

develops clients' social capital.

However, onerous or restrictive treatment requirements can interfere with clients drawing on the social resources available to them. Frequent and regular compulsory attendance at treatment services has been associated with higher drop rates from treatment. Enforcement of coercion through the early use of penalties undermines the programme because starting the programme is not a solution – finishing it is.

Person centred care planning is limited. Procedures that precipitate transgressions of probation national standards at an early stage into breach proceedings, are unlikely to lead positive outcomes. They are more likely to deliver the penalty of a prison sentence and are not the best way to change behaviour.

FROM THE FLOOR

This debate was aired at the National Drug Treatment Conference, last month. Here are a selection of delegates' views.

'Drugs and crime have become inextricably linked – we've demonised users. We have already gone too far. It's getting difficult to support users proactively.'

Daren Garratt, The Alliance

'Criminal justice is just one way into treatment that improves treatment all round.'

Gary Seaton, criminal justice project co-ordinator

'If this is something the US government supports, we should approach with great caution.'

Robert Newman, professor from the US

'Criminal justice has just one option – of locking you up. He who pays the piper calls the tune – this is not the way to have a discussion about treatment.'

Conrad Spencer, manager of a DIP service

'People have to commit a crime to get into the treatment service.'

Doctor from Sussex

'The objectives aren't smart.'

Ex-probation officer

Delegates voted to defeat the motion by a substantial majority.

'It is important that applicants are able to demonstrate that they have recovered from any substance misuse problems. Whether this is the 'two-year rule' or for a shorter period has to be judged on a case by case basis.'

Cover Story: 'The Two Year Rule', DDN, 7 March 2005

Can I congratulate you on last issue's stimulating Cover Story: two-year rule. It is critically important that these areas are debated widely.

In relation to the model of good practice and the Healthy Options Team's [HOT] employment policy quoted in your article, it should be noted that the HOT team is a part of our Trust's East London Specialist Addiction Service. The Trust's policy was incorrectly quoted in the article and therefore I would like to state the correct position:

- All staff are expected to be drug-free when employed;
- The Trust does not accept that staff may use illicit drugs whilst under employment;
- Relevant life experience is taken into account; however applicants would still need to demonstrate that they meet the criteria as specified within the job description and person specification.

The participation and involvement of current and former substance misuse service users within the planning, delivery and evaluation of services is critical and without this input we cannot develop culturally sensitive and responsive services.

Service users who have recovered from substance misuse problems and wish to become employed by health and social care agencies are also, in my view, to be welcomed, since their personal understanding of substance misuse issues provides a unique perspective. However, it is essential that any applicant is able to cope with the challenges and responsibilities that any job brings with it, and because of this it is important that applicants are able to demonstrate that they have recovered from any substance misuse problems. Whether this is the 'two-year rule' or for a shorter period has to be judged on a case-by-case basis.

The Trust does however have policies in place to support staff if they are experiencing difficulties and individuals'

problems are addressed on a case by case basis in a confidential and understanding manner, in line with NHS guidance and good practice.

John Wilkins, Director of CAMHS, Specialist Services and Modernisation, East London and The City Mental Health NHS Trust

Let's drop this two-year rule nonsense and move on

An average stay at Phoenix in the 1970s, including re-entry was about 12 months, and there was always an expectation that a proportion of 'graduates' would eventually work in Phoenix House, on staff. In order to prevent that assumed Phoenix dependence, the two-year rule was established. 'Phoenix Graduates' who wanted to return and work as staff were expected to either find paid or voluntary work in the community or attend college, whilst maintaining a cursory level of contact with Phoenix for at least another 12 months. This created a two-year period, drug-free before working in the 'community'.

The reasons behind this were based on pragmatism not evidence. However, an urban myth soon developed around the two-year rule and a SCODA policy was adopted in 1997. (There had been an informal adopting of the same policy at a SCODA conference in 1979-ish).

There was no sound reason for adopting the two-year rule outside of Phoenix House, at that time. Nevertheless, they did.

I would suggest that if we have so little faith in the treatment services ability to assist people to change, then we need to question our ability to commission and provide them.

I know there will be those out there in DANOSland who feel that less than 12 months is 'too close' and we need to ensure that former users are not put 'unduly at risk'. This smacks of being a wee bit 'nanny state-ish'. Call me a buff old traditionalist, but I think we need to accept that people can apply for posts on their own merit. If they fit the essential

criteria, interview them; if they are appointable, do it. I'm sure that we are not permitted to discriminate on the grounds of someone suffering from a chronic relapsing condition if they demonstrated that they are the best person for the post. I think we might even be on dodgy legal grounds if we start asking people to declare their past drug use, as a way of filtering out particular candidates. Nor should anyone be expected to declare it voluntarily on an application form. I know I didn't.

Let's drop this two-year rule nonsense. It's an anachronism that has no place in this world. Phoenix House has changed, drug treatment has grown up, and former drug users know what they want and it isn't patronising. Let's move on.

Andy Fox, Drug & Alcohol Action Team Manager, Calderdale MBC

Do coke and methadone create heroin effect?

In the article 'Best environment for long-term support is primary care' (DDN, 7 March, p5) there is a statement that 'poly drug use seemed increasingly commonplace, such as adding coke to methadone to create the effects of heroin'.

Neither I nor some of my colleagues had heard of this mix before, and wonder why adding a stimulant to an opiate should mimic the effects of another opiate. One suggestion was that the coke produces the heroin 'rush' that is not present with methadone. Could you please confirm this, or explain the reason if this is not the case?

Ian MacDonald, Cheltenham Parent Support Group, www.cpsg.org.uk

The article was a news report on Dr Chris Ford's speech to the National Drug Treatment Conference. Dr Ford responds:

'Poly drug use is more common, probably mainly because of availability of drugs. Methadone by itself is fairly non-euphoric, particularly oral methadone, and there may be some evidence that some people take additional drugs to supplement the effects. Commonly used are alcohol and benzos, both depressants, and cocaine, a stimulant – which may have more logic: the coke 'peps up' the methadone, giving it a more euphoric effect, similar to poor heroin but not the same.

If you look at Swiss trials prescribing heroin, cocaine use went down. Looking at the National Treatment Outcome Research (NTORS), crack use with people on methadone went up.