue with colleague Tim Gunner (*DDN*, 5 October, page 15). 'With 65 per cent of homes having internet access and 80 per cent of those people accessing social networking sites, the opportunity to reach out to these people is too good to miss,' said Mr Gunner.
www.netmums.com

Calculating coverage

A new web resource to help services estimate whether syringe distribution matches estimated need has been launched by Harm Reduction Works. Coverage – the extent to which healthcare interventions reach their target population – calculator available at *www.harmreductionworks.org.uk/5_web/coverage_calculator/index.php*

UNSPOKEN TRUTHS

No one knows how many people develop serious alcohol and drug problems to cope with the legacy of abuse, but anecdotal evidence – and common sense – would suggest that it's a large number. **David Gilliver** hears from two organisations that are trying to help

Back in January we ran a feature on the courses being offered by the Southmead Project in Bristol, in partnership with the Training Exchange, to equip drugs workers with the necessary skills for when their clients disclose that they have been victims of sexual abuse (DDN, 26 January, page 14).

The Southmead Project has received a good deal of interest since the article was published, something which chief executive Mike Peirce believes is testament to how overlooked issues of abuse and trauma are in the drugs field, as well as the appetite among many practitioners to do something about it. 'It was quite an overwhelming response, and the very fact that it was from people from all over the country was self-explanatory – we had the NHS, detox units, prisons, all sorts,' he says.

It goes without saying that disclosure is difficult. According to the NSPCC, 16 per cent of children aged under 16 experience some kind of sexual abuse during childhood, with three-quarters of them not telling anyone about it at the time – a third will still not have told anyone by early adulthood. However, when people do finally summon the strength to talk about these issues, it's essential that drug and alcohol staff are able to deal with them properly.

Delegates from across the country attended the project's two-day *Anchoring trauma* course for practitioners, with another scheduled for December. 'The feedback was brilliant,' says Mike Peirce. 'The overriding message was that it was about time that this type of training was made available – this is from frontline drug workers.' They'll also be delivering the training in prison, starting with HMP Downview next year.

Does he feel the size of the response was indicative of how these issues are overlooked at treatment level? 'The frontline workers are fully aware of what's going on but they know their agencies can't or won't do anything about it, because they don't get the funding,' he says. 'The reality of the situation is not getting back to government think tanks, so policies aren't geared up to include it. They're more aimed at harm minimisation. That's not a cosmetic approach – that would be unfair to drug and alcohol workers – but we're looking at the presenting problem while all the other stuff underneath is going on as much as it's ever been.'

Part of Southmead Project's mission statement is a belief that anything that doesn't address these underlying issues simply amounts to a sticking plaster. 'We can do whatever we like, and CBT and all the other interventions are useful, but unless we're able to determine that what happened in the formation of people's identities need not be the guiding force in later life – that it can be addressed, that people can come to terms with their trauma and be emancipated, there's far more of a chance of relapse. We all know we need the harm minimisation strategy – without it we'd be in even more of a pickle. But we have to look at the consequences if it doesn't include strategies that go that bit further – what are we doing in terms of prevention?'

Duncan Craig is the founder of Survivors Manchester, a support organisation for male survivors of sexual abuse and rape. He also works for Lifeline's community detox team in the city and spent six years in a needle exchange and harm reduction centre, so he knows all about the links between abuse and substance misuse. Does he feel it's something that remains largely under the radar? 'Absolutely,' he says. 'It's under-reported and under-researched. The only thing that people seem to try to get statistics for are actual disclosures – what we know from that, from the British Crime Survey and the other crime surveys, is that one in seven men will be victims of sexual abuse and one in four women. Most researchers say that's a conservative estimate because it doesn't take into account how many men don't report, because of a whole host of emotional issues – guilt, shame and the way society expects men to be.'

Department of Health figures state that up to 60 per cent of patients in mental health facilities have been either physically or sexually abused as children. Substance misuse is one of the most frequently reported long-term mental health consequences of abuse, but comparable figures for people in drug and alcohol services remain hard to come by.

'I've never found any,' says Duncan Craig. 'I think it's down to fear on the practitioners' side – of "what the hell do we do with this?" We know that if somebody doesn't report at the point of trauma, for want of a better word, that on average women will take around three years to disclose, while men will take between seven and 14 years. We have a problem with men accessing mental health services and GP services in this country, so they're not getting help anyway, and on top of that they're certainly not going to get help to reveal that they've been abused as children or raped in their teenage years. Seven to 14 years is a hell of a long time to maintain unhealthy practices to cope, which is often drugs and alcohol – to forget, to push away those horrible feelings.'

He knows this all too well, as a survivor of abuse himself. 'I know what my coping mechanisms were, and they weren't healthy by any stretch of the imagination,' he says. 'So what happens is that nobody addresses these issues in drug services. Drugs workers, especially in prescribing, don't have time to sit down

and talk and many workers don't know how to handle disclosure – it can be a terrifying thing to be faced with. So you get people going through treatment, but – if the reason they're taking drugs in the first place is to forget – when you remove the drugs in detox the memories come back even more raw than before.'

Even putting compassion to one side, it seems obvious from an economic standpoint that ignoring these issues is storing up problems for the future. 'From a cold, hard business point of view, if it's costing something like £3,000 for a ten-day detox and nobody's addressing the root cause of why someone's using drugs – if that is childhood sexual abuse – aren't we just throwing money out the window?' says Duncan Craig. 'That person is going to go back and use drugs because this can of worms has been opened and the professional didn't know how to manage it. I hear that so much from the people I come into contact with.'

Both stress that the key thing is for disclosure to be encouraged and, once people have finally managed to summon that strength to disclose, for them to be believed – something the Southmead courses consistently reinforce. Duncan Craig feels that in many ways the social care sector is actually afraid of the issue. 'I've been on training courses where it's been mentioned and then it's been silenced. We all know that abuse and rape happens in silence and secrecy, and professionals absolutely should not be perpetuating this attitude of "we don't want to know".'

Mike Peirce believes that acknowledgement, at least, of the issue is finally starting to spread. 'We're at the crucial point where awareness is growing, bolstered by increasing alarm about what's happening with young children in our country, the dysfunction, the cycle of abuse,' he says. 'But again we don't have enough information. What we do have is information on the impact of things like domestic violence from Childline and other organisations.

