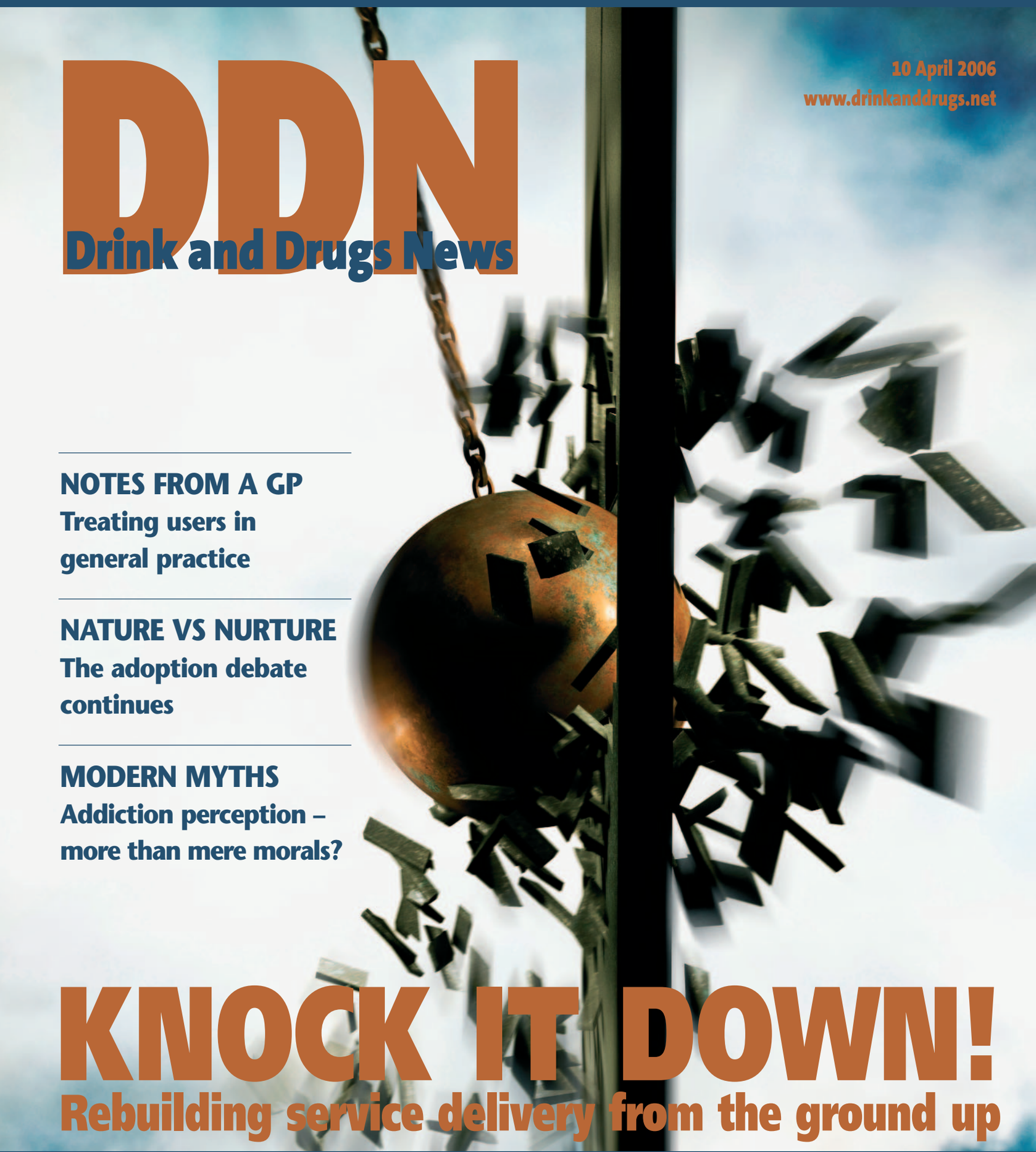
From FDAP in association with WIRED

DDN
Drink and Drugs News

10 April 2006
www.drinkanddrugs.net



NOTES FROM A GP
Treating users in general practice

NATURE VS NURTURE
The adoption debate continues

MODERN MYTHS
Addiction perception – more than mere morals?

KNOCK IT DOWN!
Rebuilding service delivery from the ground up

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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

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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
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Substance Misuse Management in General Practice

Drink and Drugs News

10 April 2006

Editor's letter

Breaking the cycle of substance misuse and crime keeps coming up – and always the talk is of how to provide meaningful support to help people engage properly with the community.

While building recognition for the vital role of family support, Adfam's conference in Birmingham gave a reminder of the reality for many: a quarter of people lose their homes when they go into prison, and many young people lose their school place when they are taken into custody.

Yet we talk about people feeling displaced and not being able to get a foothold with housing, education and social care services. The 'Drugs and Alcohol Today' conference last week also debated basic and neglected needs – against a background of target-proving and the worry of diminishing resources. Are we scratching around the same problems – and is there a case for revolutionising the way substance misuse services are run, as Peter Mason and Richard Gutch suggest (cover story, page 6)? Surely the idea of opening the market to all types of provider could stir a culture of innovation. Are we afraid of change? Of course money is always tight, but the article suggests ways of getting beyond being 'strapped for cash' and into planning for the future with long-term optimism.

Our letter pages are full again this week, and we're glad of the chance to print your opinions. Keep them coming – your views are vital if we are to keep a rounded perspective on such sensitive issues.

Against a backdrop of the latest DIP measures going live at the end of March, including testing on arrest, it's interesting to step back to the late nineteenth century with William Pryor on page 12. With opium on sale at the corner shop and Queen Victoria reaching for the hashish, it's fascinating to reflect on how times have changed.

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In this issue

DDN launches new on-screen format and bookshop

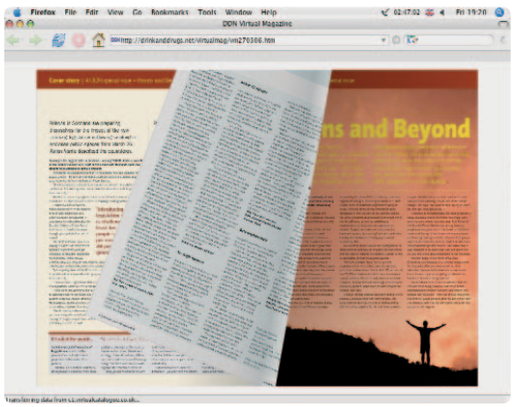
Drink and Drugs News is now available as a 'virtual magazine', as well as a printed version, and is viewable on our website, www.drinkanddrugs.net.

This exciting new format allows you to 'flick through' the pages of *DDN* on the screen, replicating the feel of reading a printed copy. Faster than downloading a PDF, the magazine lets you zoom in by clicking on the pages and allows you to jump straight to specific articles.

The new format will be a bonus for our advertisers as it enables us to widen our circulation even further and increase the readership of *DDN*, both in the UK and overseas. Each advert can also be hyperlinked direct to the advertiser's website. Please take a look and let us know what you think.

The *DDN* bookshop is also now fully operational. We have partnered with Eclector to create an online bookshop stocking a vast range of titles relating to substance misuse at discounted rates. Visit *http://drinkanddrugs.net/drinkanddrugsnews.html* and click the bookshop link to enter, and you can search around 200 titles all priced at least 15 per cent below the standard retail cost. Through the *DDN* shop you can also enter the main Eclector site and browse 420,000 titles on all kinds of subjects.

By buying any book through the site you will not just be making a saving, you will also be helping to fund the free circulation of *DDN*.



http://drinkanddrugs.net/drinkanddrugsnews.html

Adfam conference: Partners in prevention

Family support to reduce offending

With a 'huge programme of reform' underway, the role of the family is clear in reducing offending, Helen Edwards, chief executive of the National Offender Management Service (NOMS) told Adfam's 'Partners in Prevention' conference in Birmingham.

'If we were once unsure about family support, we're not any longer,' said Ms Edwards. The role of voluntary and community organisations was also recognised, being 'more in touch with special interests and needs' and having first hand knowledge through user involvement.

'They challenge the system,' said Ms Edwards. 'We need to make sure we have a framework that enables this.'

While targets were 'being met, or almost being met', there was much to be done. Since coming into post four years ago, Ms Edwards had seen the enormous pressure on estates from overcrowding and a prison population at an all time high. Community sentencing was still not seen by the public as a real option, she said, so was not yet being used properly.

Questions that had to be tackled, included 'are we locking up the right people? Why so many women, people with mental health problems, young people and foreign nationals?', she said.

Once imprisoned, were we doing enough to ensure interventions would make a difference, to make sure people didn't return: 'It's really hard when they come out,' Ms Edwards said. 'People don't understand how hard it is to come off and stay off drugs.'

Introduction of offender management was at the heart of the new system and was 'about making sure one person is at the centre of treatment'.

Aftercare was vital, with a good range of interventions to stop people from heading back into the system. With one in four prisoners who had stable accommodation losing it when they began their sentence, it was vital to provide prisons with stronger links with local communities.

NOMS was determined to shake the system by introducing commissioning, in response to 'a challenge so big that ministers want to do things differently', said Ms Edwards. Commissioning would change the focus of services, onto what the offender needed.

The next two years of rolling out a commissioning model would introduce an element of challenge. 'It means we can be quite demanding on what we want,' she said. 'Good performers have nothing to fear.'

Prison not the answer for vulnerable people

Prison is not the way to deal with vulnerable people in the community, said John Boyington, director of prison health and offender management partnerships at NOMS.

People in the offender system were 'on the wrong side of social inequalities', he said. Primary care was a critical gateway to the system, and after 50 years of the NHS, health services for people in prisons were being made an NHS responsibility. From 1 April primary care trusts would take on the role – which would be 'just the start of the process', according to Mr Boyington.

The new health white paper (published in January) was about giving people more choice and listening to what people said they needed, he said. Strategy for prisons tied into this, working towards 'proper, effective, meaningful partnerships' and moving away from institutional care, towards community care.

Drug treatment in prison was improving, and there was a better response for people with alcohol problems, said Mr Boyington. 'But we need to improve offender access to health and social care services.'

There was a tendency to pigeonhole families, which Adfam's new *Partners in Reduction* toolkit would help to address. People needed rights and responsibilities and continuity in life – and 'more than just a roof over their head', he said.

Young people need a different approach

Prison also doesn't work for the majority of young people, according to Mary Wyman, head of service development at the Youth Justice Board.

'There are a lot in custody at the moment that would be dealt with better in the community,' she said. Most were 14 or over, but with a reading age of seven, and half had been in care. There was very high substance misuse – mostly cannabis and alcohol, rather than class A drugs. Some were found to have suffered violence or sexual abuse at home.

The Youth Justice Board had just published a resettlement strategy with the aim of engaging with them in custody.

'Young people in trouble are entitled to the same services as other young people – somewhere safe to live, an education. We try to improve access to these essential services,' said Ms Wyman.

Accommodation caused most problems. 'There is nowhere for them to go,' she said. 'Everyone thinks they should live at home, but it's not always suitable.' Their problems could be compounded, as they were likely to lose their place at school when they went into custody.

