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DDN
Drink and Drugs News

8 May 2006
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8 May 2006

Editor's letter

If treating drug users was just about prescribing methadone, then you might as well do it over the internet. Primary care is about treating the complex needs of the individual, and can have a special role for drug patients in empowering them in many aspects of life. Prof Mark Bellis told the RCGP conference that doctors are among the most trusted professionals, and it is within their scope to create a special relationship with a patient and their family.

But he also mentioned that doctors can be among the least accessed professionals, and contributions from other speakers – including the mother of a heroin user – indicated why. For while some GPs talked wholeheartedly about linking with other services and the need for proactive collaboration, this carer turned campaigner gave a picture of GPs who listened to drug-using patients with the volume turned right down.

The conference consensus statement, voted for by nearly 700 delegates, called for general practice to scrutinise itself according to the standards of the best – and to call upon partner organisations to make sure there is an 'overall systems approach'. It acknowledged that there is a postcode lottery at present that fails to keep many of the most vulnerable clients from falling through the net and fails to take responsibility for their physical and mental wellbeing.

And what could be more fundamental to wellbeing than a roof over your head? The government has just announced that it will address the need for better housing and support for drug users – but, says Shelter (page 10), this has to be done through an inclusive approach that takes on board the needs of all drug users, and not just those who are already half way towards recovery and independence.

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In this issue

Media Watch

Mexico was set to become one of the most permissive countries in the world when it comes to narcotics, by lifting its ban on small amounts of marijuana, heroin and cocaine possession. The government said legislation would let authorities concentrate on violent drug gangs, but the move appalled their northern neighbours. The Mayor of San Diego, on the border, said 'We need to register every protest the American government can muster.'
The Times, 4 May

Mexico's president has bowed to pressure from Washington to shelve its legislation legalising the possession of drugs. Vicente Fox did not mention pressure from the US as he asked congress to reconsider the plan, after they had already passed it on Tuesday.
The Telegraph, 5 May

East Ayrshire Council has responded to 1,687 objections to plans for a drug rehab centre in Kilmarnock. The local community opposed its location in a residential area because they were afraid of crime and had concerns about public health and safety. Chief executive of Turning Point Scotland, who proposed the plans, said it appeared to have been an orchestrated campaign. 'I don't want the perception of fear to follow us wherever we go,' she added.
BBC News, 3 May

The number of children caught in possession of drugs has grown by 942 per cent in Suffolk over the last three years, according to police. Most cases involved cannabis possession, which Ipswich's substance misuse officer said appeared to have increased with declassification.
Ipswich Evening Star, 5 May

Parents are being advised to familiarise themselves with drugs lingo, such as slang words for cocaine, by the government's 'Talk to Frank' website. A parents' drug test asks them to guess the price of an ecstasy tablet and to distinguish descriptions of speed, hash and ecstasy.
Daily Telegraph, 26 April

Drinking in parks and open-air venues is to be banned in Scotland. The move, which is intended to address public order fears when pub-goers take their pints outside to go for a cigarette, will also stop drinkers enjoying wine with picnics. Social commentator Roddy Martine said: 'you really wonder where all this control freakery will end up'.
Scotland on Sunday, 30 April

Muslim parents have blamed bhangra parties as booze marathons, which corrupt their children and send them home drunk. The parties are usually held away from Asian communities and out of sight of parents, during afternoons when students should be in lessons. Mothers were concerned that organisers were targeting students outside colleges, sending minibuses to pick them up.
The Asian News, 26 April

Edinburgh takes bin action on graveyard needle danger

Reports of discarded needles and drugs paraphernalia in Edinburgh's graveyards have prompted Action on Alcohol and Drugs in Edinburgh to introduce needle bins, as part of a trial project this spring.

The Action Team, Edinburgh's organisation tackling substance misuse, worked closely with the Council's Services for Communities' Bereavement Services Division, Lothian and Borders Police and the voluntary organisation Streetwork, to place bins for discarded needles in churchyards in the city centre.

Tom Wood, Chair of the Action Team said the initiative was about public safety.

'We know churchyards are used by people taking drugs. We also know that they are visited regularly by locals and tourists researching family and civic history or exploring the wildlife. We need to reduce any potential risk to them in this environment,' he said.

Before the bins were installed, an intensive training session on health and safety issues was held for council staff by Streetwork, Police Drug Awareness Officers and the NHS Harm Reduction Team. Staff were informed of how to identify and clear up drug paraphernalia, as not all participants were aware of how and why spoons, foils and swabs were used when injecting.

Streetwork is now carrying out outreach work with drugs users who frequent the churchyards, informing them of the bins existence and encouraging them to be used. Information materials are planned for the clinics where syringes are collected and exchanged, and a leaflet for local businesses explaining what to do with needles and paraphernalia that are found on their premises.

Mr Wood said initial reports indicated the bins were being used, and hoped to extend the project to a number of similar sites across Edinburgh.

'Our ultimate aim is to reduce the number of people using hard drugs, and that is a process of education and ensuring we have the right treatment and care for those with a drug problem,' he added.

For more information on Action on Alcohol and Drugs in Edinburgh visit www.ActionAlcoholDrugsEdinburgh.org

Berkshire's first drug information, advice and treatment centre, T2, celebrates its first birthday. More than 150 adults and young people have accessed services and support networks since it opened. Turning Point Maidenhead's service manager Simone Cadette, pictured (left) with borough chief executive and DAAT chair David Lunn, and DAAT co-ordinator Di Wright, said T2 had received consistent positive feedback from service users and their families.

Changes on way to Mental Health Act

Changes to the way mental disorder is defined are proposed through a Mental Health Bill that has implications for dual diagnosis.

With the stated intention of making the Mental Health Act 1983 easier to use and clearer who it applies to, the Department of Health will reword references to alcohol and drugs.

It will make clear that the act is not to be used to force people who are suffering from no other mental disorder, to accept treatment for substance dependence. But it will also make clear that people who are dependent on alcohol and drugs are not excluded from the scope of the act, if they also suffer from another mental disorder. Exclusion from the act will not apply to substance misuse by itself, as this is not classed as a mental disorder.

The Government says the bill is part of modernising services and moving more treatment into the community.

The Mental Health Bill briefing sheet is at the Department of Health website www.dh.gov.uk (go to 'new publications', 2 May, in the 'policy and statistics' section).

RCGP conference: workshop presentations

Case for home detox

Naltrexone is an under-used drug that can expand patient choice, said Dr Richard Watson, who explained the process of rapid opiate detoxification.

'There's wide criticism that patients are only offered methadone,' he said. 'It maintains dependence, few patients leave treatment, and it's expensive.'

Natrexone blocks opiate receptors and had been shown to have a lower six month relapse rate, said Dr Watson. He outlined a rapid detox system that could be done at home, and which some other delegates expressed reservations about.

The process included having to shake patients awake to give them drugs to reduce withdrawal symptoms and cramps, and often involved them lying on a sofa shaking and shouting incoherently. But this Asturian method, pioneered in Spain, could be carried out safely with the help of a responsible carer, he said.

Treatment with respect for the homeless

Case studies of rough sleepers had shown that not only were most of them drug users, but that there tended to be a hard core that would not be shifted, said Dr Pat Ireland, who presented on helping homeless people to manage their drug use.

'These are excluded people on the fringes of society,' he said. In his experience, providing a drug prescribing service was a matter of managing expectations: 'we don't expect homeless drug users to be calm and dignified. Most people I've seen have seriously damaged lives and for them, heroin is a wonderful substance.'

Caring for these clients through prescribing gave them self esteem and a feeling that someone was caring for them, he said. Networks were important to running an effective service: 'it takes a lot of people doing little bits here and there to make it work.' The other part of the equation was to make sure a script was high enough for the patient to feel its effects from the first week they were engaged with the service.

Tolerance levels over-estimated

Preconceptions of client tolerance levels need to be examined if opiate replacement treatment is to be effective, said Dr Jack Leach.

'The concept of tolerance is well known – but the detail less well known, he said. Restarting missed prescriptions was often based on a three-day policy, where the patient was referred back to the doctor by the chemist if they missed a script for three days.

'But the client can see this as punitive, damaging their contact with the service,' he said.

Dr Leach had asked 30 clients about their experiences of loss of tolerance and found that the outcome was not particularly clear. But it seemed that tolerance could develop quickly again, and that 'we over-estimate the extent and speed of loss of tolerance, particularly to methadone'. He concluded that it was safe to continue the patient's usual dose for a week after a break, without the patient's tolerance being affected – and that, crucially, it was dangerous to restart at a lower dose.

Women injectors take needless risks

A survey of women injectors revealed that many chose to be injected by partners because they were afraid of needles. Charlotte Tomkins, research fellow at Leeds West PCT, found many women had to wait their turn, until their partner had injected themselves first. Injecting technique could then be seriously compromised by the partner gouching with their eyes closed, missing the vein.

Many women believed they did not have the skill to inject and preferred to trust a partner, but if they were in acute withdrawal would let anyone do it, without worrying about risk. Some women thought there was no risk, as long as their injector was careful, and they did not consider blood borne viruses.