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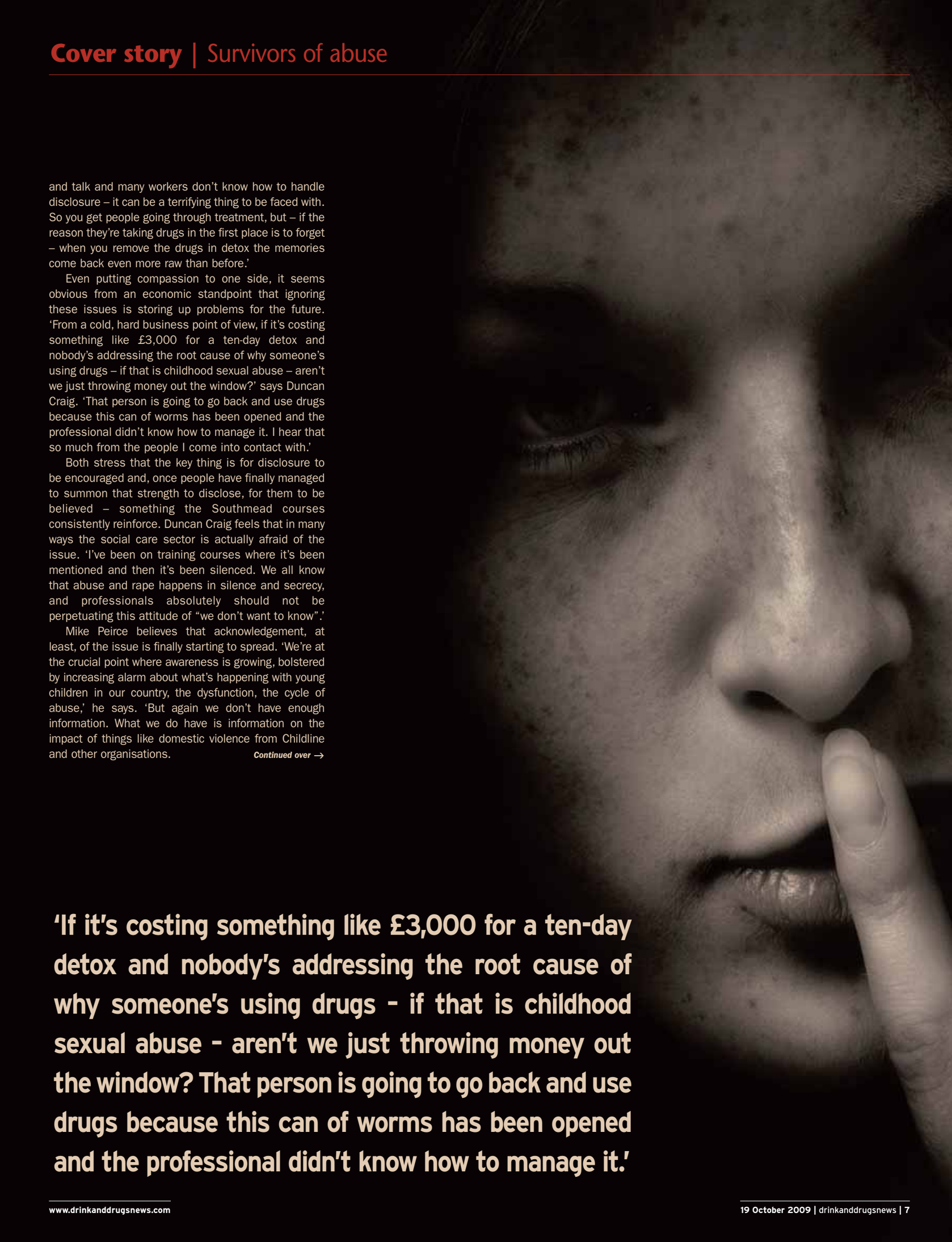

'If it's costing something like £3,000 for a ten-day detox and nobody's addressing the root cause of why someone's using drugs – if that is childhood sexual abuse – aren't we just throwing money out the window? That person is going to go back and use drugs because this can of worms has been opened and the professional didn't know how to manage it.'

'There are bits and pieces of information, so we're beginning to pick up the threads of what's available, highlight the gaps in services and try and make some sense of it, but knowing full well we need more research and more resources.'

Indeed, both organisations are finding resources to be a crucial issue. At the moment Survivors Manchester gets by on no funding whatsoever, fitting it around work commitments, while the Southmead Project only has lottery funding in place, alongside some contributions from private donors. 'Like many charities at the moment we're facing a problem staying afloat,' says Mike Peirce. 'The economic situation has compounded it, but the thing is we're true to our specialism, which is looking at something others have chosen not to look at. We spend our time and energy raising this topic and beginning to gather evidence around it, and it's not the most popular of concepts. We haven't been mainstreamed – which is something the topic needs – so we've had to rely on the short-termism of funding bids, which is not appropriate to the subject matter.'

Survivors Manchester, meanwhile, has learned how to make the most of minimal means. 'It's mostly done online,' says Duncan Craig. 'There's the website where people can get information, one-to-one online support and telephone support, and we do see people face-to-face – we can meet in a coffee shop and we're also lucky enough to have the use of counselling rooms at the Lesbian and Gay Foundation in Manchester. With technology now, someone can remain anonymous and get information and help off the internet. There's something about allowing someone to go at their pace, retain anonymity and keep control – they then become empowered enough to speak out.'

In the long term he'd like the service to become a full-time agency with its own premises, offering one-to-one counselling alongside peer support group work and prison work, but at the moment it's essentially him alongside a board that includes a social worker, a lawyer, a female therapist, a female survivor and the partners of survivors. 'It's a fantastic skills set,' he says.

What was the response like when they launched – were they overwhelmed? 'To begin with,' he says. 'Not just survivors, but professionals in hostels, supported housing, drugs workers, mental health workers, all wanting to know how to refer people. At first we thought we wouldn't be able to cope, but once we started telling them to give the clients the information and let them come to us themselves we noticed there were fewer emails but the website statistics went through the roof. It became obvious that lots of survivors are using the internet to get help, then once they feel confident enough they're contacting us and asking for it.'

At a policy level he'd like to see investment by government and by drug and alcohol strategy teams in these specialist services. 'We don't have funding and I've found myself the person that care managers and drugs workers now come to when they have a disclosure,' he says. 'There has to be some good joined-up working and some serious training. You can't have someone who doesn't really know what they're doing opening this can of worms and asking the wrong questions, because that causes harm.'

Mike Peirce says it comes down to the 'three As': 'The first is awareness,' he says. 'Then acknowledgement – the most difficult thing in recovery is to acknowledge what drugs are doing to you, but we need to work at gaining the acknowledgement from policy makers that unless we grasp this nettle we're just going to continuously inherit problems and today's youngsters are going to be tomorrow's addicts. The last A is action – that comes a lot easier when the other two are in place.'

On the subject of acknowledgement, next year he'll receive an honorary degree from the University of Bristol – does he see this as symbolic of the issue perhaps starting to gain more recognition? 'Very much,' he says. 'The university is as aware as anyone of the need for more research. It gives us credibility as a small agency to be linked with a major university, but it's invaluable from their research viewpoint to have contact with a community-based agency.'

The project's work was evaluated by the university and published as a 2007 book *Trauma, drug misuse and transforming identities* by Prof Kim Etherington. This year Greece's main drugs agency, Kethea, which offers treatment to more than 3,000 clients across 70 centres, requested the book be translated into Greek and approached Prof Etherington to run a course on trauma and drug misuse for them, which will take place later this year.

Southmead also has its own specialist counselling service for survivors of abuse, Touchstone 165. 'We had our AGM a couple of weeks ago and a client spoke out who had been sexually abused at three, and continually through her childhood. She developed alcohol problems at thirteen, opiate problems in her late teens, and she's turned her life around. She's now got a very good job indeed abroad – her confidence is there, and all the self-esteem we see with people in recovery who are moving on in their lives. They're able to move on without the clutter that abuse gives you.'

'But in a city the size of Bristol there are still very few consistently-funded dedicated domestic abuse projects,' he continues. 'When we consider the millions we spend on putting a sticking plaster over the wound, when what's underneath is still festering and hardly likely to go away. There are children in unsafe environments and, sadly, many of them will be tomorrow's alcoholics and addicts. Eighty per cent of Southmead's clients have had domestic abuse-related incidents – one or more of sexual, physical or emotional abuse or domestic violence.'

Recently, however, Southmead has been working with Bristol City Council community safety team to look at opportunities for collaboration. 'That's enormously encouraging – if we can have an input into strategies then we can perhaps produce models to be used in other communities across the country, so the door is open and it's up to us to think carefully about how we can develop strategically. It's time to grasp this and take it forward.'

It seems to be common sense that when people do summon the strength to discuss these kind of issues, that those in the drugs field should be able to deal with them sensitively and appropriately. 'I can't stress enough how painful it is to disclose, to get there – how brave people have been,' says Duncan Craig. 'But also if they're listened to, believed and worked with properly how empowering that is for them. They finally get to break the silence, to move forward and begin to make their own positive and healthy life choices. The key to all this is allowing someone the space to say it in their own time and their own words, facilitating a safe space to talk, not pushing them.

'If we're supporting someone in treatment shouldn't we be giving them the best possible chance? If they've made the effort to go into treatment and jump through all those hoops, I think we need to give them that. I'm always surprised by how many counsellors say "this is just too big, too scary" If we're not addressing these specialist issues, we're setting clients up to fail.'

www.survivorsmanchester.org.uk
Email: info@survivorsmanchester.org.uk

For more information on the courses offered by the Southmead Project contact jo@trainingexchange.org.uk

Fighting addiction

Gary Topley describes his journey from alcohol-fuelled violence to a new life helping others as a service user representative

MY FIRST AWARENESS that alcohol even existed was back in the 1980s. I was adopted when I was four, and my adopted dad was a professional darts player so a lot of time was spent in the pub from an early age, as well as going away to tournaments. As you probably know, darts and drink go together.