There was no quick fix. 'We've got to hold onto these kids when they're released', she said. Focusing on the family and making sure they were ready for the young person's release was an essential part of this.

The Resettlement and Aftercare Programme (RAP) was a brave approach and 'one step away from the usual criminal justice' as it was voluntary instead of statutory – an innovative experiment to see if young people would attend if they didn't have to.

'It's an opportunity for young people to have autonomy,' said Ms Wyman. 'Some thought the Youth Justice Board had lost the plot doing it, but it seems to work.'

Pavilion conference: Drugs and Alcohol Today

A panel debate at the Drugs and Alcohol Today conference in London last week, invited speakers and audience to consider the drug strategy of the last ten years – and what the next ten years will bring.

Primary strategy: harm reduction

'Our main strategy has been to reduce harm – and this has been grounded in public service agreements,' said Vic Hogg, head of the Drug Strategy Directorate.

The focus had been on the 'most dangerous drugs, heroin and cocaine', but the harm index – 'a system that brings together all harms drugs cause to society into a basket and values them' – had shown that harms had fallen by 24 per cent since 2002.

With treatment figures up and waiting times down, Mr Hogg said that the Drug Intervention Programme had been the flagship of the drug strategy in recent years.

The future would focus on 'continually adding to the suite of interventions' that included testing on arrest and sending those who tested positive into treatment. 'All evidence shows that acquisitive crime has come down by 19 per cent since DIP started in 2003,' he said.

Building on this progress meant better partnership working at local, regional and local level, he said, replicating best practice across the country.

'No doubt we're making progress. It will energise communities to know this,' he said.

Treatment had been about the numbers game, he acknowledged. 'But what we need to do now is make sure they're retained, and that there's a proper exit strategy for them.'

With the ten-year strategy due to end in 2008, Mr Hogg offered consultation on the future: 'Should we simply build and tweak – or should we go for radical change?', he asked delegates and the panel. 'Should we mainstream strategy and funding? Should we go for more regional local targets?'

Danger in 'rush to barricades'

'Credit has to be given where it's due – and progress has been made,' Lord Victor Adebowale, chief executive of Turning Point, acknowledged. But he had seen danger points in the drug strategy – 'a kind of panic, a rush to the barricades, a *Daily Mail* version of substance misuse treatment'.

HIV infections and dual diagnosis were among problems that continued to grow 'because the emphasis on crime reduction creates an imbalance,' he said.

'We must get harm reduction right. It's an issue for funding and commissioning,' he said.

Lord Adebowale emphasised it was high time we took alcohol seriously in this country. 'Substance misuse strategy must include alcohol,' he said. 'Until we do there is a massive imbalance. We've got to get this sorted.'

With over a million children of alcohol misusing parents, we could not ignore that we're 'sitting on a demographic timebomb', he told delegates.

Treatment doubles but more action is necessary

'With 250 per cent investment in drug treatment, our over-arching target for doubling treatment has been met,' said Paul Hayes, chief executive of the NTA.

'But would an area of health care that's met its target be a top priority for you? If you were Secretary of State, would you see it as sacrosanct?' he asked.

'My job is to see what's left to be done,' said Mr Hayes. The lack of attention to dual diagnosis was 'worrying', and we must make sure money available to fund anti-crime resources went towards funding the totality of needs.

While listing the NTA's successes in getting more people into treatment, including in prisons, Mr Hayes could not be as reassuring on resources for the future:

'In the real world it would be unrealistic to expect treatment to remain unscathed by the funding crisis in the NHS,' he said.

No silver bullets

If we don't get the funding, can we meet the demands of DIP and the wraparound approach of aftercare?, responded Martin Barnes, chief executive of Drugscope. 'If anyone cares about the drug strategy, we must lobby.'

Acknowledging there was 'no silver bullet', Mr Barnes said we needed to look more at prevention. 'There's a vicious cycle of problems feeding on each other, tied in with social exclusion,' he said.

Mr Barnes said that effective treatment meant 'anything that makes your life better', and emphasised the importance of education – a point that was echoed by others on the panel.

Alcohol services a 'poor relation'

Srabani Sen, chief executive of Alcohol Concern, began by saying she felt like the 'poor relation' in representing alcohol in a field dominated by funding for drugs – but support from delegates and the panel confirmed that her calls for realistic levels of funding were in high demand.

'I continue to be baffled at the lack of priority politically on alcohol,' she said. 'We have no money, mechanism or drivers for alcohol strategy.'

Existing data was alarming: 17 out of 18 people who required alcohol treatment did not get it – this became much worse in certain regions. If you lived in the North East, where 101 out of 102 didn't get it, 'you might as well give up,' said Ms Sen.

'We still haven't got Models of Care for alcohol, and still no screening and intervention programmes,' she said.

Last year's document [Alcohol Needs Assessment Research Project] presented a direction of travel, but there was no commitment to local targets and no sanctions for non delivery.

'If we had a fraction of drug funding we'd be delighted,' she added.

This report incorporates panelists' responses to questions from the audience.

Media Watch

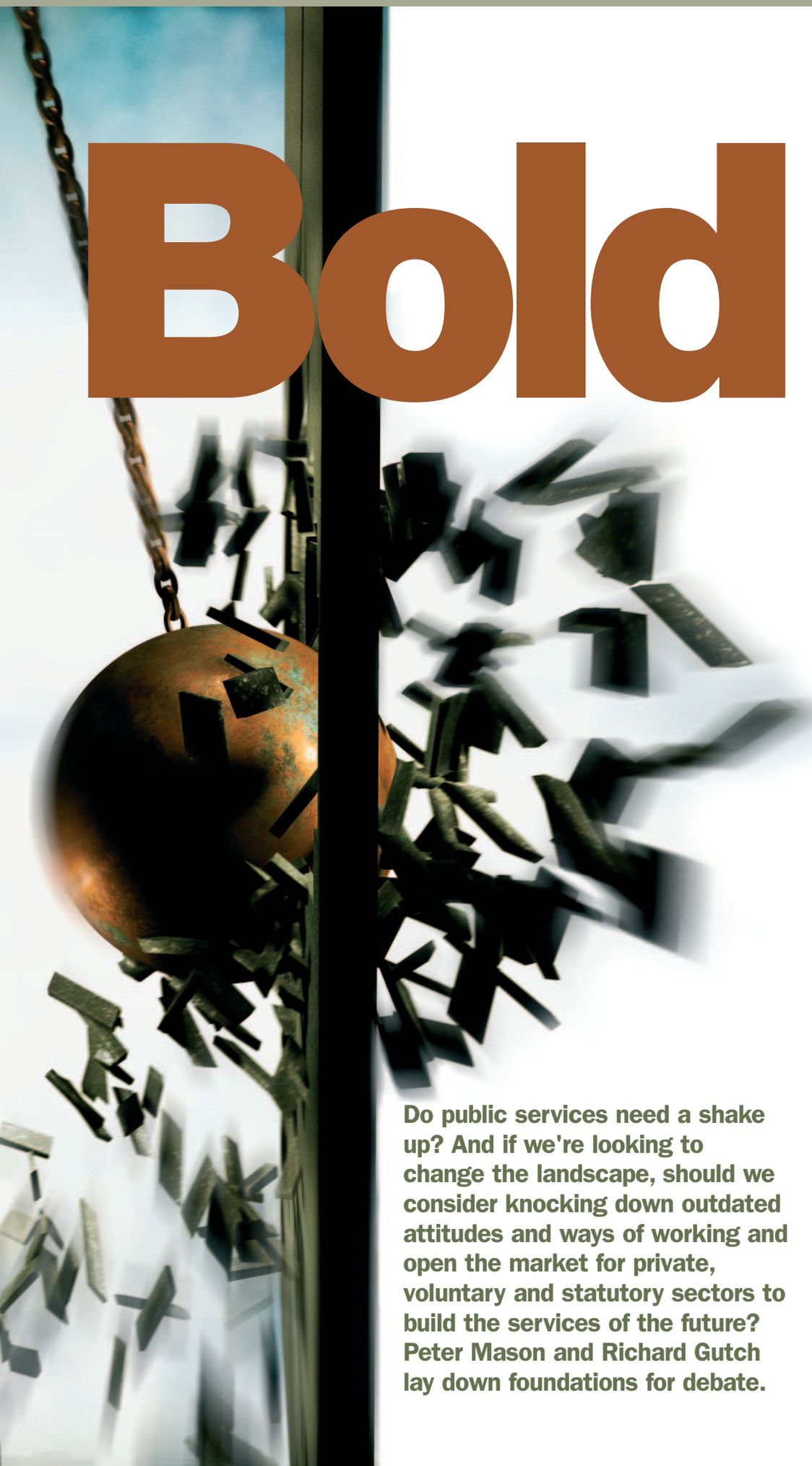
Nottingham is following in Manchester's footsteps with the introduction of the 'Best Bar None' scheme aimed at promoting responsible drinking in the City centre. Pubs and clubs are to be assessed with the highest scoring to be named 'Best Pub' in September. Nottingham City Council, seeing the success in Manchester, hopes the proposal will create a safer social environment and encourage an increase in visitors to the City.
Nottingham Evening Post, 29 March

England could be returning to the gin crisis and widespread alcoholism of 18th Century Britain. This was the view of Professor Ian Gilmore at the annual conference of the British Society of Gastroenterology. Professor Gilmore told the conference that the sale of alcohol 'next to bread and milk' in supermarkets posed serious health risks and also urged the government to take seriously the problem of inaccessible people, like those drinking excessively at home.
Manchester Evening News, 22 March

Police now have the power to arrest drinkers displaying anti-social behaviour in Tunbridge Wells due to a new ban on alcohol in public places. Linda Mortley, community development manager at Tunbridge Wells Borough Council, identified a key difference between 'people having a friendly gathering and a group... who are just drinking and causing disorder' and believes the new measure will increase public safety and reduce the number of people who feel intimidated by anti-social drinkers.
BBC website, 7 April

Since the fall of the Taliban regime in Afghanistan, the production and exportation of opium has become the main source of income for the country. Drug experts in Britain are concerned that this could mean a huge rise in the availability of cheap heroin on our streets. Not only will this mean that dealers have access to a larger supply of heroin, but the class A drug is also likely to be significantly purer than many users are accustomed to, posing a serious risk of inadvertent overdose.
The Independent, 6 April

Coventry's school children were asked to take part in an in-depth survey into drinking, crime and drugs. The survey, compiled by 'Communities That Care', identified 'risk factors' that would influence a child to drink or take drugs. Among the results were findings that 3 per cent of the city's 11 to 16-year-olds had tried Crack Cocaine with 11 per cent of all pupils admitting to carrying a weapon. The shocking results have given Coventry, specifically its schools, significant pause for thought.
Coventry Evening Telegraph, 6 April



Bold new order

We could be on the brink of revolutionising the way substance misuse services are run – but only if we have the courage to embrace change and the imagination to do things differently, argues Peter Mason

Do public services need a shake up? And if we're looking to change the landscape, should we consider knocking down outdated attitudes and ways of working and open the market for private, voluntary and statutory sectors to build the services of the future? Peter Mason and Richard Gutch lay down foundations for debate.