Nearly all the women Ms Tomkins had talked to had been harmed by being injected, through misses, bruising, hitting arteries and nerves, and through overdose.

Primary care could increase awareness of the complexities involved, she said, exploring the social situation of patients and reinforcing harm reduction messages on the safest techniques to use. She advised women to be more independent through self-injecting, or to communicate with their injector throughout the process.

Study sets agenda for primary care

Many drug patients visiting their doctor have other health problems or mental health problems that make primary care the ideal place to treat them, said Suzanne Corrigan, who had conducted a study to monitor good practice across the London boroughs of Brent and Harrow.

Examining results, Ms Corrigan had realised that issues relating to alcohol were not showing up, and identified under-reporting of alcohol problems as a significant issue that GPs needed to address.

'Primary care settings are the ideal place for harm reduction interventions,' she said. Hepatitis B and C work was needed, and more effort to give BME patients better access to treatment. Stimulant use was 'the next big thing for primary care', she had found, and there needed to be more emphasis on blood borne viruses.

Interagency work was needed to address complex needs: 'We need a collaborative approach to non-medical prescribing,' she emphasised.

Research and guidance

Weblinks for these documents can be found in the research and guidance section of our website, www.drinkanddrugs.net

CD-Rom available from NTA to assist effective practice in relation to issues of diversity *NTA – March 2006.*

Best practice guidance for commissioners and providers of pharmaceutical services for drug users *(added April 2006).*

Guidance from NTA, Royal Pharmaceutical Society and others.
NTA – February 2006.

Evaluation of Scottish Prison Service Transitional Care Initiative *(added April 2006).*

Research report on SPS transitional care initiative.
Scottish Executive SMRT – February 2006.

The Drugs Intervention Programme *(added April 2006).*

Information on the Drug Intervention Programme.
Home Office, DSD – January 2006.

Khat Report 2005 *(added April 2006).*

Report on khat from Advisory Council on Misuse of Drugs.
ACMD – January 2006.

Further consideration of the classification of cannabis under the Misuse of Drugs Act *(added April 2006).*

Addendum to report on classification of cannabis from Advisory Council on Misuse of Drugs.
ACMD – January 2006.

Methylamphetamine Review *(added April 2006).*

Review of methamphetamine by Advisory Council on Misuse of Drugs.
ACMD – November 2005.

Guidance on Good Practice *(added April 2006).*

Guidance on good practice in drugs prevention.
Home Office, DSD – August 2005.

Developing peer led support for individuals leaving substance misuse treatment *(added April 2006).*

Briefing on what works in peer-led aftercare support.
Home Office, DSD – April 2005.

Ketamine *(added April 2006).*

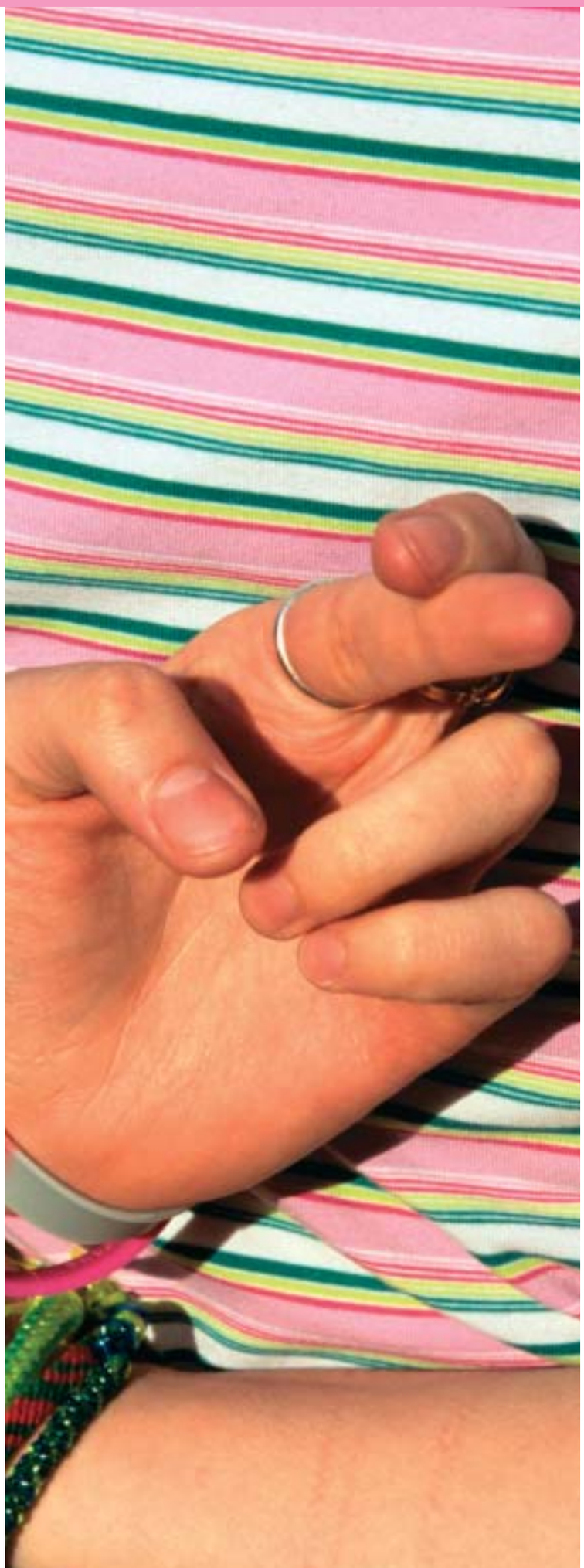
Report in to ketamine from Advisory Council on Misuse of Drugs. *ACMD – April 2004.*

The Classification of Cannabis under the Misuse of Drugs Act *(added April 2006).*

Report on classification of cannabis from Advisory Council on Misuse of Drugs.
ACMD – June 2002.

It's a lottery

The annual GPs' conference is a chance for those treating drug users in primary care to assess what's working – and for service users to tell them what's not. DDN reports.



At last week's RCGP conference on managing drug users in primary care, the co-ordinator of an active user's forum stepped up to the platform and described how a caring and responsive GP had saved his life.

There are an increasing number of GPs now willing and able to prescribe for drug users. So what was it about this consultation that made a difference and introduced a profoundly positive intervention to 20 years of injecting drug use?

'It was the first time someone listened,' he explained simply. 'Engagement with this GP was instant. I could tell he cared. He showed respect and trust and gave me a bit of hope that I could build on.'

This was the eleventh national conference aimed at GPs, nurses, and all those who work with or plan for the treatment of, drug users in primary care. Each year the service user involvement is stronger and more meaningful: at the end of the two-day conference a consensus statement is read out and debated. The statement confirms all parties' understanding of what general practice should be aiming for in treating drug users, what the profession's priority's need to be, and who needs to be actively involved in making it work.

This year's theme, 'Are we delivering effective care in general practice?' shone a torch into all corners of primary care. Some surfaces were more polished than others. The NTORS study showed that primary care is better than specialist services at

This conference believes that:

- Effective care for drug users is being delivered in general practice, because we have inherent ability and flexibility to see the person rather than the drug.
- Good care is dependent upon all players, including service users and carers, working well together in a whole system approach which is adequately resourced.
- However provision remains patchy.
- We all need to:
  - Take up the challenge to audit and evaluate our work.
  - Train and offer training opportunities to undergraduates and graduates.
  - Actively promote good practice amongst other colleagues in general practice and the wider drugs field.
  - With colleagues develop a nationally agreed outcome monitoring tool.

We call upon the NTA, HCC, Government and local commissioners to take account of the effectiveness of primary care provision and ensure universal coverage of this within an overall systems approach.

Conference consensus statement from 670 delegates.

retaining people in treatment, with better potential for linking with wraparound services, said clinical director Dr Jenny Keen. But on the other hand, Dr Keen warned, too many GPs still felt that prescribing for drug patients was not their job, and many others did not accept that maintenance could be a safer route to abstinence than detox.

'It was the first time someone listened... Engagement with this GP was instant. I could tell he cared.'

Dr Keen's examples were two of many that surfaced during the conference, illustrating how good practice in one area was still too often mirrored by inadequate services that left service users vulnerable to a postcode lottery.

When Maureen Roberts, a mother, carer – and now by necessity, a patient advocate and vociferous campaigner – first came into contact with her GP on the subject of her son's heroin addiction, she was told he didn't deal with that. Another doctor put him on too low a dose of methadone, which was titrated up to 65ml by another. 'This made my life bearable, but he needed more,' she explained.

After more of the same, she started protesting at the 'woefully inadequate' service in her area. 'The town I live in has a population of 23,000. None of the 12 GPs would even look at prescribing.

'I saw they had a square service for round people,' she said. 'It's not treatment, it's punishment. I want services to treat people with kindness. We can turn people back into good fathers, mothers, sons, daughters. But the treatment has to be there.'

