

Trouble at Tier 3

We read with interest the article by Sebastian Saville (*DDN*, 30 January, page 8). It is an interesting and thought-provoking piece. Given the sums of money involved, the topic is highly important.

We are interested in the estimated proportions of good, acceptable and poor quality Tier 3 Services from Mental Health Trusts. We think that the argument can be taken further by considering the management arrangements of substance misuse services within Mental Health Trusts.

We took a decision three years ago to reorganise and create a substance misuse directorate within a Mental Health Trust. There is therefore a clear substance misuse presence on our Trust Board, with heads of service accountability for service delivery and all areas of service governance at a local level.

We manage and are accountable for all substance misuse investment. Our view is that 'Trouble at Tier 3' can arise when substance misuse services are swamped by Mental Health Trusts' wider priorities rather than being a strong and influential player within the Trust. Management structures and effective leadership, which is focused on and steeped in substance misuse, are key to this.

Dr Louise Sell, associate clinical director, and Cath Moran, service director, substance misuse directorate, Bolton, Salford and Trafford Mental Health and NHS Trust.

Cleaning up drug practice

I have worked as a GP in the drug field now for over 20 years. It is an area of work that I enjoy and believe is of value. It is sometimes difficult but always rewarding.

BUT it also never ceases to amaze, frustrate and anger me how badly this area of medicine is sometimes practised. I had never heard of the practice of 'blind reduction' until I read about it in Daren Garratt's article 'keeping it dirty' in 30 January's *DDN*. I must admit that I didn't really believe it could happen, as the practice seems ethically and morally corrupt and appallingly bad medicine. So I set out to investigate – and discovered to my horror that it does happen, and some practitioners almost seemed proud of the practice. This appalled me almost more than the practice, as there was a



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sense that the practitioner felt they were getting one over the person receiving the prescription, who was obviously not to be trusted and a lower form of life. I was called naive and collusive when I questioned these attitudes.

Anyhow, back to the practice of blind reduction – what is anyone trying to achieve with this practice? I am at a loss! Methadone maintenance can be a vital part of good treatment, if used well. It allows people to sort out other parts of their lives and improve their health, until (and if) they want to move on to detoxification and abstinence. Non-consented slow methadone reduction is still a common treatment modality in the UK, but has no value and has proven harm with increased risk of overdose and death. Blind reduction is even worse! In my experience, people who use drugs have an enormous knowledge and experience of drugs. The people who I have spoken to who have been subject to this blind reduction regime felt humiliated and dirty; of course they knew it had been diluted so what does that person do – take it or get

nothing? In what other area of medicine are people treated in such an inhumane way? If the person is topping up it is very likely they need more methadone, not less!

If that argument is not won, what about the evidence? Let's think about diabetes instead: somebody needs 20 units of insulin morning or night, but the worker or doctor thinks that is too much – plus the person had admitted to eating cakes so the insulin is diluted and given to the person. In this case when it was discovered, the doctor or worker would be up before the GMC before you could say diabetes; why is it different in drugs? I leave you to answer that one.

If any service or GP is undertaking this barbaric, unethical treatment, please stop. It would also be helpful if the NTA would come out firmly against this practice. And if any person using services has experienced this practice and would like to challenge it, please give the Alliance a ring.

Chris Ford GP, SMMGP GP Adviser and Alliance board member. (*The Alliance's phone number is 020 7837 4379.*)

Alcohol-free is fun

It was encouraging to read the feature on Hope UK's important drug education work and the timely Thirst for Life campaign (*DDN*, 13 February, page 8).

When I was a social worker in London's East End for over 20 years, I worked with many people who were harmed by alcohol. Increasingly I have been convinced of the need for a major national campaign to highlight the benefits of healthy and safe alcohol-free lifestyles.

More people would choose this option if they were aware that people can enjoy life and have fun without alcohol. I would be glad to hear from other readers who have a similar view on trying to reduce Britain's biggest drug problem.

I feel strongly on this issue because I last drank alcohol when I was 13. Since then I have had a tremendous amount of fun and am now a fit and healthy 61-year-old who still loves playing cricket – and I can't wait to get my pads on again and my bat in my hand!

John D Beasley, press officer, United Kingdom Alliance

Kingdom of the blind

Simon Morton's letter 'Come on NTA!' (*DDN*, 13 February, page 11), comments on an article written by Daren Garratt which referred to a conference presentation reporting the practice of 'blind methadone reduction' in a single locality in the North East of England.

