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Drink and Drugs News

25 September 2006
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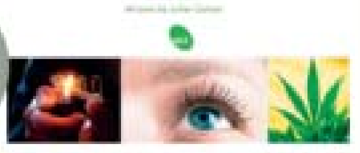

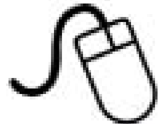

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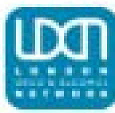

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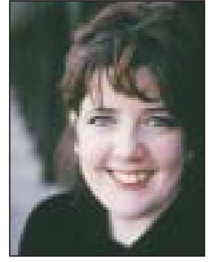
Drink and Drugs News

25 September 2006



Editor's letter

What works in getting drug education through to young people? Some of the most respected researchers in the field were upfront about the fact that they didn't know and had no magic solutions, at an Action on Addiction Conference this week (page 10).

But the expertise brought consensus that current programmes are having little or no effect in schools – and the new ACMD report goes as far as saying that some drugs education may even be counter-productive (news, page 4).

Some action is straightforward: there was a strong call for more evidence based research to confirm what does work, and it will be interesting to see the evaluation of the Home Office's 'Blueprint' programme next year.

Other proposals are more complicated and involve personal freedoms being sacrificed for the greater good. Should the price of alcohol be increased for example? Do we use fiscal means to put it out of reach? Or do we educate with the help of parents and mentors to help young people grow up with informed choices about whether to tipple a little now and again or join the nation's binge-drinkers? I'm sure that many of you working with young people will have thoughts on all this.

Our cover story this issue (page 6) is a great example of tailoring a service to fit the needs of clients, rather than the other way round. Dual diagnosis is such a complicated area of treatment that it took patience and determination for the team at Walsingham House to get the service they needed. Cliff Hoyle and Brendan Georgeson said one of the main challenges was to have the humility to let go of professional protectivism and listen to suggestions from workers on other teams. What a great example of pooling skills in the clients' best interests.

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News in brief

Dope Dash
Two new interactive games have been launched on the FRANK website, www.talktofrank.com. Dope Dash and Stoned Invaders were designed by Ryan Jones and Jack Martin to spread awareness among teenagers about the dangers of smoking cannabis. The two teenagers developed the game after winning a FRANK competition.

Hep B hope drug
The drug Baraclude (entecavir) is now available in the UK to treat chronic Hepatitis B infection. The oral antiviral therapy inhibits the replication of the Hep B virus and has been welcomed by the head of the liver unit at St Mary's Hospital in London as an important new medication in reducing patients' viral loads, reducing their risk of developing liver cirrhosis and liver cancer.

Speedballing on the rise
The practice of 'speedballing' – taking heroin and crack together – is on the rise, according to a survey of 20 UK towns and cities by *DrugLink* magazine. Editor Harry Shapiro comments in the latest issue that if the trend for speedballing continues, 'it will be bad news for attempts to reduce the spread of injecting-related diseases and the number of drug overdoses'.

Police clue up on drug harm
Police in Scotland are revolutionising the way they deliver messages about substance misuse. The Get Real DVD has been developed by the Scottish Crime and Drug Enforcement Agency and Scottish Executive and includes video clips of real life effects of drugs, alcohol and tobacco on individual users, as well as information on the law. The director of SCDEA said it was an important advance in the Scottish Police Service's harm reduction activity.

Testing not the answer
Employee drug testing is not the only way to tackle workplace drug and alcohol problems, says the EAP Institute in Dublin. Director Maurice Quinlan advises a six-point plan that includes updating contracts and workplace policies and extra training to handle employees who might be under the influence.

New strategy overdue on drugs education

Drug prevention programmes are having little or no impact on schoolchildren's behaviour – and could actually be counter-productive, according to a new report from the Advisory Council on the Misuse of Drugs.

The finding was among key messages in the ACMD's 'Pathways to Problems' report, published this week, which explicitly includes alcohol and tobacco in its terms of reference for the first time in acknowledgment of their equally hazardous status to other drugs.

While emphasising that information provided by schools needed to be 'accurate, credible and consistent', the ACMD warns against relying solely on education to address deep-rooted problems that underpin many young people's substance use. Poverty, family instability, and parental attitudes are identified as key influencing factors in encouraging young people to use tobacco, alcohol or other drugs hazardously, and the report calls on government to 'continue to invest heavily' in minimising poverty and supporting the most disadvantaged in society.

Specific measures are suggested in response to findings that availability directly affects consumption rates. The government is urged to increase excise duty on alcohol, and to raise the age for buying tobacco products from 16 to 18, with stringent prosecution of vendors that do not require proof of age.

Recommendations are made against a backdrop of children younger than ten smoking and drinking; escalating statistics for drinking and smoking among young girls; and a willingness to experiment with various drugs by the age of 15 that gives the UK among the highest rates of young people's drug use in Europe.

Despite the conclusion on ineffectual school programmes, the ACMD presses for better communication to young people about the real hazards of drugs, alcohol and tobacco – through the school system, further and higher education, and through responsible reporting in the media.

Among those to welcome the recommendations in the report, Lesley King-Lewis, chief executive of Action on Addiction said that it carried 'a very clear and long overdue message for the development of future health policy'.

Pathways to Problems, available at www.drugs.gov.uk/publication-search/acmd/pathways-to-problems/Pathwaystoproblems.pdf
See feature on page 10 of this issue.

Thames borough aims four strikes at underage drinking

Thames Valley Police and the Royal Borough of Windsor and Maidenhead DAT have teamed up to tackle binge drinking with a 'four strikes and you're out' scheme.

The four-stage process has the joint aim of reducing anti-social behaviour and intervening with young people who are at risk of developing a drink problem.

The first time they are caught drinking in a public place the young person's alcohol will be confiscated, their name and address will be taken and a letter outlining the four-stage process sent to their parents. At the second offence police will visit their home to speak to their parents. At the third 'strike' their contact details will be passed to the T2 drug service, who will send literature and phone the household to suggest a one-to-one session with the young person. At the fourth offence an Acceptable Behaviour Contract (ABC) will be developed, which includes sessions with a young person's substance misuse worker.

Carol-Anne Matic, the Royal Borough's anti-social behaviour co-ordinator said the joint initiative was part of their 'firm stance against those who will not change their behaviour and demonstrates the commitment of all agencies involved in stamping out this type of anti-social behaviour'.

Other initiatives in the borough include Operation Legless, where the police's anti-social behaviour team target hotspots on Friday and Saturday nights to confiscate alcohol from under 18s before they can get drunk.

Parents should be 'alcohol role models'

New ways to tackle risky drinking behaviour among schoolchildren are suggested in new research based on 10,000 15- and 16-year-olds.

The study, published by the Centre for Public Health at Liverpool John Moores University and Trading Standards North West, looks at binge drinking, frequent drinking and drinking in public places. It found that nine in ten of those surveyed drank alcohol, with nearly 40 per cent regularly binge drinking (five or more drinks in one session) and a quarter drinking two or more times a week. Half of the sample drank in public settings, including bars, clubs, streets and parks.

Older siblings, friends and adults were a common route to buying alcohol, leading to increased levels of drinking; but importantly, where parents provided their children with alcohol there was less likelihood of binge drinking and drinking in public places.

Authors of the report suggest that positive parental role models should be developed to give models for sensible alcohol consumption, and encourage parents drinking alcohol with their teenage children at meals to educate them about moderate alcohol use. They also suggest that parents could be given advice on monitoring their children's expenditure so they can check money is being spent appropriately.

More investment in policing underage sales, accompanied by severe penalties, were seen as the way forward on tackling underage sales.

Lead author of the report Mark Bellis, director of the Centre for Public Health, advocated a Mediterranean approach to using alcohol 'with food and with restraint'. He called on parents to be involved as alcohol role models and educators as 'the ability to drink sensibly is not a gift people are born with, but one that must be learnt.'

The Pace Youth Theatre performs 'Ready or Not' to schoolchildren in Scotland as part of the Scottish Drug Enforcement Agency's 'Choices for Life' initiative. The drama plays out the effects of peer pressure on three main characters and wraps hard-hitting messages in a stimulating musical performance. Pupils of 11 and 12 years old have been given a two-hour educational lesson on drugs and alcohol before performances, which are being held at venues all over the Scotland. The show will make an appearance in Manchester at the ACPO conference in November.