The words 'patchy' and 'postcode' came into everyone's roundtable discussions at the conference, said Dr Chris Ford. GP prescribers are now available in 95 per cent of areas, according to Dr Jenny Keen, but 'is it working, is it effective?,' she wanted to know. 'We need to look at what we're trying to achieve.'

Dr Keen wanted more peer-reviewed research to measure outcomes in primary care – not just the traditional ones, but 'ones which make us safe and special, and particularly good for drug users. We see patients over a long time.'

Dr Mark Gabbay, senior lecturer in general practice at the University of Liverpool, agreed that primary care needed relevant outcome measures that went beyond the patient's length of contact with the service.

'How do we measure being drug free, social measures, access to housing and education, psychological wellbeing?' he asked. Peer reviewed journals did not welcome evidence that was vulnerable to scientific dismissal, he said. 'We need more valid and reliable collection tools to tackle entrenched attitudes like "drug users make unfit parents".'

But there was plenty of supporting evidence that showed primary care as providing cost effective treatment, and a valid collection system must go hand in hand with common sense, he said.

'If commissioners say where's your evidence that this is effective, say "where's your evidence that it's not?",' he suggested. The need for more evidence should not be a bar to making the most of the contact time primary care has with patients, he pointed out.

Prof Mark Bellis, who conducts research at the National Collaborating Centre for Drug Prevention, wanted GPs to make more of the findings of a survey that showed doctors are among the most trusted professionals – but also among the least accessed.

His talk centred on why people use drugs, what influences them to continue, and the links between drugs and other parts of their lives.

Such knowledge would help GPs to engage more, enabling them to provide the holistic care that all the speakers talked about – including service user representative, John Howard.

'Treatment is getting better, but it's very delicately balanced. Aftercare and throughcare are lacking,' he stressed.

'Users are expected to engage, but engagement is a two-way thing. There should be open access and support, detox and rehab, throughcare and aftercare. Housing is a very big problem indeed. Education and training are lacking – there's nothing after using. There's not enough being done on Hepatitis C, not enough funding to treat people, and a lack of care and concern.'

But despite the problems of scarce resources, Mr Howard wanted to stress the life-saving value of operating with 'flexibility, patience, honesty, trust, respect and compassion', and wanted other service users to be able to share his own positive experience.

'Keep up commitment to drug users and slowly things will change,' he urged. 'Keep chipping away.'

DDN

'Our knowledge needs to take in sophisticated use of different drugs. We also need to acknowledge that drugs can be enjoyable. What's the choice for young people in spending their average £8.20 a week pocket money? They can have a badminton court for an hour for six to eight pounds. Or they could have two to three ecstasy tablets, two litres of alcohol, or 10 to 15 joints.'
Prof Mark Bellis, Centre for Public Health and National Collaborating Centre for Drug Prevention

'I would hate to think the money we've brought into the industry was just going into making drug companies even richer. The social reality of providing treatment is much different to 40 years ago when we introduced methadone. We're committed to expanding methadone maintenance, but most users said they want to be drug free in our users' survey. At their first encounter this is battered out of them because they're told it's risky.'
Mark Gilman, regional manager, NTA North West

'There's no better place for users to see someone than primary care. It's regular, accessible, and you can get an appointment. But if someone gets a bad attitude at reception it really messes them up ...Will crunch time for the NTA mean crunch time for drug users and drug treatment?'
John Howard, founder and coordinator, Reading User Forum

'We should participate in research when possible. We should take decisions away from prejudiced commissioners and back to primary care. Very often we're led by secondary care research, but the populations aren't the same.'
Mark Gabbay, senior lecturer in general practice, University of Liverpool

'GP attitudes are improving, and many are completing RCGP training courses. Many GPs are showing they're willing, with accessibility and a holistic approach. They're a one-stop shop to treating other things.'
Dr Jenny Keen, clinical director, The Primary Care Clinic for Drug Dependence, Sheffield

'Services in my area are woefully inadequate. It's not treatment, it's punishment.'
Maureen Roberts, patient advocate and carer

From the workshops...

'People may have stable methadone usage but when they move area they often have to start at step one again, back to daily prescribing. We need more professional trust between GPs.'

'Problematic drug use is very variable and personal unlike other illnesses where everyone shares similar symptoms.'

'Most people I've seen have had seriously damaged lives. For them, heroin is a wonderful substance.'

'Some people have been so abused that rage is appropriate. With drug help they become more relaxed, and able to talk about it.'

'Alcohol problems are under-reported by patients. It's a big issue for GPs.'

'There was lots of confusion among patients on the risks of being injected. Some thought there were no risks as long as the injector was careful. There was no consideration of blood borne viruses.'

'It's the practice of many drug teams to be quite draconian when restarting missed prescriptions, and it's unnecessary. Evidence suggests we over-estimate the extent and speed of loss of tolerance, particularly to methadone.'

PHOTOTAKE Inc. / Alamy

'Bruce Alexander... updated us on his infamous ''Rat Heaven'' experiment. In response to all those trials where rats continually hit levers in a frenzy of isolated greed, Alexander had created a mini park where happy lab rats apparently consumed far less self-administered morphine than their relatives.'

Unhooked Thinking

After many years of attending conferences in the treatment field it begins to feel a bit like treadmill activity – a fair bit of policy deja-vu and a lot of statistical massaging. If we want to attract vibrant staff and dedicated UI volunteers, the scene could maybe do with a vision injection and be prepared to take a peak outside the themes such events tend to rehash.

Unhooked Thinking has taken its time arriving and offered the possibility of asking questions the treatment industry does not, or maybe cannot, ask. Spanning formal treatment practice, academic thought and the culture of 'what addiction is' the three-day event was held in a fantastic building in Bath and looked way to interesting to ignore. The speakers' list provided delegates with an excellent variety of themes – both in the main hall and parallel breakout sessions. In addiction the usual, detached process of conference non-interaction was removed by staging many presentations in 'chat show' style or allowing extended question and answer sessions with the featured presenters and audience.

Although there was no strict separation or progression of themes as the event proceeded, the introductory session by the Unhooked hosts helped clarify why the event had been planned and gave and indication of what expectations were. The fact that many areas of addiction discussion were rather randomly programmed isn't a criticism – more a reflection of the fact that this is a novel and somewhat uncharted conferences region.

It was good to see Stanton Peele in the flesh instead of relying on a book or his (rather good) website, because he has a certain 'no nonsense' style of communicating. He admits he is from a non-therapy oriented background and seems to be all the better for it. This ability to step back and look at the bigger issues centres his perspective on the fact that addiction isn't a 'thing' to be treated – far better to create security and stimulus in a person's life if you want to see them move on from undesired behaviour.

Two of the other main speakers that stood out were Professor John Davies who provided an excellent session on the language games addiction and how the phenomenon has become a contemporary, storytelling myth and Bruce Alexander who, in addition to other things, updated us on his infamous 'Rat Heaven' experiment. In response to all those trials where rats continually hit levers in a frenzy of isolated greed, Alexander had created a mini park where happy lab rats apparently consumed far less self-administered morphine than their relatives.

Some presentations chose to look at the broader angles of addiction. GP Gordon Morse provided a humorous take on The Meaning of Life – illustrating this with references to how we've developed addiction like tendencies in home furnishing and as a species become determined to evade the issue of death.

Other sessions focused in on the more usual areas of addiction and treatment such as covering how rapid opiate detox was being used in China and a glimpse into the Italian treatment system. Sue Blackmore's parallel session seemed to be in a category of its own, but the room was near to full. She provided us with a lively history of LSD and its current potential in therapy – and ultimately, what first looked like a subject slightly out of synch with the rest of the programme, ended up blending well with the general direction the event was taking.

The audience for the event was mostly made up of people from the formal treatment community and academics. This type of event is never going to pull in large amounts of people currently in treatment – which on one level is a shame because it's dealing with the very issues that need discussing in the twenty-first century.

I'm personally sceptical about just how many of the good ideas raised at Unhooked will in the long run influence formal treatment policy, as at the heart of what the event was about was an overall questioning of the way we've chosen to tackle the issue in recent years. What's occurred now though is that we now have a broader yardstick for just what can be discussed within the treatment field – and this is no bad thing.

David Griffin, by email

Better late than never

If you trawl the NTA's web site you will be aware that a course is being run by Oxford Brookes University for commissioners on commissioning. It is apparently heavily subscribed. You might wonder why it has taken eight years of the Drug Strategy to provide training to equip commissioners, especially when the efficient and skillful management of their role is absolutely pivotal to an effective treatment system. But, better late than never. However, I am concerned that apparently this training does not include input from providers in the voluntary sector, something confirmed to me in person by two senior NTA officials.

If nothing has changed since that recent conversation, it is surely an opportunity missed. Effective treatment commissioning, purchasing and delivery are all about the building and managing of relationships to have a positive effect on the client.

We need to understand each other's worlds, priorities, and pressures. What better time to explore this than at a time when commissioners are presumably open to learning?