Back then the smell of alcohol made me feel sick, but alcohol would become my best friend and worst enemy. I first experienced it in any quantity when I was sent away to boarding school – we'd often go into the local town and drink, more or less always quite excessively. This was when I was about 14 years old.

It wasn't long until I was expelled because of drink-related violence. I came back drunk from the town one night and my friend started being sick – when the housemaster questioned us I flew at him with a chair in a drunken rage. I was placed into local authority care, and it seemed the right thing to walk around the town at weekends in a big group, getting as drunk as we could and fighting rival towns and villages. After a while it was 'watch that Gary, he drinks and fights' – a reputation it became hard to shake off.

I met my real mum after I left care, and both her and my older brother were big drinkers. My mum once said to me that she wanted me to drink like her to make her proud, and at one stage tried to make me drink a bottle of vodka – I did it as I wanted to make her happy. I was 16 and so drunk I remember fighting with the wind on the way home. Now it's been 12 years since I've spoken to her.

A couple of years later I moved into a hostel. I'd started cutting myself after getting drunk and moved there for support. I was drinking heavily in there, from around nine in the morning – most days I'd drink at least ten pints of lager, plus a few cans. I'd regularly cut myself, get into fights and into trouble with the police and it seemed wherever I moved I had this label of Gary the drinker – he likes a fight and is nothing but trouble.

I moved to the Derbyshire area in around 2001. By this time I'd been in lots of trouble, had numerous failed relationships and had even been refused custody of my son, partly because of my drinking. But I was to learn that this was my journey – I needed help. I didn't know what I wanted, but I knew for sure I didn't want to give myself that label, alcoholic.

When I moved to Derbyshire the same pattern continued – drinking, fighting and failed relationships, until last year I was sent to prison for an alcohol-related offence. My girlfriend was pregnant and came to visit me, crying as she left. I walked back to my cell thinking 'Gary why are you so selfish? When someone who loves you, and who needs you most at this time, sees you in here, and through your own stupidity and selfishness you're not there for her?' I got back to my cell and cried. 'What a waste of space', I thought. On the next visit the same thing happened.

After I was released I wrote to Derbyshire police and expressed an interest in doing something to help others, because I was now sick of my worst enemy – alcohol. They referred me to Derbyshire DAAT, and this year I started as a service user representative. Operation Relentless is running across Derbyshire until November (see page) and I and other reps went out with the police meeting people and raising awareness during Alcohol Awareness Week. The police have been very, very supportive, and I'm interested in doing other alcohol awareness work, if anyone will find me of use.

'I'd started cutting myself after getting drunk and moved there for support. I was drinking heavily in there, from around nine in the morning – most days I'd drink at least ten pints of lager, plus a few cans.'

I am now completely drink-free and in a stable relationship. I have a beautiful daughter, Jasmine, who one day I just want to say 'Daddy, I'm so proud of you'. I'm also taking driving lessons and feel I've finally taken the steps to get my life at last on track. In the future I hope I can be there to support alcoholics on their journey of recovery, give them a shoulder to lean on and help them believe with inner strength, courage and determination that they too can overcome their dark times with drink, work within their realistic sights, and become free of alcohol, just as I have.

Contact Gary at: Garytopley29@aol.com

'If nothing else, articles such as Peter's do seem to succeed in dragging the dinosaurs from the methadone swamp, suffused with contradictions and inconsistencies, and showing a stark disregard for what is actually happening and what it is that people (professionals and those seeking recovery) actually want.'

From bad science to bad faith

I read Professor O'Hare's response to the Peter Martin article with disbelief (*DDN*, 5 October, page 8). His allegation that the 'recovery agenda is a dishonest political agenda' is an amazing accusation that targets academics, policy makers and practitioners, not to mention countless individuals in recovery and their family members with a pejorative and slanderous dismissal. In the context of recent recovery marches in Inverness and Liverpool, the successful Serenity Cafe events in Edinburgh and the ongoing commitment of a multitude of community projects and activities, it is an astonishing piece of reactionary writing that is as far from evidence-based and scientific as any of the individuals or groups who are casually and lazily dismissed in this letter.

If nothing else, articles such as Peter's do seem to succeed in dragging the dinosaurs from the methadone swamp, suffused with contradictions and inconsistencies, and showing a stark disregard for what is actually happening and what it is that people (professionals and those seeking recovery) actually want. Professor O'Hare kindly asserts that 'I am in favour of helping people who use drugs to stop, if that is what they want' – I am sure all of those advanced in their recovery journeys will be delighted to know that they have Professor O'Hare's permission. However the tired old clichés of 'raising false hopes' and 'relying on faith' are both inaccurate and misleading. Each of the large UK outcome studies as well as their US predecessors (NTORS, DORIS, DATOS and DARP) have all shown effective transition to stable recovery for a proportion of those entering treatment, while the huge evidence base for mutual aid (not only for the individual in recovery but for their family members and children) are effectively outlined in *Circles of Recovery* (Humphreys, 2004) and a more recent paper on family recovery (Andreas and O'Farrell, 2009).

I would also be interested to know Professor O'Hare's evidence base about the rates of 'functioning members of society who are able to work' from maintenance studies in the UK. Surely, such a paragon of the empirical evidence base will not let us down in this regard? As a matter of interest in a paper in *Drug and Alcohol Dependence* by Darke and colleagues, assessing ten years of drug deaths in Australia, they happen to note employment status in the groups they compare. At the time of death, 26.4 per cent of heroin deaths were in employment, 19.7 per cent of deaths from non-prescribed methadone were in treatment compared to 8.8 per cent of deaths among clients of methadone services. This is cross-sectional and opportunistic, but runs counter to the argument that – for whatever benefits – methadone treatment is associated with high levels of functioning.

However, the most disappointing and frustrating aspect of the letter is that it trades in tired old oppositional clichés that demonise recovery as 'unsafe', about a seamless transition to a 'Conservative government' and that it all 'relies on faith'. Any one of the recent William White monographs will challenge the faith assertion – there is a sound international empirical base, while the other attempts at scaremongering are laughable or insulting. We have long heard the mantra of the grim reapers of pessimism – 'our way is the only way to stay alive' with debatable evidence, but the suggestion that people's recovery and celebration of it is motivated by party politics is really below the belt. It is not only scaremongering it is extremely offensive to many of us.

Fortunately, through vehicles as diverse as the Recovery Group UK, the UK Recovery Academy and the Recovery Consortium, the recovery 'movement' will continue to thrive in its glorious diversity and community-driven focus, irrespective of the revisionist demonising of out-dated and myopic thinking.

Dr David Best, reader in criminal justice at the University of the West of Scotland

Recovery voices get louder

I was interested to read Professor Pat O'Hare's letter, framing the recovery agenda as 'dishonest', raising 'false hopes', 'ignoring evidence', reliant on 'faith', 'undeliverable financially' and 'not a public health approach'. Strong words.

I think there may be a misunderstanding of what recovery is at the heart of the professor's concerns. He equates it in his letter to becoming abstinent (which it is not, although becoming drug free may be part of recovery) but actually gets closer when describing clients on maintenance treatment. This 'gets them back as functioning members of society who are able to work and support their families'.

Many of us who've worked in maintenance would struggle to demonstrate that treatment with methadone alone achieves this for large numbers of people, but the point is that most of the definitions of recovery (Scottish Government, Betty Ford, UKDPC *etc*) have this sense of fulfilment, society and contribution at the core, regardless of whether recovery is medication assisted or abstinence based.

Of course we need to support and deliver harm reduction services; there is no conflict here. Rather than harm reduction permeating all services as the professor suggests, let's have all harm reduction services permeated by recovery – the active belief that with the right support people can move on.

