DDN
Drink and Drugs News

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‘All the talk of treatment and reintegration into society means nothing if we don’t help former substance users with basic financial management.’

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DDN Drink and Drugs News

Published by CJ Wellings Ltd, Southbank House, Black Prince Road, London SE1 7SJ

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

Reporter: David Gilliver
e: david@cjwellings.com

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

Advertising Sales:
Faye Liddle
t: 020 7463 2205
e: faye@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
Charlotte Middleton
t: 020 7463 2085
e: subs@cjwellings.com

Events:
e: office@fdap.org.uk

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Editorial – Claire Brown

When credit's due

Small steps could help cash in on long-term results

'Because of small and avoidable money problems, people's treatment either stalled or stopped.' This statement on page 7 explains why this article is our cover story this issue. The Both Sides of the Coin project attempted to bring representatives from mainstream financial organisations together with the drug and alcohol field to debate practical ways of bringing basic financial management to those most in need of a leg-up from poverty. It's not an easy exercise, hampered by prejudice and inertia, but at least the word's going around that practical steps are within reach. Credit unions are a viable option to tell clients about – yet many drug and alcohol workers are unfamiliar with the way they work. Read the article and pass on the essentials.

As alcohol debates rage on (where they can get a look in in the press at the moment) the government has launched its public consultation on what should be included in its mandatory code of practice to tackle irresponsible drinks promotions (page 4). Yet it has already declared that it will not introduce the minimum price per unit, despite all the recent evidence that raising alcohol prices cuts alcohol-related hospital admissions. Alcohol Concern are among the campaigners that must be feeling like they are banging their heads against a wall constructed by a hysterical media – will government ever follow public health evidence to its logical conclusion, or will the 'nanny state' jibes continue to keep them blowing in the breeze of public opinion (page 8)?

There's more evidence that caring and consistent keyworking makes all the difference on page 11, where John gives a service user's perspective of the criminal justice system, and there's a reminder from Daren Garratt (page 9) that an inconsistent approach to keyworking can not just hold back service users, but sabotage their progress so far – a timely reminder that no amount of cost-cutting can compensate for good workers who know what they are doing.

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The EU cannabis mountain

Around 1,750 tonnes of cannabis are consumed in the EU and Norway every year, according to new estimates released at the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) recent conference in Lisbon. The figure comes from an EMCDDA survey, the full report of which will be published later in the year, which also found that cannabis production in Morocco – a country with a long history of supplying the drug to Europe – has declined. Delegates at the conference also heard that drug use in Europe was now entering a 'more stable phase'.

Develop dual diagnosis

Improved services for prisoners with a dual diagnosis of mental health and alcohol or drug problems need to be 'urgently developed', according to a new Department of Health report. *The Bradley report – Lord Bradley's review of people with mental health problems in the criminal justice system* states that too many people are passing through the system without their mental health needs being recognised, often leading to a cycle of reoffending. The report's recommendations are intended to establish a 'baseline' for mental health care services in criminal justice, said Lord Bradley. Report available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694 *The way those with substance misuse issues are dealt with by the criminal justice system is the subject of a major conference in London on 25 June. Visit www.conferenceconsortium.org for details.*

Pilot partners

Seven partnerships across England have been awarded Drug Systems Change Pilot status, the NTA has announced. This means the partnerships will be given the freedom to explore new approaches to treatment and ongoing care that could help 'determine the future direction of regional and local drug funding, commissioning and delivery systems' says the agency. The pilots, which will operate for two years, are Bradford Safer Communities Partnership, Hampshire/Southampton Partnership Trust, Hertfordshire DAAT, Leicester City DAAT, Safer Essex Partnership Board, Safer Lambeth Partnership and Sefton DAT.

Drinks code consultation begins

The government has launched a public consultation on what should be included in its mandatory code of practice to tackle 'those who promote irresponsible drinking'.

Among the proposals in *Safe. Sensible. Social. Selling alcohol responsibly* are mandatory codes for pubs, clubs and supermarkets, a ban on 'all you can drink' promotions, speed drinking competitions and the dispensing of alcohol directly into customers' mouths, as well as steps to make sure that small glasses of wine and single spirit measures are always offered alongside large.

Local authorities will be given new powers to deal with retailers, with those who fail to comply with the new codes facing potential loss of licence – or imposition of licence conditions – £20,000 fines or six months in prison. In alcohol 'hot spots' where two or more establishments are 'clearly associated with alcohol-related crime and disorder', councils will have additional powers to ban bulk buy promotions and all glass containers, restrict happy hours and pub crawl promotions and enforce the Challenge 21 proof of age policy.

The consultation also considers whether retailers should have to display information on unit content, and shops carry information about the health impacts of alcohol. However it states that the government has decided not to introduce a minimum price per unit of alcohol, as recommended by the chief medical officer (*DDN*, 23 March, page 5) and strongly supported by organisations such as Alcohol Concern (see this issue, page 8), as it would 'unfairly punish the sensible majority of responsible drinkers'. 'Further research' into minimum pricing would be carried out, it says.

Plans to introduce a mandatory code were announced in last year's Queen's Speech (*DDN*, 12 January, page 5), following widespread disillusionment with the effectiveness of voluntary codes of practice. The government has said it wants to hear the views of 'health bodies and the third sector who have to deal with the impact of alcohol-related harm'.

'Alcohol related crime and disorder costs the UK billions every year in police and hospital resources, not to mention the effect it has on the lives of millions of decent people who want to enjoy a night out,' said home secretary Jacqui Smith. 'It is not about penalising the majority who trade responsibly, but the government has a duty to tackle this issue which affects us all.'

The proposals were 'a necessary step in the right direction', said Alcohol Concern. 'For too long, the industry has failed to regulate itself,' said chief executive Don Shenker. 'This new code will help people make healthy choices while further protecting communities from crime. While we broadly support the code, we're concerned that some of the local conditions will be impractical to apply and ineffective. For example, banning bulk buying should be a national requirement, not a local option. Many off-trade venues, including supermarkets, still sell alcohol at irresponsibly low prices. Therefore, the government should not be afraid to consider the chief medical officer's proposals for a minimum price.'

Meanwhile a report from the House of Commons Business and Enterprise Select Committee on the relationship between pub companies and their lessees states that the high rents charged by large pub chains, alongside a failure to pass on discounts to tenants, are leading to increasing disparity between the price of drinks in pubs and off-licences, encouraging more people to buy cheap alcohol to drink at home.

Consultation available at www.homeoffice.gov.uk/documents/cons-2009-alcohol Consultation period ends 5 August. Select committee report available at www.parliament.uk/parliamentary_committees/berr/reports_publications.cfm

For Alcohol Concern chief executive Don Shenker's views on how the government should tackle cheap alcohol, see page 8.

Internet could boost drug treatment, claims EMCDDA

Internet-based drug treatment programmes could be a cost-effective way of reaching those in rural areas where distance is a barrier to accessing treatment, as well as young people whose 'pattern of drug use falls between experimental and problematic', according to a new report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Demand for treatment is rising in the EU, says *Internet-based drug treatment interventions*, especially from young cannabis users and 'socially integrated' drug users who may not feel comfortable accessing treatment centres largely aimed at injecting drug users – particularly those seeking treatment for the first time.

The report, which focuses on the methodologies of a sample of internet-based treatment interventions across Europe, acknowledges that treatment without contact between client and professional remains controversial and is still in its early stages. However, it could prove to be an additional tool for professionals, it says.

Alongside low maintenance costs, it could 'offer specialised services in rural areas, where distances are too great to access drug treatment centres,' it says. 'It could also prove to be a cost-effective way of providing support to a larger number of clients than traditional treatment centres are able to offer, given their limited capacity and human resources.'

The report focuses on online programmes that comprise 'a specially developed/adapted, structured and scheduled drug treatment intervention', as distinct from general websites about drugs. The study looked at services for cocaine, ecstasy and cannabis users, with 32 per cent of users of one German-based free service reporting as abstinent after completing the programme, and up to 72 per cent retention rates for the programme's seven-week duration.

However, 'the evidence is currently far from sufficient to draw final conclusions' on the effectiveness of internet-based treatment, says the report, which calls for further investigation and evaluation.

Internet-based drug treatment interventions available at www.emcdda.europa.eu/html.cfm/index78701EN.html

See feature in our next issue on how Turning Point is tackling the barriers to accessing treatment in rural areas.

Younger people may be drinking less as 'gender gap' closes in UK

Drinking rates among younger people in the UK may be starting to fall, according to a new report from the Joseph Rowntree Foundation (JRF). However, the overall 'gender gap' in harmful and hazardous drinking is narrowing, according to *Drinking in the UK – an exploration of trends*.

The study, based on a systematic review of research over the last three decades, found 'a slight overall decline in weekly drinking by men and women in Great Britain in recent years, especially amongst adults aged 16-24'. The study cautions against interpreting this as a 'convincing downward trend', but says that it is 'interesting and surprising that there is no further increase in drinking behaviour in this group'. However, the increase in average units of alcohol consumed by women over 25 since 1992 has been 'marked', while consumption by men aged 16-24 has fallen since 2000.