Nick Barton, chief executive, Clouds

Seek and you shall find

I don't normally respond to anonymous mail, but I feel compelled to make an exception to the latest offering from 'name and address withheld' (*DDN*, 24 April, page 9) on a few points.

Selective quoting is something anon has chosen to do; therefore I would like to ask them if this is the same George E Valiant, Class A (non-alcoholic) trustee AA General Service Board, who said the following:

'I am not a class A trustee because AA helped save my life. I am not a trustee because AA saved the life of someone that I loved. I am a trustee because of all the organisations I have ever been involved with AA is the one that has evoked my deepest admiration. I am a trustee of AA because it works.' (AA and Non-alcoholic friends – a Debt of Gratitude. www.intergroup.org/cpc/art)

If anon has found difficulty in accessing information about the effectiveness of 12-step facilitations, and fellowships such as AA, I suggest they log on, or register on www.medscape.com and punch in the relevant search words.

Insofar as relapse prevention is concerned, anon claims that the 12 steps are unable to do this. They are advancing it as a statement of fact, based on no more than being an 'ex member' – but which particular step is the person who slips, or relapses, working at, the time they choose to use or drink again?

It is apparent from anon's letter that 'the programme did not work' in this instance – or perhaps judging by the comments made, the writer felt unable, or unwilling, to work the programme; whereas the excellent article on CA (DDN, 24 April, page 12) highlights the effectiveness and

personal experiences of those who choose to behave differently.

In any event, I wish anon a speedy and lasting recovery. A recovery that may be enhanced by setting themselves free from the obvious and deep resentment being carried, a resentment that I fear will harm them, far more than anyone else.

One final question: I wonder if they have ever considered that 'God' could be a mnemonic for good orderly direction? A vital process for those seeking lasting recovery.

Peter O'Loughlin, Eden Lodge Practice

No stereotyping

I would like to thank Dr David Shewan and Simon Parry for taking the time to respond to my last Background Briefing (*DDN*, 10 April, page 15).

I agree with your sentiments. In fact, I argued the point of not making generalisations about heroin in the first of this series of articles. I emphasised the need to take into consideration drug, set and setting. I pointed out that whilst a small minority of people had their lives seriously affected by the drug, other users led normal lives over long periods of time.

At the end of this first heroin Briefing, I pointed out that we would first 'look at the heroin experience from the perspective of people of whose lives have been seriously affected'. We cannot ignore that some people have terrible experiences after becoming a heroin user (many also had horrible experiences before their drug use), and these need to be described.

After looking at the recovery from dependent heroin use, I will go on to look at other forms of heroin use. I have every intention of trying to break down the awful stereotypes that exist within this field – not just the media, but also some professionals.

David, you talk about my 'model' and my truly 'pharmacocentric position'. I have no model and I certainly do not hold the latter position – please read some of my other Briefings, particularly the ones about cocaine. I was a neuroscientist for 25 years, and left the field because I did not feel the discipline was helping people recover from substance use problems.

Professor David Clark

Email your letters to claire@cjwellings.com or write to: Claire Brown, Editor, DDN, Southbank House, Black Prince Road, London SE1 7SJ.
Letters may be edited for reasons of clarity or space

Comment

Methadone challenged on its home turf

Is there a worrying methadone backlash about?, ask Tom Carnwath and Chris Ford

The recent National Drug Treatment Conference in Glasgow (9-10 March) had the usual stimulating and eclectic mix of debate and instruction, but with a new twist.

The liveliest debate at the conference was about whether too much methadone was now being prescribed, to the disadvantage of other forms of treatment.

In the main debate, Neil McKeganey reminded us that the seminal document 'AIDS and Drug Misuse' (DH 1989) claimed that HIV infection had become more of a public danger than drug misuse, and that this statement was the trigger for rapid expansion in methadone prescribing. He thought that drug services were right to respond to this challenge at the time, but that with hindsight he felt, we now realise that the statement was wrong. In his view, HIV has turned out to be much less of problem than the legion of young people increasingly trapped on a prescription of the dangerous controlled drug, methadone.

David Bryce, from the Calton Athletic Recovery Club, drew on his own experience of dependence to argue that recovery and abstinence were the 'only right goals' for addicts. He was aggrieved and disturbed at the thought of so many young Scottish brains being rotted by methadone.

We also had Mike Smith reporting back from his intriguing street-level interviews with treatment recipients, arguing that many viewed methadone as just another street drug rather than as a form of medical treatment. It was a fact of GCSE chemistry, he asserted, that 'social deprivation could not be dissolved in green slime'.

The most surprising onslaught came from Mark Gilman, NTA Regional Officer in the North West. In a previous incarnation, as NTA Regional Officer in the North East, he had been positively evangelical about methadone, strongly pressurising DAATs to get as many people as possible into treatment, even praising those who did so at the least cost per head. He was a great ally for those of us who considered that too little methadone was being prescribed in that region, at too low a dosage.

Since crossing the Pennines, he has apparently been born again as a 12-step enthusiast and a staunch advocate of abstinence. His was a key speech in the session on prison treatment. He called his talk 'ships that pass in the night', arguing that prisons were wrongly deciding to move into methadone just at the time that, he thought, the community wanted to turn away from it.

Many of us found all this deeply depressing. Although it is true that substitute prescribing is much more widely available than it was, and the quality of its delivery has greatly improved, this is not so in all parts of the country. The average maintenance dose prescribed remains considerably less than that which is known to be effective (NB 60-120mg). Many of the anecdotes reported by Mike Smith reflected a very poor standard of treatment rather than over-treatment.

The evidence is overwhelming that methadone treatment, if delivered properly, reduces infections and death, improves health and social functioning, and is also the most effective route to eventual abstinence. These facts were taught to one of us (TC) sixteen years ago by Mike Smith himself when he first worked as a drug doctor in a team where Mike was at that time manager. Since that time continuing research has regularly confirmed these findings.

The only reason why good methadone maintenance treatment is not universally available 40 years after Dole and Nyswander established its efficacy, is because treatment policy has too often been ruled by fluctuating fashion rather than reason, and based on opinion rather than evidence. It would be very sad if the recent debate indicated another change in fashion, and the beginning of a trend away from substitution treatment rather than towards its consolidation.

Neither of us is saying substitution treatment is adequate by itself, and the NTA is now rightly emphasising 'treatment efficacy' – in other words the combination of medication with social and psychological support. There is no evidence at all however, that the latter can be effective by themselves. The reason why HIV is not a big problem in the local drug-using community is precisely because this country responded to the crisis in a timely and appropriate fashion, with methadone prescription and needle exchange programmes. Neil McKeganey need only travel to Russia to see the results of the opposite policy, or to China to find out the reason for their recent conversion to evidence-based treatment – one of the great triumphs of the harm reduction movement.

> **'The evidence is overwhelming that methadone treatment, if delivered properly, reduces infections and death, improves health and social functioning, and is also the most effective route to eventual abstinence. '**

Many of us have long considered it scandalous that methadone treatment and needle exchange have not been widely available to prisoners, in spite of the high incidence in prisons of blood-borne virus infection, and of death during detoxification and after release. The labours of a few enthusiasts to change this are finally beginning to bear fruit. It is sad to hear these efforts being disparaged by a leading officer of the NTA.

But, on the positive side, DAATs and treatment services in the North West can now at least expect a sympathetic hearing in their annual appraisals, if they fail spectacularly to meet their targets for retention and numbers in treatment. They can just say that they referred on all their heroin users to Narcotics Anonymous – and if some got lost on the way, why should they be to blame?

Opening doors to inclusion

Government has acknowledged the need for better housing and support services for drug users through a proposal for improved partnership working. But an inclusive approach is vital if all drug users are to benefit, says Shelter's Street Homeless Project. Steve McKeown explains.

The housing needs of drug users are currently attracting a great deal of interest across different disciplines, culminating in a joint letter from the Office of the Deputy Prime Minister (ODPM), National Treatment Agency and Home Office to key commissioners of service in November 2005. This proposes a new target to link up drug services and housing-related support, to increase the number of drug users accessing housing support. While supporting such formal acknowledgement and the need for improved joint working across strategy areas, a new report by the Shelter Street Homeless Project argues that a number of important issues need to be addressed if all drug users are to benefit from this focus.

Drug use and homelessness are often seen as almost inextricably linked, but despite widespread acknowledgement of this, many drug users continue to have difficulty in accessing appropriate housing and support. Government guidance suggests that one in three drug users coming into treatment are in housing need and research into rough sleeping has indicated drug use by up to 80 per cent of rough sleepers in some areas. In other areas the needs may be even higher when more 'hidden' populations (those only engaging with lower threshold services such as needle exchanges or day centres) are taken into account.

A Crisis report in 2002 highlighted the interaction between the two issues, studying homeless people in London (1). The study reinforced previous findings that drug use can be a trigger factor for homelessness but went on to conclude that homelessness was an even bigger trigger for drug use, with many drug users starting or escalating their use as a means of coping with their homeless situation. Taken together these two issues can present a 'revolving door' that many drug users find hard to escape.