Needle machines to be tested in North Wales

Automated needle syringe exchange machines are to be trialled in North Wales, giving drug users access to clean needles and syringes 24 hours a day.

The local Substance Misuse Action Team paid £4,000 for the machine, to be placed in the centre of town, and hopes to reduce the spread of viruses such as HIV and Hepatitis. The machines have become increasingly widespread in other countries over the past ten years as part of harm reduction programmes, with more sophisticated models developed to collect used needles.

But abstinence-based rehabilitation centre Touchstones 12 has spoken out against the experiment, calling it 'another nail in the coffin for any hope of sanity arising from our failing drugs policy'.

Project director Danie Strydom said police should take a zero tolerance approach to drugs, rather than advocating the use of a machine to administer them. She called for more resources for support and education facilities to tackle drug death statistics and questioned 'the £2.2m being spent by the Welsh Assembly Government on maintenance and drug reduction services, compared to £15,000 on keeping individuals off drugs for life'.

Former heroin and crack cocaine user Andy Bond joined Ms Strydom in fearing that drug dealers could use the machines to get more people hooked.

'They could be used to encourage people who may have been wary of using a dirty needle to try drugs for the first time,' he commented.

Ms Strydom called for an independent audit on all drug support facilities in Britain, 'so we can all see just how effectively tax payers' money is being spent'.

Obituary

Una Padel (21.7.56 – 29.8.06)

Una Padel, director of the Centre for Crime and Justice Studies since 1999, died on 29 August after a brave battle against breast cancer.

Originally from London, Una was a Psychology (Durham University) and Social Work (York and Newcastle University) graduate. She began her career in criminal justice as a probation officer in Newcastle, where caring for offenders in the prison system fuelled Una's existing passion for social justice and penal reform. She returned to London in 1983 to take up the post of deputy director – working alongside Stephen Shaw – at the Prison Reform Trust.

In was in the late eighties, when ignorance about HIV/AIDS caused so much stigma and fear, that Una became assistant director of the Standing Conference On Drug Abuse where she helped educate prisons and prisoners about the issues involved. She co-authored a staff training manual that helped bring about a more considered approach to the treatment of individuals in relation to HIV/AIDS.

Una viewed prisoners' families as deserving of equal attention. In 1993 she became the co-ordinator of London Prisons Community Links (the forerunner to CLINKS) where she set about ensuring that all London prisons had the benefit of staffed visitors' centres to support visitor welfare and improve the general quality of visits for everyone. She also helped establish an innovative prison based support service for families affected by drug activity and served as an active board member of Action for Prisoners' Families.

During her time at CCJS, Una worked tirelessly to improve a broad range of criminal justice policy and practice – both in prisons and the community – through education, research and influence. In 2003, she received an OBE in recognition of her work.

The world of criminal justice has lost a person of integrity, inspiration and vision and her family – particularly her daughter Morag – and friends a source of unconditional love and support.

Karen Whitehouse, friend and colleague

Drug services improving – but many could do better

Drug treatment services are improving, but there is an inconsistent picture across England, according to the NTA and Healthcare Commission's national review of substance misuse services.

Most drug action teams (71 per cent) were rated as 'fair', when their performance was rated against national standards. The review looked at how they planned and co-ordinated services, and whether they prescribed drugs safely and appropriately.

Just 5 per cent were 'excellent', 23 per cent were 'good' and 1 per cent were judged to be 'weak' on their overall rating. Particular areas of weakness were found to be commissioning of drug treatment, including substitute prescribing and a failure to use comprehensive care plans.

While there were improvements in many areas on keeping service users in treatment longer, further progress was needed, particularly among DATs who were failing to keep clients in treatment for at least 12 weeks. Methadone prescribing was judged to be good in 95 per cent of services, but some were still prescribing to standard policies rather than individual need, resulting in insufficient doses.

There was an inconsistent picture on service user involvement. While a third of DATs scored highly for involving service users in design and development of services, others scored poorly, failing to provide local user forums and planning groups, or offer any training or mentoring services.

While drawing attention to the conclusion that twice as many people now have access to drug treatment than in 1998, NTA chief executive Paul Hayes acknowledged that worst performing areas were 'failing their populations'. He pledged that the NTA would work with these areas to ensure they matched the quality of delivery elsewhere.

Detailed findings are on the NTA's website, www.nta.nhs.uk

- Kensington and Chelsea DAT are celebrating their rating as equal best in London and tenth nationally out of 149 DATs. Cllr Fiona Buxton, cabinet member for adult social care said the DAT's strong partnership arrangements between the council, mental health trust, primary care trust and police, were helping them to get to grips with difficult issues. The report noted the area's rapid and flexible access to an appropriate range of treatment services and options.

Dual challenge

For anyone working in the field, whether with substance misuse or mental health, the problems of delivering effective services for those with a dual diagnosis are well documented. The roots of these problems are manifold, and include scarce resources, policy constraints, insufficient training, lack of clarity about funding, and the diagnosis itself.

The term 'dual diagnosis' can be misleading. There is certainly not a lot 'dual' about it because people who experience any form of mental disorder plus issues with substance misuse usually have more than two problems. The term 'diagnosis' is not helpful either, because it is doctors who tend to diagnose, and this creates a mindset of medicalising complex life problems. The only way the term is useful is as a verbal shorthand where it has a common understanding across the sector. It is for this reason that we have established a dual diagnosis service at Walsingham House, which is part of the St James Priory Project, a residential treatment unit in Bristol.

Walsingham House recognised that significant numbers of people were denied access to residential rehab for substance misuse because of a diagnosed mental illness and the need to take medication. In the summer of 2005 the treatment co-ordinator, Brendan Georgeson, engaged with Cliff Hoyle, a specialist practitioner and trainer in dual diagnosis, to provide some basic dual diagnosis training to staff at the project.

At this training it was recognised that the staff at the project brought significant skills, knowledge and understanding that would be effective in the treatment of dual diagnosed clients. These included Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) as well as advanced counselling skills. The staff team just needed a reinforcement of confidence that their skills were transferable, which began with the de-mystification of the term dual diagnosis. This led to very real consideration that the service could accommodate dual diagnosed clients within the existing framework, with just a small amount of specific intervention. As Brendan Georgeson says: 'Some of the main challenges were having the humility to let go of professional protectivism and not close down when other workers from other teams suggested we could or should do things differently. Other major challenges were managing the team's anxiety about its ability to cope when mental health symptoms were particularly strong.'

By September 2005 a dual diagnosis service protocol had been established and the service was well placed to start accepting clients. Screening was conducted jointly between a focal counsellor, the dual diagnosis specialist, the client, and in some cases the client's key-worker or advocate.

This could also be completed over the telephone, as the case of screening a client from prison demonstrates. Ben was diagnosed with a personality disorder and a heroin and crack addiction. After rigorous assessment through speakerphone, Georgeson and Hoyle felt that Walsingham House could offer a service, and the case was presented to the team.

The full assessment process involves all of the counselling staff at Walsingham House who process the screening forms and decide as a team. This has to be unanimous, as a split in the team when under pressure is not at all helpful. Also at this point any concerns and anxieties can be addressed. Walsingham House admitted Ben straight from prison and following significant challenges and lessons learnt both for client and staff, Ben went on to complete treatment and is currently enjoying recovery and engaged in training and voluntary work.

Brendan Georgeson reflects on some of the challenges that clients such as Ben have brought up: 'For the counselling team, supervision and continued training have proved vital and are now mandatory. With this client group the main counter transference from the counselling team appeared to be a sense of powerlessness or loss of control, which was usually what the client was feeling, only they [the client] usually expressed it by being demanding and argumentative.'

Walsingham House opted for an integrated model of care where all interventions would be delivered through a single model, with a key worker at Walsingham House leading the care plan. Other models quoted in literature and policy guidance are: 'parallel', where services are delivered at the same time but by individual agencies; or 'serial', where interventions are sequential. Integrated models of care are considered to be most effective. The integration is consistent on different levels: structural integration means a consistency in service delivery; individual integration means the client having the opportunity to be part of a new group.

Georgeson observes that 'integrating dual diagnosed clients into a busy 12-step total abstinence rehab can work well. The biopsychosocial model we were using meant that they are encouraged to integrate into the therapeutic community and not treated any differently in terms of the timetable'.