Among other trends highlighted are an increase in drinking in middle aged and older groups, an increase in drinking in Northern Ireland compared to the rest of the UK and an increase in alcohol consumption among 'very young adolescents'. The study finds 'some evidence' that the proportion of drinkers aged under-16 has fallen since the late 1980s but, among those who drink, the number of units consumed has increased sharply since the early 1990s, especially among 11-13 year old boys.

'In the UK, women are less likely than men to drink and women who do drink consume less than men,' says the JRF. 'However, a robust trend identified across several different surveys and different measures of alcohol consumption shows a recent narrowing of the gender gap. An examination of trends over the last 15 to 20 years indicates that it is generally the drinking behaviour of women that has increased towards that of men.' The study suggests the increased independence and financial security of women, along with the influence of advertising, as possible reasons.

Alcohol consumption among older age groups is still lower than for younger people, according to the survey, but recent years have seen 'a small but steady increase.' Alcohol is 65 per cent more affordable than it was in 1980 – accounting for 5.2 per cent of household spending, compared with 7.5 per cent. It is, however, likely to be 'wealthier, better off' older people who are drinking more, it says.

This pattern is also likely to reflect a generation of 'baby boom' drinkers with drinking habits established 'at a time of great social change associated with more liberal and permissive attitudes to many social activities,' it says. 'This generation may be more likely to retain old drinking habits compared with previous generations, whose formative drinking years were associated with greater austerity.'

The government has now launched a consultation on its planned mandatory code of conduct for the alcohol industry (see story facing).

Report available at www.jrf.org.uk/publications/drinking-in-the-uk

Drug seizures 'highest since records began'

The number of drug seizures made by police and customs officials rose by 17 per cent last year compared to 2006/07, according to figures released by the Home Office. There were nearly 217,000 seizures of drugs in England and Wales in 2008/09, the highest number since electronic records began in 1973.

Cocaine was the most commonly seized class A drug, with 3.4 tonnes seized – up by 26 per cent on the previous year – according to *Seizures of drugs in England and Wales, 2007/08*. Crack cocaine seizures rose by 9 per cent and heroin seizures by 2 per cent.

The number of seizures of all classes of drug had increased. There was a 4 per cent increase in seizures of class B drugs overall – five per cent for amphetamines – while class C seizures increased by 20 per cent. Of these, herbal cannabis seizures increased by 26 per cent and seizures of cannabis plants by 47 per cent, while seizures of cannabis resin fell by 5 per cent. The Home Office pointed out that 'drug seizures can fluctuate from year to year and are not a measure of drug prevalence in society.'

Last week, however, the Serious Organised Crime Agency (SOCA) claimed that its work had caused wholesale cocaine prices to rise from £39,000 per kilo in 2008 to more than £45,000, and that the cocaine market was now 'in retreat'. Street prices of the drug, however, have remained stable, with dealers thought to be selling increasingly diluted cocaine powder.

'There have been some significant enforcement breakthroughs in recent months, but it is too soon to say whether this will have a sustained impact on the supply and availability of cocaine in the UK,' said DrugScope chief executive Martin Barnes. 'To suggest that the world cocaine market is "in retreat" is probably premature. So far the reported disruptions in supply have not fed through to an increase in street price largely because dealers are trying to maintain the price and maximise profits by selling a product that is much less pure.

'There is evidence of the increasing use of cutting agents – such as benzocaine and phenacetin – which more closely mimic the physical sensations associated with cocaine, such as a numbing of the tongue or mouth,' he continued. 'By using such chemicals, it is easier to pass off the drug as being much purer than it is. Cocaine is a harmful drug and you can never be sure of its purity or what it is cut with. Enforcement activity has a role to play, but it is crucial that people are made aware of the potential risks and harms, and that demand for the drug is addressed.'

Seizures of drugs in England and Wales, 2007/08 available at www.homeoffice.gov.uk/rds/pdfs09/hosb0809.pdf

News in Brief

Getting personal

Seventy-five PCT areas have been awarded provisional pilot status in 68 new 'personal healthcare budget' projects, the Department of Health has announced. Under the scheme – announced in Lord Darzi's *High quality care for all* report last year, patients will be given more say over the services they use and who provides them, as well as having more input into how money is spent on their healthcare needs. Full pilot status will be awarded later in the year after a programme of assessment.

'Personal health budgets provide an ideal opportunity to join up services around people's lives, rather than forcing people to knock on several different doors to get the help they need,' said Turning Point chief executive Lord Adebowale. 'They could be particularly useful for people with complex needs – for example someone with a mental health problem who has lost their job and has started drinking heavily. These people currently often fall through the gaps between services. Personal budgets are a chance to crack this problem once and for all – to start focusing on prevention and getting people's lives back on track.'

ARBD opening

A new unit to tackle alcohol related brain damage (ARBD) has been launched by the Priory Hospital Glasgow. The unit offers intensive specialist services including neuro-rehabilitation assessment and integrated care programmes and has ten single en-suite rooms specially equipped to deal with the complex needs of ARBD patients in a 'safe, age appropriate' environment. The unit will accept referrals from the NHS, including GPs, as well as the independent and voluntary sectors, and aims to offer pre-admission assessments for all referrals within 48 hours. 'Having worked in the addictions field for many years I have seen ARBD become a more prevalent, but often under-reported illness,' said Priory Hospital Glasgow's clinical services manager Michael Steel. 'This new unit will support the current ARBD treatment services in Scotland. Our aim is to help patients gain increased levels of independence and achieve progressive goals for the future.'

Both sides of the coin

All the talk of treatment and reintegration into society means nothing if we don't help former substance users with basic financial management, say **John Chell**, **David Mackintosh** and **Sara McGrail**

It was Victor Hugo who said 'There is nothing more powerful than an idea whose time has come'. Well few could argue that 2009 is the year when new ideas, and certainly the need for new ideas about finance – be it international, organisational or personal – have come to the forefront of debate and discussion.

It's also a time for those of us working in or alongside the substance use field to start thinking about finance – and not just about the need to secure the next contract. The link between problematic use of substances and poverty are well recognised, yet rarely do we see action to address some of the functional barriers this causes. Since the launch of the new drug strategy, the word reintegration has become part of our lexicon. Housing, training and employment are now recognised as being key elements of what helps people engage successfully with services and what sustains the gains they make.

But in many cases we have been missing a trick, something that's basic to being able to take part as an active citizen in our society. It's something most readers of *DDN*, certainly all those employed professionally in services, take for granted every single day – the need, at the most basic level in our society, for a bank account, somewhere to keep your money safe and some way of controlling it. It goes beyond this of course – how to run a household, how to deal with debt and loans, all the things often taken for granted. If you have ever tried to cash a giro, or rent a flat without a bank account you will soon find it's a need, not a nice additional extra.

It was from discussions on this subject that the Both Sides of the Coin project was born. Both Sides of the Coin is a small consortium of organisations and individuals, led by the London Drug Policy Forum and including KCA and Adfam, who want to explore the relationship between financial exclusion, poverty and substance

use and find ways of helping people tackle financial exclusion.

We started off by talking to service users, their families and people working on the coalface in the communities most affected by drug use. Even though we knew these issues were important, and we knew that financial exclusion was having an impact on our client group, we were shocked by some of the stories we were told. One man told us how, when he'd just come out of rehab, he'd had to use a pawnshop to cash his community care cheque because he didn't have a bank account or ID and couldn't access the money any other way. Out of his £850 grant to restart his life after rehab, nearly £145 went in fees for cashing the cheque.

Pauline, stable in treatment and a new mother, told us how she had initially been helped by a doorstep credit company, but that as time went by the loans she had just got bigger and bigger and she became frightened she'd never be able to pay them off. The temptation to start using on top, just to get a break from her money worries, became overwhelming and she began to dabble again. She said that what stopped her getting much worse was the local Citizens Advice Bureau. Only when she went along there, with her mum, did she realise that the debts could be dealt with – and that while the 468 per cent interest rate she had been charged was perfectly legal and the door stepping and pressure from the loan agent was fairly standard practice, she could get her life back and stop the mounting debt.

One father told us of his despair as, living on benefits 7himself and unable to help, he watched his son's alcohol use spiral out of control as he moved further and further into debt to illegal moneylenders. People described to us very real reductions in household income when people moved from crime to treatment. Peter, who'd been a year out of rehab and was now dealing with debts that had caught up with him from years ago, said: 'If I'd known how bad my finances would be when I gave up, I'd never have stopped using in the first place.'

To report back on our findings, share some of the thinking and look at next steps, we wanted to run a small conference for people from inside and outside the drugs field. Through the kind support of the European Bank for Reconstruction and Development, a highly appropriate venue in the heart of the City of London was secured for 23 April. An impressive range of speakers began to be assembled – but a major obstacle was encountered when we started putting the event together.

While many within the substance use field found the issue novel and challenging, some from the mainstream financial services found the concept almost beyond them. 'We don't work with people like that,' was not a unique response. However when it was explained that, if you're dealing with thousands of individuals, you most certainly do have considerable experience of working with those who have had personal or family knowledge of problems relating to drugs or alcohol, this attitude rapidly changed.