When I started working in harm reduction and prescribing services my question to every client I worked with was 'What's next and where do you want to be in a year, two years or five years?' The answer to that question often meant that both the client and I had to change the way we were working to make the goal come closer.

Working in an NHS environment where people regularly do achieve a recovery based on abstinence, with a busy and very healthy aftercare group, I do have a conviction that addicts can recover – I see the evidence every day. We work with colleagues from needle exchange to specialist clinics to GP prescribers and beyond to help people continue their recovery journey. We practice harm reduction and recovery management techniques side by side.

Hope and aspiration are fundamental ingredients in the recovery journey. It is my observation that we generally set the bar far too low in our services. Recovery does not mean the abandonment of maintenance prescribing or other evidenced interventions. It means listening to recovering people and understanding and adding to the evidence base on recovery. It means asking the question 'what next?' and it means using evidence-based interventions (such as methadone and beyond methadone) to help people get to where they want to go.

Whatever we as professionals think, the recovery revolution is more than blind faith. It is a

grass roots movement evidenced by the people in recovery who now have a voice and won't settle for second best. We need to listen to that voice.
Dr David McCartney, clinical lead, LEAP

Abstinent disservice

I think Pat O'Hare's response to the important article by Peter Martin about the need to move towards 'recovery' is a defensive over-reaction and some of his comments are silly.

I have not only worked as a drug worker in the voluntary sector for 12 years but have been in recovery myself – and by that I mean completely drug free, including free of methadone, for over 14 years. Peter's article was refreshingly honest and politically astute.

As far as drugs budgets are concerned, there will be cuts whatever government comes to power. I have always maintained, as I believe Peter Martin did when he wrote in *DDN* as CEO of Addaction, that methadone has a very useful role. But it has played this role to the exclusion of much else and Peter pointed out the reasons why, as well as the heavy imbalance in the cost of methadone to the current drugs budget.

I hear the word 'abstinence' used these days as meaning 'on methadone'. It does the client a disservice. Methadone creates its own dependency, and is very difficult to get off – and I have seen little evidence to show that people on a methadone maintenance regime are indeed moving into the kind of productive, independent recovery that Pat talks about.

People have the right to be given a chance to live free of all drugs, because that is when true freedom to grow as a human being becomes possible. I know. And please, don't say I am an evangelist if what you mean by that is some sort of criticism of my enthusiasm. I am a humanitarian, and I am not blinkered by the liquid cosh that, in the long term, methadone represents.
Richard Kingdon, director, City Beacon, www.citybeacon.co.uk

Reality land

I have been working in the substance use field for many years, originally as a social worker and for the last seven years as a counsellor working with young people.

Andy Stonard's article (*DDN*, 5 October, page 11) in my opinion hits the proverbial nail squarely on its head and then hammers it all the way home to 'reality land'. His article covers all the points that I have sadly now almost given up commenting on. In particular his comments on the NTA's reliance on statistics: well 'honest guv' they are a 'true' reflection. We all know that – don't we?

There are only so many times I want to beat myself up with my 'person-led' beliefs in the arena of substance use.
Shane Ibbs, counsellor MBACP, registered social worker

Dirty business

In the article 'Counting the cost' (*DDN*, 5 October, page 6) the author states that dihydrocodeine is 'more commonly known' as diamorphine. Wrong. Diamorphine is not another name for dihydrocodeine. Diamorphine is in fact the pharmaceutically pure form of good old street-dirty heroin.

Perhaps the author has confused 'diamorphine' with 'dihydromorphine' (which does sound a bit similar, and is a metabolite that occurs in dihydrocodeine in tiny amounts – and with insignificant effect).
Dennis Ball, team manager, Sorted Young People's Drugs and Alcohol Team, Uxbridge

This was indeed a proofing error on our part – thanks to other readers who pointed this out.

We welcome your letters... Please email them to the editor, claire@cjwellings.com or post them to the address on page 3.

Post-its from Practice

Taking the piss

How often do we need to do urine tests, asks Dr Chris Ford

AFTER YEARS OF YO-YOING between heroin and crack use, and regular stints in prison, Sinead had stabilised well on 90mg of methadone after almost a year in treatment with us. Her ultimate aim was to become drug free but she realised that she couldn't achieve that in London. So, after much thought, she decided to return home to Ireland.

I knew the system wasn't perfect in Ireland but I believed that she would be able to get methadone. What I hadn't banked on was their 'taking the piss'. I spoke to a helpful drug worker at the nearest service who asked me to fax a referral, which I did. Very shortly afterwards he phoned back and asked for copies of the urine tests. I explained that the results of the last two (one the week before in preparation for moving and one two months before) were enclosed in the letter, and that they were positive for methadone and cocaine. He sounded confused and enquired where the rest were.

I then discovered that in Ireland, it is recommended that patients on methadone treatment have a test at least once a week. The cost of a single urinalysis test for drugs of abuse is around €11 with over 10,000 patients registered on the central methadone treatment list the annual bill is around €5,500,000, which doesn't include costs such as staff time and other related activities.

Saying that, I had been equally shocked only six months before by a GP at a training session who stated that he kept everyone on supervision forever and never did urine tests. His rationale had been that he didn't care what his patients took but he wanted to ensure that what he prescribed ended down the right throat. Surely neither extremes are right?

I was surprised that I had thought to do a further test on Sinead before transfer as our usual policy follows the DoH's *Drug misuse guidelines on clinical management 2007* which states, that the testing of patients who are established in treatment can be done much less frequently. It states for example, that 'random urine checks may be helpful... at least twice a year'.

Around the world there are varying policies. The Australians, for example, state that there is no research evidence to indicate that urinalysis can reduce illicit drug use but continue to test and, in the US, although regulations vary from state to state, best practice guidelines recommend a minimum of eight drug tests per year.

So who is right? Why are we doing piss tests? The use of urines seems to have very little supportive evidence. The theory is that people with opiate negative tests are less likely to divert their prescribed methadone, and that this can be reliably used to determine who gets unsupervised doses of medication. However, I can find no evidence backing up this theory.

Perhaps at the beginning of treatment it is helpful for confirmation of drug use, for medico-legal reasons and to confirm compliance. Occasionally I have patients who request them to support their own change and motivation, which seems fine in that it supports the patient. My experience is that people are very honest about their drug use and research shows almost complete concordance if there are no punitive responses to the test results.

Another worrying thought is that I know I have had more than one row with the odd social worker who is obsessed with illicit drug-free urines and who will try to use them to determine if a parent is suitable to care for their children rather than basing this decision on their competence, assessment of their home or even their alcohol use.

So, while I am on this little rant, I can't finish before challenging the terminology the field uses: 'dirty' and 'clean'. I feel using terminology like this immediately sets up a tension between the patient and the worker.

We have just updated our urine policy at Lonsdale and it seems to get more liberal but, all things considered, perhaps we should reduce it to: Will this test benefit the patient or their treatment, or will this test protect or help the prescriber? If the answer to both is no, perhaps we should stop doing them?

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical director for SMMGP

To become a member of SMMGP and receive bi-monthly clinical and policy updates and be consulted on important topics in the field, visit www.smmgp.org.uk.

Thanks to Dr Cathal Ó Súilliobháin, a GP working in addiction, and for a fuller analysis of this topic see www.imt.ie/opinion/2009/09/taking_the _piss_is_hse_drug_te.html

Girls' talk

Sue Kenten describes how her service is helping to empower young Asian women in east London at the same time as celebrating their identity

DASL (Drugs and Alcohol Service for London) is a community-based service in London's East End, and during its 25-year history our trademark has been reaching out to those groups who traditionally find it hard to access services – both adults and young people. Starting with pilot initiatives, usually funded by charitable trusts, DASL has then gone on to integrate provision into its mainstream services, an approach that has been used successfully over the years with gay and lesbian groups, a wide range of black and Asian groups, people from Central and Eastern European communities and those affected by domestic violence.

One such initiative is Girls Talk, which supports the physical and emotional wellbeing of young Asian – predominantly Bangladeshi – women in east London boroughs through interactive group work and structured workshops. Many young Bengali women are not able to make healthy lifestyle choices or sensible decisions about alcohol, drug use or sexual health through lack of confidence, education or communication skills. There are also cultural and community restrictions that prevent young women from accessing support.