Changing a landscape starts by levelling the ground and then building to a new design. Currently the potential to create a new landscape in the way that drug, alcohol and criminal justice services are delivered is huge. We could be just on the brink of a major refit of the sector. But if it goes ahead, will the end result be better services for clients?

The first question to ask is ' is reform needed?' – and if the answer is 'yes', what will the new design then look like? Key elements are the mix of sectors providing primary, secondary and rehabilitation services and the types of organisations that emerge to exploit the freedoms coming to prominence in the health and social care market. It is easy to forget that most GPs and pharmacists working in primary care and in the high street are simply private businesses under contract to the NHS. With substance misuse services already used to operating in a mixed market economy that involves NHS trusts, voluntary and private sector providers, the next step for them could be to set themselves up as independent social enterprises.

The focus is now on 'contestability' – in other words, the opening up of the market for public services to enable a change in the mix of private, voluntary and statutory owned services, aiming to develop choice, customer focus and new innovative ways of working.

There are several drivers for this change. Monopolies have existed in many areas of addiction services, in both those provided by NHS and by large voluntary sector suppliers. Some have been woefully inadequate and have proved difficult to change. Specialist medical prescribing services have previously been relatively protected but are now under threat from organisations that can ensure clinical governance and new ways of working.

There are often problems in the interface between drugs and crime, with healthcare providers reluctant to work with criminal justice populations. This has forced commissioners to develop separate service streams.

PCT commissioners, who are now responsible for the healthcare needs of offenders and prisoners, can see that health, drugs and crime services need to be delivered in different ways to ensure equivalence and economies of scale, especially as workforce issues remain difficult with the shortage of key workers, consultant psychiatrists in addictions and clinical staff.

There is a need to introduce new ideas and innovation into drug and alcohol services. Too often, this is hampered by the sheer scale of the NHS, vested interests and professional jealousies. Positive change is often achieved more quickly in the voluntary sector rather than in the statutory services, because providers have the power to make fast decisions, implement change and trial different ways of working.

There is huge potential to mainstream drug and alcohol services into health and social care through the new contracting mechanisms that have opened up in primary care to alternative providers of medical services (APMS). But to fit into the new landscape, a level playing field is crucial.

Commissioners need to regard voluntary sector players as equal partners, working alongside statutory and private ones. They will be required to pay them on the basis of full cost recovery and give them legitimate places at the table to tender for all service modalities. Commissioners might themselves need to be regulated by a compact commissioner to ensure that this happens and that there is no discrimination.

Private providers will also be better placed to become integrated into service markets. In sectors such as residential and primary care, international groups like UnitedHealth are already looking at how substance misuse services will feature in the contracts they are now winning.

The really big changes will come when the new Mental Health Foundation Trusts decide if addiction services will be part of their core business or instead be set up as separate business entities. This separation would allow commissioners and providers to test the best arrangements for the provision of drug and alcohol services.

The recent increase in the number of public sector-led social enterprises that have broken away from Trusts to form employee-owned, not-for-profit companies to deliver primary and community healthcare are interesting models. Many drug and alcohol providers will be tempted to follow suit.

Commissioners and providers alike will need to consider their options on the new models in detail and also worry about legal, commercial and financial issues. Voluntary and community sector services will require improved public sector share and strengthening of their asset base as they take on new functions.

The Third Sector Commissioning Task Force will shortly make recommendations that aim to improve the position of the voluntary and community sector. Social enterprise support units are starting to spring up to support NHS staff and at the Centre for Public Innovation, we are also noticing an increase in requests for ideas and assistance to support the new breed of social enterprises.

With Mental Health Trusts now in Foundation Trust development mode, they too must consider the best role for their addiction services. User involvement has greater potential in organisations that are constitutionally created to involve their membership and include the capacity to employ the people they serve.

Primary care developments will accelerate with new contracting models and new providers will start to deliver primary healthcare in inner city areas where provision is currently poor. This will ensure drug and alcohol services will be a major part of the contracts.

Clearly most of this is about change management – which in itself brings particular difficulties. I believe that if we approach the way we create this new landscape with boldness and with a focus on improving outcomes and experience for service users, it will be well worth it.

Peter Mason is chief executive of the Centre for Public Innovation.

With the right financial backing voluntary and community organisations are well placed to offer excellent services to tackle alcohol and drug misuse. Futurebuilders England, a £125 million government-backed investment fund, is financing the expansion of voluntary organisations so they can meet the challenge of service delivery. Chief executive Richard Gutch explains.

The voluntary sector has a respected tradition of helping people with drug and alcohol addiction. Many of the leading providers of substance misuse services began as local charities that have now taken on a large slice of public sector provision. Voluntary agencies were often founded by inspired individuals who were personally driven to tackle the harm caused by alcohol and drugs that they had witnessed – either on the street or in their own families. This resulted in an exceptional level of understanding and commitment to service users' needs and a deservedly high reputation for the quality of their work.

The added value that voluntary organisations bring to services has been backed up by research. Futurebuilders commissioned a survey into public sector agencies (such as local councils and primary care trusts) that have contracts with voluntary and community organisations (VCOs). It showed that there were some special qualities that VCOs brought that were highly prized. These included links with the community, specialist services that target people often missed by statutory services, greater flexibility, a can-do attitude and strong management and leadership.

The government has stated that it wants to increase VCO involvement in the delivery of a range of services, including substance misuse services. Futurebuilders is helping that to happen by offering organisations a mixture of grants and loans so they can expand their services. This puts them in a stronger position to do business with public sector commissioners and to bid for contracts.

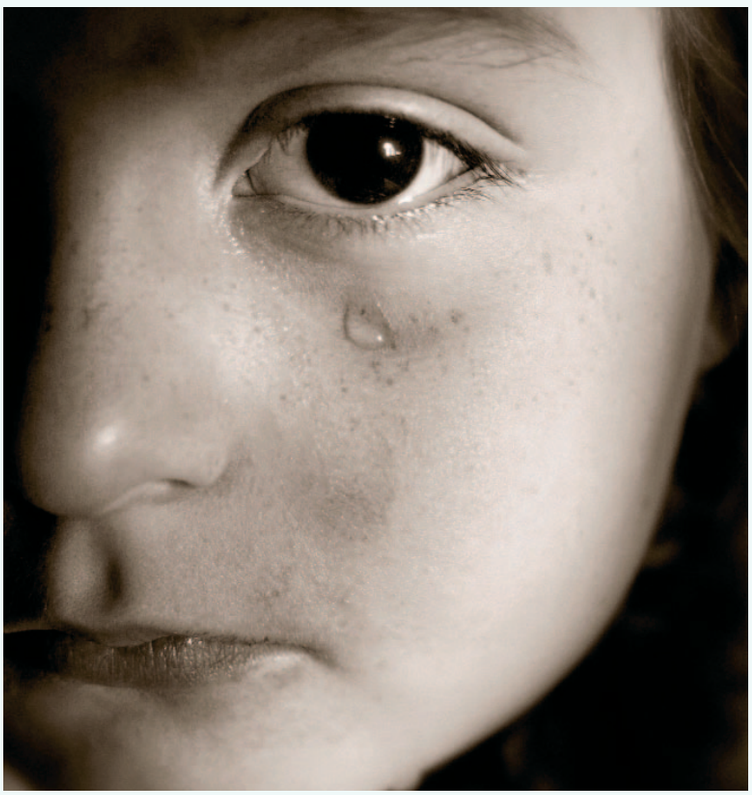
A prime example is Broadreach House in Plymouth, a charity with over 20 years' experience of supporting people with alcohol and drug dependency. Broadreach needed premises to house their aftercare service, as the rented building they were in was too small for the expanding number of people referred to them. It would have taken years of conventional fundraising to pay for the new premises they needed. Meanwhile many people needing help would be unable to get the support they need – making relapse all the more likely.

Broadreach had no guaranteed income, so mainstream banks couldn't help. Looking for a solution they applied to Futurebuilders. After a thorough application process that involved accounts and business plans being scrutinised, Broadreach was approved for an investment of £600,000. The bulk of this is a 20-year loan of £550,000 to buy a building, with a 5 per cent interest rate and a repayment holiday for the first year. The package also included a £50,000 grant – to refurbish the former furniture factory into a tailor-made centre for training and group work. Futurebuilders also provided a £10,000 grant for staff training, to update skills in line with the move.

Broadreach is able to pay back the loan through its contracts with social service and health departments, and drug and alcohol action teams. It gets a fee from the council for every client they work with. This arrangement benefits all parties. Substance misuse teams can refer clients to a service developed through years of experience and commitment. Broadreach can provide aftercare in premises that are funded sustainably through payments they get from programmes delivered. Service users get support and training in premises that they have helped to design themselves. True to the spirit of the voluntary sector, many service users who have got their lives back together return to Broadreach as volunteers or staff to support others in danger of relapse.

One of the hardest challenges facing voluntary organisations working in this sector, is getting contracts. VCOs are still often overlooked as serious players by local authorities when issuing contracts. There is sometimes a perception that VCOs may not be up to delivering services consistently, to the required scale. And many VCOs that make it as far as negotiations, find that councils see them as a cheap option and don't see why the fee should fully cover costs.

To learn more about Futurebuilders and the investments they offer see: www.futurebuilders-england.org.uk or phone the enquiries line on 0191 261 5200.



'It is comforting to think of the drug dependent parent making progress – whether through methadone or some other treatment, and achieving the claimed stability that can enable them to live full lives and be good parents. But not all drug dependent parents are in treatment or want treatment. What do we do to help their children? What do we do when the treatments are not enabling addicts to be effective parents? Do we turn away and say we have nothing else to offer...?'

Children come first

The responses to my article 'Enough is Enough' (*DDN*, 13 March, page 10) show how far the drugs field has still to travel before it takes to heart the dictum from the Children Acts that the 'wellbeing of the child is paramount'.

Drs Ford, Ford-Young and Willott may feel that much can be gained by effective treatment for drug users. I don't doubt that for a moment; however one wonders how much of their time, and that of their clinical colleagues, is spent visiting or seeing the children of addict parents? Do they see these children on a regular basis – as regularly as their addict patients? Do they know what these children are experiencing on a daily basis or do they focus, first and foremost, on the adult drug user?

It is comforting to think of the drug dependent parent making progress – whether through methadone or some other treatment, and achieving the claimed stability that can enable them to live full lives and be good parents.

But not all drug dependent parents are in treatment or want treatment. What do we do to help their children? What do we do when the treatments are not enabling addicts to be effective parents? Do we turn away and say we have nothing else to offer, or do we consider the case for adoption and fostering?

Those who responded to my piece don't want to use the adoption or fostering words, even when the children are experiencing long-term harm. They are looking on the bright side of life, but unfortunately that is not where many of these children are living. We can say in all of this that we need to engage more with parents. Actually what we need to be doing is engaging more with the children.