The event opened with some scene-setting, placing poverty and substance use in context, considering the broader public health picture, looking at experiences of individual users and the issues around benefits and debt.

We heard more heartbreaking personal experiences – of people who hid any letter from a bank because 'those sort of letters' are simply too scary to open, and of people who got letters from banks but couldn't read. Because of small and avoidable money problems, people's treatment either stalled or stopped. The conclusion to be drawn was that much of the money we invest in services and benefits is wasted if individuals can't access mainstream banking or benefits.

We were reminded that the surge of job losses as a result of the recession would mean for some that drug use and habits that are currently affordable might soon prove to be prohibitive and problematic.

There were sessions on the new benefit regime from JobCentre Plus and the potential benefits greater support may bring for individuals. This contrasted with a debate about the level of welfare support for people who are out of work and the realisation that most, if not all, of the representatives in the room from drug treatment services had little idea of the basic level of benefit their clients had to live on.

A look at illegal moneylending showed how it can trap individuals in poverty. There were examples of how action by the police, trading standards and advice agencies can help break this hold – did you know that a third of the victims of illegal moneylenders in London have problems either with drug and alcohol use or with mental health? And there was a presentation looking at how some banks – Barclays in this case – are working to address inclusion.

One presenter described an initiative in the Netherlands where a bank has established a specific account for people in drug services. They agree how money will be managed with the bank and then the bank enables them to access their funds in a sensible and measured way – meaning there's less temptation to blow wages or benefits or drugs and more opportunity to get back in control.

'Some from the mainstream financial services found the concept almost beyond them. "We don't work with people like that," was not a unique response.'

To help root all this in and demonstrate what practical help could look like, the valuable example of Airfootball was presented. Airfootball is a project that runs in East London and uses sport as a platform to tackle a host of issues including financial inclusion. The project worked closely with their local HSBC, who as well as being one of the sponsors of the project, also set up bank accounts for service users.

The important role credit unions can play in supporting individuals reinforced practical examples of what can be achieved. Credit unions can help people living on the margins of society with very small loans – things that banks really aren't well equipped to deal with. Unfortunately very few people know anything about credit unions or in fact very much about finance and financial exclusion – even key workers.

The day concluded with a consensus that this is an area which can benefit from development and where there are clear gains to be had working with agencies from outside our normal comfort zones. The Both Sides of the Coin initiative will continue to be developed – we know there is a need, and we know that with some really basic awareness-raising we can have a huge impact on people's ability to gain independence.

Both Sides of the Coin presents a big challenge for the drugs field – that of getting out of our silo. To work effectively we need to build links across many other areas of social policy, like housing, welfare rights, training and employment. If we only think in terms of treatment, then frankly we are failing the individuals and communities we are here to help. We need to build an awareness and understanding in policy areas, strategic planning and services, that matters other than treatment are important in supporting individuals' recovery, but also in preventing the slide into problematic use. The reintegration agenda provides a powerful vehicle for developing this work.

We need to work with banks and community finance institutions because they need help to grasp the problem. By working with them to see that not only should they seek to include our client group but that they already are, we can access and make effective use of the resources they provide, but which at present go unused. We in the substance use field need to ensure we don't forget to consider individuals' finance needs.

Substance use problems affect everyone in society, as do issues of finance. In both, it is those at the bottom of the pile who are most likely to suffer the worst negative consequences. For too long, actions in these areas have taken place in near total isolation. In the current climate this can't be allowed to continue – linking financial inclusion to work around substance use is an idea whose time has come. Both Sides of the Coin aims to improve the way we deal with this – to see better outcomes for individuals, services and our communities.

John Chell is a specialist in financial exclusion and community development, David Mackintosh is senior policy officer, alcohol and drugs, at the Greater London Authority and Sara McGrail is a drug policy specialist.

Sean Locke

The real cost of alcohol

In a recession, when is alcohol too cheap? **Don Shenker** asks how the government should tackle the problems associated with cheap booze

IN THE TIME IT TAKES YOU TO READ THIS ARTICLE, around 15 people will have been admitted to hospital with an alcohol related complaint. More than 810,000 people were admitted to hospital in 2007/8 with alcohol-related illnesses – that's around 1.5 per minute. The problem is that while nearly everyone agrees this figure is too high and a burden on the NHS, the government is deeply divided as to how to resolve it.

The cause of these astonishingly high admission rates – and rising by around 80,000 a year – has been squarely laid at the door of the price of alcohol. Alcohol is now around 70 per cent more affordable than it was in 1980, but taking action to tackle cheap alcohol is not a vote winner – not in a recession and not with an election forthcoming. When the chief medical officer suggested introducing a minimum price per unit of alcohol he was roundly criticised in the press (*DDN*, 23 March, page 5). After all, surely the majority of drinkers act responsibly and shouldn't have to pay more for the 'sins of the minority'? This has been the mantra of the drinks industry and certainly of the main two political parties, nervous of appearing too 'nannyish' and not wanting to upset voters who enjoy their two-for-one wine deals at the local supermarket.

Fortunately, we now have more evidence than ever of the impact of cheap sales of alcohol on harm and of the potential long-term health, crime and economic benefits of raising prices. Two recent reports from the School of Health at the University of Sheffield on alcohol price, consumption and harm have cast a light on the real cost of cheap alcohol and opened up the debate on how to solve this by introducing a minimum price per unit of alcohol sold. A minimum price would end loss leading by supermarkets and raise the price of the cheapest drinks.

Raising the price of alcohol to 40 pence per unit would halve the number of people admitted to hospital this year. In addition, there would be 16,000 fewer crimes committed and 100,000 extra days worked. These are staggering numbers. The Sheffield research shows, importantly, that it is young drinkers, binge drinkers and harmful drinkers who tend to choose cheaper drinks. Consumption levels in this group are the most affected by price increases and decreases, and, crucially, this group consumes a disproportionately large amount of alcohol.

In other words, it is young, binge and heavy drinkers who are the drinks industry's best customers. They would reduce their drinking the most if a minimum price on alcohol was introduced and the vast harms associated with their drinking would diminish. According to the Sheffield report, a 10 per cent increase in price, for example, would cut consumption among 11 to 18-year-olds by 35 per cent. The same price increase would only amount to a 10 per cent decrease in consumption among moderate drinkers.

This is because moderate drinkers tend not to be so choosy about the price of their drinks – they do take advantage of price offers, but similarly are just as likely to spend a bit more. Whereas heavy drinkers would end up paying on average £2.60 more per week for their drinks if a minimum price of 40p per unit was introduced, a moderate drinker would only pay 11p more. This level of price increase alone would save the country £7.8bn over ten years.

You might well assume that without heavy drinking the profits of the drinks industry would diminish significantly, as higher minimum prices force heavy drinking groups to spend much less on alcohol. Ironically, if a minimum price were introduced, the industry would continue to profit, as although the volume sold would decrease, prices would be higher. In fact a 40p minimum price would yield an extra £633m, split between the on and off trade.

Although higher alcohol taxes would be the ideal way to raise the cost of alcohol and allow public funds to be spent on alcohol services, the off-trade will always absorb the increases unless they are forced not to sell below cost. The Police and Crime Bill, currently being debated in parliament, will establish a mandatory code of practice to tackle irresponsible sales from the on-trade, such as 'ladies drink free' offers or £1 shooters. While this is welcome, dealing with loss leading in the off-trade, which allows supermarkets to charge less than £3 for a 3 litre bottle of 6 per cent cider, is much trickier unless there is a minimum price per unit.

Alcohol Concern has long argued that alcohol needs to be made less affordable. The obvious solution to this is to raise taxes, which we have argued for. But to shift the trend of bulk-buying and deep discounting, something else is needed to force the industry's hand. Scotland is looking to introduce a minimum price on alcohol – will England follow as it did with smoke free legislation? If we want to reduce alcohol harm, then let's hope so.

Don Shenker is chief executive of Alcohol Concern

Placebo effect

The letter by Christine Hudson (*DDN*, 4 May, page 6) may seem impressive but when studied contains nothing of substance – much like homeopathy.

She accuses me of being an 'aggressive sceptic' yet challenges nothing of the content of my letter (*DDN*, 6 April, page 9). She also insinuates I am in the pay of the pharmaceutical industry – I can say I am not, but I am interested in the scientific method which has brought untold benefits to our society. This is a predictable attack from people in her position. It seems fair to say she has a vested interest in muddying the water and allowing silliness to go unchecked.

I might as well present myself as a registered unicorn expert as she a registered homeopath – there is no evidence that this drivel works beyond the placebo effect, full stop. She can disprove this by showing verified, replicable double blind trials, which the pharmaceutical industry is reasonably expected to do. Let's be clear, the alternative medicine industry is a multi-billion dollar worldwide industry not some friendly, hippy cottage industry.

I know full well amino acids are necessary for human health. We can manufacture some ourselves, but others we need to get from our diet. I am also aware that nutrition and a balanced diet are vitally important for our health and wellbeing.

The phrase 'natural medicine' is one that attempts to make things seem nice and harmless, yet it has little meaning. Many medicines we use are from, or have been developed from, 'nature'. But nature contains many things that do us harm and it is simplistic to use it a byword for 'good' or 'nice'.