Within the Bangladeshi community, there are high levels of mental illness, domestic violence and – with younger women – self-harm. The Girl's Talk project has provided a positive example of how young Bengali women can be part of the solution, working with women from some of the poorest boroughs in London – places where work with young men around drugs, drug-related crime, gang culture and anti-social behaviour is often prioritised over that with young women, as they pose fewer immediate problems.

Many young Asian women grow up in a context of familial conflict, with clashes between family expectations, honour and duty, and in a western society that offers higher levels of aspiration within the context of a different moral code. Opportunities can be very limited for these girls, and it may be difficult for them to develop to their full potential.

Girls Talk is designed to create a supportive and interactive context of learning which enables young people to explore their experiences and concerns, and address their physical, sexual, emotional and social wellbeing in their transition from girl to young woman growing up in an inner city, multi racial area.

It was initially funded as a pilot project by the Tower Hamlets Children's Fund. Working with young Bengali women, the project facilitated closed group sessions, lasting for 90 minutes in 'neutral' school spaces, and run over an eight or 12-week programme during the school term. It used the topic of alcohol to signpost other areas of concern for the girls and allow more open discussion about taboo subjects.

Since then the project has developed and now includes a wide range of topics according to identified needs, with schools, former participants and commissioners all helping to shape new and different programmes. Workshops explore identity, personal development, self-esteem, relationships and friendships, female roles and community expectations alongside substance misuse, domestic violence, communication skills, stress management and coping strategies.

While recent reports have shown that, overall, drinking rates among young people may be starting to fall (*DDN*, 18 May, page 5), there seems to be an emerging trend of young people from second and third generation black and Asian backgrounds presenting at services where historically they would not have done so. Research suggests that there is a shift in attitude to the use of alcohol among this cohort and, as there is a direct correlation with patterns of young people's use and problematic use in adulthood, this group needs particular attention. Cultural pressures to control use or be abstinent are changing, so programmes like Girls Talk provide an important forum to discuss these changes and how they are influencing behaviour and norms.

The delivery of the project is flexible and has been adapted to cover new or emerging areas of concern. One area is that statistics for Bengali women entering higher education or meaningful employment continue to be poor. According to Sarah Glynn's report for the Institute of Geography, *Playing the ethnic card – politics and ghettoisation in London's East End*, 'Bengali ghettoisation has seemed only to increase….and, of course, many Bengalis do not have the resources, financial or cultural, to move away. For a small minority of their children, the frustration of limited prospects can be expressed as racism against others over whom they see themselves as superior, such as 'white trash' or Somalis.'

According to data from the Office for National Statistics in 2004 a third of Muslims of working age in Great Britain had no qualifications – the highest proportion for any religious group. They were also the least likely to have degrees or equivalent qualifications (12 per cent). Among women, Bangladeshis and Pakistanis were the least likely to have a degree, at 5 and 10 per cent respectively.

The Girls Talk programme responded by exploring roles and routes into employment, examining concepts of self confidence, self worth and independence. Although many young women in the group placed great emphasis on love and marriage, young women were encouraged to aspire to jobs that allowed them more freedom and control over decision making and relationships at home. Young women understood that they needed to demonstrate behaviour that would allow their parents to trust them by becoming more focussed on studies and future plans.

Many young women were not aware of the amount of choice and opportunities available to them – in many cases, not enough time, thought or resources are put into exploring higher education options or careers that will allow them to have the economic independence and self confidence to deal with family expectations and conflict. Girls Talk offered this time, working with those most at risk of exclusion or poorly performing. With teenage pregnancy rates high in east London, DASL has also delivered a Girls Talk teenage pregnancy programme funded by Tower Hamlets PCT, giving young people the information and support they need to delay early sex and to use contraception effectively when they do become sexually active.

Young women are given the opportunity to explore sexual health, relationships, marriage and decision making, with an emphasis placed on respecting their own bodies and in turn an expectation that partners or boys in general would do the same. Although many women in the Year 9 group said they were not having sex and had no intention to, for religious or cultural reasons, it was important for the programme to explore the pressures that young women face with new freedoms, such as when leaving school. The group acknowledged that although sex before marriage is a taboo issue for this group, many were having sex.

'While recent reports have shown that, overall, drinking rates among young people may be starting to fall… there seems to be an emerging trend of young people from second and third generation black and Asian backgrounds presenting at services where historically they would not have done so.'

To give a flavour of what the workshops involve, here's an example of an exercise designed by participants from previous Girls Talk sessions. They chose to use an exercise that involved a shopping analogy, with young women asked to think of shops where people buy their clothes. There were a range of responses including Primark, the market, Peacocks, H & M, River Island, New look, Zara, Selfridges and Harrods. Participants then went on to list why different people shop at particular shops, with concepts like 'easy', 'cheap', 'expensive', 'quality' and 'classy' as well as the need to travel further for clothes that were harder to get. They then made links to how young women should respect themselves physically and emotionally and how people may see them if they acted a certain way. The group also explored 'precious' products like diamonds, things that were hard to obtain, and the idea of comparing this to ways of looking at virginity.

Opening up discussions in a way that is relevant and designed by the girls themselves, in their own language, is a major strength of Girls Talk; another is that a Bangladeshi female worker runs it. To sum up, it's about being young, female, Asian and living in east London… sharing experiences, knowledge, fears and aspirations as well as being happy, healthy and celebrating identity.

We've had an extremely positive feedback from teachers, pupils and commissioners alike. Teachers tell us that their girls get a lot out of the programme, that they already see a difference in the attitudes of some, and how it helped for them to have someone else to talk to – they all want to know when we're running the next programme. But we're not stopping there – we've already got two spin-off projects, Boys Talk and Parents Talk, designed and ready to be piloted, along with a Girls Talk smoking cessation project.

www.alcoholeast.org.uk

Sue Kenten is chief executive of DASL.
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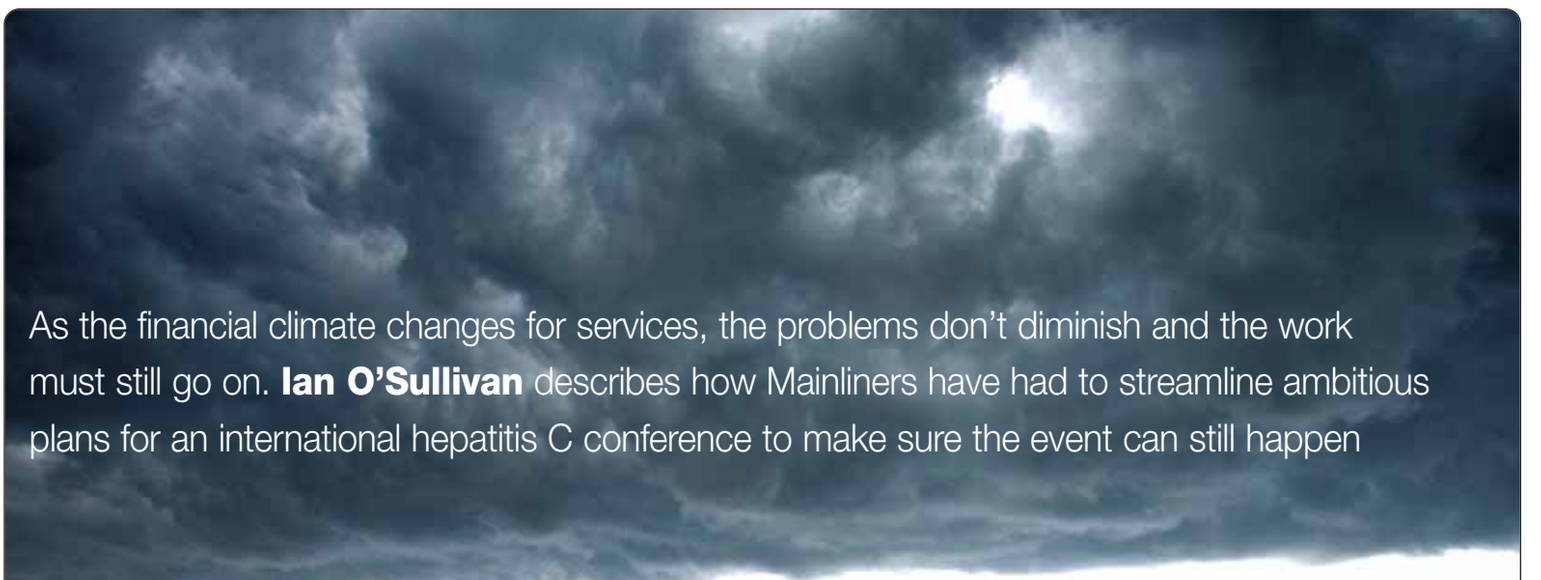