To assert that dependent drug use is incompatible with effective parenting may offend the politically correct. However, in the Hidden Harm report of 77,928 drug-using parents, 54 per cent had their children living elsewhere – often with other family members. In the Drug Outcome Research in Scotland study, while 57 per cent of male drug users interviewed were parents, only 16 per cent were living with their dependent children. These statistics are not about poverty or the individual failing of the drug using parents, they are about the destructive impact of dependent drug use on families and the sooner we recognise that, the better both for the parents and their children.

Professor Neil McKeganey, Centre for Drug Misuse Research, University of Glasgow

No easy answers

My response to Professor Neil McKeganey's article 'Enough is enough: when addiction must mean adoption' (*DDN*, 13 March, page 10) is that it is not that simple.

What if the primary care giver is no longer chaotically abusing drugs? Child neglect is inevitable if the primary care giver is still dependent on drugs, as her parenting capacity will be severely impaired. Also, the possible causes of drug use need to be explored both in the past as well as the present.

Major considerations in assessing risk to the child of a drug addict:

- That there is a supportive adult monitoring his progress and who is not an abuser of drugs and alcohol.
- That there is a stable environment for the child to be brought up in.
- Whether there is a positive social network, such as Narcotics Anonymous which the primary care giver has engaged with in making a transition from the mesh of the drug culture into a non-drug culture support network.
- The motivational state of the substance misusing primary care giver. If the primary care giver appears highly motivated to make a lasting change away from drug misuse, this is a good base to work from, especially if they are willing to accept help and to be subject to monitoring.

The primary care giver should be given another opportunity to access and benefit from joined-up help. Drug treatment, including rehabilitation, should be provided, either as a day programme or in a residential setting and be accompanied by frequent and random urine testing at least once weekly.

The primary care giver should attend Narcotics Anonymous or any other self-help group. There should be regular, at least quarterly, child protection reviews on a multi-agency basis. The primary care giver and the child should be formally registered with a general practice and have a named GP responsible for their general medical care, so that the child can have regular health checks.

General advice on parenting should be included in the primary care giver's support package. He/she probably grew up with predominantly poor role models in their formative years, and little in the way of support networks. Should a further pregnancy occur, this should be confirmed early and the patient referred to the statutory child protection, antenatal and specialist drug services.

In the event of a relapse, there should be a low threshold for referral of the primary care giver for urgent clinical review, and the findings disclosed to the relevant statutory child protection agency for consideration of the impact on parenting capacity and the risk of harm to the child.

The reality is that relapse is always possible and the primary care giver may go back to illicit drug use. Relapse does not automatically mean failure. It may provide an

opportunity to re-learn relapse prevention techniques of avoidance, control and escape from relapse cue/trigger situations. Should the primary care giver relapse into chaotic drug use, evidenced by positive samples, there should follow a rapid, evidence-based decision-making because, considering the very young age of some children, their welfare can be seriously compromised within a short space of time. The agencies and the courts need to work closely in this respect. In my experience, provided with the evidence, the courts have always been quick to grant emergency protection or care orders.

There are not many choices between a rock and a hard place. Addiction is either chaotic or stable, or in recovery or stages in between, and adoption is an alternative to fostering with various degrees of parental contact, depending on parental progress. It is not simply a choice between addiction and adoption – and I pray it never gets to that stage.

Dr Francis Labinjo, locum consultant psychiatrist in substance misuse, West Kent NHS and Social Care Trust

References:
Drug Misusing parents: Key points for health professionals J Keen and LH Alison Arch.Dis.Child; 85: 296-299 (2001).
Hidden Harm: needs of children of problem drug users. The report of an Inquiry by the Advisory Council on the Misuse of Drugs (2003).

CARAT over-assessment

I have watched the emergence of CARATS with interest over the past six years and applaud the aims of counselling assessment, referral advice and throughcare. However my experience indicated that there is an over abundance of assessment (which is target driven) and referral onto other agencies. The CAT (counselling advice and throughcare) has literally escaped from the bag.

As a counsellor and therapist, I am working in prisons with talented CARAT staff who have been undermined by the ever-increasing burden of the KPT (Key Performance Target). 'Get that DIR/CSMA/and care plan down' at all costs. What can you place in a care plan? The waiting lists for courses are immense. There is a shortage of counsellors – the prison health services are over burdened.

Individually tailored courses, programs and initiatives have been dropped for alleged accredited courses. PASRO has replaced prison rehabs, with the exception of RAPt.

The prison population is increasing. The client group is becoming more diverse and demanding, mental health problems are the norm and are evident at each induction group.

CARAT tries to address the needs but I fear that all that is achieved is temporary first aid. Partnership, education, training, support, resettlement and harm minimisation as discussed at the 'Prisons and Beyond' conference (*DDN*, 27 March) are the things we need to provide, but these aims are being forsaken to get the boxes ticked and meet the KPTs. I haven't even mentioned the issues of alcohol and PPOP (Persistent Prolific Offender Programme), funding for rehab *etc*.

I choose to work in prison because I believe in rehabilitation rather than containment. I was branded a Care Bear (in Brian Arbery's words), but in time, prison staff recognised the relevance and improvements that I, and many others like me, were making with the prisoners. However I fear that the addict's progress is being sacrificed for the need of the auditable target. The loser is the client – and of course, society – unless real resources are put into CARAT services.

Alan Rushmore,
HMP Wayland, Norfolk

12-step works

Although your correspondent (Name and address withheld, *DDN*, 27 March, page 8) is clearly not impressed by the track record of 12-step treatment approaches, the published literature shows that these do work.

Hazelden's success in 1998 (in terms of abstinence at one year) was documented at 53 per cent and if anything, is now better still. In medical terms, this is a highly effective intervention. There are numerous studies supporting 12-step treatment and fellowships. Although our anonymous contributor worries about coercion, there are alternatives to choose from, although the efficacy of some of the treatments on offer is less well documented. Let's not knock a treatment approach that has helped so many people into recovery.

Dr David McCartney, medical officer, Castle Craig Hospital, Scotland

Reference: Stinchfield R, and Owen P, Hazelden's model of treatment and its outcome. Addictive Behaviors; 23(5):669-683 (1998).

Ignorance is no excuse

The letter by the person who is 'appalled' to read Peter O'Loughlin's article on RAPt's Island Day Programme (*DDN*, 27 February, page 10) has appalled me, especially as it seems clear that 'name and address withheld' does not seem to have any idea at all what the RAPt Programme is all about. The comments near the end of the letter, that 'RAPt is a rather worrying step towards US-style religious-coercion-as-drug-treatment' is the most ridiculous statement I have ever heard, and obviously said in total ignorance of the RAPt Programme, or, if the person is familiar with the RAPt Programme, a quite deluded perception.

The RAPt Programme is very similar to all other 12-step treatment programmes, based on the fellowship tradition started by Alcoholics Anonymous. Those who engage with the programme recognise that they suffer from a life-threatening disorder, usually so acute that they have come face to face with death, reached out beyond themselves, and come to believe in a 'higher power' after the miracle of recovery has spontaneously arisen in them. I have never met a person yet, who has had this experience through the RAPt Programme or any other 12-step Programme – and I work on a daily basis in a 12-step treatment centre – who thought is was a 'religious-coercion-as-drug-treatment' experience!

What the person who wrote this letter has missed out, is that there are many people living in freedom from recidivism linked to criminally-involved drug addiction (that had blighted their lives through a pattern of continually returning to prison for one sentence after another, driven by their addiction), who are now free from that pattern and living fulfilling lives, reconciled with their families, able to pursue happiness. Many of these former prisoners, male and female, would never have got into recovery at all had treatment not been available for them in a prison environment. The founders of RAPt knew there were people in prison who could not access treatment because they were serving prison sentences and would remain in that pattern of continually returning unless something could be done while they were in prison.

Great effort of a thankless and selfless sort, over a long time, with many rejections and much resistance from 'dinosaur' prison service personnel, was made to get the RAPt programme going. For those who were privileged to be beneficiary to this selfless effort by people who were not selfishly motivated, but keen to help the helpless, there was no evidence at all of 'coercion' or 'religion.'

What was evident, was huge sacrifice and hard work, both by the prisoners on the programme, who had to run the gauntlet of ridicule from their fellow prisoners who did not want to change and were jealous, and by the RAPt staff, who had to endure the scepticism and behind-the-scenes sabotage from the old-school screws who did not want the prisoners to get recovery, because it might prove them wrong in their blanket assumption that all prisoners were beyond reform. RAPt proved them wrong!

I don't know where the person who wrote that letter is coming from! Who do they think they are? Where do they get the right to criticise, in such a ridiculous manner, a programme that insists on the individual doing the work themselves, and goes into the prisons and helps those who nobody else wants to help?

If anything is true about the Island Day Programme, it is that a small group of dedicated individuals have got together, with the backing of their management, and gone into a deprived area, chronically afflicted by substance abuse, and set up a programme that works (evidence-based through Project MATCH), that gives freedom of choice to the individual, and backs those who choose to do something about their addiction by making them aware of a tried and tested means of accessing abstinence-based recovery. What is 'religious-coercive' about that?

I wonder if the person who wrote the letter is not jealous of people trying to access abstinence-based recovery. There seems to be a hint of this in the text of the letter.

John Graham, RAPt graduate and counsellor/addiction therapist, St Anne's on Sea, Lancashire

Please don't let me be misunderstood

I thank Mike Trace of RAPt for his detailed response (*DDN*, 27 March, page 8) to my letter in the previous issue.

It was not my intention to turn the excellent work being carried out by RAPt into an argument against what is referred to as 'harm minimisation'; I was merely expressing my personal beliefs, and if my letter conveyed otherwise, I apologise.

Compelling reasons for Twelve Step Facilitation (TSF) is the research that has been published by numerous authorities over many years, including the American Society of Addiction Medicine, Research Society on Alcoholism, and National Development and Research Institutes (see references). These independent studies conclude that not only does TSF minimise harm by focusing on recovery, but those who enter into such programmes after detox or rehab, remain alcohol and drug free for much longer periods than those who choose (or are not encouraged) to do so.

In direct contrast I have yet to hear of any medical or scientific evidence that TSF has adverse influences on recovery. However we cannot overlook the fact that many of those who misuse alcohol or other drugs either have, or develop, other mental, behavioural, and/or emotional disorders that need to be addressed if lasting recovery is to be sustained.

I am in wholehearted agreement with Mike Trace, that no single intervention has all the answers to the problems of drug misuse. In fact a further reason for my enthusiasm of TSF is the elegant way in which the 12 steps of recovery, together with other models of therapy, and no less than ten cognitive and behaviour activities, designed to assist progressive change, fits into the various stages of Prochaska and DiClemente's 'Cycle of Change'. This transtheoretical model, which has withstood considerable critical examination, caters for every stage that users may be in, including those who are 'not ready', a phrase I consider to be entirely judgmental, and counterproductive.

I can accept that there are those who are unwilling to let go of their habit. I also recognise that there are many who believe that they would not be able to function without their drug(s) of choice. There are also many who find the idea of relinquishing alcohol and drug use absolutely terrifying. It does not necessarily follow that they are 'not ready', it means that they are either 'unwilling,' (pre-contemplation) lack faith in their own ability and resources, (contemplation) or are simply too fearful. I would not condemn any of them as 'not ready'.