Adverse effects will not be experienced from many treatments when they have no effect. The body has remarkable ways of healing itself and it is quite wrong to correlate taking some inert substance with an active substance.

While there is a tendency to eat too much food nowadays and some processed foods we eat have little nutritional value – and while sugar, caffeine and so on do affect our mood – it is ridiculous to suggest that we are not better fed that we have ever been with a huge variety of fresh food. Christine speaks of the attention paid by farmers to their stock, yet then goes on to suggest what they produce does not constitute food. Some of the phrases she uses simply do not have any meaning.

Science, unlike alternative therapy, is not a closed loop and is transparent and there to be studied and criticised – this is what academics in the field are doing. Naturally there are then questions of human behaviour and politics to deal with, but these can be studied and understood too. The psychology of what we believe and why we believe it is fascinating and counterintuitive and shows how little we know ourselves – again highlighting the need for a dispassionate approach.

It is good to be sceptical of people telling us what to do and scrutinising big pharma, Tesco etc, but Christine's energies seem misguided and she only offers fantasy. Science can be seen as difficult and boring, but it has led to all the advances in our civilisation including adding decades on to life expectancy and reducing disease. This is what we now take for granted and also what has set the scene for Christine and her ilk to make unsubstantiated claims and derive money and power from them.

N Scott, substance use and mental health worker, Staffordshire

Good and bad behaviour

I sympathise with the 'good mother' methadone user (*DDN*, 4 May, page 7) who wrote protesting about my letter, which included references to aspects of other users' bad behaviour.

But nowhere does my letter (*DDN*, 23 March, page 6) say or imply that all drug-users exhibit such forms of behaviour. I list only what statistics from the West Yorkshire and Thames Valley Police, the *Big Issue in the North* and other authorities have revealed, and I do so not to condemn those who are the victims of addiction, but because I want to expose the failure of government to help such addicts and their communities by failing to utilise available rehabilitation systems which, in 69 to 84 per cent of cases, can help users recover the comfortable natural abstinence into which 99 per cent of the population are born.

I didn't say 'most users cause accidents,' which is untrue. I said 'addicts and drunks cause the most road accidents (and acquisitive crime),' which is statistically accurate. Please read my letter again.

The lady says 'going into rehab doesn't cure you and most go in over and over again', and she is right. Three years on methadone cures only 3 per cent, and rehabs struggle to cure 22 per cent. But addiction recovery training helps more than 69 per cent to get themselves off, and comfortably stay off, drugs for the rest of their longer and healthier lives – at a cost equal to only three years on methadone and benefits.

I have known many methadone users, because I am part of a team which helps them get off, and it is because I care that I have for 20 years fought for a more frequent and assured recovery of drug victims. If the lady would like to inspect our premises and talk to our staff and current and former students, I would be happy to arrange a cost-free confidential visit for her.

Kenneth Eckersley, CEO Addiction Recovery Training Services

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at www.drinkanddrugsnews.com

Notes from the Alliance

From pillar to post

Essential stability in treatment can be sabotaged by an agency approach to keyworking, warns Daren Garratt

A really good friend of mine re-engaged with his local treatment service last October after a bit of a lay-off. He had an appointment with his key worker last Friday and he really wasn't looking forward to it.

Why?

Because it was his third key worker in six months and he knew that he was faced with the daunting, unwelcome and unnecessary burden of having to recount painful, purposefully buried memories of his past to a complete stranger again, despite being put through the same ordeal just a few weeks ago and a few weeks before that.

Because he'd built trusting, supportive relationships with his previous two key workers and he was afraid it might not happen again.

Because, despite being back in treatment for over half a year, he felt he was back to square one again, with little or no progress being made on this, his latest treatment journey. Sessions with those two previous key workers regularly left him feeling positive and improved his sense of wellbeing. The current situation of 'being pushed from pillar-to-post' only made him, in his words, feel like scoring.

And it's easy to understand, share and sympathise with his frustrations. The relationship between a user and their key worker can prove essential in enabling someone to achieve their desired treatment outcome, but like all trusting, supportive relationships, in order to grow they require belief and, perhaps more importantly, time.

Unfortunately, the rise in relying on agency staff to take on key worker roles means this is a luxury that may be denied to more and more users as the trend continues.

Agency work is, more often than not, temporary, and although treatment services benefit from employing agency staff – as it enables them to address capacity issues relatively easily, and the workers themselves benefit by bolstering and expanding their CVs and dipping their toes into different work environments and disciplines – what benefit does the user get when they find out their key worker has decided that drugs work isn't for them so they're going back to generic social work, and despite all the work they've collectively done so far, they've got to start all over again? None, quite frankly.

It's well accepted that the effect a drug will have on an individual is influenced by that individual's mood, the people they are with and the environment they are in. I think there's a legitimate argument to say we also need to apply this principle to drug treatment or recovery, whatever you choose to call it. A fundamental pillar of a successful treatment journey is stability, and effective, long-term client/key worker relationships can provide this stability when it is most needed. Temporary agency staff – regardless of how professional and committed they are – cannot guarantee this, and as the cycle of disruption continues, so users' chances of achieving a successful treatment outcome become inarguably compromised. And that's not fair.

Daren Garratt is executive director of the Alliance.

Making the Connections

DDN reports from the first Connections Project conference in Krakow, where delegates shared best practice and innovation from different countries' criminal justice systems

'Drug use is illegal in prisons, therefore there is no drug use in prisons, therefore we don't need to provide drug services for prisoners.' This was a quote heard by a UK government minister in the early 1990s, International Harm Reduction Association (IHRA) co-founder Professor Pat O'Hare told delegates at the first conference of the Connections Project in Krakow, Poland. Fortunately things had moved on from there, he said, quoting examples of best practice, needle exchange and substitute prescribing that were helping to slow the spread of hepatitis C and HIV in countries as diverse as Spain and Moldova.

The challenges faced by those attempting to introduce harm reduction measures in prisons in many ways mirrored the struggle in the wider world, said Professor O'Hare. 'Prison is a hostile environment for harm reduction. When I first started in the mid 1980s, the world was a hostile environment for harm reduction – but if I look now, it's not so hostile.'

Improving harm reduction and fighting the spread of blood borne viruses by sharing best practice and innovation across criminal justice systems was precisely what the Connections Project was set up to do, explained project director Alex Stevens. Launched in Autumn 2007, the project is managed by The European Institute of Social Services (EISS) at the University of Kent, and builds on the work of previous projects as far back as the 1994 European Network on Drugs and Infection Prevention in Prisons. However, it had widened the scope of the work outside the prison walls to include the criminal justice system as a whole, he said.

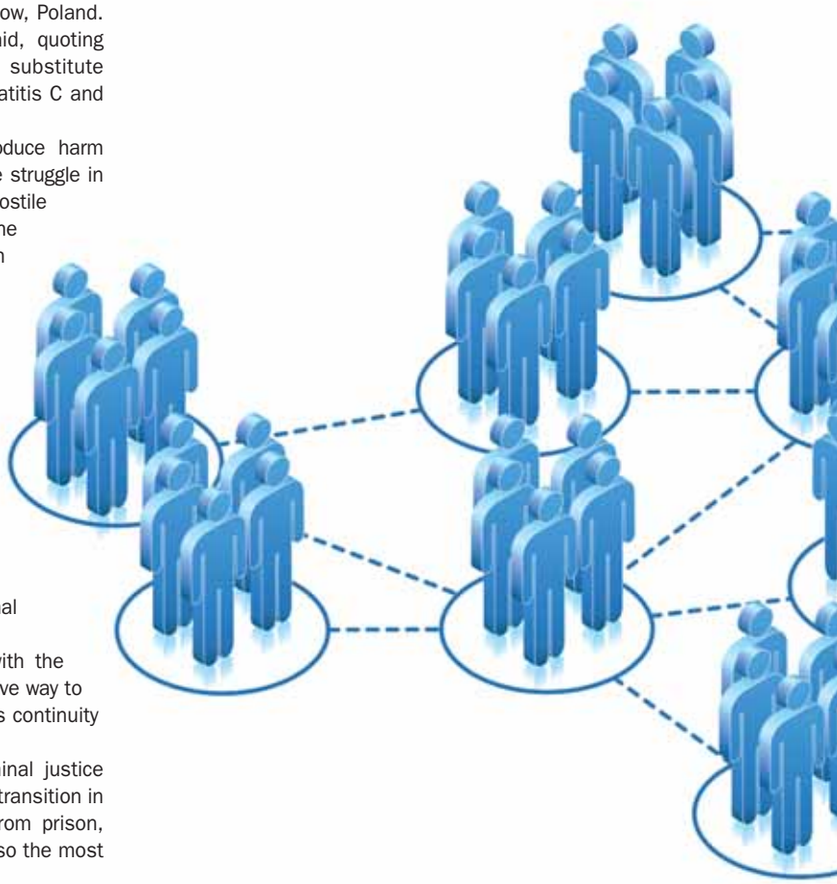
It was essential to reduce use of imprisonment, with the Portuguese model of decriminalisation offering an effective way to cut prison populations, as well as making sure there was continuity of treatment, he said.