A good practice guide published by the ODPM in 2002 (2) reinforced the need for a range of accommodation that provides for continuing drug users as well as those who wish to live in a drug-free environment. There is a whole array of accommodation that could be used for drug users, including night shelters, hostels, shared houses and independent tenancies, although not all of these options are available in all areas. Support can also be provided in a number of ways, including in-house specialist workers, generic workers with training, peripatetic services, floating support or links to community-based specialist services. Such variety with all its permutations could go a long way to meet the differing needs of drug users with different patterns and levels of use. Yet many drug users find themselves with access to only the most insecure housing or excluded from most, if not all, provision in their area.

So what are the barriers?

Certainly there is an issue with demand exceeding supply for single homeless people with support needs, and this is likely to be ongoing given the reductions in Supporting People funding – the principle funding stream for housing-related support. This problem is particularly acute in smaller localities with no direct access provision and sometimes as few as one or two projects to cater for all the housing and support needs across their area. However even where services are provided, there are still more hurdles to get over. Some housing projects exclude drug users altogether. Others will only consider drug users who are already engaged in structured treatment or who can demonstrate a commitment to change. Virtually all housing projects incorporate admission criteria stating that drugs or drug use will not be tolerated on the premises, with the ultimate sanction being eviction.

On the face of it, many people may feel such criteria are perfectly reasonable. Housing providers need to facilitate a safe and supportive environment for all their service users and, above all, work within the law. These criteria present major barriers to problematic and continuing users. There has also been a noticeable emphasis in some recent trade press articles, on providing housing and support for drug users 'in recovery' or for those who are 'drug free'. While again supporting such a focus, it is important to also consider the needs of those not yet ready to start structured treatment or cease illicit use.

This raises a number of fundamental questions: What can be done for these people? Are they 'too difficult' to assist? Should they stay homeless until they are ready and able to address their drug use? What happens in the meantime? Where do those 'in recovery' or 'drug free' go if they relapse?

It should be noted that even the most explicit of conditions excluding drug users, does not mean drug use won't occur. All housing providers should plan for, and safely and effectively deal with it, when it does. Moreover, the admission criteria cited above may have the unfortunate side effect of discouraging drug users from open discussion and engagement with housing and support services regarding their drug use. It has long been suggested within the housing and homelessness sector – often with supporting evidence – that many drug users minimise or deny their problem in order to get into housing projects and then continue illicit use. This situation creates immense risks to themselves, other residents and staff. This can also displace drug use away from the project into less safe or hygienic and more public places.

Other drug users will self-exclude, feeling the service may be unable to provide for their needs with the inevitability of eviction, and they become part of the 'hidden' unmet needs. Some projects, to avoid continual evictions of residents for drug use, operate informal procedures that, worryingly, practically amount to 'don't tell me about it or let me see it, and I don't need to know'.

None of these situations are satisfactory and none fully manage the risks involved. We are also left in a situation where drug use can be a trigger for homelessness, homelessness can trigger an escalation of drug use, but the drug use itself can be a barrier to getting housing and support. For some, the revolving door becomes an indefinite trap. This is even more frustrating given that appropriate housing and support can be powerful motivators in helping people to address their drug use.

Shelter's *Safe As Houses* report identifies a number of housing projects which provide an

alternative to many of the problems above and an approach that can complement, in an integrated way, more traditional housing and support services working with those engaged in treatment or requiring drug-free environments. All will give access to problematic and continuing users and use a harm reduction approach to acknowledge and safely and effectively manage risks, including drug use on site, while encouraging engagement with treatment.

The seven projects (Sinclair Project, Leeds; Wallich Clifford Community, Cardiff; New Steine Mews, Brighton; Single Homeless Project, King's Cross; In Partnership Project, Blackburn; St. Mungo's projects, London; Julian Housing, Norfolk) incorporate different forms of housing provision, from hostels and dispersed houses to floating support in independent tenancies, showing the adaptability of the approach and challenging the notion of 'one size fits all'.

But what of the legal implications?

The 'Wintercomfort case' that resulted in the imprisonment of John Brock and Ruth Wyner from a Cambridge day centre under Section 8 of the Misuse of Drugs Act (1971) had a marked effect on the homelessness sector. Fear and misinterpretations have hampered developments in this area, however neither Section 8, nor the more recent Section 1 of the Antisocial Behaviour Act (2003) prevents the development of services such as those above. The projects' very existence, together with their endorsement by the police and local authorities, should instill confidence in providers that this can be done. The major proviso is that it needs to be done properly.

Building on the work done by the Release Inclusion Project, all of these projects have developed comprehensive, balanced and adaptable drug policies, together with practices which underpin them. These are spelled out to service users and staff, and disseminated across the organisation and to stakeholders, particularly the police and local authorities. The projects actively manage the physical environment, prohibiting drug use in communal areas and with sharps bins available in bedrooms, bathrooms or toilets.

Great emphasis is placed on staff training, support and supervision, together with a holistic approach to support which values qualitative and softer targets, particularly for those with multiple and complex needs. Effective links are also established and maintained with a broad range of other agencies and specialisms.

The benefits of this approach are clear to see, particularly in housing users who would otherwise be excluded. Projects report increased openness, allowing better management of risks and safer practice. Access to health care is increased with better wound care and prevention and management of overdose. Although the projects do not set a requirement for users to engage in structured treatment in order to be housed, treatment access, retention and outcome rates are considerable.

The report was launched at a series of regional seminars attended by 400 people, representing housing providers, local authorities, DAATs, Supporting People teams, support service providers and the police. A website has also been created by KFx (www.drugsandhousing.co.uk) to provide a forum for sharing resources, good practice, problems and solutions to take this work forward. The work is developing but there are still many difficult questions and issues to be raised, not least in terms of the current demand and the resources to meet it. However these cannot be used as reasons to ignore the challenges posed in providing housing and support to such a socially excluded group.

photocritic.org / Alamy

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1. *Fountain, J and Howes, S. Home and Dry? Homelessness and Substance Abuse Crisis, London, 2002.*
2. *ODPM, Homelessness Directorate and Home Office Drug Strategy Directorate. Drug Services for homeless people, ODPM, London, 2002.*

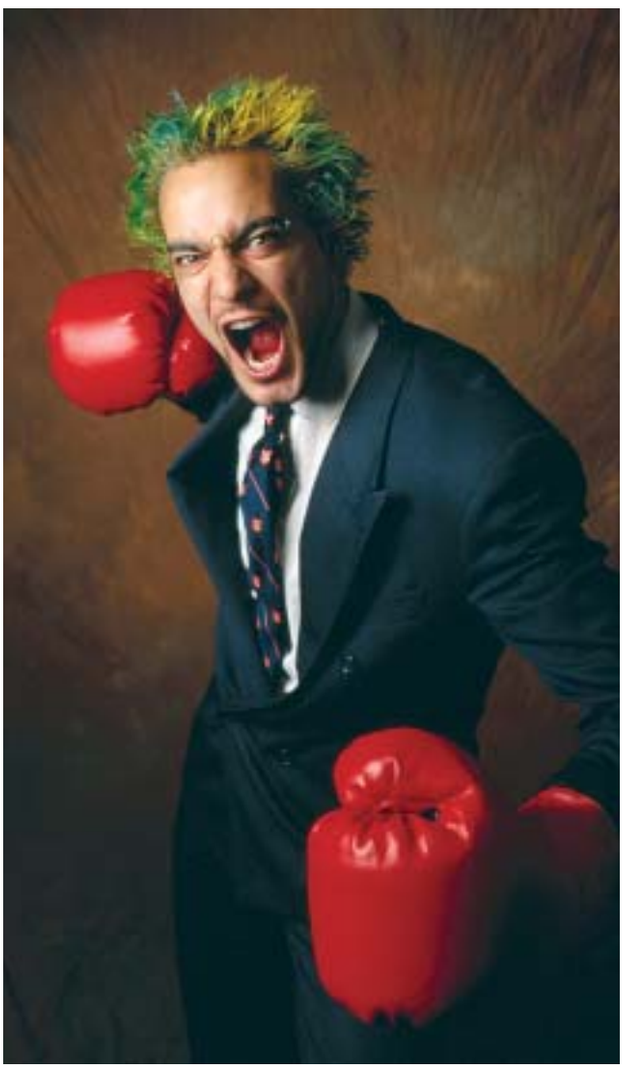
Steve McKeown is senior development officer at Shelter's Street Homeless Project.

Safe As Houses: An inclusive approach for housing drug users is available for purchase from the Shelter Bookshop (www.shelter.org.uk).
Further information relating to the report, including all of the presentations from the recent launch seminars, can be found in the resources section of the www.drugsandhousing.co.uk website.

'Housing providers need to facilitate a safe and supportive environment for all their service users and, above all, work within the law. These criteria present major barriers to problematic and continuing users... Are they "too difficult" to assist? Should they stay homeless until they are ready and able to address their drug use? What happens in the meantime? Where do those "in recovery" or "drug free" go if they relapse?'