A case example is John, experiencing both positive and negative symptoms of schizophrenia while at Walsingham House. He was encouraged to describe to the group, with a counsellor present, what it was like to be John and what his illness meant to him. This had the effect of the group embracing him more, rather than being judgemental and separatist.

This kind of integration is a powerful therapeutic tool. Cliff Hoyle points out that it was appropriate to do this is John's case, whereas dual diagnosed clients with a psychosis usually need a level of symptom stability to engage in a residential programme. John's family visited while he was resident with Walsingham House and on each occasion described what they saw

Seeing the obstacles that dual diagnosis clients face when trying to get into treatment led Cliff Hoyle and Brendan Georgeson to tackle the situation head on. They describe their practical approach to making residential rehab accessible to substance misuse clients with a mental health problem.

as a huge improvement. John has been abstinent for eight and a half months.

A further element for effective service delivery came in the form of partnership arrangements with locality community mental health teams, substance misuse teams, placement funders (if different) and other agencies such as probation. To date, relationships with statutory providers have not been consistent, which has been part of our learning. There have been particularly effective arrangements with a local assertive outreach team, but less so with a more generic mental health team. The geographical distance of referring agencies has also been a factor.

One client who was accepted from a London borough had received appropriate input while in their area. However, once placed out of this area the local mental health service, which still held clinical responsibility, was unable to respond in the event of a potential crisis. This was understandable owing to the time and distance involved; psychiatric time is valuable.

Walsingham House had also had problems accessing timely psychiatric review for clients who were previously unknown to mental health services. It was starting to become clear that the project needed more than effective interventions; it would need to be able to accept clinical (psychiatric) responsibility for clients. This responsibility would extend to offering GPs prescribing advice so as not to conflict with accepted dual diagnosis prescribing guidelines. This clinical input would need to be in the form of a qualified psychiatrist.

In July this year a psychiatrist with experience in substance misuse was recruited. In our view this is a crucial addition to the provision. This appointment is a sessional arrangement where each client will receive an assessment, a mid-way review and end of treatment through care recommendations. There is also capacity for urgent clinical response. The appointment allows for greater consistency overall in the application of good practice to clients with a dual diagnosis.

It has been widely recognised that diagnosis of any mental disorder is difficult while the client is misusing substances. There are many anecdotal stories of mis-diagnosis of clients, including periods where the client may have been sectioned, *ie* detained under the Mental Health Act 1983. There are other occasions where a mental illness may have been masked by substance misuse and only come to light in abstinence. Some people may refer to this as self-medication, although the relationship is often more complicated than that.

'It is too easy to use the self-medication argument and miss the underlying complexity,' states Hoyle. There are many working in the substance misuse field that believe the only reason most of their clients do not have a psychiatric diagnosis is because they did not come to the attention of a psychiatrist while they were using. With the medical and specialist input for dual diagnosis at Walsingham House, some of these complex issues can be addressed once a period of abstinence has been achieved.

Abstinence from substance misuse is recommended in order to diagnose a mental disorder, which includes mental illnesses ranging from depression through to psychosis and personality disorders. It is often found that clients are receiving prescribed medication for diagnosed problems during periods of illicit substance misuse. While the medication may have been effective at that time, once abstinence has been achieved a medication review is indicated.

Medication holidays can be a useful way to accurately assess current mental health state once a period of time has elapsed to rule out withdrawal syndromes. For residents at Walsingham House, this would likely be at the half-way point of treatment – usually six weeks. To achieve this, the client would need to be in full agreement that it is in their interest, and psychiatric, specialist and therapeutic opinion is sought to ensure that withdrawal of medication is appropriate. If the holiday is appropriate, either for withdrawal or reduction of psychiatric medication, a crisis plan is devised in advance to rapidly prescribe psychiatric medication if necessary. This approach informs accurate diagnosis of mental health state or rules out possible past mis-diagnosis.

As well as dual diagnosis specific interventions, the generic therapeutic programme at Walsingham House is also shown to be especially effective with dual diagnosed clients. These include counselling, physical exercise, diet, self-support groups, art therapy, family contact and family work, and access to spiritual expression (transpersonal experience). There is also an expectation that the clients attend self-support groups. Self-support is shown in much of the literature to be beneficial for dual diagnosed as well as substance-dependent groups for the continued recovery, self-efficacy and wellbeing of the client.

However, not all clients will feel able to engage in self-support environments following residential care, which highlights a continually challenging area for the treatment of dual diagnosed clients: 'After Walsingham House – where?', is the necessary question.

Integrated pathways for this client group are still developing. 'This may represent an area of long-term service development,' Hoyle points out. 'Enhanced partnerships with housing and mental health support services are essential for positive long term outcomes.'

For further details visit: www.stjamesprioryproject.org.uk. To discuss the dual diagnosis service you can contact Brendan Georgeson, treatment manager on 0117 929 9100 and Cliff Hoyle, dual diagnosis specialist on 07950 747 237.

Notes from the Alliance

Time to join forces for a new public health approach to replace the failed drug strategy, says Daren Garratt.

Everyone who reads DDN has been affected by the current 10-year drug strategy, and will undoubtedly be affected by what replaces it; whether that's as a user or carer who's concerned about quality of treatment, an employee who's concerned about their livelihood and career path, or a tax payer who's concerned about the millions of pounds of public money that has been spent and where/if/how it's made a difference.

And while I think it's fair to say that although there have been undoubted advances in various areas that have improved, and even saved, the lives of many, many users, you'd be hard pushed to find anyone who can mount a credible defence of this strategy's success as a whole; particularly when one considers the considerable amount of money that has been pumped into it.

I am, therefore, honoured to be able tell you about a newly formed, informal coalition of organisations and individuals called the Drugs and Health Alliance 2008 (DHA). This group, spearheaded and chaired by Transform, wants to ensure that any new post-2008 national drug strategy moves away from the restrictive and often counterproductive focus on crime reduction and treatment targets, and embraces a wider public health approach that acknowledges other fundamental factors such as poverty, social exclusion and mental health issues.

But how do we ensure that the same mistakes aren't made again and we establish a more inclusive, mainstreamed, cross-departmental Government approach that begins to address the real issues that underpin the harm experienced by users, their families and our wider communities?

Well, the DHA believe we should seize the current political opportunity to demand democratic input into the policy making process. In plain English, this means let's exercise our right to call for an independent review of the current drug strategy, let's identify the issues that we need to raise for the new strategy and let's get them on the political table.

This is a debate that needs to start now though, because it's not long until 2008 and once that new strategy's upon us there's very little we can do to effectively change it. To this end, the DHA has agreed to write a letter to ministers calling for a transparent, independent review of the current drug strategy, and the opportunity to be involved in a process that shapes future policy decisions.

But we also need to turn the spotlight on this issue and get this debate into the wider public arena. So, if you're concerned about the way things have gone over the last few years, or perhaps more importantly, the way things will probably continue to go over the course of the next strategy, then these are the questions, issues and demands that you should be raising too.

By working together we hope to effectively influence the government's drug agenda and finally achieve the reductions in drug-related harm that we all seek.

So, for more information about the DHA and how you can get involved please contact info@tdpf.org.uk

Daren Garratt is development manager at The Alliance. You can also see him in concert with the Nightingales – visit www.thenightingales.org.uk/gigs.htm for a list of gigs. New album 'Out of True' is released on 2 October...

Love and Baggage

William Pryor takes an unhooked look at how addiction and relationship go together

We may sing endless songs about it, but love is a force we can't explain, even though we know what it is when we experience it. When we don't have it, we tend to be unhappier than when we do have it; we tend to forget we ever knew it. When we're in a state of love, the world is good; it wraps us in confidence and light. When we love, our being has purpose; we know why we're here.

Love is open, tender, giving, generous, peaceful and so many other adjectives. It needs no defending. The Chinese character denoting love is made up of other symbols: one for a heart in the middle, between signs for 'accept' at the top, and 'feel', or 'perceive' at the bottom. Bertrand Russell described love as an absolute value. It cannot be reduced, however hard neurochemists may try.

To be in love with someone is to have a relationship with them. To be in love is to see ourselves in the mirror of the other; to see our baggage in the rosiest tints. But it is also to be ecstatic, which gives the mirror the pink colour. Some of us would like to be in love all the time. We also use the word to pick out those experiences that particularly turn us on, from 'I love Marmite', through 'I love being stoned', to 'I love sex'. Indeed being in love with someone else often leads to an erotic experience we adore.