The opportunity to work with drug users in a criminal justice setting was a vital one, stressed Stevens. 'The points of transition in the criminal justice system, such as arrest and exit from prison, represent the greatest risk to people's health, but are also the most opportune moments for harm reduction and drug treatment interventions.' Conditions in custody could increase chances of cross-infection but for many a police cell, court or prison could represent their first opportunity to access treatment, he said.

For professionals to make the most of these opportunities, however, it required strong partnership working across all agencies, said George Gallimore of the UK Police Federation. 'The key to success is good working relationships and an understanding of the limitations of any process.' However these things did not happen overnight, he said, adding that the UK had seen a shift from 'policing drugs to policing drug users'.

There had been a definite shift in the nature of drug use, delegates heard, with a high proportion of younger arrestees testing positive for cocaine and stimulants rather than opiates, and seeing themselves as recreational rather than problematic drug uses. The increase in 'summary justice' like on the spot fines also raised questions, said Mr Gallimore, as there was an argument it could lead to an increase in acquisitive crime to pay the fines.

At the two-day event speakers offered regional perspectives – one of the main focuses of the conference was to highlight the disparity in harm reduction services between Eastern Europe and most countries in Western Europe. Peter Sarosi of the Hungarian



Civil Liberties Union told delegates that in most Eastern Europe, less than 10 per cent of IDUs received substitute prescribing treatment. Public opinion on drugs also varied widely across Europe, he said, with more than 50 per cent of people in Poland supporting a 'total war' on cannabis compared to less than 25 per cent in Denmark. Most Eastern European states also had more repressive drug legislation and a 'lack of proportionality in sanctions and focus of law enforcement', he said.

Delegates came from as far afield as Russia and the United Arab Emirates as well as most of the EU, and this sharing of regional experiences and perspectives was exactly the point of Connections, said project coordinator Cinzia Brentari. 'It's these elements of sharing best practice that the project will continue to focus on in the second half of 2009 and the start of next year,' she said. 'We're planning to organise a training academy on harm reduction in prison where we will expose prison and NGO staff from Eastern Europe to evidence and good practice on the implementation of infection prevention services in prisons. The project is also involved in defining the criteria for good practice, and we are already hard at work planning the second conference for spring 2010.'

For more information, as well as presentations and reports from the conference, visit www.connectionsproject.eu

Partners in criminal justice

ONE STRIKE AND YOU'RE OUT

In the latest in our series, **John** gives us the service user perspective of the criminal justice system

ABOUT FOUR YEARS AGO I was living rough and had been for eight or ten years. I was selling the *Big Issue* but I got banned from selling it for a while, so I started begging and was arrested for begging.

I was charged with something like 'placing myself in a spot with intention to beg or gather alms' – that's how they word it. I went to court and was given a conditional discharge. I had a few fines and I ended up going back again a few months later, still on the same charge, but because I'd got on a script and took a supporting letter to court, they gave me another discharge and cleared my fines, because they said they could see I was trying to make an effort.

That worked out well, but before they'd sent me to the CJIT team, saying 'they'll get you sorted out on a script'. But if you miss one appointment they stop the script, which defeats the object. That's one of the biggest problems – they literally give you one chance – if you miss one appointment they stop it straight away. When people are trying to get away from the using lifestyle and all of that, it's hard to keep appointments. The intention's there but sometimes you'll get waylaid and think 'I'll go in tomorrow', but by then it's too late.

People don't seem to understand how difficult it is to get out of that cycle – even if you're on a script and comfortable, everything's still new and different and it can be scary. The last thing you need is to go and see someone who's supposedly trying to help you and they're just moaning and bitching at you, saying you haven't done this or that. They need to listen to service users more. It's hard to explain how difficult that life is unless you've lived it, which is why the whole service user involvement thing is so good – some places are really starting to listen. I was at the *Voices for choices* conference – more things like that would be really good.

Some workers seem to have a list of rules and regulations that they read out and that's it – you don't get a say, it's their way or no way, that's the impression they give. It can come down to the individual worker. Some of them seem like they genuinely care and want to help you, but if you're stuck with a worker who's not like that and you ask for a change, chances are you can't get a decent worker because everyone else wants that worker as well.

You can get sent from the police station or the court and told you have to go for this appointment, it's part of your sentence and if you don't go you can be called back, and that's it – you're passed on to the next place and once you get there they don't seem to stay in touch with whoever sent you there. The system is getting people into treatment, but they could be a bit more lenient – miss an appointment and you can be back in court.

I'm pretty much settled now. I don't have any court cases pending, I've got my own council place and I'm just plodding along on my script, which is being done by a drug clinic rather than through the court system. I went from the streets, to a homeless hostel, to a shared house you could only move into once you were scripted. I got in there straight away, and they help you with filling out all your council forms and everything – the council where I live is good when it comes to housing people from hostels. It worked out well.

I've got a really good worker now who I've known for years and get on really well with. That makes all the difference – having a worker who doesn't just come across like they care and understand. You know the ones who are just saying it, and the ones who genuinely do.

Understanding what is working and the 'pinch points' in the criminal justice system relating to drugs and alcohol is the aim of the Conference Consortium's forthcoming event, 'Somebody else's shoes', on 25 June in London. Visit www.conferenceconsortium.org for details. In the run-up to the conference DDN will be interviewing a selection of people within the system, to give insight to different roles and how they relate to each other.

Drastic measures

The controversial drug disulfiram, known by the trade name Antabuse, makes people violently ill if they drink while taking it. **Richard Shrubb** describes how it finally stopped him drinking when all else had failed.

I had been forced into treatment for alcoholism when I was diagnosed with paranoid schizophrenia in 1999. I wanted to live life again when I started to receive my £172 a week disability benefits, so coercion to sober up would not work – I had been on Jobseeker's Allowance for six months and no employer would touch me with a barge pole. The extra money meant I could breathe again financially, but also get some pent up stress out of my system.

I moved into a shared, supported house for psychiatric patients, and this became my problem – all my mates and I lived together and we wanted to have a good time, 24 hours a day, 365 days a year.

I attended the Robert Smith Unit (RSU) specialist alcohol treatment day hospital in Bristol, and at one point managed 10 months of sobriety before boredom drove me to drink again. I had no direction, and sobriety lost its charm. I would drink myself incontinent in the next three years – even an irritable bowel didn't deter me from drink.

Yet boredom was also my salvation. You need a stimulus like total boredom to kick you up the backside from time to time and, while it caused me to drink, it also made me start looking to the future. I started a City and Guilds in journalism, which led to an interview for an MA in broadcast journalism and me winning a place at University College Falmouth. My dad told me to take a year out to sober up. Instead, I attended the RSU and AA, lying at both that I was sober. How they didn't see through it I'll never know, but I owned up in June 2004 and was ostracised by my AA group and thrown out of the RSU.

At the RSU I'd heard of a drug that makes you violently ill if you drink, called Antabuse, the trade name of disulfiram. I was interested but they consistently refused me. Preparing this article, the Royal College of Psychiatrists put me in touch with Dr Alison Lowe, a consultant in addictive behaviour at Hertfordshire Partnership Foundation Trust. She didn't seem surprised that I was refused the drug.

'We are bound by the Hippocratic Oath which states "first, do no harm",' she said. 'Antabuse is a punitive drug, where you are given the choice of sobriety or harming yourself – 20 years ago we would have taken someone into a psychiatric unit, given them the drug and then given them an alcoholic drink in controlled conditions, to show just how violently ill the reaction makes them. We realise now that alcoholics are punishing themselves already, and another way to harm themselves wouldn't deter the drinker. We prefer to treat them with therapy and a controlled detox programme now, as it teaches people to take care of themselves – the opposite of what they do drunk.'

Listening to Dr Lowe, I understood why the RSU were so negative. I was in a circle of friends who wanted me at my most unpredictable and fun loving and it was in their interest for me to be drunk. Aspirating vomit – and potentially choking to death – after drinking on disulfiram could have happened to me, because I was under such pressure to drink. I met them last year and they wanted me to go out and get trashed with them again, one more time for posterity.

Studies show that Antabuse only works if the patient wants it to. A report in the *Journal of Clinical Psychopharmacology* states that 'in clinical trials, disulfiram has demonstrated inconsistent results in helping patients to abstain from alcohol, and patients poorly adhere to a disulfiram-treatment regimen. This has raised questions about disulfiram's practicality in the treatment of alcohol dependence.'

Bristol PCT, which funds the RSU, describes its policy on when to prescribe Antabuse: 'Generally, Antabuse is given to people who are struggling to remain sober and the fear of an adverse reaction to alcohol helps to support them in their psychosocial treatment to remain sober. Evidence suggests that it is most effective taken in a supervised fashion, either with their treatment team or partner. Some patients like to have it as a safety net.' Tellingly, the use of disulfiram is right at the bottom of a long list of interventions that the PCT suggests. The anti craving drug acamprosate sits just above, with the caveat that it only works with 60 per cent of those given the drug. Psychosocial interventions are much preferred in the NHS.