Fighting for survival

User involvement should not just be about getting better treatment. It should be about bringing about long-term change to society's attitudes, says Dr Michelle Cave of the Alliance.



What is user involvement, with whom are we involved and to do what?

This question has become more relevant to me over the past few years, as I have been involved in setting up groups. Some have flourished, while others have either limped on for a while in name only, or simply withered away. Those that have endured are committed to making desperately needed changes in their area, as a result of consistently poor services. Obviously this type of involvement is essential and must continue, as the only way change has come about is because the group members have persevered in difficult circumstances.

Clearly then, local groups are important, but in spite of this user involvement must entail more than just local treatment changes. If things are to improve, involvement has to be more than sitting in a room sponsored by a government organisation and talking. Talking in circumstances like these is only useful if there is someone taking it seriously. After all, you can talk until you are blue in the face, but if no-one is listening, all you end up with is a sore throat and a blue face. We must look beyond the local and immediate.

One way user involvement has strengthened its influence is by forming an association with other interested groups such as medics and academics. This alliance with like-minded professionals who are in positions of power has allowed us to implement some of our wishes – without them we are, in reality, powerless. Users have no formal or legal structures through which our opinions and beliefs can directly influence policy, so we literally depend on this support. While their co-operation is highly valued, it is not enough. Ultimately, it means that users still depend on powerful intermediaries.

As a result, it is almost impossible for us to influence the way we are perceived in society. If users are to ever find a place of legal acceptance, if we are ever going to see the right of someone to use quality drugs safely, we have to make major changes ourselves. We must be recognised without prejudice, as equal members of this society; to achieve this, users need to be part of the design and outcome of policy. Participation in the decision-making process is essential.

There are two prominent groups in our society who took the fight to the law makers and won. These are the gay and the women's

'Some flourish, some limp for a while, some wither away...'

Wiltshire Service User Group was featured in our 'Fact File' last autumn (DDN, 5 October, page 13) when the group was off to an optimistic good start. DDN talked to Ben Holtom about the group's unwilling demise.

'After such a good start in September last year and high optimism at the time of our Fact File article, our numbers dwindled rapidly and by Christmas we were down to a hard core of five people,' says Ben Holtom, who set up the group.

'I assumed the authorities would continue to support the initiative, but there has been an alternative process under-way to involve users and carers in the development of services,' he says.

Holtom is disappointed that the value of his group does not seem to have been recognised.

'People don't always like going one to one – they're not always ready to pour their heart out,' he says of local initiatives to involve service providers in user groups. 'It can be much easier for service users in a group situation.'

The group also felt its niche was to share members' skills with each other. Someone with counselling skills would listen to others; another member would teach others to cook.

It was important to the group to create its own dynamic, says Holtom. 'The group was empowering people – and people who were recovering wanted to help others. One woman who regained control after 15 years now wants to do some fundraising for the user group.'

Sharing practical skills was

movements; there was a time when both these groups were persecuted and gaoled. Forty years ago, predicting that a gay couple could freely marry in the twenty-first century would have seemed absurd. This group were medicalised and criminalised – just as drug users are today. Similarly, it was not long ago that women were considered incapable of rational thought; therefore exclusion from politics, education and anything else too demanding was routine. Unfortunately, many women were themselves convinced of this, so it meant the fight was even tougher than it needed to be.

It is from these two influential groups that user involvement could take models for action, ways to influence the organisations that govern our lives. We must strive to be involved in the argument ourselves – allowing others to do it for us means that important issues may be diluted or avoided completely, as they are not politically expedient.

This brings me back to the nature of user involvement. I would suggest that user involvement must result in more than improved drug treatment: life is much more than treatment, just as it is for anyone who attends some sort of clinic as a patient; we need to be making changes that affect the entirety of our way of life.

How do we aim to make these changes? Can we become a movement as the Gay population did?

I believe that we need to address the most important question of all – prohibition – important because of the massive impact it has on our lives. Everything related to drug use, the quality, cost and availability are all affected by the illicit status prohibition bestows upon it. While there is no quality-control of drugs, and people cannot be legally educated to use drugs safely, there will always be problems. Users need to put prohibition at the centre of the debate, if we are ever going to make a real difference to the way we are viewed in society. Treatment, while important, is not enough.

After all, what exactly are we being treated for? Are many of us in fact being medically treated for an opted lifestyle?

If we really want a different way of life, if we want to be able to choose freely, then we have to fight for it as the woman's movement and the gays did.

As Christabel Pankhurst said: 'We are not ashamed of what we have done, because, when you have a great cause to fight for, the moment of greatest humiliation is the moment when the spirit is proudest.'

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a way of bringing chaotic users back to normality, he says. He knows of members who are still struggling, and who miss the group. He knows of someone who is drinking again, and another who's 'having a bad time'.

Holtom felt that Wiltshire SUG played the fundamental role of a user group – 'filling the black hole for users who are isolated and lonely after detox, with nowhere to turn to'. He's worried that individuals are not being accessed, particularly as service users are spread over a rural area, and there is no money for transport.

'We should be supported as one of a number of vehicles that offer help,' he says. 'A user group shouldn't be fitted to what the service provider wants.

'We can't make any progress because we're in a cloud of bureaucracy – pre-meetings, meetings, debriefing meetings. Politics shouldn't get in the way. It should be about the service users, not the service providers.' **DDN**

Post-its from Practice

Hepatitis C

Treating Hepatitis C patients is a stark reminder of the shocking state of Hep C treatment in this country, say Dr Chris Ford and Dr Janet Gillespie.

John had come back to get the results of his recent blood tests. Registered with us for the past six years, his drug use is very stable on 90mg of methadone but his major problem has always been alcohol, which he finds more problematic to control. He is also positive for Hepatitis C and because he was feeling more unwell, we had repeated his blood tests. A couple of years ago, he had attended our local hepatology clinic but had been told that he was not eligible for treatment due to his continuing use of drink and drugs. Sadly, his liver functions tests were worse and for the first time his alpha-fetoprotein was elevated, raising the possibility that he was developing liver cancer.

John's situation is not unusual. The prevalence of Hepatitis C is between 0.7 to 1 per cent of the UK population, equating to about 470,000 sufferers. Injecting drug users account for over 92 per cent of cases. Shockingly, Britain is the worst country in Europe at treating Hepatitis C infection, risking many lives because of inadequate screening and treatment for the illness. Less than 10 per cent of potential cases of infection have even been diagnosed.

The treatment situation is also appalling with only a tiny fraction of infected patients entering treatment. It is estimated that this lack of foresight will cost the NHS up to £8 billion over the next 30 years. Hepatitis C treatment now cures between 40 and 80 per cent of those infected. Early treatment may have prevented John's recent deterioration, but only 1-2 per cent of infected people in the UK receive NICE approved treatments, compared with patients in France who are 6 to 12 times more likely to enter treatment programmes.

In our practice, (list size 14,000) we have 93 known patients who are positive for Hepatitis C. (Statistically, there should be 98 to 140 patients.) We have referred 38 of them, but only 4 (8.3 per cent) have commenced treatment. The other 34 have not been offered treated for a number of reasons, the commonest ones being because they continue to smoke or inject drugs or drink or have declined a liver biopsy. None of these are evidence-based reasons for refusing treatment, but seem to reflect opinion based medicine – perhaps something to do with the patient group who suffer this condition?

And why haven't the other 55 accepted our gentle persuasion for referral? Their reasons are varied: judgmental attitudes of hospital staff, out-of-date information about treatment, fear of the liver biopsy and feeling that they are not worth it. Many of them said they would accept treatment in general practice. This is now being done in a few areas and, for us, seems to be a practical way forward.

At 39 years old, John should not have to die from a preventable disease. With the necessary resources, support and funding, Hepatitis C treatment can and should be developed in general practice – it's our choice... and their lives!

Dr Chris Ford GP Lonsdale and Clinical Lead for SMMGP, and Dr Janet Gillespie GP Lonsdale Medical Centre

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

Just be a friend

Dear Joanna
You can take a horse to water but you can't make it drink. You have made your friend aware of the dangers of what they are doing and you have offered to help them find help for their problem – the rest I am afraid is up to them.

Drug treatment is shown to have a very low success rate when the client has to be coerced into treatment (just look at the evidence from the DIP services if you don't believe me). Your friend will access help when the time is right for them, and only they will know when that time is. All you can do is be a good friend and be there when the time comes.

Ben, by email

Support when needed

Dear Joanna
I'm assuming from your concern that you think your friend's drugs use has reached harmful levels? He obviously does not, and ultimately as an adult he has to decide what is right for him. You cannot make that decision for him and on a practical level nor can you drag him by the hair to his nearest drug treatment service. All you can do is provide him with information to allow him to make an informed decision on his drug taking. You have to try and remember he is your friend not one of your clients. All you can do is offer advice when he asks for it and provide support when he needs it.

Bill W, Birmingham

You have the right

I am guessing you'll get a lot of responses going on about client confidentiality and the like – but that is not the issue here. There is a clear difference between client confidentiality and confidentiality between friends. And you also have responsibilities towards your friends which are different, and wider, than those towards clients.