Neuroscientists don't want to be left out of this discussion. They've found that when people testify to feeling love, there are bucket-loads of testosterone, oestrogen, dopamine, norepinephrine, serotonin, oxytocin, and vasopressin in their brains. To be in love is to be high. To be in love with someone who is in love with you is a double amplification of the most rhapsodic human experience.

Trouble is we get confused about love, so badly do we want it. All those neurochemicals make it hard to distinguish love from lust, need, want, greed and other malfunctions of the self. When I first fixed heroin it was very like falling vein over needle in love. The morphic high apparently freed me from carrying the baggage of my self. I was ecstatically what I wanted to be. I had a new purpose: to continue this love affair. I wanted more. I couldn't stop. All symptoms of addiction.

Mystical love is the true absolute value; it transcends the self and its baggage, it is beyond space, time and the self. It is therefore the opposite of addiction, which, in the end, is an obsessive clinging to an illusion of one's self being in love. At first heroin freed me from my unhappiness, and in that release I could love what I saw of myself in its mirror. But what I saw was an illusion. Our worldly love is a stepped-down form of mystical love, maybe all we can take

'Trouble is we get confused about love, so badly do we want it. All those neuro-chemicals make it hard to distinguish love from lust, need, want, greed and other malfunctions of the self.'

while absorbed in the world. The more it is stepped-down, the more we confuse it with something we can possess, the closer we get to addiction.

The theme of Unhooked Thinking 2007 is Love and Baggage. It's our baggage – our frustrations, depressions, misaligned expectations and neurochemical misappropriations – that turns love to the dust of need. Addiction and mystical love are the two most powerful relationships we can experience, at opposite ends of the continuum of humanity – addiction is a prison, love liberation. At Unhooked Thinking 2007 we'll examine the connections between love, conflict, relationship and family. We'll be talking about how we can unhook our thinking about addiction from the clichés of medicine and criminal justice; we'll be thinking about the role of love in the treatment of addiction; we'll be rummaging in our baggage to see what we can let go.

Unhooked Thinking is on 9-11 May 2007 at Bath Guildhall. Visit www.unhookedthinking.com

'We therefore believe and can demonstrate that we are meeting the needs of all those requiring treatment, whatever stage they are at.'

Outside the zone

I am writing further to Dr Rupert White's letter (*DDN*, 11 September, page 9) in response to an article on zoning within the Tier 3 provider drug treatment, here in Sandwell (*DDN*, 3 July, page 10).

He commented that 'I am surprised that the commissioners and NTA in the Midlands are willing to endorse such a model'. As the commissioner, I can state that the DAAT was involved in developing the zoning system, as were the NTA, staff and service users.

The system has been in operation for three years and we have been very pleased with the results for many reasons, including the fact that staff and service users can clearly see what progress has been made, in respect to treatment.

Dr White was concerned as to what happens to those service users that don't fit his model. In Sandwell we commission nine providers of adult drug treatment services, to ensure that we meet the needs of our service users.

One such provider is Addaction. Addaction work with those who are unable or unwilling to undertake structured drug treatment. This can include motivational work, overcoming barriers *etc*. Everyone who falls out of treatment is referred back to Addaction.

We therefore believe and can demonstrate that we are meeting the needs of all those requiring treatment, whatever stage they are at.

Elaine Woodward, senior commissioning manager, adult drug treatment

Misled on AA

As a member of Alcoholics Anonymous for over 12 years, I was saddened by the misleading statements about AA made by Mary Longley of Broxtowe and Hucknall PCT (*DDN*, 11 September, page 11).

It is not true that a self-assessment of severe dependency is the criterion for admission. In fact, a statement read out at meetings is that the only requirement for membership is a desire to stop drinking. Nobody is forced to do or say anything unless they wish to do so.

It is true that AA does not duplicate the methods used by other organisations. AA has its simple programme, which for over 70 years has helped enormous numbers of people to become sober. It also willingly co-operates with other agencies.

Mary Longley appears to disapprove of AA not accepting any outside finance. This is the case for several good reasons, including standing on our own feet as part of our recovery. When I attend meetings with professionals, the constant theme I hear from them is the threat of having their funding cut, and the impossibility of reaching the targets they are set. By its independence, AA is free of such constraints.

John W, Gloucestershire

Top site

Richard Carus's online resource for recovery mentioned in 'News in brief' (*DDN*, 11 September, page 4) is a wonderful idea and support for all who are at any stage of recovery.

I logged onto the site, registered and also had a chat with Richard, and I believe that with the way things are changing with policy and funding that this site has huge potential to support the country as a whole.

As a new website, this will take time to establish. But there is a quote that 'without change there is no progress, and without progress there is no future'. Whatever support there is for us addicts is wonderful, and this initiative needs support from all areas.

I would like to thank Richard for his initiative, and encourage others to log on.

S. Rendell, Hertfordshire

The website is at www.recoverycafe.co.uk

Comment

Rehabs in crisis

The funding crisis has deepened for residential services, and many more face closure by the end of the year. Swift action from the NTA could save the day, says Brian Arbery.

Previous articles in *DDN*, notably that by Nick Barton (*DDN*, 5 June, page 8) have focused on the problems affecting residential service providers. These problems have now escalated into a major crisis affecting registered residential services, in terms of the number of referrals and consequent admissions. Despite the apparent rise in the pooled treatment budget (itself reduced by around 10 per cent from the original 41 per cent) many providers have experienced an alarming decline in the number of people being referred for residential detox and rehab.

A number of providers (ADAPT, Clouds, Phoenix House, RAPT) with support from others, have taken the matter forward in association with EATA, to the NTA and Department of Health who have agreed to meet them, although this will not take place until mid October.

The fall-off in referrals has been substantial and some units are now down to occupancies below 40 per cent. This is not only crazy at a time when usage is supposed to be increasing, it is unsustainable.

It is believed that the underlying reasons for this situation may stem from a withdrawal of community care funds, theoretically committed by social services departments, which have traditionally been used to fund residential placements. This has been accompanied by a similar cut in PCT allocations. Local DATs, DAATs and partnerships have failed to make up the shortfall by using Pooled Treatment Budget monies, probably because to do so would prevent them meeting their targets in other tiers.

There is a very real prospect that a number of services will cease to exist by the end of the year unless the situation changes. The real loser in this ludicrous state of affairs apart from the potential service user will be the Home Office, who, in one of its guises, will pick up the bill if people are unable to access residential services. It will have a serious negative impact on the drugs/crime agenda and will almost certainly result in more people moving back into drug use and crime, on leaving prison. Given the scientific evidence that confirms the overwhelming evidence on effectiveness of residential interventions, this makes no sense at all.

Bizarrely, while all this is happening, the NTA is seeking bids under an ill thought out programme to provide additional residential places. This has been typified by consultation processes which did not consult providers, 14 day deadlines for submissions of interest (costed), *etc.* Reports suggest that some of the consultations with DATs have been extremely limited, with meetings being poorly attended. Just half a dozen of the London DATs were apparently represented at their regional meeting and it is suggested that in the South West, there is considerable dissatisfaction with the way the consultation process was handled by the NTA, with some DATs not appearing to have responded at all. This issue is also being raised with the NTA.

At this moment in time it is impossible to predict how this situation will develop and whether any way will be found to save some of Britain's most effective treatment services. It is known that the matter is being taken seriously enough by some interested parties – so much so that it was raised in a meeting at 10 Downing Street. What is now needed is action by the NTA to resolve the problem before it is too late.

Brian Arbery is chief executive of ADAPT.

If drug prevention in schools is ineffectual, as the ACMD's new report suggests, what lessons can we learn? Action on Addiction invited experts to give their perspectives at a 'new directions' conference this week. DDN reports.

What's the way forward for drug education?

'Be open to new ways'

'Rhetoric is not good enough. We need evidence on what works, and individual prevention initiatives,' said Professor John Strang, director of the National Addiction Centre.

There's evidence of a flop, he said – 'and that flop is our huge prevention programme throughout the world'. Were there other ways of prevention for young people?, he asked.

Prof Strang suggested that we need to go 'from flop to Fosbury Flop', and summoned the example of Dick Fosbury's inspirational new way of tackling the high jump at the 1968 Olympic Games. His message was that we need to be open to ways of doing things differently.