I left my friends in 2004 to move to Falmouth to do the MA. It was hard and lonely – I discovered quickly that no matter how sane the psychiatrists said I was, I was too nuts for my class. My behaviour was so erratic that by March 2005 I was facing being thrown off the course and I told my consultant the urgency. George Best had just died, in part due to the reaction of the Antabuse implants in his stomach to his renewed drinking. Simply, I said to the Dean and my doctor that I needed to sober up now. The threat was fantastic. I was prescribed Antabuse by my psychiatric consultant and on 3 March 2005 I stopped drinking and would not drink again – this article celebrates four years and two months of sobriety.

You have three days after taking the pill before it is safe to drink. This is why I am sober – I may really want a drink tonight so I won't take the pill, but the way I operate I won't want a drink tomorrow so I will take the pill that day. I've never lasted longer than 48 hours between pills.

I had a Librium detox, a course of benzodiazepine tablets that mimic alcohol in the system, which you start on a high dose and rapidly reduce to zero over a short period. During this time the body unwittingly detoxes itself without serious risk. Even so my bedroom stank because of the sweats and I shook uncontrollably. The pain of that time is not something I'd return to in a hurry, so that reinforces sobriety as well. By email, a friend in the US helped me through the emotional side of the detox – you no longer have a crutch to support yourself emotionally without alcohol, and coming back to reality is a frightening experience.

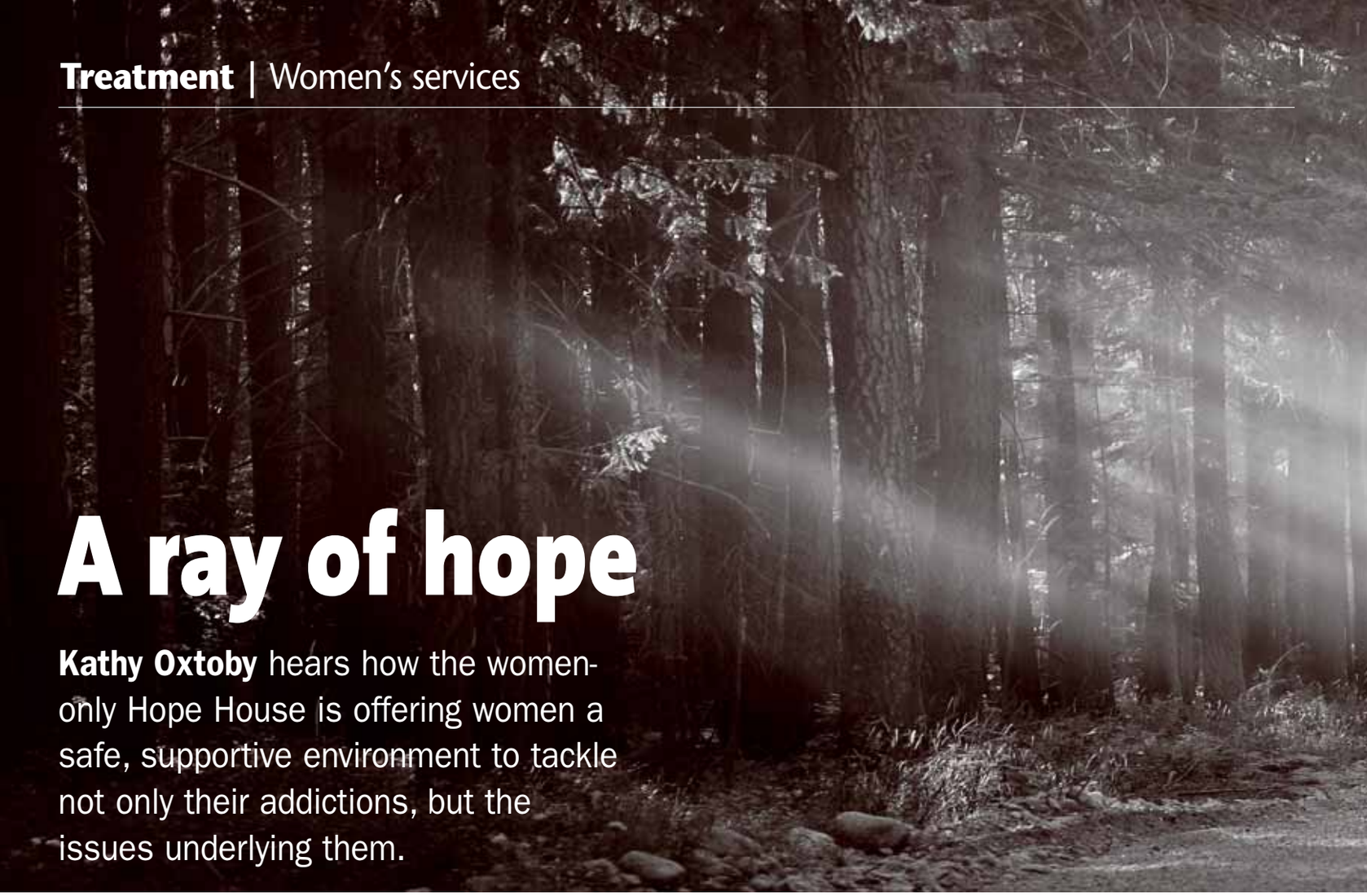
In the early days, I was going through hell with little support and under extreme stress to complete a one-year masters degree. I walked off two stones in weight on the Cornish coast path, and a side effect of the drug was a serious relapse of my psychosis that would ruin my relationship with the BBC despite brilliant feedback when I did my placement there. I ended up jobless and, with two weeks notice, faced homelessness. I used a credit card to pay the deposit on a flat in a nasty area of Bristol, where I would completely break down. I kept sober because I knew that drink would make things far worse. The AA group I was in refused to renew contact with me after the lies, and I struggled on alone.

An acquaintance suggested I move. I did so – to a great flat in the outskirts of Bristol. With a reinvigorated home life I started to have fun again – sober. I met Penny while running a radio group for the mentally ill in Bristol in 2006, and we fell in love and married, moving to the Forest of Dean last year.

We have a business and, like a child, it can keep us up for several sleepless nights on the trot, and never leaves our side. My restlessness drives me forward – we can't say life is great now, but the drive and energy I once devoted to having a good time is now entirely focused on making the now good and tomorrow better.

'Generally, Antabuse is given to people who are struggling to remain sober and the fear of an adverse reaction to alcohol helps to support them...'

Oleg Filipchuk, iStockphoto



A ray of hope

Kathy Oxtoby hears how the women-only Hope House is offering women a safe, supportive environment to tackle not only their addictions, but the issues underlying them.

By the age of eight, Elizabeth (not her real name) had an eating disorder. By her teens she had begun using drugs. By her 30s, Elizabeth was in 'a soul destroying cycle of breakdown, then recovery', she says. Support from Narcotics Anonymous and Overeaters Anonymous would help her to achieve abstinence for a few months, even years. But she would repeatedly turn to drugs, alcohol and overeating, because no support group had ever addressed her underlying traumas, which were deep rooted in a childhood marred by physical and sexual abuse, bullying and rape.

Then a friend who was going through recovery suggested Elizabeth might be cross-addicted, and in need of a high level of support. She sought help from Action on Addiction who referred her to its women-only residential second stage treatment centre – one of only a few of its kind in Europe.

Six months later, Elizabeth feels able to face the world without her addictions, and says she owes it all to Hope House. 'I'm passionate about the place. It offers support for women like me with complex needs. It has been a life saver,' she says.

Of the women who have stayed at Hope House since it was established in 1988, many have emerged from the experience not only free from their addictions, but also having begun to deal with the deep seated issues that drove them to misuse in the first place. By being deliberately female it allows women to recover without the stresses and competitiveness that can sometimes develop in a mixed environment. Jahque Price-Rees, clinical team manager at Hope House, explains that some of the residents have faced male related traumas, 'so they need a women-only environment to feel safe to face their addiction cycle and repair themselves'.

For many women who come to the female-only environment, benefits are not immediately obvious. Susanne Hakimi, head of London client services at Hope House, noticed that new residents would say 'I don't want to be with all women – I get on better with men'. 'What became apparent was that this was about how the women viewed themselves,' she says. 'And sometimes it was about how men had manipulated them. So we needed to help them have a better relationship with themselves, which would lead to better relationships with their mothers, their daughters and other women in the fellowships where they could get support.'

After working on secondment for a year, it also became clear to Hakimi that Hope House needed to develop strategies to work with a client group with complex needs, where alcohol and drugs misuse were combined with such issues as food disorders and physical and sexual abuse. Staff devised a programme that involved residents going back to the start of their problems. They also looked at how to put structure in residents' lives after years of being out of control.

Hakimi was asked to manage the project in 2002. That the scheme has recently expanded from an eight-bed Victorian terrace in Maida Vale to a 23-bed residency in Clapham is a reflection, she says, 'of the work we've done, and that we're not afraid to work with women who have been through the mill'.

The women who come to Hope House are from 'all walks of life and cultures', Price-Rees says. 'Some have children in care and some are mourning the loss of children. Some were in prison and some have been involved in prostitution.'