However, I am unable to accept that tacit permission, resulting in subliminal encouragement to continue using their drug(s) of choice, is worthy as being described as 'harm minimisation'. The continuing use of addictive and psychoactive drugs continues to harm the user. The hypothesis that dependent users can 'learn' to control, or cut down their usage, contradicts medical and scientific evidence. Further evidence of the futility of this hypothesis is all too apparent in the extremely high rate of those on Drug Treatment Orders, who continue to re-offend.

There have been a number of reports indicating that the majority of those who have become dependent wish to be drug free. Surely our function is to work with where those users are, to seek ways in which they might become willing to relinquish their habit, to introduce them to environments where they can encounter others who felt the despair that they may be experiencing, but have managed to free themselves. In short, to engage with them, rather than seeking to persuade, or coerce them into engaging with us. That we might fail more often than we succeed is a distinct possibility; we would at least have the consolation that we have not contributed to their problem by implying, or conceding, that they should continue using until they 'are ready'. I consider that to be tantamount to telling them they are not and never will be ready, thereby re-enforcing their sense of hopelessness.

It never ceases to amaze me that those who preach the gospel of 'harm minimisation' for dependent users either ignore or fail to accept that addiction is permanent; that it is either passive or active. Perhaps the most obvious example is smoking, no one talks about cutting down on smoking, it is always abstinence. Claiming that users, dependent or otherwise, can learn to use highly addictive, mentally and physically and spiritually damaging drugs safely, is about as responsible as saying that people can be taught to smoke safely.

Peter O'Loughlin,
The Eden Lodge Practice

References: 1, Medscape Psychiatry & Mental Health: 9 (1), (2005); 2, Research Society on Alcoholism: Published by Lipincott Williams & Wilkins (2005); 3, Laudet. A.B. Morgen. K. William. L. White. M.A. Alcoholism Treatment Quarterly, 26.12, (Spring 2006).

'I have watched with increasing dismay and anger as journals, agencies and organisations in this field use the slang of addiction to adorn and describe the services they provide. The publications department of the National Treatment Agency has become HIT. DDN is in association with WIRED, and the one that pushed me over the edge in January's issue of DDN was the training advertisement asking 'did I need a fix'. Please!

Escaping dependence, not treatment

In the NTA's Business Plan for 2005-06 (I haven't seen the one for 2006-07 yet) there is a paragraph that begins: 'Access to detoxification and residential rehabilitation will become one of the most important routes *out of treatment*.' (My italics).

This wording creates a false impression of the role of these two interventions, while implying that only substitute prescribing amounts to treatment. Detoxification and residential rehabilitation are not routes out of treatment; they are treatment routes *out of dependence*.

Nick Barton,
chief executive, Clouds

Sensationalism does us no favours

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The publications department of the National Treatment Agency has become HIT. DDN is in association with WIRED, and the one that pushed me over the edge in January's issue of DDN was the training advertisement asking 'did I need a fix'. Please!

There are too many more examples to mention. Quite often the headlines and sub headings in these journals contain puns and allusions around drug use that would put the tabloids to shame.

This practice is often in tandem with graphic and often garish illustrations or photographs of drugs or of people taking drugs. I was a drug user for many years and I am no prude but I find these images and texts vulgar and offensive. They certainly do nothing to enhance the perception of drug services in the wider community.

Is it an attempt to ingratiate themselves with the client group or a pathetic attempt to appear hip? It fails miserably on both counts if it is. As a user I remember encountering this sort of nonsense. It alienated and embarrassed me. It was like your dad trying to dance or your teacher trying to appear knowledgeable about music. In a word, dreadful.

If we were primarily dealing with eating disorders would it be OK to call our professional journals 'PIE' or 'BINGE' and illustrate them with pictures of people gorging themselves or vomiting? Of course it would not. It would be deemed denigrating and insulting. How this approach would transfer to sexual addiction I dread to think. How then, is it OK to treat the subject of drug addiction as some sort of trendy joke or material for an eye catching front cover?

My suspicion is, that for all our talk of unconditional positive regard, there is a perception still of drug users as second-class citizens.

As an addict in recovery, I find this approach patronising and deeply offensive. As a member of this profession, I find it deeply embarrassing.

Phil Owen, by email

Comment

'Had a time limit been imposed, I would have failed.'

Anna Millington, mother of an 11-year-old, ex-class A drug user, and now active user representative, trainer and consultant, explains how support helped her turn around her life.

Any parent will tell you they love their child – drug users are no different. Loving your child is not the same as taking responsibility and parenting to societal norms. But then the idyllic picture of parenting Professor Neil McKeganey presents (*DDN*, 13 March, page 10) is not something many parents have the ability to achieve without intense help – and of course, time.

We spend less time with our children, we are unable to control outside influences, we often make mistakes and we often get things wrong. However, as a drug using parent, we are supposed to be able to tackle a chronic relapsing condition, disassociate ourselves from the lifestyle and people we know, come to terms with why we may have used drugs in the first place to enable us to remain drug free long term, learn to parent effectively and change the often ingrained ways of thinking – all within a specified time limit and under intense scrutiny!

Let's keep this in perspective. Mckeganey offers no new profound insights; this is the same utilitarian rhetoric that has been circulating within the social services and drug treatment agencies for a long time: that drug using parents should be able to find a way to combat their addictions, within an agreed time scale, without appropriate support in most cases (due to lack of funding) – or lose their child.

The assumption Mckeganey and others make is that the child would not be exposed to some of the same situations and risks, regardless of the parental drug use. He portrays this idyllic image of parenting and safety, and unfortunately for many children this is not the case. They are often exposed to criminality and limited life options from a young age, different sub cultural behaviours and norms. We must not collude with this idea that if we took away the drug use, the child's life would always be dramatically different.

Who would choose a drug user as a parent? Most of the children of drug users, I would guess. Ultimately, children wish to be with their parent, regardless of what they may be doing in their life. Being a drug user is representative of where you are, what you are doing, not 'who' you are, or all you will be. The child sees past this most of all.

Being a parent can often be an added incentive to successful treatment – but usually this occurs when emotional blackmail, like the sort touted by Mckeganey is not used, and the guilt and discrimination heaped upon parents who use drugs is lightened. The issues are engaged positively, instead of punitively. I see evidence of this continually in the North West, Kirklees, Southampton, and elsewhere. They offer a supportive, proactive hand of friendship, disregarding the old reactive, punitive stances. They also get results.

Loving one's child and having an issue with substances are not joined; they are entirely separate entities. You can love your child, be a parent, and still make irresponsible choices.

There is no doubt that children can suffer from parental drug use, and that there are issues that need to be addressed. However, highlighting some worse case scenarios does not make the situation presented the norm. Looking at the reality of the reactive stance to remove the child often reveals no real positive outcome for the child.

There is some delusion still about the UK 'care' system. Most professionals can attest that the care system seems to throw out many young people who have low self esteem, low aspirations, have been exposed to sexuality at a young age, drug use and criminality – the exact personality that often becomes embroiled in problematic using.

Mckeganey would have us buy into the notion that there are masses of people out there willing to adopt these children. The sad reality, as any adoption or related agency will reveal, is that placing a child over the age of two for adoption is not an easy process. There is not an endless stream of loving caring families wishing to take on an older child (with issues).

The majority will travel from insecure foster home to insecure foster home. Often the child is exposed to the very same activities and systems that they may have been removed because of. He makes the assumption that our care system actually fosters a caring, responsible, safe environment for children, disregarding the clear evidence base that it is not.

Growing up amid serious drug use is not something that most parents in deprived areas can minimise. Drugs being bought and sold, and the associated criminality, are all part and parcel of many schools and housing estates up and down Britain.

Mckeganey also paints a picture of exemplary social services interventions that are offered. However as the social services often vocalise, many areas are overworked, under funded and under staffed. In-depth counselling and intensive supervision are not services that are easily available in the main.

Parents who use drugs will often do for their child what they are unable to do for themselves. We must make sure that we allow them the opportunity to be able to make these progressive and life changing advances, without the pressure of time limits and emotional blackmail.

I did not suddenly 'become' a parent who loved my child when stopping drugs; I have always loved my child dearly. I have at times in the past been irresponsible, not made correct choices, and put my needs before that of my child's – but then I see this behaviour replicated by many parents in other forms.

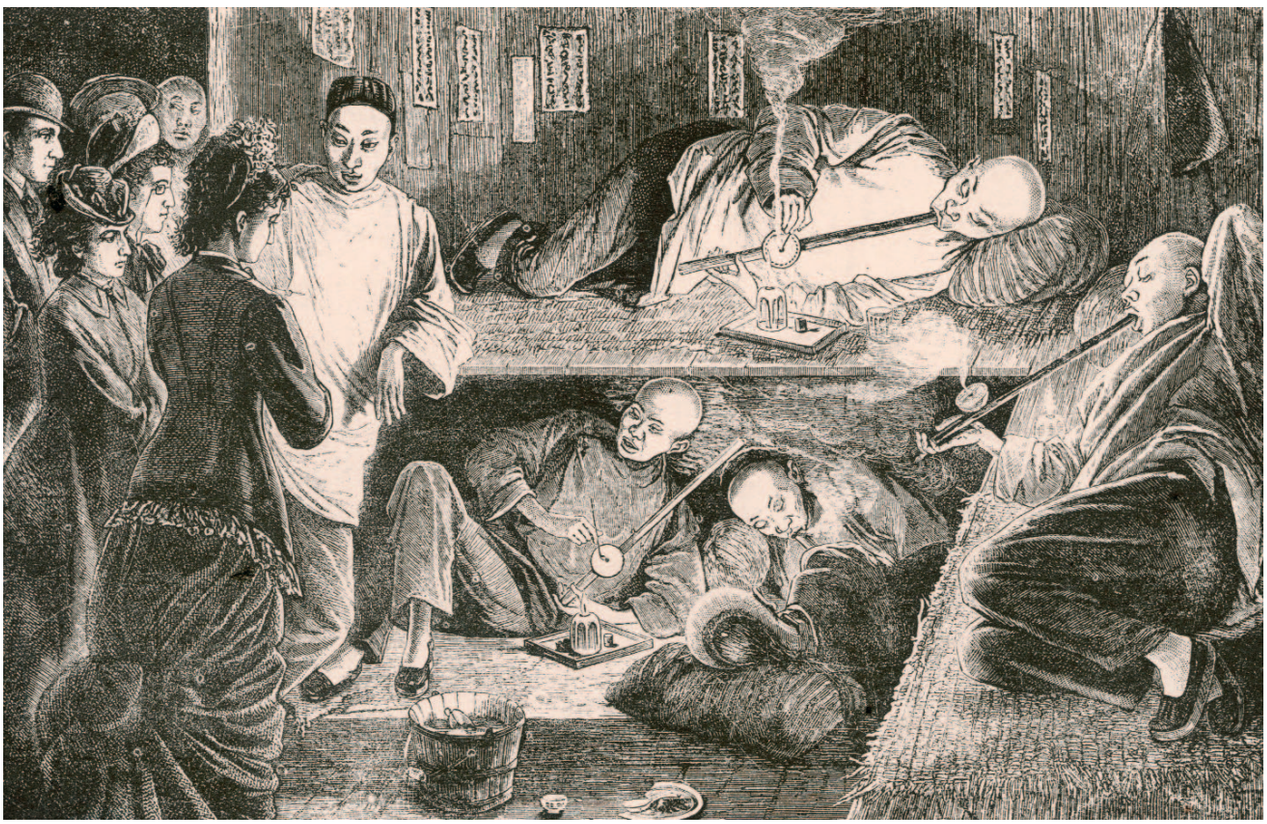
My journey took five years – no doubt far too long for the likes of Mckeganey. I am sure, had a time limit been imposed, I would have failed. Yet today I am the proud parent of a much-loved, secure, happy and articulate bright 11-year-old. Yes, she has suffered from my behaviours – but she suffered from being exposed to them in the area she was born into. Could someone else have offered her a more stable environment? No doubt at one point they could have, but let us not allow ourselves to believe that she would have been 'loved' more – that she would have been cherished and adored, wanted and needed more, a picture Mckeganey presents.