Drug prevention meant noticing alcohol and tobacco as well as tabloid coverage, he stressed. There were many different ways of looking at prevention, but all depended on understanding the nature of the relationship between drug use and harm. Not all harms could be associated with dependence – drink driving for example.

Clues to consumption levels were found in the price of both licit and illicit drugs: data for tobacco showed an extraordinarily close relationship, and heroin now costs about a third less than it did 25 years ago, he pointed out.

New work was being done on prevention approaches, with harm reduction a guiding principle. Prof Strang underlined the ACMD report's recommendation that any drug prevention initiative should be designed with evaluation in mind.

'Evaluation is essential'

Dr John McLeod of the University of Birmingham examined what we know about substance misuse patterns in young people, and concluded that the UK evidence base is rather scant.

'We need evidence from large longitudinal studies – and studies that measure consequences. Also cross-sectional surveys and snapshots,' he said.

What we do know is that drug use reflects availability, he pointed out, and tends to peak in the mid to late teens. The number of alcohol users are stable, he said, but overall consumption of alcohol is up.

'We're now at a situation where most young people use alcohol, and about a third smoke. Cannabis use has increased substantially,' he added.

Risk factors for drug use were found to be genes, parental drug use and smoking, but it was hard to explain the huge increase in drug use, using these individual factors.

'A lot of use is by young people who are not identified with risk factors – which is why a lot of prevention is not a success,' Dr McLeod explained.

While the health risks of taking drugs or drinking more than 21 units of alcohol a week were becoming well charted, it was not known how to prevent problem drug use effectively. But Dr McLeod said this was no excuse for not rising to the challenge of finding preventions that do more good than harm, and called for evaluated research.

He suggested that a logical direction would be to focus preventative efforts on those experiencing adversity and social disadvantage in early life – a key recommendation of the ACMD report.

'Young people need accurate and credible information'

Dr Laurence Gruer, director of public health science at MHS Health Scotland and a member of the ACMD, gave insight to the report's 'elephantine gestation', involving civil servants representing key government departments.

The result, he believed, gave a fresh look at patterns and trends, including tobacco and alcohol for the first time, as they are 'no less harmful'. The report aimed to recommend practical ways of reducing use, gave evidence of how easy it is to get different drugs, looked at ways of prevention, and weighed up implications of research for policy.

'If we compare ourselves to the rest of Europe, we have some of the highest drug use,' he pointed out. 'We need to look and see if we can learn.'

The ACMD had been particularly concerned about trends on alcohol consumption, particularly among young women, he said. They had looked closely at substance misusers' circumstances and home background, and the effect of substances being cheap and easy to obtain, despite substantial efforts by police. A picture had emerged of Britain as a 'dangerously tempting and inviting environment'.

Looking at evidence of school-based initiatives, many were flawed, said Dr Gruer, with little information on exactly what's done. Most school programmes had great variability and gave a very mixed picture, accompanied by few evaluations of effectiveness.

Dr Gruer highlighted rigorously researched, evidence-based policy as the way forward, underpinned by accurate and credible information for young people on risks of substances. Tough measures on enforcing age limits, raising duties to affect prices, and restricting advertising for legal substances should be complemented by the report's initiatives on targeting vulnerable children, supporting those from disadvantaged backgrounds and recognising the value of good parenting.

Adding alcohol and tobacco to the ACMD's remit had given a more integrated approach to all psychoactive drugs, he added.

'Engage with partners to develop solutions'

Elaine Runswick, director of student support and partnerships at Barnet College in London, gave insight to developing drug intervention programmes in further education.

It was a chance to facilitate social inclusion, particularly among the large proportion of students from disadvantaged areas, she said. The further education sector included more than 250 colleges in England, with over 3m learners annually engaging in a variety of activities, from AS/A levels to employment skills. Many were looking for a second chance at education and skills.

Drug problems don't manifest themselves very easily in the college environment, Ms Runswick explained. Her own college had experienced problems of people coming into the grounds to deal and they had to work with police and security guards. 'It can be a challenge making sure students are safe,' she said.

The college had developed a drug and alcohol prevention policy, and disciplinary procedures for when things went wrong. Every student has a personal tutor who looks after welfare and personal support, and they can have access to counsellors, welfare advice staff, learning mentors, a youth and community team, and staff to guide them on careers and education. In addition they have good partnership working with Connexions and Impact.

A rise in drug usage in a local estate triggered the initiative of an agency coming into college to work with them, said Ms Runswick. They now helped with training, further development of drug and alcohol prevention programmes, and worked directly with young learners.

'We all need to be engaging in developing solutions,' she commented.

'Start by looking at what already works'

Nicola Singleton is principal research officer at the Home Office crime and drugs analysis research programme. She explained that the evidence-based education programme 'Blueprint' is now in its final stages of developing a model of best practice for drugs education.

'We're trying to get people out of silos and focusing on kids' needs across the board,' she said, explaining that the programme had taken on alcohol, tobacco and volatile organic substances as well as illegal drugs.

'Blueprint wasn't trying to reinvent the wheel. It was developed from an evidence base and evaluation was integral to the process,' stressed Ms Singleton.

A starting point had been looking at key features of education programmes that worked. 'We identified features that would meet the needs of schools as effectively as possible,' she said.

Young people's involvement needed to be interactive to give insight to their perceptions. 'Getting kids to evaluate what's going on highlights that there's not as much drug-taking going on as they think,' she revealed.

Fifteen lesson plans were developed with an editor of education material, then piloted with four areas in the East Midlands and North West England over two years. Findings from a four-year evaluation of the pilot will be due late next year.

'Take a multi-pronged approach'

Sara Skodbo, Home Office senior research officer, added that involving parents in Blueprint had been difficult, but had been attempted through homework exercises. Media sessions had been held for local journalists, to encourage a positive local culture around drug education.

Involving the community had entailed engaging schools, retailers, health policies, media, parents, local DATs, and the Parent Trust, among others.

'A multi-pronged approach will maximise outcomes,' she explained.

Findings have already been used in developing key stage 3 resources in schools; the evaluation questions include the basic question to teachers and young people: do you think Blueprint works? **DDN**

How would you move forward? Responses from the panel to audience questions

Dr Laurence Gruer:

'We have identified a massive dilemma: how draconian should you try to be? Do you go as far as preventing drug users from having kids? Do you take kids away? Or do you support families? The latter would be desirable. We're trying to help parents as much as possible.'

'I would put up the price of alcohol. I would make a ban on smoking in public places active in England – it would stop young people from starting to smoke.'

'I would not consider that the benefits of drug testing would outweigh the disadvantages. There are false positives and vast apparatus. If we took it to disadvantaged areas it would be hugely chaotic.'

Professor John Strang:

'There are very simple things we can do; our approach should be to quantify the effects. Science ought to be able to inform our thinking better... it's well worth trivial investments for a large return.'

'I would make good shrewd investment in strategic research. And more investment in causing the change for people who want to get out of the situation they're in. Most change occurs through own self-initiative, not treatment – so we need something that guides that.'

I agree [with the doubts about drug testing]. If you have what seems like a good idea, you need to think it through. You can even buy sachets of clean urine on the net in the US. I want to know how big an impact things have; what I'm not happy about is seeing investment without evidence of impact.

Dr John McLeod:

'We need to clarify pathways. Parents share genes – but this doesn't lend itself to intervention strategy. So it makes sense to focus on disadvantages, not drug use.'

'I would like to see more funding for research and more evaluation of policy – policies directed at redressing disadvantages in young children. I want a war on childhood disadvantage.'

'I've no idea how we make drugs unfashionable. Drug testing is a screening intervention – there's no basis to say it's useful at the moment. I hope it'll be evaluated for harm if it's introduced.'

And a comment from the floor...

'The strength of alcoholic beverages was 2.5 per cent several years ago. It's now difficult to buy less than 4.5 per cent. Binge drinking blames the consumer.'

My son aged 17 has been using cannabis since the age of 15, which has affected his career path. Up to this age he was with a professional football club and was due to sign a contract, which would have taken him to 18, and he would have had the opportunity to develop a career. The effects of cannabis have completely changed his life, as he has become verbally and physically aggressive, which resulted in him being arrested and moved from our home. He lived in a hostel for three months but was evicted due to violence and drug abuse and has returned home. We have little or no support from the YOT team (Social Services) or GP, his behaviour has deteriorated and he rarely leaves the house. The stress this has caused my wife, daughter and myself has affected our whole life. Does anybody have similar experiences or advice so we can take our life and his forward?
Ashley, by email

Change comes from within

Dear Ashley
I know that this may sound a little trite – but he has to want to change. As a young persons drug and alcohol worker for the NHS this is something I often encounter. I do not understand the help available in your area. You say you 'have little or no help from YOT'. Little or none? Your GP should know of local support. The local adult team will have details of young persons services, as will the local DAAT.