So if you think it's in your friend's best interests to break his confidence, you have every right to do so. You may even have a moral responsibility to do so – though you have to be prepared to lose him if you do. Having said all that, I can't actually see much benefit in trying to get your friend into treatment if he doesn't want to go – they would be unlikely to accept him, he'd be unlikely to go even if they did, and would be even less likely to stay.

I know, because I have been in a very similar same situation myself. I did actually persuade an agency to take a friend of mine in, I even managed (after many very heated and unpleasant arguments) to get him in a car to go there – but when he got there he refused to go in. Over the following year he nearly died twice – but eventually did go in to treatment, on his own terms, and did really well. And we're friends again too!

Derek, Acocks Green, West Midlands

Back off

Dear Joanna,
With reference to the dilemma you find yourself in:

Firstly, I would query why you have suggested getting your friend help from the treatment agency where you work – what about client confidentiality? How comfortable do you think your friend would feel being treated in your workplace?

Secondly, why are you assuming that you would save his life? The vast majority of drug and alcohol users do not die from their habit.

Thirdly, from what you say, he has already indicated in no uncertain terms that he does not want your help. It may be that he is not having particular problems with his use at the moment and is not ready to seek help or move into treatment.

Back off, Joanna, keep your friendship and hard as it is, wait until he indicates that he wants help. Successful treatment and support always has to come at a point when the user himself is ready to choose that option.

Your friend is fortunate that you are so concerned about his welfare so don't jeapordise your friendship in your rush to make him 'well'.

Good luck and best wishes,

Irene MacDonald. CPSG, Cheltenham.

When he's ready

Dear Joanna
No matter how hard we try to help someone, if they are not ready for help (they may never be) they will not accept it. It feels like your friend wants you to be a 'just a friend' and accept them as they are. By trying to force your friend to get help is sending the message that you don't accept or respect them.

It's so hard to watch someone you care about slowly killing themselves, but the reality is it is your friend's choice.

It sounds really tough, all the best.

Liz, Shrewsbury

What about you?

Dear Joanna,
You have kindly made the offer to arrange help for your friend at your agency and he has declined that offer. It sounds as if your friend might not be ready to access treatment at the moment and trying to coerce him into engaging with your agency might only encourage him to withdraw further away from help.

What you can do is support him as a friend; be available to talk, visit, go out for coffee or a movie or whatever. Ask him if there is anything you can do for him at the moment and see what he says. After all, you are his friend, not his keyworker, so make sure you treat him as such and not like one of your clients.

Also, Joanna, what about you? It can be extremely painful witnessing a friend going through destructive drug and/or alcohol use. Sometimes, we might decide to make the difficult decision of having to walk away if their substance misuse affects us too much. It could be useful to ask yourself how your friend's using is affecting you, and if you need any support yourself; Families Anonymous offer support groups for those affected by loved ones who use drugs and alcohol. Good luck.

Phil, by email

Reader's question

I've just had a bad experience with a service user. On our second meeting I was trying to explain her options for getting in contact with services, when she stormed out saying I didn't understand her, and what was the point. I feel devastated – I've not been in my job that long, and feel as though I've failed my client badly. Can anyone give me advice on handling things better in future?
Shelley, Birmingham

Email your suggested answers to the editor by Tuesday 16 May for inclusion in the 22 May issue of DDN.

New questions are welcome from readers.

The drug experience: heroin, part 5

In his latest Background Briefing, Professor David Clark starts to look at the process of recovery from dependent drug use, as described in seminal research by James McIntosh and Neil McKeganey.

In the last four Briefings, we have looked at the experiences of people whose lives are seriously affected by heroin. In the present Briefing, we will take a first look at the recovery process for those people who become dependent on heroin. We will focus on the research described in the seminal book *Beating the Dragon: The Recovery from Dependent Drug Use*, by Professors James McIntosh and Neil McKeganey.

These researchers interviewed 70 recovering addicts (the term used by the authors) to gain insights into their views of the recovery process. While the vast majority of the sample had been dependent upon opiates, most would have been classed as poly drug users at the height of their drug use. The average length of time that interviewees had ceased using their drug of choice was 4.3 years (range: 7 months to 12 years).

For this sample, the process of giving up drugs was not a single, once-and-for-all experience. The great majority had made several attempts to stop. A variety of reasons were given for attempting to stop use. Among them were: impact of use on their partner, children or family; threat to their own health; to prevent children being removed from them; a sense of tiredness of demands of maintaining habit; death of someone close; and the threat of prison.

The researchers pointed out that the experiences and events that interviewees cited as reasons for stopping use did not 'appear to differ in type or quality as far as successful and unsuccessful attempts were concerned. The same sorts of reasons were given for both'.

They propose another factor – centred on the addict's sense of identity or self – that distinguishes successful attempts from unsuccessful attempts at stopping drug use.

More specifically, the person wishes to restore what is described as a 'spoiled identity'. The central feature of a spoiled identity is the realisation by the person that he exhibits characteristics that are unacceptable to himself and to significant others.

McIntosh and McKeganey emphasise that the theme that dominated their interviewees' accounts 'is their concern to recapture a sense of value and self-respect; in other words, a desire to regain a positive self. Whereas earlier attempts to abstain tend to be utilitarian in nature and geared to achieving a particular practical outcome – such as getting one's partner to return or avoiding losing one's children – what characterises the successful attempt is a fundamental questioning and rejection of what one has become, together with a desire and resolution to change'.

'A variety of reasons were given for attempting to stop use. Among them were: impact of use on their partner, children or family; threat to their own health; to prevent children being removed from them; a sense of tiredness of demands of maintaining habit; death of someone close; and the threat of prison.'

Of course, this desire to restore one's identity is not sufficient to lead the person to stop using, but it is, in most cases, a necessary condition.

The negative impact that a person's life as a drug addict had upon their sense of self was expressed in various ways: a deep unhappiness, sense of self-disgust, and a revulsion of the drug-taking world they inhabited. There was a recognition by the individual that their drug-using identity was no longer acceptable and had to change.

A memory of the person's drug-free existence remained and this could play a role in the decision to quit in two ways. Firstly, it acted as a comparison for the addict to realise how bad their life had become. Secondly, it provided a basis for hope, as they had been different in the past and could be so again.

The process of recognising and acknowledging a spoiled identity and the subsequent decision to give up drugs were usually the result of a gradual process of realisation.

The circumstances which forced addicts to review their identities could be single events, ongoing experiences, or usually both. Often, it was the impact that their drug use was having on people close to them that forced addicts to confront what they had become.

The decision to quit was often precipitated by certain 'trigger' events. However, for most addicts the trigger came at the end of a period of reflection and review that had been going on for some time, sometimes months and even years.

The recognition that one's identity has been spoiled is not sufficient for one to give up drugs. The person must have a desire for a new identity and a different style of life. Positive occurrences (*eg* the birth of a child) can re-awaken an addict's perspective on the future and show that it can be better than the present and be worth striving for.

Addicts also have to believe that it is feasible to develop a new identity and life.

Some of the sample decided to quit following a rock-bottom crisis. The person had deteriorated to such an extent physically, socially and psychologically that there were only three possibilities open to them. Firstly, continue, but this would lead to total degradation of identity and likely physical damage as well. Secondly, exit through suicide, which was given serious consideration by many addicts at this stage, and tried by some. Thirdly, try to beak the addiction and thereby exit a drug-using career.

Despite the role of rock bottom experiences, the majority of the sample exited on the basis of what appeared to be a rational decision. This decision generally involved a conscious balancing of the pros and cons of continuing drug use.

Recommended Reading:
James McIntosh and Neil McKeganey (2002) Beating the Dragon: The Recovery from Dependent Drug Use. Prentice Hall.

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G.H.P - A voluntary social enterprise of practitioners, trainers and therapists – dedicated to promoting best practice and support for those involved in drugs and alcohol. Whether they be workers, volunteers, parents, families or users of services

Having attended many large events & conferences over the past few years. We wanted to organise something more intimate where workers could have discussions & debate with prominent professionals and practitioners. We hope that this will promote best & respectful practice amongst our peers in the drugs field.

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Professor Mark Griffiths – Slot Machine Addiction in Teenagers
Danny Morris – Harm Reduction
Sylvie Jackson – Nutrition & Detoxification
Shelagh Robinson – Supervision & Self Care
Several speakers still to be confirmed

Cost 1 day £95.00 – 2 days £175

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Have you got experience you would like to share with others. Are you based in or around the midlands? We are always interested, if you would like to facilitate one of our training days as a freelance trainer then we would like to hear from you. If you are a professional then send a C.V. and covering letter.

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UNIVERSITY OF KENT

Training for Drug & Alcohol Practitioners

Kent Institute of Medicine and Health Sciences

Programmes from 2006/07

Our university accredited, modular programmes incorporate the "Models of Care" framework, DANOS competencies and QuADS benchmarks. Being taught in five-day blocks, they are accessible to students living in or outside Kent, are ideal for those new to or returning to study. All programmes aim at a wide range of professionals in healthcare, counselling, criminal justice, the community and social care etc. who access clients with substance use related problems.