This practice – also known as 'Fixed Volume Reduction (FVR)' – is more common in in-patient detoxification settings but also occurs in the community where a client is on a comparatively small dose of methadone (30mls and under) after a long period of stable substitution therapy and is having trouble ending their use of the drug altogether. In these circumstances, and on the wishes and fully informed consent of the client, a programme may be embarked upon where the same volume of liquid is dispensed (eg 30mls) but the amount of methadone in the mixture is decreased without the patient knowing what the rate of reduction is. When the patient has been taking a mixture without any methadone in it for some time (for example two weeks) then they are informed of this and they are then asked to agree the next steps in their care plan with their prescribing clinician.

The evidence base regarding this

practice is limited, although there is one study from the in-patient literature that suggests people do better in detoxification when they are well informed about what to expect. However, there is anecdotal evidence to suggest that this practice, providing there is a clear and unprompted desire on behalf of the patient to try this intervention after other more common strategies have been exhausted, can be effective. There are a number of caveats to this, such as ensuring there are safeguards in place for relapse onto street drugs and that other prescribing options (*ie* buprenorphine) are not suitable.

What this practice should never be (as suggested in Daren Garratt's column, DDN, 30 January, page 6) is some sort of punishment following a urine test that is positive for non prescribed psychoactive drugs where a member of staff in the drugs services secretly waters down prescriptions at the point of dispensation.

With regard to the situation in the North East, the PCT/DAT Implementation Group concerned produced a comprehensive paper on prescribing issues in March 2005, which specifically alluded to FVR and co-facilitated an event with the NTA and CSIP (formerly NIMHE) to address this and other issues within the treatment system. The treatment service concerned denies that the practice of involuntary reduction ever took place. Added to this, the area in question only has pharmacy-based dispensation.

The NTA is committed to ensuring that there is high quality and effective treatment available to all, based on evidence and founded on therapeutic commitment. Central and regional NTA staff are in no way complacent and acknowledge that there is much to do in many areas to build on the rapid expansion of capacity and quality treatment services that the field has achieved in the past few years. With regard to the central point made in the original column by Mr Garratt, it is the NTA's view that high quality methadone maintenance (as part of a wider package of support) should be available to all who require it and abstinence should be seen as another option for intervention and not in any way superior.

Colin Bradbury, Regional Manager North East, National Treatment Agency for Substance Misuse (NTA)

Comment

Giving up the weed The recent Channel 4 documentary 'Giving up the Weed' screened as part of its Addiction week (Monday 20 to Friday 24 February) highlighted that away from the arguments surrounding the reclassification of cannabis, many young people are struggling to overcome its grip on their lives. Jonathan Akwue, of In-volve, explains.

The documentary featured the actor and rapper J Rock of Big Bruvas fame who had been smoking weed for 14 years and was desperate to give up. It charted J Rock's struggle to give up one of the constants in his life and

witnessed how he coped without it.

Realising that he needed support, J Rock turned to In-volve who provided him with one-to-one with specialist coaching sessions on how to overcome his reliance on cannabis. The programme showed how misconceptions about the drug's effects have led to it becoming ubiquitous throughout society, and how some young people now believe that weed is legal and easy to give up.

In-volve believes that the arguments over the legal status of cannabis have led to a polarised debate where the needs of young people with cannabis-related problems have sometimes been overlooked. In our extensive experience of working with young people across the country we have found that cannabis is often their most pressing issue.

Where some services have tended to play down this issue and concentrate on class A drug use, In-volve has developed a successful model of addressing cannabis use that is based in part on exchanges that have been taking place over a number of years between our organisation and Danish treatment programmes for young people and adults that focus specifically on cannabis use.

The Danes have come to identify the need for programmes that target the nature of the drug and the experiences of the user in the same way as we have different treatment programmes for heroin use and crack cocaine use, rather than more generalist counselling or diversionary interventions that they have recognised as having little long term effect. They have also come to the conclusion that the continued use of cannabis during treatment programmes for other drugs has a significant negative impact upon outcomes. In some parts of the country, their statutory services are beginning to integrate voluntary cannabis intervention programmes into services for adult users.

The encouraging news is that these approaches to working with cannabis users clearly work. At the conclusion of the one-month intervention J Rock told the programme:

'I do a test to see whether I've still got THC in my system, and I pass. It feels amazing. It's the first time since I was 13 I've had no weed in my system. Beyond all my achievements, I'm most proud of this. No-one can tell me I'm a pot head any more. And I've realised you don't need weed in your system to be a heavy rapper. You don't need weed to be the best actor. You don't need weed for anything, you just need yourself.'

For more information contact akwue@in-volve.org.uk or see: www.in-volve.org.uk



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