However, he has to want it. Are you looking for his support or yours? I am sure he is an intelligent young man, therefore he has made choices in his life. They are to use cannabis, to leave football, to be violent and to be evicted. There are numerous young people I work (and have worked) with that have done some or all of these things, but many who have not.

Drug users vary, but they are all human beings with the same drivers, conscience and needs. Most are not violent, most are not aggressive, most are not thieving from their domestic providers. Many go to school, work or train and use all forms of substances.

For support, you may need to differentiate your family needs from his help needs.

If he is threatening you, report it to police. If he is stealing from you, he needs to understand the consequences of his actions. Many parents put up with behaviour that they would not be allowed to do themselves, but often 'sheltering' them is not the best action. You say he rarely leaves the house, so where does his cannabis come from? His behaviour has deteriorated – why? If he wasn't using drugs, would you kick him out?

I suggest you look for support for yourselves first, as without you, when he is ready to change, you won't be there.

Secondly, if he wants help, then he is ready. It may take weeks, months or years, but it is him at the end of the day. Try those services mentioned, but do not blame yourself – it is a choice of his!
Dave, young persons drug and alcohol worker

Change comes from outside

Dear Ashley
We are two recovered alcoholic/addicts and have our own personal development business in which we work with both parents and children in similar circumstances. Although there is no short cut to these matters, in brief there are two issues here.

How to move your life forward is to start putting in place solid boundaries in every area – emotional, financial, social and personal. When boundaries are in place and adhered to, this will set an example to your son of you taking personal responsibility and accountability for your own part in these circumstances and empowering you to come out of victimhood.

Your son's behaviour will only change when you change, and his life will only move forward when he takes personal responsibility and accountability for his behaviour. We treat the root cause and not the symptom. If you need any further help with this matter please do not hesitate to contact us.
Veronica and Lesley, Ultimate Personal Development, tel 0870 460 8168.

Tread softly

Hi Ashley
It sounds like you're all going through a tough time and you have run out of ideas.

You say that the support services have been of little help, but they can only help someone who will engage with them. Maybe your son is just not ready.

Does your son want the support as much as you do, or is he feeling pressured to change?

It could be your son is very confused and may not even know what kind of support he wants or needs. He may be demotivated, lost, confused, with feelings of hopelessness, anger and perhaps some depression.

Often users feel a lot of guilt for the stress they cause the family, so it will be important to reassure him. Let him know he is loved and cared for, without applying any pressure to change.

If you are able to sit down with him I would ask him some questions about what he really wants and needs, and be prepared to just listen.

Drugs are often symptoms of underlying problems and it could be that you have missed what the real problem is.

Adolescence can be a tough time and maybe your son has used drugs as his way of coping. Exams and the transition from school to work/college can be a testing time for any young man.

I would suggest that you find support for you and other family members and let your son tell you what he wants. If he is unable to decide, or simply doesn't know, I would suggest he sees a qualified counsellor who can help him increase his confidence, feelings of self-worth and motivation, so that he can explore his feelings – especially his anger.

If he feels really listened to and understood, then your son may be able to find his own way through this tough time.

Even if your son won't engage with support services, there is nothing stopping the rest of the family from getting some support. You will have a sense of hopelessness and may feel as though you have failed as a parent and it may be worth talking your feelings through with someone.

A support such as counselling that focuses on your son as a person rather than the drug problem may be of some use to him. Find someone who won't try to stop his drug use but help him to understand it.

You may have to back off and accept that we can't always help – and it may be you who needs some help to accept this.
Mel, drug worker/counsellor, Wolverhampton

Self-medicating?

Dear Ashley
I was sorry to read your letter about the problems you have been experiencing with your son.

There are no easy answers in a situation like this. However, many young people smoke cannabis and their behaviour does not change as dramatically as your son's has. I work with drug users and those suffering from mental health problems. My comments in this letter are not intended to be a diagnosis, but raise issues that you could consider.

There is a lot of research available about possible links between cannabis use and schizophrenia. Some people suggest that those experiencing the onset of schizophrenia may use cannabis to self medicate. Others believe that cannabis use can cause symptoms in those with a predisposition to mental illness.

You do not say how your son's behaviour has recently deteriorated, but you mention that he rarely leaves the house. Symptoms of schizophrenia can be negative or positive. Negative symptoms include a lack of motivation, some self-neglect and isolating from other people.

Many people are frightened at the prospect of mental illness, but with the right help and treatment sufferers can live entirely normal lives in the long term. I would suggest that you go back to your GP and request some further help and assistance.

If things are really bad at home, you could also contact your local community mental health team and ask them to attend at your house and assess your son.
Nikki, Berkshire

Reader's question

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

Email you suggested answers to the editor by Tuesday 3 October for inclusion in the 9 October issue of DDN. New questions are welcome from readers.

Keeping it out of the family

Children of parents with problematic alcohol use receive nowhere near the amount of support they need, which is why Alcohol Concern is stepping in to improve their chances. Parenting policy officer Suzanne Murray explains.

The Alcohol Harm Reduction Strategy for England states that there are up to 1.3 million children affected by parental alcohol problems, but this is probably a conservative estimate. Indeed gaps in the research have resulted in wide ranging estimates of the number of children affected as being between 300,000 and 2.5 million.

It is well documented that problematic alcohol use by a parent can significantly affect the quality of their parenting, and their children can suffer a range of physical, psychological and behavioural problems as a result of living in such an environment.

However parents and children can and do cope when there are alcohol problems in the family. It seems that some children are more resilient and do not develop problems, either when they are young or when they reach adulthood. Professionals should therefore be working with families to build children's resilience.

There are specific protective factors that are realistic and achievable for parents which increase the probability that children will not suffer short or long-term harm from parental problem drinking, and these factors can be developed with the help of informed, supportive and non-judgemental professionals.

With so many children affected by parental alcohol misuse, meeting the needs of these families is a huge challenge to professionals working in children and family services and those in alcohol support services. Unfortunately the level of support available is falling short of these families' needs, leaving many professionals frustrated that they can only provide a minimal service to meet an ever-increasing demand for help and support.

This state of affairs reflects the lack of policy drive and practice guidance for working with children and families affected by alcohol misuse. Although the Every Child Matters agenda is striving to safeguard and promote children's welfare, the specific stressful impact of parents with alcohol problems on family members is often overlooked.

The Hidden Harm agenda primarily tackles parental drug, not alcohol, use. Where it is considered, the alcohol harm reduction strategy for England is individualistic in its focus on the drinker and fails to make any recommendations for action in response to the needs of children and families affected by parental alcohol misuse. Further models of care for alcohol misusers pass only scant reference to the needs of children and families and mention nothing about how integrated care pathways are going to be mapped.

In light of these deficiencies, Alcohol Concern has developed resources and training to support professionals in the health, education and social sectors working with problem drinking parents and their children. These resources highlight that responsibility for supporting families with parental alcohol problems sits within all frameworks, meaning that all agencies have a role to play in identifying, referring and supporting problem drinking parents and their children as early as possible.

A web-based toolkit has been developed for professional groups – teachers, school nurses, practice nurses and general practitioners, health visitors, children and families social workers, and alcohol workers – to help them support the children of problem drinkers. It provides information and guidance to fit with their role and remit in working with children, and explains what they can do to help them be resilient.

The Parenting and Alcohol Project at Alcohol Concern has also designed training and guidance for professionals who are in contact with problem drinking parents, including alcohol specialists and those in the health, education and social sectors. Nearly 500 professionals nationwide were trained earlier this year and initial feedback suggests the training has been successful in achieving its aims. Supporting guidance has been developed on issues such as promoting protective parenting and resilience, child protection, domestic abuse and multi-agency working.

More work is still needed to support these families. There should be a national strategy to tackle alcohol problems in the family, led by a public health minister, and an identified lead at local level for family alcohol misuse issues. Links should be developed between DAATs' action plans, local alcohol strategies and local children's services plans – and all should take account of the needs of children of problem drinkers. This should go hand in hand with more research into the number of children affected and into how further services should be developed.