Certificate in Substance Misuse Management (Stage 1)

This access level Certificate provides a broad introduction for people currently working with problem substance users, or expect to be in the near future. The programme is delivered in Canterbury & across the UK where there is a cohort of 10 or more students. It is a recognised benchmark for those who seek an accredited qualification. The programme also benefits social, health and education professionals in all sectors whose work includes significant contact with problem substance users

18 month programme from September 2006 or by negotiation

Certificate in the Management of Substance Misusing Offenders (Stage 1)

This Certificate is an access programme for prison and probation officers, drug and alcohol workers, health and social care professionals working with problem substance users in the criminal justice system. It includes NTA and Home Office strategies, eg. DRRs, CJIP, CARAT and DIP issues, ethics, cultural factors, managing challenging behaviour and working in multi agency criminal justice settings. Available across the UK for cohorts of 10 or more students.

18 month programme from September 2006 or by negotiation

Diploma in Substance Misuse Management (Stage 2)

The Diploma provides a framework for understanding the nature of substance misuse and addiction processes from biological, psychological and social perspectives, and focuses on the settings and approaches within which treatment is provided. The Diploma is appropriate for practitioners working in Tiers 2, 3 and 4a services for drug users or people with alcohol problems.

2 year programme from October 2006

BSc in Substance Misuse Management (Stage 3)

The BSc programme provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours, this includes training in ethics, research methods and the development of a research proposal. You will be encouraged to develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. POST-GRADUATE OPPORTUNITIES are also available in this area of study.

2 year (top-up of Diploma) or 4 year programme from November 2006

For further information and an application form, please contact:
Teresa Shiel, Programme Co-ordinator, KIMHS, Research and Development Centre, University of Kent, Canterbury, Kent, CT2 7PD
Telephone: 01227 824330 Email: T.Shiel@kent.ac.uk www.kent.ac.uk

Drug problems and poverty – the poor relations?

22 June 2006
Glasgow Caledonian University

- Are we clear about the connections between drugs and poverty?
- What can treatment services do to help, beyond a prescription?
- Are training, education and employment the main routes out – and what are the alternatives?
- Have we under-estimated the challenges?

Key speakers will include:
Dr Aileen O'Gorman, University College Dublin
Dr Charles Lind, NHS Ayrshire & Arran – Community Health Division
Frank Pignatelli, Chief Executive, learndirect scotland
Morag Gillespie, Scottish Poverty Information Unit, Glasgow Caledonian University

Workshop themes include:
- Children in poverty: stopping the cycle
- Making the connection – drugs strategies and regeneration
- The homelessness factor
- The service user perspective and lessons from prison: drug users as citizens' advisers?
- Carers: reducing the money worries

Further information/bookings contact Lisa:
(t) 0141 221 1175 (e) Lisa@sdf.org.uk (f) 0141 248 6414

ScottishdrugsForum | information unit

New! – Society for the Study of Addiction Travelling Scholarship

Get financial help to travel/study in the addictions field, internationally!

Apply for the new SSA £2,500 Travelling Scholarship, available twice per year.

Train abroad - visit international meetings, laboratories or clinics.

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See our website for more details:

www.addiction-ssa.org

Or contact us on: +44 (0)113 295 1345 (tel/fax), or membership@addiction-ssa.org (email).

It's not too late to join the SSA for 2006 – membership only £85 p.a. including 1 year's subscription to *Addiction* and *Addiction Biology* (if you apply before the end of June – 6 months subscription included after this date). Members are also entitled to discounted attendance at our Symposium in November.

The London Centre for Psychodrama
Group and Individual Psychotherapy

The London Centre for Psychodrama Group and Individual Psychotherapy

Training address Great Portland St, W1 6PF

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Commences September 2006
The course is aimed at those who are considering a full professional training in psychodrama psychotherapy as well as those with an established professional qualification who wish to enhance their working practice by the use of psychodrama philosophy and action techniques.

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Commences January 2007
The course offers an accredited UKCP training in group and individual psychotherapy. It aims to produce practitioners who will be professionally competent in these areas. The British Psychodrama Association (BPA) accredits the London Centre for Psychodrama Group and Individual Psychotherapy as a Training Organisation and is the accrediting body within the UKCP.

For further details on all courses contact:
Jinnie Jefferies, Course Director,15 Audley Rd, Richmond Surrey TW10 6EY
Tel 0208 9485595 Email jinjefferies@aol.com or chesnera@aol.com

www.londoncentreforpsychodrama.org

fdap | HIT.

DANOS based induction training

HIT and FDAP have developed a new series of short courses specifically designed to teach the knowledge and skills covered by the DANOS units in FDAP's Drug and Alcohol Professional Certification Scheme.

These modules will be run in Liverpool in the first instance - but will be rolled out nationwide thereafter.

Core skills for Working with Substance Users - 15, 16 & 17 May
AA2 Relate to and interact with individuals; **AA4** Promote the equality, diversity, rights and responsibilities of individuals; **AA6** Promote choice, well-being and the protection of all individuals; **B15** Promote effective communications for and about individuals.

Assessment of Substance Users - 31 May & 1 June
AF2 Carry out assessment to identify & prioritise needs; **AF3** Carry out comprehensive substance misuse assessments; **AB5** Assess & act upon immediate risk of danger to substance users.

Ensuring Effective Health & Safety - 22 June
BD4 Promote, monitor & maintain health, safety & security in the working environment.

Personal Professional Development - 23 June
AC1 Reflection on an develop your practice; **AC2** Make use of supervision.

INTRODUCTORY OFFER: Register for all 4 of the above courses at a reduced rate of £600 plus VAT when using the code P5FD5.

For further information about the courses, please contact HIT Training on 0870 990 9702 or email training@hit.org.uk.

Community Drug Project

Providing quality services in response to the changing needs of diverse communities

CDP continues to be a pioneer in developing services to address the wide ranging issues facing communities from problematic drug use. We run a range of high quality innovative services based on our principles of partnership working, accessibility and harm minimisation.

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Project Manager

The Source Crack Service - Wandsworth SW8 **£28,449 - £31,191 pa**

You will have overall responsibility for the clinical management and day-to-day running of this service and directly manage 7 permanent staff. You will be an integral part of our management team and be expected to contribute to the strategic development of the organisation.

You should have extensive experience of working with service users in the substance misuse field. You should also have at least 1 year's experience of staff management and supervision as well as excellent skills in care provision development, implementation and monitoring. **REF: CDP/01/G**

Project Workers

Quantum Direct Access Service - Forest Hill SE23 **£23,982 - £27,012 pa**

This open access service is seeking Project Workers with good working knowledge of harm reduction and the physiological and psychological effects of drug use. You will need to demonstrate experience and knowledge of GP shared care and be able to advise and support primary health care professionals in relation to drug use and treatment. You will be expected to work some weekends. **REF: CDP/02/G**

Project Workers

Southwark Contact Team - Camberwell SE5

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As part of the Drug Intervention Programme (DIP) in Southwark, we work in police custody areas and magistrates courts targeting those offenders arrested for trigger offences and who have tested positive for Class A drugs.

You will assess clients, develop care plans, manage a small caseload of clients and provide outreach support to engage clients whilst awaiting treatment. You should have a good understanding of the complex needs of chaotic drug users and demonstrate the ability to make effective interventions. You will work on a rota basis in both court and custody including some evenings and weekends. **REF: CDP/03/G**

For an application pack for any of the above vacancies please telephone on 020 7840 0099 or email: jobs@communitydrugproject.org.uk quoting the relevant reference no.
Closing date for completed applications: 22nd May 2006 www.communitydrugproject.org.uk

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LOCALITY MANAGER

Ref: B160

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Taking forward the implementation of our modernisation programme, you must be an effective leader and experienced manager of substance misuse treatment services. We are an established community based structured treatment service, who have been successful in securing significant service development over the last few years. We are now reviewing and consolidating our current service provision, strengthening the care management processes in line with Models of Care, and working with commissioners to further develop the comprehensive and integrated service provision to meet service user needs.

You will be working with an enthusiastic and positive team in taking forward the service in Carmarthenshire, whilst working collaboratively with the Locality Managers for the other two counties. There is the opportunity within the post to maintain specialist clinical involvement, or take a lead for specialist areas dependent on skills, interests and service need.

With a professional/clinical qualification, you will have experience in a relevant field, and in managing and developing substance misuse services.

For informal enquiries please contact Gill Phillips, General Manager on 01267 244442.

Application forms and job descriptions are available by contacting the 24hr answerphone on 01267 239871 leaving your name, address and job reference or email jobs@pdt-tr.wales.nhs.uk

Closing date: 19 May 2006

This post is subject to the new terms and conditions of service to be introduced under the Agenda for Change Agreement

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For further information about other vacancies at the Trust please visit our website at www.pdt-tr.wales.nhs.uk