As the financial climate changes for services, the problems don't diminish and the work must still go on. **Ian O'Sullivan** describes how Mainliners have had to streamline ambitious plans for an international hepatitis C conference to make sure the event can still happen

Under darker skies

A KEY THEME of all party conferences in the last few weeks has been that dreaded word 'cuts'. Nobody could fool themselves into thinking that the generous increases in public spending that have benefited the third sector in the last decade can continue in light of the need to drag the economy back from one of the worst economic downturns in the post war period.

Organisations that work in the substance misuse field have become used to making a little go a long way. With full-cost recovery something to aspire to rather than a daily reality, most projects run through public funding or grant-making bodies are used to making the most out of limited funds. The reality of the next few years will mean that organisations will have to continue to prove their flexibility and innovation in delivering vital services to those who need them most.

But what about organisations that have been caught in the crossfire of this unprecedented downturn? What happens to events and projects that have been planned under one set of economic conditions, but which have to be delivered under much darker and more uncertain skies? The current climate in many ways gives organisations a chance to prove to funders their ability to roll with the times, to change quickly and deliver a comprehensive service at a fraction of the cost.

Mainliners is a national charity based in London. Dedicated to reducing the harm caused by substance misuse and bloodborne viruses, it has had a key role in fighting the battle against hepatitis C throughout the UK by organising the International Hepatitis C Conference. After a highly successful two-day event in Derby in 2008, the organisation decided to create a larger and more ambitious conference in 2009, to reflect the larger role that hepatitis C is beginning to play in public health planning. With the Scottish and Welsh governments moving forward with comprehensive, cross-sector plans, and the Greater Manchester hepatitis C strategy showing that large regional drives within England can also successfully address the issue, the time seemed right to expand the conference.

With the vision of a three-day programme, Mainliners planned the 11th International Hepatitis C Conference in partnership with the University of Manchester and the Greater Manchester hepatitis C strategy. A national steering committee consisting of some of the most prestigious voices in research, public health and the voluntary sector was involved in putting together a programme that featured 60 speakers from 15 countries, and acted as a showcase for some of the most innovative and practical research into the treatment and prevention of hepatitis C.

Unfortunately, the economic situation began to bite ever deeper into the plans for the conference and it soon became clear that, despite the hard work and enthusiasm from all concerned, the event would have to be refashioned.

'The economic realities of the last two months made it increasingly difficult for Mainliners to create a financially viable conference,' said David Badcock, chief executive of Mainliners.

'Between a failure to secure corporate sponsorship for the event, and cutbacks in the NHS affecting our key delegate market, it became increasingly necessary to look once more at the conference set-up. Our first priority must always be to our service users, and it was clear that the risk we assumed in setting up such an ambitious conference could affect frontline service provision. This is unacceptable, despite the value that the conference could bring.'

Instead of cancelling the conference, Mainliners worked with its major partners to refashion the international conference into a one-day event. The new conference condenses the themes and presentations of the original three-day programme into one structured session and distils some of the key initiatives and directions that those engaged with the battle against hepatitis C have fought at a local, national and international level.

For those who work in the substance misuse field, the programme contains many exciting presentations on topics such as decreasing the amount of hepatitis C among young injecting drug users and guidance for injecting equipment services, as well as presentations on reaching isolated communities and HIV/hep C co-infection. As well as an international perspective offered by speakers from Australia, China and America, the evening session will offer an exciting UK specific perspective from some of the key players in the Scottish, Welsh and Greater Manchester plans.

'We feel that the conference is vital to maintaining the momentum behind the various public health initiatives to combat hepatitis C and to encourage other regions into action,' said David Badcock. 'The credit crunch has forced all organisations to offer more value for money, to all their stakeholders. But through rethinking our format, we've been able to keep to our objectives while adapting to survive these difficult times.'

Ian O'Sullivan is office manager at Mainliners. For more information please contact Mainliners on 020 7022 1890 or visit www.hepc09.org.uk.

The 11th International Hepatitis C Conference takes place on 16 November at the Lowry Hotel in Manchester.

Recipes for recovery

LIGHT IN THE DARKNESS

There are plenty of ways to stay healthier in the long winter months, says Helen Sandwell

Here we are at the point of seasonal change once more. Nights are drawing in and lots of us are waking up to darkness in the mornings. This can be a depressing time for some people.

For those who suffer from Seasonal Affective Disorder (SAD), autumn moving into winter is marked by symptoms such as decreased energy, lack of concentration, sleeping longer and difficulty waking, carbohydrate craving, weight gain and depressed thoughts. Watch out for seasonal changes in mood with your clients – they may be affected by SAD.

Although the exact causes of SAD are not yet known, the changes in light intensity and day length are major players. Along with these, the decrease in levels of manufactured vitamin D is now thought to have a role.

Melatonin, produced by the brain when light is reduced, is a sleep signal and, in winter, short days and low light produce more melatonin, contributing to the hibernation behaviour of SAD. Light box therapy can have a benefit for 60-80 per cent of people with SAD, but just getting out on those clear, crisp autumnal days may also help regulate melatonin and boost serotonin.

Vitamin D is produced in the skin in response to UV light, but only when the sun's rays are of adequate intensity – at certain times of the day in late spring, summer and early autumn. As a rough guide, it's when your shadow is shorter than you are. Our skin is capable of making masses more vitamin D than we normally obtain from food, so synthesis in this way is hugely important. Our bodies can store vitamin D for some time, but as the winter progresses, stores diminish. Unfortunately even the sunniest winter's day in the UK won't help boost vitamin D levels, although it may help SAD in the other ways mentioned.

Hypovitaminosis D is an increasing problem in the UK, but shows geographic and seasonal variations. Studies have shown that following on from summer only 5-10 per cent of those living in the south east have hypovitaminosis D, whereas in the spring, following months of reduced daylight when vitamin D stores are exhausted, up to 70 per cent of Scots are affected.

Only a couple of small studies so far have shown that vitamin D supplements can help reduce symptoms of SAD, but an editorial in the *Journal of Psychiatry and Neuroscience* earlier this year suggested that the time has come for clinical trials into the antidepressant effects of vitamin D. Other effects on the brain are likewise in the early stages of research, but low levels of vitamin D may also play some part in schizophrenia, bipolar disorder and autism.

The main dietary source of vitamin D is oily fish, so this is even more important in the diet over the next few months than for the rest of the year. Some have suggested that it's the vitamin D in oily fish which is important for brain health, rather than the omega-3 fats. But for whatever reason, encouraging your clients to eat more oily fish this winter can only be a good thing.

Helen Sandwell is a freelance nutritionist. Her website is at www.goodfoodandhealth.co.uk

Helen's nutrition toolkit, giving healthy eating advice relating to substance use, is published by DDN on CD-rom – email charlotte@cjwellings.com for details.