Alcohol Concern's resources for working with problem drinking parents and their children will soon be available at www.alcoholandfamilies.org.uk and will be launched at their conference on Alcohol and the Family in London on 13 October. Download the booking form at: www.alcoholconcern.org.uk/doc/1110

Methadone: the original research

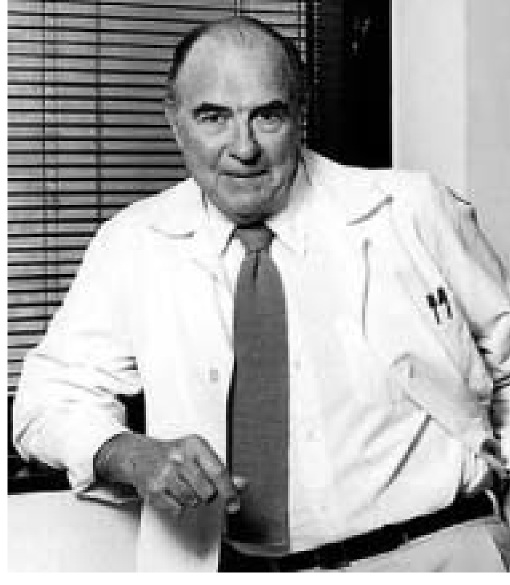
Mike Ashton continues his trawl through the back issues of *Drug and Alcohol Findings* for *DDN*, to remind us of the pioneers of methadone maintenance.

This August the pioneer of methadone maintenance, Dr Vincent Dole, passed away aged 93. Last year was the 40th anniversary of his and Dr Marie Nyswander's (later to become his wife) first research paper on the treatment, a milestone we commemorated in *Drug and Alcohol Findings* by reassessing its significance. From now until the end of October 2006 that assessment is available for free download from *www.drugandalcoholfindings.org.uk*. It argued that their paper was not just a historical milestone but remains of contemporary significance – a reminder of how methadone maintenance was first and arguably should still be done.

The 'maintenance' element was not the innovation; rather it was the technical advance represented by methadone. Maintenance we already had with morphine and similar drugs, but the roller-coaster cycles of these short-acting heroin substitutes meant patients were nearly always feeling the effects of the previous dose or anxiously awaiting the next, dominating their lives and impeding rehabilitation. The 'eureka' moment came when, a year before the first research was published, two of Dr Nyswander's patients were switched to methadone. They were among six admitted to New York's Rockefeller Institute's research ward in the search for a substitute drug which would prevent withdrawal from and craving for heroin and normalise physiological functioning. For convenience and to avoid perpetuating the risks entailed in injection, ideally it would be taken by mouth. Ideally, too, a single dose would hold patients over an entire day and the effects would come on and fade gently, avoiding heroin's multiple daily steep ascents into euphoria and descents into withdrawal.

Dr Nyswander and her colleague Mary Jeanne Kreek had both seen signs that methadone might fit the bill. It could be taken by mouth, prevented withdrawal, had been used for detoxification, and seemed longer lasting and more even-paced than the alternatives.

Early in 1964 it was tried on the first two patients. Their behaviour changed dramatically: 'They got up, got dressed, stopped obsessing about drugs and began going to night school', recalled Dr Nyswander. Still, she remained unconvinced that methadone could counter the temptations on the streets, waiting 'in total terror every night' for her charges to return to the ward. Temptations there had been in the form of people scoring drugs, but rather than join in, the pair 'went and got an ice cream'. The remaining four patients were switched to methadone with similar results. Eventually all six found jobs while maintained on doses ranging from 100 to 180mg a day.



Left: Dr Vincent Dole, pictured in the early 1980s. Above: With Dr Marie Nyswander.

Dr Nyswander's trepidation was typical of her caring and dedicated attitude. While other therapists and clinicians dismissed the addicts' stories as the ramblings of disturbed minds, she insisted that much could be learned by carefully listening and encouraged the rest of her team do the same.

By May of the following year, Dole's team had documented methadone's impact on the 22 patients who featured in the first research paper, establishing that for most it was indeed the substitute they had been looking for – a once-a-day oral drug which kept craving and withdrawals at bay and which (in high enough doses) neutralised normal doses of heroin, enabling patients to get on with their lives. In Britain and the USA, the mass expansion of methadone maintenance which followed the early research departed from the Rockefeller prototype, abandoning elements which British services are now being encouraged to revive. Professor Dole's team individualised dosing, titrating the amount they prescribed to eliminate each patient's need to supplement methadone with heroin and to render the patient's usual heroin dose ineffective. At around 80-120mg a day, their dose levels were way above those which became typical and which in Britain are now seen as having been sub-optimal.

The Rockefeller approach was also avowedly maintenance, analogous to long-term corrective (not curative) treatments for the metabolic diseases such as diabetes in which Professor Dole specialised. But the British clinics often emphasised eventual reduction and withdrawal, though often over an indeterminate time scale, a fudge which experts now want to see clarified.

Finally, the emphasis 40 years ago on intensive support and most of all on reintegration into work and education has been rediscovered by England's National Treatment Agency and is being emphasised in Scotland – with one important difference: Professor Dole's team saw their reintegrated patients as continuing on methadone, while in Britain today reintegration is seen as a way of ending treatment without unduly risking relapse.

Though it dates back 40 years, in these respects the Rockefeller prototype comes closer than many of today's programmes to what is now aspired to as good practice. Almost certainly this partly accounts for its startling success, but there may also have been other reasons not so readily replicated – not least dedicated, caring and well-trained staff such as Drs Dole and Nyswander.

Mike Ashton is editor of Drug and Alcohol Findings; email him at da.findings@blueyonder.co.uk
For the full article referred to in this extract and more free content visit www.drugandalcoholfindings.org.uk

The disease model of addiction

In the next Background Briefings, Professor David Clark looks at theories of addiction, beginning with the disease model. This model is central to the philosophy of Alcoholics Anonymous (AA) and the 12-step Minnesota Model.

In future Briefings, I will look at treatment of substance use problems and addiction. However, before doing this, I thought it best to look at some of the main theories of addiction, and some of the factors that are thought to contribute to addictive behaviour. This will help us to understand better the rationale behind certain therapeutic interventions.

Readers who are particularly interested in theories of addiction must read the excellent new book by Robert West, in which he assesses a large number of previous theories and then develops a new theory of addiction that brings together diverse elements from current models.

The disease model of alcoholism and drug addiction assumes that they are chronic, progressive illnesses (or diseases), similar to other chronic diseases such as Type 2 diabetes and cardiovascular disease. Addiction is considered to fit the definition of a medical ailment, involving an abnormality of structure in, or function of, the brain that results in behavioural impairment.

At the heart of this model or theory is that addiction is characterised by a person's inability to reliably control his use of alcohol or drugs, and an uncontrollable craving or compulsion to drink alcohol or take drugs.

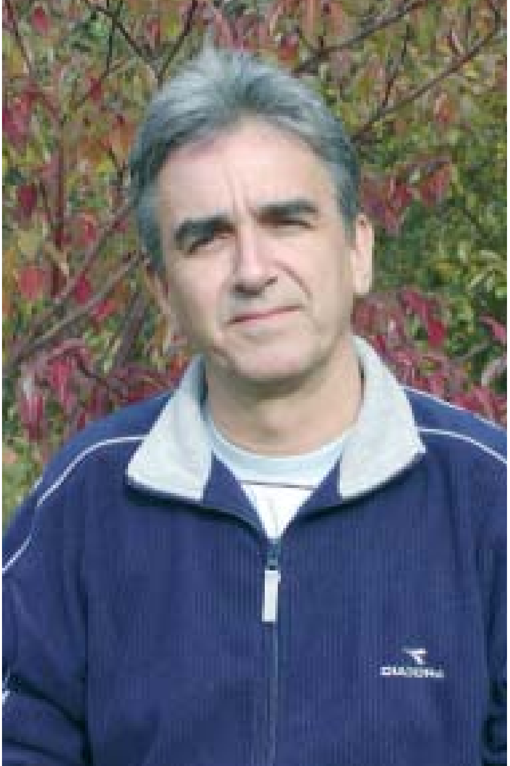
The loss of control can be manifested during either a short or long time span. A person may begin what they believe will be a short drinking session, but after one or two drinks find it impossible to stop drinking. Over a longer time period, they may make the decision to definitely stop drinking, but after an interim period (maybe days) resume drinking.