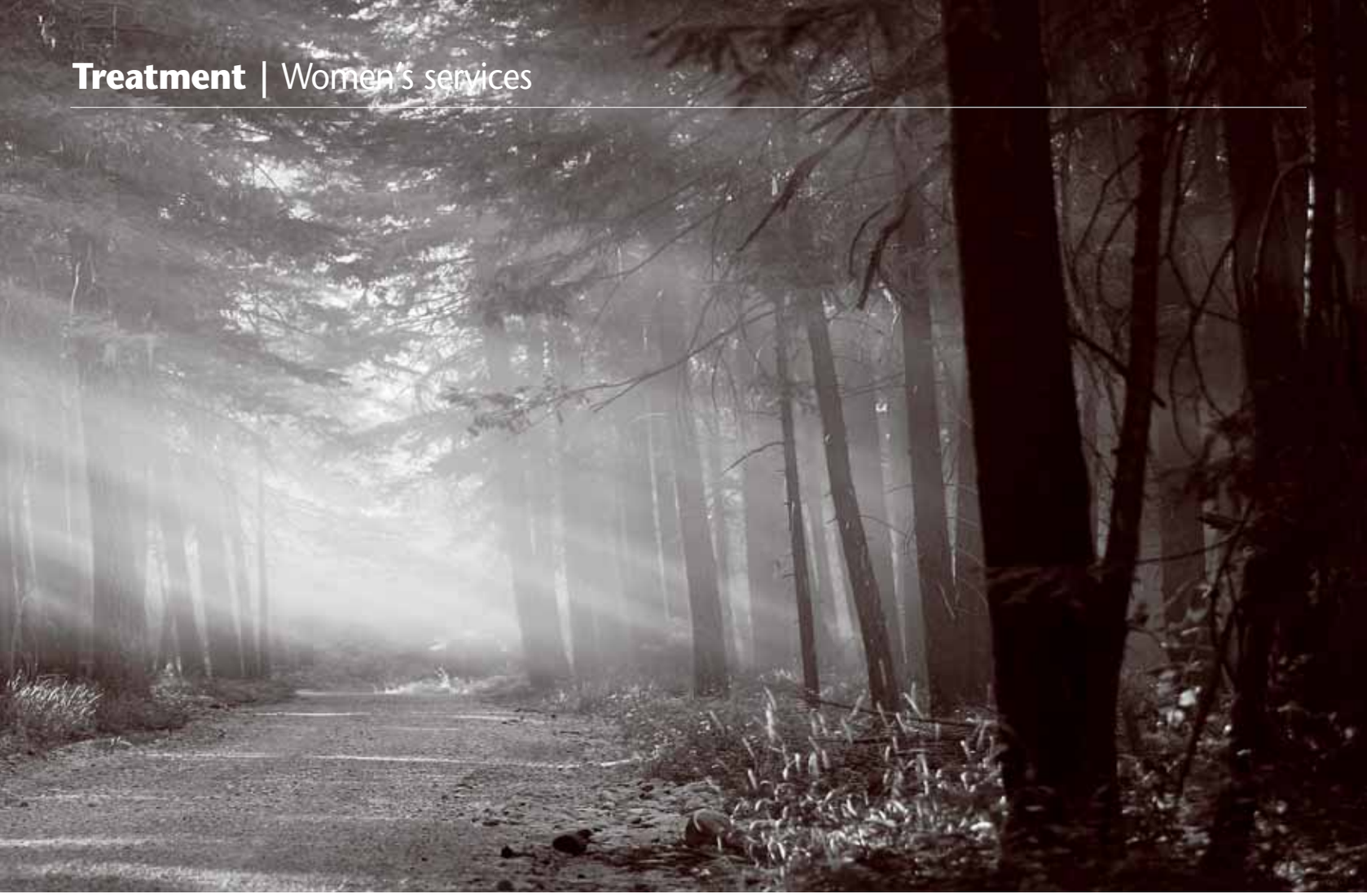
Referrals are accepted from many sources, including Clouds, a primary treatment centre, and from local authorities. The scheme also takes private patients, but everyone is seen on a 'first come, first served' basis. To be accepted into Hope House, residents must be female, over 18, at least two weeks drug and alcohol free and have preferably attended a primary treatment programme. They must also have a desire to remain abstinent in the long term.

Residents work with a small team of qualified counsellors and therapists with an expertise in addictions counselling and treatment, and each receives an individual treatment plan to work through. 'Each woman is treated as an individual. It's about our stories and our needs,' Elizabeth explains.

As part of the abstinence based 12-step programme, which can last from three to six months, residents work one-to-one with a counsellor and do group work to share their experiences of recovery with other people in a similar situation. They are provided with guidance on the best ways to ensure they do not relapse and are invited to attend workshops and life skills groups. Social activities are organised so that residents can strengthen their relationships with each other, and family visits are also encouraged.

It's all about offering residents 'a structured programme to give them a bridge back to life', Price-Rees says. 'In surrendering to abstinence, residents need to find other ways to survive. We try to give them a sense of purpose.'

Residents are encouraged to take part in educational courses, voluntary work and recreational activities to help rebuild their lives. Price-Rees points out that often, because residents' bodies are 'ravaged when we see them', they learn about the basics of nutrition and cook meals together, to build



up their health and boost their self confidence.

Being in an all female environment has been an invaluable part of the healing process, Elizabeth believes. 'I have felt safer here than I've ever felt in my life. I've been able to stop the struggle, to fall to pieces and to begin to grieve and heal.'

That process doesn't stop once residents leave the programme. A weekly aftercare group and quarterly follow up sessions are available for one year, and residents are encouraged to attend groups such as AA and NA for ongoing support.

While the success of the programme is difficult to measure there are signs that Hope House is 'getting something right', Hakimi believes. A high number of former residents attend aftercare and many return to Hope House to tell residents about their experience.

Current residents are now looking forward to building a life outside Hope House and one client with a history of alcoholism recalls how her life has turned around since entering the programme. 'I'm doing a diploma in holistic massage, I've rebuilt connections with my family and my best friend says I can hold her baby, now that she's not worried I'll drop her,' she says. 'I'm proud of myself for the first time.'

Next on the horizon is setting up a family programme, says Hakimi, so that partners and children can play a greater part in the recovery of residents.

Elizabeth's period in recovery at Hope House is almost over and she believes the experience has given her hope for the future, while 'trying to find new ways to ensure the past doesn't come back'.

'I won't go back to destructive behaviours,' she says. 'Instead, I feel hopeful again.'

Information on Action on Addiction's services, including Hope House, at www.actiononaddiction.org.uk

'Women-only environment has helped me move on'

Without her treatment, Rehana Ahmed believes she 'would probably be dead by now'. Rehana started drinking aged 16 to escape from an unhappy home life. At 21 she had an arranged marriage – 'but I didn't want this', she says.

She began drinking heavily after losing twins when she was seven months' pregnant. Later she divorced. At 29 she married again, but continued to deal with her loss through alcohol.

By this time, Rehana was also self-harming. 'I wanted to die. I slashed my wrists. I burned myself with an iron to kill the pain inside. Outside I was numb. I couldn't even feel myself doing this.' A blood test showed she was close to developing cirrhosis of the liver. After three weeks of detox in hospital, she went through the SHARP outpatient programme for drug and alcohol dependency, where she was advised that Hope House might be able to help.

'It was make or break – if that didn't work, nothing would. But the staff did everything they could. My counsellor was with me more than once a day, because of what I'd been through.' Having been unable to speak about her grief, Rehana now found she 'couldn't stop talking'. 'I went through everything with the counsellors – my childhood, losing the twins. I talked and I cried.'

Being in a women-only environment was 'fantastic', she says. 'There were no men telling you what to do. I did a lot of sharing. And the residents relied on each other.'

After six months in residential care, Rehana went to a support house for people in similar situations. She has now been sober for nearly two years and will start a course in health and social care in September so she can become a support worker to help others with addictions.

Through the therapy she received at Hope House, Rehana has been able to visit her twins' grave and now hopes to move on. 'I'm looking forward to having my own place. I want a happy, peaceful life, and to help other addicts in recovery.

'I'm not looking back. There will be ups and downs in my life I know, but if I stay sober and follow the programme I'll be fine.'

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Please request a job description to find out what you need to apply or, to discuss this opportunity contact Max Harris or Sue Bandcroft at Safer Bristol on 0117 914 2222.

Apply Online at **www.bristol.gov.uk/jobs**

Please note we cannot accept CVs. Applicants must be either EU nationals or hold a current permit that will enable them to work in the UK.

At Bristol City Council, we value having a workforce as diverse as the city we serve. We therefore welcome, develop and promote people from all sections of the community.

Our city a great place to work

BRISTOL CITY COUNCIL

bridgegate drug services

Bridgegate Drug Services is an independent company with charity status and funding that provides services for people with substance misuse problems, their families and concerned others, in Peterborough.

We are an equal opportunities employer and committed to supporting the development of our staff.

INVESTOR IN PEOPLE

We are pleased to offer the following opportunity:

Project Co-ordinator

(COSMIC, Preventative and Family Services)

Salary £25,940 - £28,862 p.a. (NJC points 31-35).
In Peterborough. (Full-time at 37 hrs per week).

We require an experienced practitioner to manage and drive forward the COSMIC project. This is a well-established project, recently mainstreamed through the award of a Preventative & Families Support Services contract. COSMIC provides services to children/ young people, who have been affected by familial drug use, their carers and significant others.