Families Plus
Professional Development

"Thinking Beyond the Individual: Working with Families and Substance Misuse"

Course dates
Mon 18 – Fri 22 Jan 2010
Mon 17 – Fri 21 May 2010
Mon 4 – Fri 8 Oct 2010

Following publication of the NTA guidelines "Supporting and involving Carers", this professional development focuses on the importance of working with families and carers and offers training in:

- Evidence based practice
- Exploring theoretical models of working with families
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With visiting lecturers, Professor Alex Copello (Birmingham and Solihull Substance Misuse Services & the University of Birmingham) and Lorna Templeton (MHRDU at Bath – Avon & Wiltshire Mental Health Partnership NHS Trust and the University of Bath) presenting current research

This course is accredited by the University of Bath

For details and an application form: **Families Plus**
Jill Cunningham House, East Knoyle, Salisbury, Wiltshire SP3 6BE
Tel: 01747 832015 Email: debby.williamson@actiononaddiction.org.uk

Action on Addiction

INVESTOR IN PEOPLE

Clouds has merged with Action on Addiction and the Chemical Dependency Centre to become one organisation

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Society for the Study of Addiction

Annual Symposium, 2009
'Treatment Policy'

Thursday 12 and Friday 13 November at the Park Inn, York, UK

Christine Godfrey will give the Society Lecture:
'Addiction Treatment: Do economists contribute to the policy debate?'

Themes:
- Service-user involvement
- Young people & families
- AERC symposium: What does the AERC do?
- The Randomised Injectable Opioid Treatment Trial

The AERC panel will consist of:
Angela Attwood (University of Bristol), *Val Curran* (University College London), *Debby Allen* (Oxford Brookes University), *Alyson Smith* (University of Wales Institute Cardiff)

Prices:

SSA member	£220
Non-member	£250
Unwaged member	£140
Unwaged non-member	£170
Additional dinner guest	£35

Speakers:
- Gillian Tober, Leeds, UK
- Gerhard Bühringer, Dresden, Germany
- Anne Lingford-Hughes, Bristol, UK
- Jo Neale, Oxford, UK
- Ann McNeill, Nottingham, UK
- Connie Weisner, California, USA
- Rhoda Emlyn-Jones (OBE), Cardiff, Wales
- Eileen Kaner, Newcastle, UK
- John Kelly, Boston, USA
- John Cunningham, Toronto, Canada
- Antoni Gual i Solé, Barcelona, Spain
- Keith Humphreys, California, USA
- Isidore Obot, Geneva, Switzerland

There will also be 3 sessions of delegate speakers, as well as many delegate posters.

Contact
Email: graham.hunt@leedspft.nhs.uk
Phone/Fax: +44 (0)113 295 2787

Visit our website for more details & application forms:
www.addiction-ssa.org

StreetScene

Night Support Worker

SOUTHAMPTON, HAMPSHIRE

Closing date : 12th November 2009
or before if the vacancy is filled prior to this date.

Visit **www.drinkanddrugsnews.com** for full job details or our website for more information about our organisation

www.streetscene.org.uk

Email enquiries to Angie Howson-Green at angiehg@streetscene.org.uk

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National Conference on Injecting Drug Use

Meet us at the NCIDU in Glasgow on 26th & 27th October. The NCIDU organisers are at the forefront of the harm reduction response to illicit drug use and are committed to preventing blood-borne virus transmission, drug related deaths and to improving the health of drug users. Our team are supporting the exhibition and will be available on the Concateno stand to answer any questions.

Choices

As a customer of Concateno, you have a wide variety of testing methods to choose from:

	Back to lab	On-site
Drugs of abuse urine testing	✓	✓
Drugs of abuse oral fluid testing	✓	✓
Alcohol testing	✓	✓
Hair testing	✓	
Blood borne virus testing via dried blood spot	✓	
Blood borne virus testing via oral fluid	✓	

If you would like further information on any of the above services, please ring **Customer Services on 01235 861 483 and receive a FREE 2010 Concateno pocket diary when you quote reference: NCIDU09**

Concateno plc
92 Milton Park, Abingdon, Oxfordshire, OX14 4RY, UK

CGP7346 Ed.001

TRAFFORD COUNCIL

TENDER

EXPRESSIONS OF INTEREST ARE INVITED TO DELIVER AN INTEGRATED ASSESSMENT AND HARM REDUCTION SERVICE FOR SUBSTANCE MISUSERS IN TRAFFORD

Trafford Council, are seeking applications from suitably experienced providers to deliver a Substance Misusers Triage, Assessment and Single Point of Contact Service. The contract is to provide:

- *A Single Point of Assessment for Adult Substance Misusers*
- *A process to ensure that those adults are referred to and attend the appropriate treatment services*
- *An Outreach Service to some areas in Trafford to work towards an increase in the number of substance misusers who enter into treatment*

It is anticipated that the contract will be awarded in March 2010 with a proposed start time during Summer 2010. The contract period is 3 years (Possibility of extension subject to funding and performance).

Deadline for receiving Expressions of Interest: 12 noon, Monday 2nd November, 2009

For further information and to express an interest, please contact: Heather Stanton, Corporate Procurement Team, Trafford Town Hall, Talbot Road, Stretford, M32 0TH.
Tel: 0161 912 1287 Email: heather.stanton@trafford.gov.uk

THE SALVATION ARMY

Gloucester House

addictions rehabilitation centre

Owned by the Salvation Army Housing Association, Gloucester House has been helping people with alcohol and drug dependency issues since 1961. It is a male-only rehab that specializes in treating alcohol, drugs, gambling and dual diagnosis.

- *12 step integrated primary and secondary programme for a minimum period of 12 weeks for each programme.*
- *Full-board accommodation for up to 15 men.*
- *Individual counselling offered.*
- *Smoking cessation clinic.*
- *Relaxation and mindfulness sessions.*
- *Occupational therapy sessions including; woodwork and framing, pottery, gardening, literacy and computer classes.*
- *All funding options accepted.*
- *Conditions of admission are following assessment and abstinent on arrival (people on reducing substitute regimes will be considered).*

For details of charges, service specification, referral pack, summary of outcomes etc, contact: The Manager, Gloucester House, 6 High Street, Highworth, Wilts SN6 7AG

Tel: 01793 762365 **www.salvationarmy.org.uk/gloucesterhouse**

TRAFFORD COUNCIL

TENDER

EXPRESSIONS OF INTEREST ARE INVITED TO DELIVER AN INTENSIVE TREATMENT AND COMPLEX NEEDS SERVICE FOR SUBSTANCE MISUSERS IN TRAFFORD

Trafford Council are seeking applications from suitably experienced providers to deliver an intensive drug treatment and complex needs service within the borough. The contract is to provide:

- *A Recovery focused intensive treatment process for adult opiate and class A substance misusers*
- *A process to ensure that adults with complex needs can access appropriate psycho-social interventions and/or psychological therapies*

It is anticipated that the contract will be awarded in March 2010 with a proposed start time during Summer 2010. The contract period is 3 years (Possibility of extension subject to funding and performance).

Deadline for receiving Expressions of Interest: 12 noon, Monday 2nd November, 2009

For further information and to express an interest, please contact: Heather Stanton, Corporate Procurement Team, Trafford Town Hall, Talbot Road, Stretford M32 0TH.
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SE4

Crime Reduction Services Training Officer

£31,935 - £33,306

Ref: COM565

Are you able to champion and drive forward high quality drugs misuse services?

Do you have a track record in sustaining high quality service delivery?

The Training Officer will be responsible for working directly with young people on an individual or group basis in order to offer harm minimisation, intervention and treatment to young people around substance misuse.

You will be able to build successful relationships between a range of children and young people agencies, to facilitate work programmes, initiate drop in sessions and undertake casework.

You will also lead on training for the community and London Borough of Lewisham workforce as a specialist in drugs and alcohol.

To be successful, you must have demonstrable experience and a working knowledge of relevant substance misuse coupled with a knowledge and understanding of the range of interventions used.

In return we'll offer excellent development opportunities, plus a range of benefits that includes a final salary pension scheme, flexible working and the opportunity to make a real difference to our local community.

If you enjoy a challenge then this is an exciting opportunity to join an established team.

For further details including a full job description, and to apply online, visit http://ls/C14/CouncilVacancies/default.aspx and search under Job Ref: COM565.

This post is subject to a Criminal Records Bureau (CRB) Disclosure.