Wanting to change, and having the abilities, support systems and social tools to do so, are completely different things. Let us ensure that every opportunity and option is delivered to try and keep the family structure together, before we abandon the child to a fate that will in all probability be negative and life lasting, and condemn the parent to a lifetime of guilt and self-punishments for failing to be able to help their child. Let us toss out of the window this assumption of hedonistic choices and pleasures being placed above loving one's child, and understand and accept the reality that many problematic users are medicating and stemming pain, not seeking pleasure.

I do agree that children cannot wait indefinitely. But until we can all be assured and convinced that these children, if removed, will definitely be 'better off', let us concentrate our efforts on keeping the family together, working with them as a unit, and addressing proactively the issues, with a view to a positive outlook for all. Let us not allow ourselves to collude with the 'Mary Poppins' notion that being placed in the 'care' system automatically equates to that child then being loved, nurtured, focused upon and empowered.

Articles like this merely rubber stamp the fear that many parents have about accessing services – parents who wish to come for help, yet are trapped by the risk that doing so may cause the removal of their child. Let us accept that in reality, those who inflict great abuse upon their children are not in the main parents who use drugs. More often than not, parents remain out of treatment until they are problematically and chaotically using, because of these very stances – and so is it any wonder the fear of accessing treatment becomes a self-fulfilling prophecy?

Addiction:



Dr John Stith Pemberton, a medical herbalist, died in Atlanta, Georgia in 1888, aged 56, from what would later have been called morphine addiction. He was beginning to make money with his Pemberton's French Wine Coca, which he copied from Vin Mariani, a blend of Bordeaux and coca. The latter's Corsican inventor, Angelo Mariani, made great use of celebrity testimonials to advertise his product, citing Thomas Edison, Émile Zola, Queen Victoria and no fewer than three Popes.

Dr Pemberton's rip-off was marketed to middle-class intellectuals in an Atlanta traumatised by being on the losing side of the civil war. In an interview with the Atlanta Journal, Pemberton claimed the drink would benefit 'scientists, scholars, poets, divines, lawyers, physicians, and others devoted to extreme mental exertion'. Among the many conditions he suggested it would help was, ironically, the very condition that would soon kill him, morphine dependency.

Addiction is a construct of modernity, one that knows no boundaries of class, circumstance or intellect, a mythic construct that seems to explain what is nigh on inexplicable, our strange response to the pain of being human. Not that people weren't doing addict-like things before the industrial revolution, they just didn't get into such a moral song and dance about it.

Some statistics. Two million people are now locked up in the world's jails on drugs offences. About 50 per cent of all prison populations are heroin and cocaine users. In the UK at least £2 billion worth of goods are stolen annually to buy illegal drugs. There were half a million 'problem users' of class A drugs in 2003 – up from 1,500 in 1963. There are now some 30,000 professionals whose work focuses solely on drug and alcohol misuse, teaching their fellow human beings how to live!

Equivalent statistics from 1852 caused nothing like the moral panic we experience with today's numbers, but then the zeitgeist was different. On 8 March that year, *The Times* reported: 'From the annual accounts relating to trade and navigation... it appears that the quantity of opium entered for home consumption in 1850 amounted to 42,324 lb.'

That's 22,867 kg of opium consumed in British homes in 1850 — nearly all in 'medicinal compounds'. If the 3,929 kg of heroin seized in 2001 represents, say, 10 per cent of the actual weight consumed, then maybe, despite its dramatic move from medicinal compounds to street drug, opiate consumption hasn't changed that much in volume, especially when you take the growth in the size of the population into account.

By comparison, in the UK in 2003 there were 114,000 deaths from tobacco smoking, 30,000 from alcohol misuse and 1,800 from all illicit drugs put together. There are now 3 million people dependant on alcohol (compared to 1.6 million dependent on illegal drugs). As they say in California: it's a zoo out there!

Until well into the twentieth century, all psychotropic substances were legal in the UK, whereas, in modern times, the £300 billion spent on street drugs around the world every year becomes one of the biggest drivers of crime, corruption, abuse of power and even terrorism – simply because those drugs are illegal. For instance: opium is Afghanistan's only visible export, filling 87 per cent of world demand, mostly consumed by western economies. And the resurgent Taliban is now one of its major producers, after having cracked down heavily on its production when in power. Now driven into the margins by NATO, they have made alliances of convenience with opium warlords. The War on Drugs meets the War on Terrorism in a mythic alliance.

And the underlying reason people spend

a myth of modernity?

Invasion of body snatching devils, reflection of society's ills, refuge of the weak, or road to inner paradise? William Pryor holds our perception of addiction up to the light.

that £300 billion? They are slaves of the myth we give the name 'dependency 'or 'addiction'. I use the term advisedly. Levi-Strauss wrote: The purpose of myth is to provide a logical model capable of overcoming a contradiction (an impossible achievement if, as it happens, the contradiction is real). This sense of 'myth' is of a chimera of the mind that controls our understanding of every aspect of the compulsive use of mood-changers and their supply. Joseph Campbell made it more poetic: Myths are public dreams, dreams are private myths.

The contradiction behind the myth is this: addiction is both real and not real. No-one can deny the reality of a full-blown junkie or alcoholic in hot pursuit of his next fix or drink – his need is a palpable and frightening force. But addiction is also unreal: many addicts just stop, with no intervention, no treatment (Miles Davis and John Coltrane both got off heroin by shutting themselves in quiet rooms in the country for a couple of weeks). Such addicts get through the body's 'withdrawal symptoms' and emerge the other side, transformed and able to take up their lives and improvisations with a new clarity.

And for all those for whom getting straight is a much bigger battle, addiction is still not what it seems. The myth of addiction emerges from the cracks between its physiology and it being a cover story for a host of other, largely unrealised, social, cultural and psychological dissatisfactions and vexations. Addiction is more than a metaphor for the unspeakable unhappiness it masks. It is an expression of the difficulty of being fully human in a world of modernity, a desert with no lasting oasis of happiness.

Though the seeming reality of addiction is the result of the body's undeniable physiological response to being given repeated doses of toxic chemicals (its dependency on the substance and subsequent withdrawal symptoms from it), 12-step proponents of the illness model of addiction say there is more. They say this mysterious sickness will be with you for the rest of your life, long after you have stopped using. They must mean it is an illness of the self, not unlike sin.

The myth of addiction is actually a public nightmare not a dream, a nightmare in which we try to fight off an invasion of body-snatching devils. Our secular society of separate selves needs to be able to see evil, so it can be cast out. Addiction takes on the form of the weak, and therefore evil, self who cannot cope with being a modern human. This is why pushers are second only to paedophiles in the demonisation stakes — they spread the disease by turning ordinary decent citizens into weak and evil junkies. The modern self understands itself at the end of the pusher's syringe – let it penetrate and you have the illness, the sin of weakness; resist and you are a hero citizen. A defining moment!

An addict's private myth is a dream that he will one day be able to revisit that first high when he soared way above his cramped, unrealised self into the stratosphere of mania and omniscience, a dream of Eden that can never be realised.

Back to Atlanta: in 1885 the good citizens of the city adopted strict temperance legislation forcing Dr Pemberton to find a way of taking the alcohol out of his tonic. After much experimentation he concocted a syrup made from coca leaves, kola nut (chewed in many West African cultures for its high caffeine content) and damiana (a mild psychoactive South American herb used to treat coughs, constipation and depression). The syrup was taken mixed with soda water. He called it Coca Cola.

It is the lens of hindsight that gives this story its frisson, that makes these Victorians look like money-grubbing hypocrites. But they weren't – well, no more than we are today. The population as a whole held psychotropic substance use in a rather different way from the febrile and contradictory attitudes we hold today, despite a few well-chronicled exceptions like that of laudanum-crazed Coleridge. In the late nineteenth century the only mind-altering substance to be illegal, and that in small pockets, was alcohol. The most-used medicines were opium and its derivative morphine. Opium bought from the corner shop was often cheaper than gin and had become the preferred escape route from the miseries of the new industrial cities of Britain.

Today 25 per cent of the adult UK population (50 per cent of under 29-year-olds) are criminals because they take illegal drugs. Here is another contradiction the myth seeks to explain – half of all young people in the UK break the law to be normal! The beginnings of this moral dissonance can be traced back to the 19th century. Despite visiting an opium-smoking house in the 1860s and his self-medication with the drug during his tour of America in the 1870s, Dickens, with just a tinge of racism, was one of the first to demonise East End Chinese opium dens, most notably in The Mystery of Edwin Drood. Such moral posturing would culminate in the first legislation against narcotics in the second decade of the twentieth century, also driven, in part, by racist notions of needing to protect decent citizens from Chinese, Mexican and other well-known users of drugs.