You will have an extensive background, and proven track record, in social care with experience of direct work with children/young people and their families. You will be a qualified social worker, registered with the GSCC and ideally hold a counselling qualification and be registered with the BACP. You will have a sound knowledge of Every Child Matters and Safeguarding procedures; a knowledge of substance mis-use is a clear advantage. The post-holder will develop and oversee services to adults, children/young people in a variety of settings, both in group work and on a 1:1 basis, and manage a small team. He/She will be responsible for meeting targets and reporting to funding authorities; and will have a flexible & creative approach to the work.

(For further info, please contact Sarah Nichols on 01733 314551.)

For an application pack please call Ali on 01733 314551, or email : mail@bridgegate.org.uk. Applications close 2 June 09. Successful applicant will be subject to a CRB check.

Welcome

Welcome is a voluntary sector organisation providing single point of contact for those affected by substance misuse in the borough of Solihull. We are currently looking to recruit to the post of:

Substance Misuse Worker

The successful candidate will be primarily based within our drop in centre and the role will include:

- Providing information and advice, and the provision of wrap around services
- Provide assessment and care planning
- Work with evidence based models to provide structured interventions for service users
- Contribute to the provision of our structured day care program by providing activities, for example, holistic therapies and group work
- Manage a caseload of service users

To be successful you will have a minimum of twelve months experience working within a substance misuse treatment setting and a good understanding of the treatment system and treatment delivery.

For an application form and an informal chat about the role call Nikki Penniston (Service Manager) on 01216784730 or 01216784745

Welcome is a member of

sias

Closing date for applications: 1st June 2009
Interviews to be held on: 8th June 2009

ripple

Ripple Drugs Services Ltd

Male Drugs Worker/Trainee Male Drugs Worker

(37 hrs 5days/week)
Salary Range: £18,000 to £23,500 dependent upon experience.
(This post in accordance with section 7 (2) (b) of the Sex Discrimination Act 1975)

Temporary Clinical Drugs Worker

(37 hrs 5days/week)
Salary Range: £18,000 to £23,500 dependent upon experience

Youth Projects Coordinator

(37 hrs 5 days/week)
Salary Range: £20,000 to £24,000 dependent upon experience
This post will involve some evening and weekend working

Job details can be viewed at: www.drinkanddrugsnews.com

All positions are primarily located in the Buttershaw area of Bradford and subject to Criminal Records Bureau Enhanced Disclosure
Closing date for applications is 1 June 2009

For further information contact 01274 696900 or e-mail info@ripple.org.uk

ST JAMES PRIORY PROJECT BRISTOL

WALSINGHAM HOUSE

Residential Support & Treatment for People with Addictions

Addictions Counsellor

£23,418 – £26,802 + 'on call' allowance

We are seeking a qualified and experienced counsellor to join a team providing quality support and treatment for people with a substance dependency. Experience of Dual Diagnosis is desirable. For information and an application pack contact:

0117 929 9100

www.stjamesprioryproject.org.uk

Action on Addiction is currently recruiting for:

COUNSELLORS X2

(full time) – SHARP, London
Salary from £24,512 per annum,
25 days holiday per year plus additional benefits
Closing date: 3 June 2009

Administrator

(25 hours per week)
Hope House (women-only) Project, London
Salary up to £17,117 per annum
(FTE £23,965 per annum)
There is a genuine occupational requirement that the post holder of this role be female.
Closing date: 19 June 2009

Senior Administrator

(full time) – SHARP, Bournemouth & Poole
Salary up to £20,626 per annum
plus additional benefits
Closing date: 3 June 2009

For more information and to apply for any current vacancy please go to the jobs section on our website.

www.actiononaddiction.org.uk

The Chemical Dependency Centre, Clouds and Action on Addiction have merged. The new organisation is called Action on Addiction. Charity No. 1117988

Action on Addiction

INVESTOR IN PEOPLE

Service User Coordinator, Drug and Alcohol Action Team

WEST SUSSEX DRUG & ALCOHOL Action Team

£26,000 – £28,300 per annum
Based in Chichester, working across West Sussex

This is a brand new role where you can really make your mark.

A real communicator, with the proven ability to influence the action of others, you will coordinate and lead on service user involvement across the County supporting groups and individuals to be truly engaged in decision making.

You will use all your negotiating and problem solving skills, working with a wide range of stakeholders, to help us build and enable services that are truly needs led. Knowledge of service user involvement techniques would be valuable, but more important will be the enthusiasm and motivation to make a real impact.

Applications for both full time and job share welcome.

This post is subject to a Criminal Records Bureau Check.

Closing date: Monday 1 June, 2009.
For an application pack, please go to www.westsussex.gov.uk/jobs or e-mail jobs@westsussex.gov.uk or telephone 01243 642140 (24 hour).
Post reference number: 60013805

CRI

CRI North & Midlands

CRI works to create safer and healthier communities. We help people to break free from harmful patterns of behaviour by delivering innovative services which have a measurable impact on both health and community safety issues. Our services are hallmarked by an emphasis on quality, a responsiveness to local priorities, and an outstanding record of achieving targets.

INVESTOR IN PEOPLE

Drug Interventions Programme (DIP) Barnsley

CRI deliver the Drug Interventions Programme (DIP) in Barnsley. The service aims to increase the numbers of drug-using offenders entering and successfully completing treatment, reduce drug-related crime and improve the quality of life of offenders, their families and communities. Barnsley DIP provide enhanced drug arrest referral, community support and assertive outreach services to substance misusers identified through pro-active contacts carried out across the borough.
We are now seeking to recruit the following staff:

DIP Safeguarding Worker *(Ref NM212)*

£24,089 – £25,884 per annum • Full-time 37.5 hours per week

We are looking for an experienced substance misuse worker who has excellent knowledge and understanding around Hidden Harm and the Protection of Vulnerable Adults. The successful post holder will be a designated Safeguarding "Champion" working alongside and supporting a team of Generic DIP Workers to provide a range of effective and evidence based interventions that aim to engage and support individuals in line with Safeguarding Children and Protection of Vulnerable Adult legislation. The post will be the main contact for external partners in relation to safeguarding issues and will ensure that clear and concise pathways are in place with all local safeguarding networks in relation to both children and adults in addition to co-ordinating the implementation of internal CRI Safeguarding policies.

Closing date: 4th June 2009

Only electronic applications will be accepted via www.cri.org.uk

The successful candidates will be subject to a Criminal Records Bureau check at enhanced level.

In return for your commitment and enthusiasm CRI offer excellent terms and conditions and comprehensive training and development opportunities.

Committed to anti-discriminatory practice, CRI aims to be an equal opportunities employer.
Crime Reduction Initiatives is a registered charity in England and Wales (1079327) and in Scotland (SC039861), Company Registration Number: 3861209 (England and Wales).

Safer communities, healthier lives

SMART is a rapidly growing not-for-profit organisation, delivering drug and alcohol interventions across the Thames Valley region. The organisation is recognised locally and nationally for innovative and effective interventions with substance misuse clients and has been cited in a Home Office report as a model of good practice. We are currently looking to fill the following vacancies:

SMART INNOVATIONS IN DRUG SERVICES

SERVICE MANAGER

Berkshire East / Salary Range £34,417 - £37,454

We are seeking an experienced, highly motivated individual to be based at Bracknell and manage and develop services across Berkshire East. Services to manage are varied and include Community, DIP, Aftercare and Alcohol.

If you would like to discuss this role informally please call Shaun Morley on 01865 515318.

Closing Date: Monday 15 June 2009.
Interview Date: Tuesday 23 June 2009.

ALCOHOL ARREST REFERRAL WORKER

Berkshire East / Salary Range £21,867 - £25,101
12 month fixed term contract

Our innovative projects are designed to break the cycle of offending and transform the prospects of problem drug users. The worker will provide interventions to those individuals and support them through the process of accessing the relevant services to meet their needs.

Closing Date: Thursday 28th May 2009.

For an application pack for either role, please contact Mary O'Byrne on 01865 515318 or e-mail enquiries@smartcjs.org.uk

www.**smartcjs**.org.uk

Invitation to Tender

ISLE of WIGHT COUNCIL

SUPPORTED ACCOMODATION

The Isle of Wight Council on behalf of the Community Safety Service (formerly known as the Safer Neighbourhoods Partnership) invites Tenders from suitably qualified contractors for the provision and development of units of accommodation for service users in local drug treatment. The contract is to run from March 2010, subject to full community consultation and statutory approvals.

The closing date for receipt of Tenders is 14.00 on 15th June 2009.

Persons proposing to submit a Tender are advised to read the Invitation to Tender carefully to ensure that they are fully familiar with the nature and extent of the obligations to be accepted by them if their Tender is accepted.

The Council's Authorised Officer for the purposes of this Invitation to Tender is
Ms Mandy Sellers, Commissioning Manager, Drug Action Team,
Community Safety Service, Charter House,
14 St Thomas' Square, Newport, Isle of Wight PO30 1SL

Telephone 01983 550980
Email: mandy.sellers@iow.gov.uk