London Borough of Lewisham is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share in this commitment.

Closing date: 26 October 2009 at 12 noon.

POSITIVE ABOUT DISABLED PEOPLE

Lewisham **www.lewisham.gov.uk**

LANCASHIRE DRUG AND ALCOHOL ACTION TEAM

Breaking the cycle of substance misuse

NHS Central Lancashire

Expressions of interest

to tender for the provision of adult community tier 2 and 3 and criminal justice services in Central Lancashire.

Substance Misuse Services in Central Lancashire are changing. Our vision is for an integrated drug and alcohol service with a focus on the recovery model and further development of service user led treatment programmes.

Lancashire Drug and Alcohol Action Team (LDAAT) in partnership with NHS Central Lancashire welcome expressions of interest from suitably experienced organisations for the provision of adult community tier 2 and 3 and criminal justice substance misuse (drug and alcohol) services in Central Lancashire (which is comprised of three boroughs; Chorley, South Ribble and West Lancashire and Preston City).

The successful provider will have a proven track record in delivering services that create a positive culture within the workforce and service users, recognise the importance of the wider family and community, and focus on the recovery and social re-integration of service users. The ability to work in partnership and the capability to transform the way community and criminal justice substance misuse services are delivered is essential. We would welcome partnership bids from public sector, private sector and voluntary sector with a clearly identified lead organisation.

The contract will initially be for 3 years with an anticipated start date of 1st October 2010, with the option to extend for a further 2 years subject to performance, recurrent funding and national policy. It is anticipated that contract award and service mobilisation will be confirmed by 25th April 2010 following a competitive tender process.

- The contract value for this service will be in the region of £5,000,000 per annum.
- A memorandum of information will be available from the 6th November 2009 at: *http://ldaat.org/consultation-documents/*
- A bidder information day is scheduled for 6th November 2009.
- The service specification will be made available to short listed bidders at the invitation to tender stage.

To record an expression of interest and to request a PQQ please email centralforward@centrallancashire.nhs.uk by 5pm on 3rd November 2009

Late applications at any stage will not be considered under any circumstances.

ADRAN GOFAL CYMDEITHASOL, IECHYD A THAI
Tîm Camddefnyddio Sylweddau - Llanelli

Gweithiwr Cymdeithasol
(Dros dro hyd 31ain Mawrth, 2011)

£25,472 - £30,011 (SO1/2/POA) Cyf.: 014543

Bydd daliwr y swydd newydd hon yn gweithio mewn tîm arbenigol sy'n darparu gwasanaeth gofal cymdeithasol i oedolion sydd â phroblemau yn sgil camddefnyddio sylweddau. Mae'r swydd yn gyfle i weithio'n greadigol gyda grwp cleientiaid amrywiol.

Bydd yr ymgeisydd llwyddiannus yn gweithio'n glos gydag ystod o gydweithwyr ar draws y sectorau statudol a gwirfoddol, a hynny dan amgylchiadau sy'n her ond sy'n rhoi boddhad.

Bydd daliwr y swydd yn gweithio mewn canolfan ami-asiantaeth newydd yng nghanol tref Llanelli, a bydd yn cael goruchwyliaeth gyson, cyfleoedd i gael hyfforddiant, a chy-morth gan gyfoedion o fewn tîm sydd wedi ei hen sefydlu.

I gael sgwrs anffurfiol am y swydd, cysylltwch â Kelvin Barlow (Rheolwr y Tîm, Camddefnyddio Sylweddau) drwy ffonio 01554 779649.

Gwneir cais am archwiliad o gofnodion troseddol ar gyfer y swydd hon.

Dyddiad Cau: 30ain Hydref, 2009

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SOCIAL CARE, HEALTH & HOUSING DEPARTMENT
Substance Misuse Team - Llanelli

Social Worker
(Temporary up to 31st March 2011)

£25,472 - £30,011 (SO1/2/POA) Ref.: 014543

This new post will form part of a specialist team which provides a social work service to Adults with substance misuse problems. This post provides an opportunity to work creatively with a diverse client group.

You will work closely with a range of colleagues across the statutory and voluntary sector in a challenging but rewarding environment.

Based within a new multi agency base in Llanelli town centre, you will receive regular supervision, opportunities for training and peer support within an established team.

For an informal discussion please contact Kelvin Barlow (Team Manager, Substance Misuse) 01554 779649.

A criminal record disclosure will be requested for this post.

Closing Date: 30th October, 2009

Apply online
www.carmarthenshire.gov.uk

Application forms are also available from
01267 234567 or e-mail
direct@carmarthenshire.gov.uk

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Kaleidoscope

Substance Misuse Nurse TEAM LEADER

Kaleidoscope Project, Kingston-upon-Thames
Salary: £27 – 31,000
35 hours per week – flexible working

Kaleidoscope is a community project, providing a range of holistic services to drug users and marginalized people. These services include Methadone treatment, needle exchange and a blood borne virus service. The postholder will be responsible for supervising the Nursing Team. Previous experience of working with substance users essential. General and psychiatric nurses may apply.

Closing date: Friday 30 October 2009

For an application pack contact
Veronica Snowball on 01633 246196,
or by email at veronica@kaleidoscopeproject.org.uk

SHEFFIELD DRUG AND ALCOHOL ACTION TEAM

Consultant to develop Sheffield Alcohol Strategy Update

Competitive quotes in writing are invited for the production of the Sheffield Alcohol Strategy Update 2010 which will build upon the agreed alcohol vision for Sheffield. Deadline for completion is 31st March 2010.

Work will include:

- Literature review to scope relevant research
- Stakeholder consultation
- Data review of local and national data
- Benchmarking

Submissions in writing by 5pm on Friday 30th October 2009.
Immediate start in November required.

For further information contact Cheryl Thorne
Tel: 0114 205 3671
e-mail: cheryl.thorne@sheffieldpct.nhs.uk

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Mental Health NHS Foundation Trust

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• REF: 436-YASCC-0063-TEAM-MNGR

The Addictions program is part of Birmingham and Solihull Mental Heath NHS Foundation Trust, one of the largest mental health and addictions service providers in the country. We are a forward thinking, innovative and supportive program with strong academic and training links to the University of Birmingham.

If you want to work within an excellent environment and lead a team of highly committed staff continually striving to provide the best services possible, then we want to hear from you.

If you wish to discuss this opportunity please contact Tim Farley, Addictions Service Manager on 0121 301 1635.

Please apply online at www.jobs.nhs.uk

For the hearing impaired send an SMS/Text to 0777070087 with the job reference name and address.

Closing Date: Sunday 1st November 2009.

Successful applicants are subject to a criminal records bureau disclosure.

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COMMUNITY SERVICE AREA

Substance Misuse Service User and Carer Involvement Co-ordinator

Ref: COM0040

Fixed term until 31 December 2011 continuation subject to further funding.
SCP 23-31 £20,198 - £26,276

Closing date: 2 November 2009.

Application forms and further details are also available from **www.torfaen.gov.uk** or e-mail **job.vacancies@torfaen.gov.uk** Tel: **01495 742560** quoting the reference.

TORFAEN COUNTY BOROUGH / BWRDEISTREF SIROL TORFAEN

Staff Nurses – Band 5 • Substance Misuse – Ref: 755-CLCH-97, Mental Health – Ref: 755-CLCH-98, Primary Care – Ref: 755-CLCH-99 & 100.

Doing time can be the final straw for some people. Those with only one barrier between them and a very dark place – you. Join the groundbreaking nursing staff at HMP Wormwood Scrubs and you'll be handed some of the toughest assignments imaginable. Crime often carries with it mental health issues, drug abuse, HIV or alcohol addiction... But because of the circumstances, the sense of achievement when you turn a life around is immense. Nursing qualifications, experience and the appetite to take advantage of industry-leading training are vital. However, we also look for people with the strength of character to overcome the challenges of an environment like this – and help our prisoners do the same. Visit **www.jobs.nhs.uk** to apply, using the appropriate reference number. Closing date: 4th November 2009.