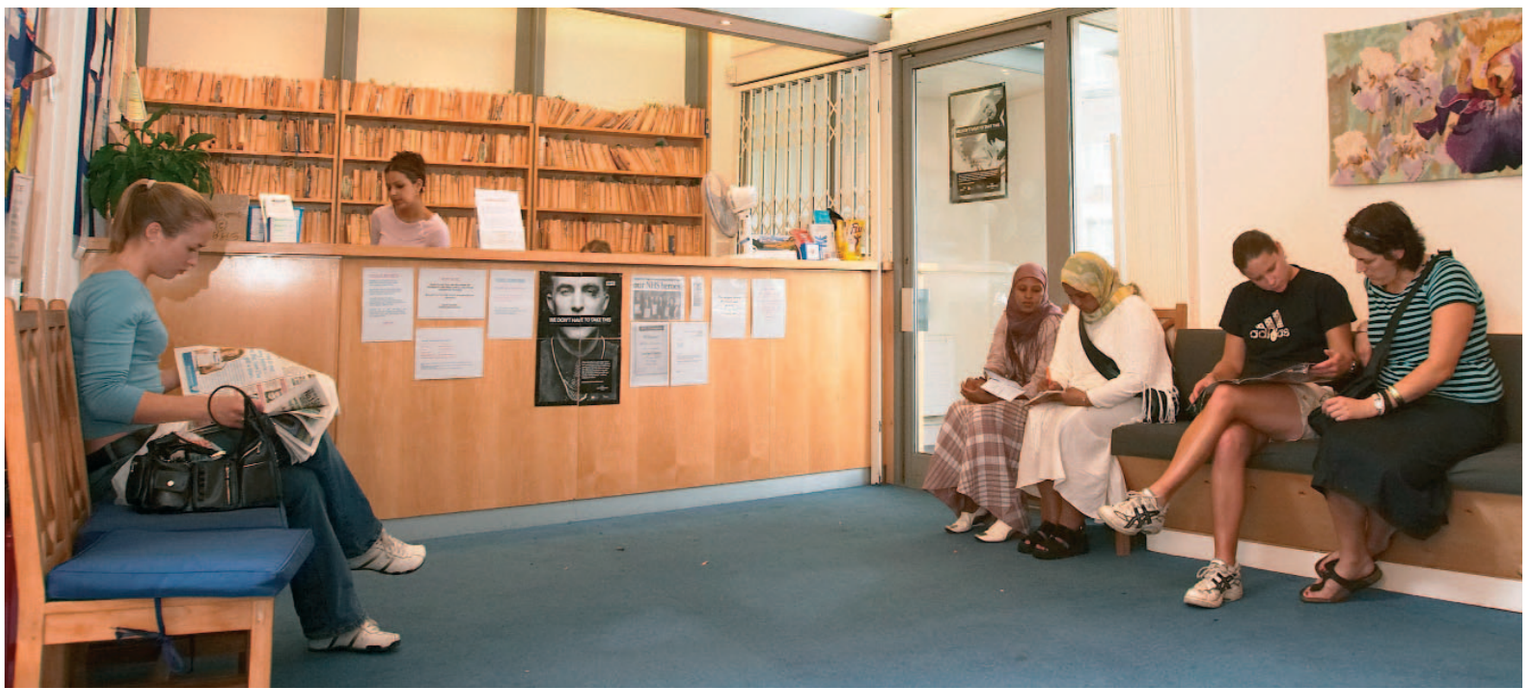
But remember: several Popes endorsed Vin Mariani, Pemberton felt the target market for his concoction of coca and cola included poets and divines, and the Empress of India herself was known to take hashish to help with her menstrual cramps. Indeed, use of the word drug to mean narcotic or opiate probably begins just when a radical cultural, moral and demographic change in attitudes towards – and therefore the practice of – ingesting psychoactive substances for pleasure began.

Thomas de Quincey started another strand of the myth, the romantic junkie hero, prepared to risk everything in pursuit of some arcane, mysterious inner paradise, a strand spun further by the beats like Burroughs and Trocchi (and indeed myself). But this strand has been impotent to even dent the huge negativity of the addict and addiction myths. They are too useful as they are. To give it shape, the unhappiness that plagues our families and society needs such mythic tales. It's not that addiction is untrue, but that it is something else.

William Pryor is director of Unhooked Thinking, the addiction conference, being held on 19-21 April. Visit www.unhookedthinking.com

Recommended reading: The pursuit of Oblivion – The first ever comprehensive single-volume history of narcotics and illicit stimulants. Available from the DDN bookshop http://drinkanddrugs.net/drinkanddrugsnews.html at a discounted rate.

Dr Chris Ford sets the scene for a regular column on treating drug and alcohol patients in general practice. This issue: the patient becomes a priority as soon as they enter the waiting room – whatever their needs.



Post-its from practice

General practice is an odd and wonderful place where we see people of all ages and all walks of life. Over 98 per cent of you are registered with us and you come and see us on average about 5 times a year! You come with everything from boils, to bunions through to heartache (both physical and psychological). All you have to do is live in the practice area, register and away we go. There is no fee to join and you don't have to confirm motivation to attend.

We are good at listening, not so good on curing, but great at managing chronic conditions, such as diabetes, asthma, drug dependence and heart disease. We also have our part to play in the whole care of patients with HIV and other blood-borne viruses such as Hep B and C.

A systematic review of quality of care in general practice concluded that the published research in the field presents an incomplete picture of the quality of clinical care. But a substantial number of well-designed studies exist comparing care by GPs to that of specialists, which show 'no significant difference in quality of care and health outcome for care delivered by GPs even when substituted for secondary care specialists' and 'primary care physicians are more likely than specialists to provide continuity and comprehensive care resulting in improved health outcomes'.

We see the whole range of people and are able to provide care for the person not their condition. We are a model of patient centred care, working pragmatically with risk assessment and harm reduction. We don't always cure, but we care and reduce harm. What is so different about caring for drug users? Why should treatment care and access to general practice be any different with people who have a drug problem? Well, increasingly it isn't! The national average for practices being involved in drug treatment has increased from 20 per cent in 2002 to over 40 per cent in 2006.

People who use drugs present to general practice in a variety of shapes and sizes. The last two new patients with drug problems we accepted on to the list were typical of the range of people who chose to present to general practice.

First was a woman of 67 years who was obviously nervous and said she had specifically asked to see me, as her friend had informed her that I might be able to help. She stated she had two problems: first, she had for several months increasing constipation and second, she was receiving a prescription for injectable methadone from a private doctor and could no longer afford to pay his bills. Seeing this woman in the street you would not have guessed that she had been using drugs for over 40 years and had settled with a private prescription for the past ten years. She had been discharged from several NHS facilities for a variety of reasons, but the commonest was requesting injectables. She had not received health care beyond her prescription from any of these facilities or her private prescriber.

Her drug prescription seemed the easy part and after a full assessment, checking with her current prescriber and observing her taking her regular dose, we took over her drug treatment. Her constipation was caused by bowel cancer, which has since been treated.

Secondly was a young man of 22 years who wanted to be reassured that I would not tell his parents before he began to discuss his heroin and crack problem. He has settled well on substitute prescribing and is beginning to understand and manage his crack use with counselling. His plan is to stop sometime, but at the moment he is able to receive treatment and continue his college course.

Both can sit and wait in the waiting room without anyone knowing why they have come to see the doctor, or other members of the health care team. Both are receiving help with their drug problem, their physical health and their psychological problems and both will continue to be registered with us wherever they are on their treatment journey.

Dr Chris Ford is a GP and Clinical Lead for SMMGP. Look out for the 'Post-its from practice' column, in every other issue of DDN.

The drug experience: heroin, part 4

In his latest Background Briefing, Professor David Clark continues to describe the experiences of heroin users who have their lives seriously affected by their drug use, looking at how they live with their addiction.

In their seminal book *Beating the Dragon* Professors James McIntosh and Neil McKeganey describe heroin addiction as an extremely hard taskmaster. Clients from the Peterborough Nene Drug Interventions Programme who recounted their stories to us also repeatedly referred to the comprehensive way that their heroin addiction took over their lives.

'My whole life, my whole being was centred on drugs and any means to get them you know. My whole life revolved around drugs, drugs, drugs.' (From *Beating the Dragon*.)

At the peak of their addiction, users are often using large amounts of heroin. At this time, the process of funding, finding, and using the drug becomes a daily routine. Heroin becomes the most important thing to the user, and very little else matters to them at this time.

Heroin users progressively spend less time with their family and loved ones, and more time with other drug users. They became affiliated into drug-using networks, although these new drug-using acquaintances are not generally considered to be friends. The nature of these relationships is not genuine or real, and tends to be very fickle.

As people become immersed in the drug-using lifestyle, their life before drugs gradually becomes a distant memory. They become stuck in a vicious circle, whereby the drug is affecting their lives yet they need it to function normally and even to 'survive'. Some people use heroin to 'numb' their emotions and remove themselves from the reality of their situation, *ie* the problems the drug has caused.

The lives of heroin users often become characterised by secrets and lies. This is commonly due to shame and embarrassment, as they have become something that they had looked down on previously and are living a life of which other people disapprove.

For many heroin users, it becomes impossible to sustain their drug use legitimately. As tolerance levels rise, increasing amounts of drugs are required, and therefore more money is needed to fund the habit.

In many cases, criminal activity becomes the most common way of funding heroin use. Shoplifting is especially popular, particularly among female users, while burglary, street theft (bag snatches) and car/bike crime are common sources of revenue for male users. Some people support their habit by dealing in drugs, while some may resort to prostitution.

Many report that they would steal anything from anyone in order to support their habit. Their own families are frequent and ready targets for theft.

'You've got no boundaries, which is wrong. And you lose all of your emotions, you know. You don't feel guilty, it's just "me, me, me, I want that, I need that", and you don't think of others, what it does to others.'

Some heroin users report that crime simply becomes a routine part of their day. Involvement in criminal activity frequently leads to involvement with the criminal justice system, and sometimes imprisonment. Some users consider this philosophically as being an occupational hazard.

Some of the interviewees in our research became locked into a vicious cycle – of crime to fund habit, to prison sentence (and a period clean), to release from prison, to re-introduction to drugs, to return to crime, to prison. They frequently felt stuck in this cycle and did not know how to get out of it.

Many users report how their behaviour and personality changed during their drug-using days. They often felt that they acted very out of character.

They describe how, in the world of drug using, everyone thinks primarily about themselves, and more specifically, about feeding their addiction. Many are lacking in morals and conscience and have no consideration for anyone else. They live a life full of deceit and manipulation.

'You've got no boundaries, which is wrong. And you lose all of your emotions, you know. You don't feel guilty, it's just "me, me, me, I want that, I need that", and you don't think of others, what it does to others.' (Hopkins and Clark, 2005).

One major occupational hazard of regular heroin use is deteriorating health. For injecting drug users, serious vein damage is common and there is an ever-present risk of contracting blood-borne viruses such as Hepatitis C and HIV. There is also a risk of overdosing.

Alongside physical health damage, many heroin users experience mood and mental health problems. Periods of low self-esteem, depression, anxiety and mood swings are frequently reported. Users will regularly have negative opinions of themselves and what they have become. This can sometimes lead to contemplating, or attempting, suicide.

Many heroin addicts also use other drugs, such as benzodiazepines and alcohol, and this can result in further complications (*eg* increased risk of overdose) and further contributes to deteriorations in health.

Users can neglect to pay attention to their appearance and personal hygiene. They lose respect for themselves and for their wellbeing.

It is common for users to experience a breakdown in their family relationships due to their drug use and the resultant changes in their behaviour. They may be kicked out of home, or their partner may leave them. Many users, in particular men, lose contact with their children.

In general, the lifestyles of heroin users are very unsettled. Many may experience homelessness through relationship breakdown or through losing their homes due to going to prison or inability to maintain rental payments.

Although heroin use can have devastating effects on both the user and those close to them, it is possible to overcome heroin addiction and resume a healthy and positive lifestyle. In our next Briefing we will start to look at the process of recovery.