Craving was defined by Jellinek, a key player in the development of the disease model, as an 'urgent and overpowering desire'. It can be viewed as a feeling that compels the person to do whatever it takes to obtain the object of the addiction, even when there are potential harmful consequences.

The disease model of alcoholism and addiction is central to the philosophy of Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and the 12-step Minnesota Model.

This approach assumes that the impaired control and craving are irreversible. There is no cure for alcoholism and drug addiction; they can only be arrested. The alcoholic or addict must maintain a total and lifelong abstinence from all mind-altering drugs, except nicotine and caffeine.

In addition to their physical effects, alcoholism and addiction are considered to impact on the cognitive, emotional, social and spiritual functioning of those affected. Like other diseases, there is a natural progression, so there continues to be a deterioration in overall functioning until a 'bottoming out', unless a person enters treatment or receives the right sort of support (*eg* AA/NA).



'At the heart of this model or theory is that addiction is characterised by a person's inability to reliably control his use of alcohol or drugs, and an uncontrollable craving or compulsion to drink alcohol or take drugs.'

The AA view is that alcoholism and addiction are also characterised by 'denial', or resistance to accept the essence of addiction – the failure of one's own willpower and the loss of one's own self control.

The 12 steps of AA/NA and the Minnesota model are a suggested pathway for ongoing recovery. The essence of this recovery pathway is a changed lifestyle (habits and attitudes) and a gradual spiritual renewal. The person must accept that his own willpower is insufficient to conquer addiction – he must receive the help of others who have been there – and must avoid taking that first drink.

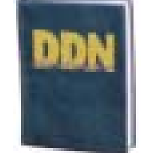
Some people find the concept of alcoholism or addiction as a disease helpful for understanding their condition and the path to recovery they can take.

They find consolation in the fact that they have a condition that can be understood in terms of the same model as diabetes or heart disease. They can feel less guilty about their condition, and they can join a programme that offers a clear personal goal (abstinence), a pathway for ongoing recovery (the 12 steps), and a life-time of support (via AA).

There is much (often heated) debate about the disease model and the implications that it has for therapeutic interventions. In brief, it is argued that there is no single constellation of alcohol related problems that could be described as alcoholism (there are a range of problems), there is no evidence that addiction and its core elements are irreversible, and progression of the problem is not inevitable.

Opponents of the model also point out that the disease model can lead to people avoiding self-responsibility, believing that the disease must be attended to by experts, rather than the changes come from within (albeit with help from others). Opponents also point out that being labelled as an alcoholic or addict for a lifetime, and spending a lot of time with other alcoholics and addicts, does not help the person attain a fully balanced lifestyle and re-integration back into society.

What is apparent, is that some people can be helped by this theory and the AA approach, while others will not find it suitable.



Recommended reading:

Robert West (2006) Theory of Addiction. Blackwell Publishing (available at discounted rate from the DDN bookshop at www.drinkanddrugs.net).

Nick Heather and Ian Robertson (2001) Problem Drinking. Oxford Medical Publications.

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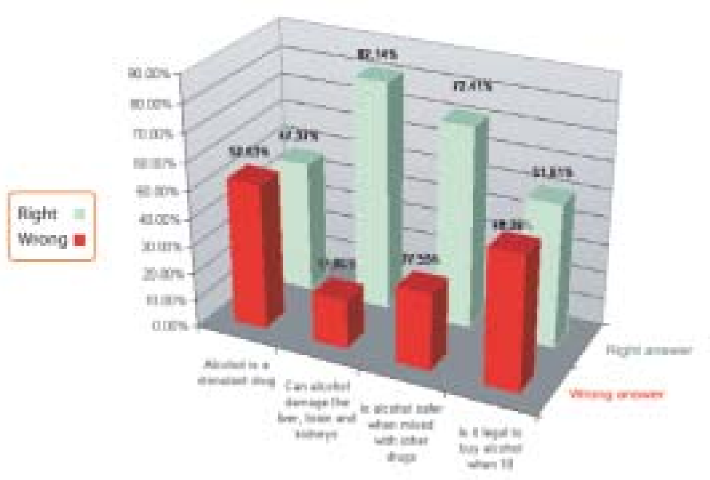

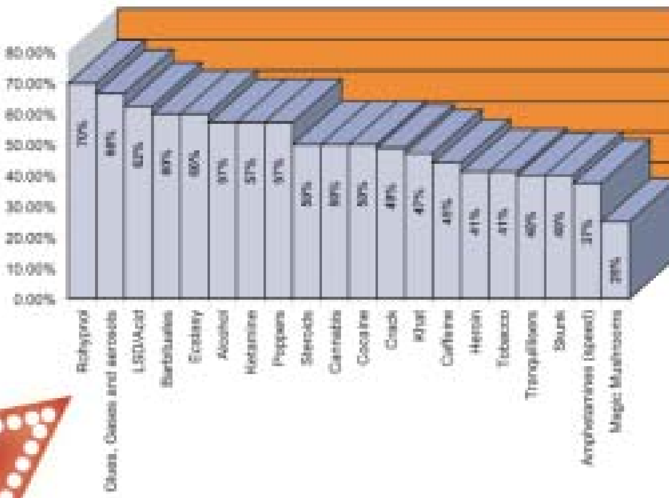

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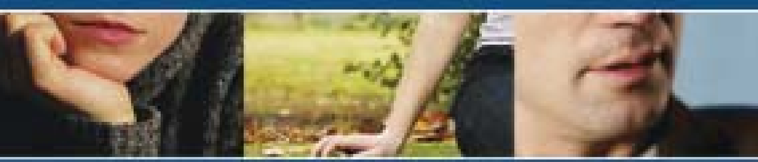

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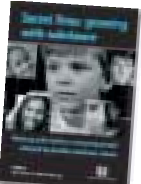

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If you feel you are that special person and would like to find out more please contact: Jenni Stephens, Head of Specialist Children's Services on (01905) 681525 or Phil Deakin, Co-ordinator, Worcestershire Substance Misuse Action Team on (01905) 766009.

For an information pack please see www.worcestershirehealth.nhs.uk or telephone (01905) 681633 (24 hour recruitment line) or e-mail jobs@worcs-ssa.nhs.uk quoting the reference number 569/5248.

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For an informal discussion please contact Drugaid Chair.

Drugaid: 029 2088 1000.
Closing date for applications: 12 noon, 6 October 2006.
Interviews: w/c 16 October 2006.

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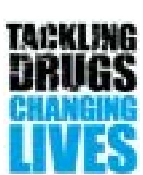

Sheffield Drug and Alcohol Action Team (DAAT) is seeking expressions of interest for the provision of a consultancy for a period of six months to work on development of a citywide Alcohol Strategy for Sheffield.

A significant amount of work has already been done and a draft strategy has been produced. The consultant would be required to carry out a series of consultations with stakeholders, and use the findings to form the basis of a strategy that will that will provide an effective, comprehensive lead on reducing alcohol-related harm in Sheffield. The consultant will set up a system for monitoring and evaluating the Strategy.

Sheffield DAAT plans to award the contract in November 2006. Expressions of interest should be sent, *no later than 9 October 2006*, to:
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Please contact: Helen Bold, Contracts Team Leader, Procurement and Commissioning, Buckinghamshire County Council, County Hall, Aylesbury, Bucks, HP20 1YG or email: hbold@buckscc.gov.uk

The closing date for the receipt of tenders is: 12 noon on Monday, 13th November 2006.

Enquiries about the service should be addressed to: James Sainsbury, Bucks DAAT Joint Commissioning Manager Tel: 01296 382780 or email: jsainsbury@buckscc.gov.uk

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Tel: 01491 643255. Fax: 01491 643114. E-mail: lauren.hodge@hmps.gsi.gov.uk

Closing date for receipt of completed applications is 19th October 2006

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- Consultation with partners at both strategic and operational levels.
- Compliance with models of good practice in crack treatment and interventions both locally and nationally.

Proposals will only be accepted from interested parties with substance misuse or related research experience.

For further information please contact business manager for substance misuse Trevor Givans on 020 7716 7182 or email trevor.givans@lambethpct.nhs.uk
Lambeth PCT, 1 Lower Marsh, Waterloo, London, SE1 7NT

Proposals should be submitted to Lambeth PCT no later 5.00pm, 4th October 2006

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