Recommended Reading:

Aimee Hopkins and David Clark (2005) Using Heroin, Trying to Stop and Accessing Treatment. www.wiredinitiative.com/pdf/Nene1.pdf

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

Tam Stewart (1996) The Heroin Users. Rivers Oram Press.

Since my new manager started six months ago, the culture of our organisation has changed completely. Everything now is about setting and meeting targets, and clients seem to come last. I raised my concerns with her at my one-to-one, but she just said 'welcome to the real world'. I've started to hate a job that I loved. Is there anything I can do apart from keep my head down or leave?
Eleanor, by email

Working in union

Dear Eleanor,
Is the issue a personal one, or do other people working within the organisation feel the same way as you? You need to understand how your fellow workers feel about the changes and then perhaps you can all approach her and voice your concerns. This has to be done very carefully and sensitively, as you do not want to appear to be stirring up trouble but as a long-standing employee I feel you have the right to a more understanding and consultative approach than your new manager has shown you to date.

You should bear in mind though that the new manager probably feels far more vulnerable and insecure about her new position than her outward appearances show and may be hiding behind her brusque exterior. Perhaps if you give her time and try and work with her, your client focused outlook and her target driven approach need not be mutually exclusive and will eventually lead to an improved service for the clients, which is I bet what you both ultimately want!
Margaret Deman, Hampshire

Targets are needed

Dear Eleanor,
It can be very hard to adjust to working in a new way but sometimes it is what's needed. You say that 'everything is now about setting and meeting targets, and clients seem to come last' but surely the targets are there to quantify the quality of treatment your clients are receiving? Without targets and performance indicators how can you gain a true picture of how many successful outcomes you achieve for clients and identify parts of your programme that can be improved?

The drugs field has changed immensely over the last few years and will continue to do so as there is an increase of professionalism in the field. The message from the NTA and Home Office is that we need evidence backing up the work of treatment agencies in order to justify continued funding. It sounds to me like your new manager is trying to implement this ethos at a smaller scale within your agency and I agree with her that you have to move with the times and yes (in her words) – welcome to the real world!
Rick Badger, Birmingham

Back to first principles

Dear Eleanor,
I feel that although it obviously has a great personal impact on you, this is a problem that affects the field generally. There is something about this issue that has the potential to paralyse the workforce and therefore deprive our clients of the help they need. It is characterised by the kind of dilemmas you express at the end of your question; of either loving or hating the work and having to choose between resentful submission or abandoning ship!

I think that it is important to return to first principles in order to make sense of this. When initially choosing to do the challenging work we do, most of us asked some important questions. What it is we are doing? What are we trying to achieve? Is it effective? Could it be improved? This is the basis of research and I think that we should always be engaged in a process of reflecting on our practice at this level. It is a fact that sometimes the demands for statistics, reporting and achieving targets are clearly driven by a need to 'tick boxes'. If this is what your manager means by 'the real world' it is important to keep it in perspective. We do have the opportunity to bypass all that cynicism.

What this means practically is that we must become more proactive in our attitude. The work we do with clients is important but it shouldn't happen in a vacuum. It has to take place in a wider context, because that is where our clients need to be able to function successfully. Rather than 'resisting' the demands for statistics, targets and monitoring, we should start thinking about how we can influence the process to ensure we employ them to improve our effectiveness – which is what clients need us to do. If we think there is a better way to monitor, measure or quantify, we should be putting forward our ideas and suggestions with passion and enthusiasm.

What are the implications for us? Just think of the potential benefit to our clients of us moving out of the comfort zone of 'either/or' thinking and modelling a different kind of attitude to managing change.

It's got to be worth considering!
Kirby Gregory,
head of client services, Clouds.

Talking tough

Dear Eleanor,
Of course I know nothing about your workplace but your manager is probably using tough talk to communicate to you the scale of the change that is needed in your agency. Maybe your local Drug Action Team (who she has to satisfy at the end of the day) hasn't been happy with every aspect of your agency's performance. Maybe you can find out why these targets have been chosen.

Try not to take it too personally, but she is probably right.

Services will survive or close depending on whether or not they can demonstrate that they are meeting an ever-increasing number of imposed targets. This is the reality of work in the drugs treatment field, and it tends to be that way across most health and care specialisms nowadays. It is difficult to know where you could move that wasn't like that.

While it is true that targets are not ends in themselves, and they may not always get met, the point of them is to drive up performance. As long as the targets are meaningful it is possible, and maybe likely, that patients will end up benefiting.

Ask yourself: are there ways that you can work 'smarter' to continue to do the job you love and get the case recording, paperwork, *etc* done? The answer is probably yes. Time management and concise recording, for example, are important skills and they can be learned and improved.

Good luck.
Simon Morton, social worker

Reader's question

I've been in my job as a drug and alcohol worker for four years now, and want to move into management. Could you suggest what sort of training and qualifications I should look at doing?
Caroline, Sheffield

Email your suggested answers to the editor by Tuesday 18 April for inclusion in the 24 April issue of DDN.

New questions are welcome from readers.

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At Phoenix House we're in the business of helping substance misusers rebuild their lives. Our innovative range of services include Prison projects, community based initiatives and holistic rehabilitation programmes across the country – and we are continually developing and extending our expertise to meet the changing needs of our clients. In partnership with London Area Office we are looking for a number of drug workers for our rehabilitation units at **HMP Pentonville and HMP Brixton**. Have you got what it takes to join us at these key projects?

Salary subject to review April 2006.

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Working as part of the drug rehabilitation PASRO team, you will carry a challenging personal caseload working directly with offenders, both individually and in groups. You will deliver the programme in accordance with HMPS directives whilst drawing on your own skills, knowledge and experience to get the best out of the client group. Previous experience of working within rehabilitation, treatment and re-offending prevention services would be beneficial. PASRO training will be given. The starting salary for this post is £22,427 or £23,015 dependent on experience. The higher salaries in the range can be achieved through annual performance appraisal.

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INVESTOR IN PEOPLE

Oxfordshire drug & alcohol action team

Invitation to Tender

Oxfordshire Drug and Alcohol Action Team (DAAT) is seeking expressions of interest for the provision of an Aftercare Service, aimed at drug users who have engaged with community or prison-based structured treatment programmes. The county-wide Aftercare Service will be abstinence-focused and will offer individually tailored support packages.

Applications are invited from contractors suitably qualified to provide the Aftercare Service. The Service will be based in Oxford, and will include an IT and Resource Suite, as well as offering detached and/or peripatetic services.

The Aftercare Service will assist individuals in sustaining treatment gains and achieving personal development by offering clear schedules of defined activities. It will provide, or broker the provision of, appropriate services in relation to the support needs and goals identified in an individual's aftercare plan.

Oxfordshire DAAT anticipates the contract will be awarded in September 2006, for an initial period of three years with an option to extend for a further two years subject to funding and satisfactory contract performance. Tenders will be assessed according to the principles of the Most Economically Advantageous Tender (MEAT), and the contract will be awarded on the basis of quality of services, ability to perform and tendered prices.

Interested organisations that wish to obtain tender documents should write to:

Sam Read, Commissioning and Contracts Manager
Oxfordshire DAAT, 29 New Inn Hall Street, Oxford, OX1 2DH

The closing date for the receipt of completed tender documentation is 4.00pm on Monday 3rd July 2006. The deadline for receipt of requests for contract documents, additional documentation, or matters of clarification, is 4.00pm on Friday 16th June 2006.

A notice relating to this tender has also been placed online in the Official Journal of the European Union (Tender reference: 42957).

Supporting young people

Project Worker/Senior Practitioner

£20,800 - £28,200

Young People's Substance Misuse, Wokingham

This is an exciting opportunity to develop new services to young people at Tier 2 and 3 in partnership with Wokingham Council's Children's Services and Drug Action Team. You will need a relevant qualification in social work, nursing, counselling or substance misuse and experience in delivering services to Young People with substance misuse issues. An ability to develop new initiatives within a multi agency context is essential, as is the ability to engage effectively with young people on a one-to-one basis and in group settings.

This post is subject to an enhanced disclosure check via the CRB.

For an information pack please telephone 020 8498 7011 (answerphone), minicom number 020 8551 3234, or download the information pack from **www.barnardos.org.uk/work_with_us.htm** and apply online. Please quote Ref: LE5172.

Closing date: 4 May 2006.

Interviews: 18 May 2006.

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Barnardo's
GIVING CHILDREN BACK THEIR FUTURE

Welcome is a leading drugs rehabilitation charity operating in Solihull. It provides a high quality range of services for people who misuse drugs and for their families. Welcome provides key Tier 2 provision of services in the Solihull Borough which includes a drop in centre, needle exchange, harm minimisation work as well as being the single point of contact for people accessing services in Solihull. It also provides a number of Tier 3 services such as counselling. The service is based in the north of the Borough but also involves work in the south of the Borough.

TEAM LEADER - Community

Salary £25,000 plus 5% non contributory pension, 25 days annual leave, 11 bank holidays . An Excellent Personal Development Opportunity

Due to outstanding growth Welcome is currently recruiting a Team Leader to manage a team of people who work in the community. The role includes managing staff, developing services and working with service users.

TEAM LEADER – Counselling

Salary £25,000. Plus 5% non contributory pension, 25 days annual leave, 11 bank holidays

Welcome is also recruiting a team leader to head a small counselling team who work with drug users and their families. The role includes managing staff and building relationships with other agencies.

Further information about both posts is available from
Lesley Wilkinson, Executive Director on 0121 678 4730.
For an application pack please contact Mary Lealan on 0121 678 4730.

These posts will play a critical role in the further development of services in Solihull. Welcome is committed to training and development so the post holder will be given opportunity to develop skills and will make a difference to the delivery of a quality service in Solihull.

Closing Date: 24 April 2006

Cyngor Sir **Powys** County Council

Powys

Dual Diagnosis Worker (Mental Health / Substance Misuse)

CSSC464 Radnorshire, Mid Wales

£25,437 to £29,859
(bar) £30,843 to £32,487

This new post is in response to the new expectations contained within the Welsh Assembly Governments 'Substance Misuse Treatment Framework - for co-occurring Substance Misuse and Mental Health Problems' and will be based within the Community Mental Health Team (CMHT) in Llandrindod Wells.

You will carry out a wide range of assessment and care management tasks associated with the social care needs of people with substance misuse problems and / or mental health. You will work as the link between CMHTs and community based substance misuse services and be a key member of specialist planning and development groups.

To meet this challenge you'll need to be an enthusiastic and committed team player. You will have a relevant professional social work qualification and knowledge of issues relating to substance misuse and process and models of rehabilitation. You will need experience of working in the substance misuse and mental health fields, care management skills and the ability to work effectively in a multi agency/ partnership setting.

Powys County Council is a relatively small, friendly and supportive organisation. Powys is a great place to live with beautiful countryside, lively towns, good schools and reasonable property prices. A relocation package of up to £8000 is available plus new lease car, travel expenses and family friendly policies.

For information/applications please call the Workforce Planning Unit on 01597 826887; or email allyson.boswell@powys.gov.uk or apply on line at www.powys.gov.uk

Closing date: 28th April 2006