

'At the same time as service providers are telling us they have disastrously low occupancy rates, others are reporting healthy take-up. Even some of the organisations whose senior managers are talking about a 'crisis' have at the same time been reporting 90 per cent occupancy to Bedvacs.'

Neither 'bizarre' nor 'ill-judged'

The NTA has acknowledged, since its inception, that the funding regime for residential rehabilitation providers is inadequate and needs reform. The residential rehabilitation sector has been funded primarily from a community care system designed for the needs of the elderly. Furthermore, most provision is spot-purchased, not commissioned within a managed market.

This can cause problems for residential services serving regional or national catchments, giving rise to regular concerns about the under use of residential provision and the consequent impact on the financial viability of providers.

In this context, the Department of Health/National Treatment Agency initiative to expand residential provision is neither 'bizarre' nor 'ill-judged', as suggested by Brian Arbery in his article (*DDN*, 25 September, page 9) but the best opportunity we have had since 2001 to consolidate and double residential capacity in order to maximise service users' opportunities to complete treatment, and also to ensure that those who are commissioned to provide residential treatment in the new environment have access to an adequate and reliable revenue stream.

Whatever the improved prospects for the future, Brian paints a picture of 'crisis' about the present and demands immediate 'action' from the NTA.

Unfortunately it is difficult for us to act until we know whether we are dealing with a new crisis or a recurrence of the problems we have all been living with for years. At the same time as service providers are telling us they have disastrously low occupancy rates, others are reporting healthy take up. Even some of the organisations whose senior managers are talking about a 'crisis' have at the same time been reporting 90 per cent occupancy to Bedvacs.

The NTA needs to understand where

we are on the continuum of explanations – from a widespread system failure to invest in residential services to the normal operation of market forces, which can create winners and losers – before we can plan an appropriate response. In developing this we are fully involving EATA as the umbrella body for many of the affected providers and have held meetings directly with representatives of the providers.

The NTA remains committed to the consolidation and expansion of the residential treatment sector as part of the treatment effectiveness strategy. If our current investigations identify a systemic problem which is jeopardising this strategic aim, we will act to remedy it. However, if what we identify is the appropriate operation of market forces causing a 'crisis' not for the sector but for individual providers, then it would be inappropriate for us to act.

In any event, action in advance of understanding the issues is clearly not going to help anyone.

Paul Hayes, chief executive, National Treatment Agency for Substance Misuse

Scared of commitment?

I sympathise with the frustration expressed by Brian Arbery at the large-scale under-utilisation of residential rehabilitation as a treatment modality (*DDN*, 25 September, page 9). He locates a central responsibility for this failure with the NTA and worries that a lack of financial commitment from local authorities may be preventing placements. To be fair to NTA, their strategic and operational responses may not be the primary or only forces influencing this particular agenda, and likewise there may be more than just resource issues at play.

I used to work in a locality from which a lot of rehab placements were made. There were usually one or two people

about to be assessed or waiting to go in; a couple doing their placements; and someone coming out. This is in contrast to the area in which I work currently where, to my knowledge, there have been no drug rehab placements in the last two and a half to three years, and not because of lack of access to beds or a lack of financial resources.

Rather, it is as if there has been a gradual decline in the knowledge and skills in the practitioner workforce around rehab, which in turn has perpetuated a vicious circle of under-placement. How does one, for example, meaningfully talk to a patient about rehab if one has never actually seen it used, successfully or unsuccessfully?

In my view, the explanation for the stark contrast in uptake between these two authorities is the extent to which rehab is a real and live treatment option within the provider agencies of the respective areas. And moreover, the extent to which it may be similarly real and alive for the friends, families, and drug using peers of all those service users who have experienced both the challenging and positive aspects of rehab: who have come back home because it hasn't quite worked out right this time, or in this particular rehab, but who have been able to reflect on and – crucially – share their experiences; or who, conversely, have successfully achieved and maintained abstinence, and who are living proof of the power of rehab for their former peers. In other words, the difference is a critical mass of informed and aware service providers and service users.

There is a national educational task around residential rehabilitation that needs to be undertaken, and while the NTA is charged with the overall performance management of the sector, it would be wrong to place the burden of this educational and training responsibility onto the NTA. It should be squarely on the DAATs themselves, and their Tier 2 and 3 provider agencies.

Name and address supplied

Extreme lengths

Thank you Professor David Clark, for your invaluable series of 'Background Briefings'. The current series which examines the theories of addiction (*DDN*, 25 September, page 15) has the hallmark of your normal succinct style.

I am sometimes amused at the extreme lengths that opponents of the disease model seem prepared to go to in order to discredit this model which is

rooted in factual experience, scientific and medical research.

To argue that there is no 'constellation of alcohol related problems that could be described as alcoholism' is disingenuous when, in fact the criteria for it is so clearly documented in both DSM-1V and ICD-10. The proposition that 'there is no evidence that addiction is irreversible', ignores the evidence that has accumulated over many years. I acknowledge that much of this evidence is anecdotal and self reported, but for anyone who has taken the time and trouble, to attend a few hundred 'open' meetings of groups such as AA and NA, the similarity in the history of literally thousands of those who have made countless and diverse efforts to moderate, or control their consumption of their drugs of choice, and subsequently failed, is hard to ignore.

When one then considers that such fellowships are based on the concept of self, rather than expert help, are not motivated, or influenced by political, or funding considerations and consist of people from differing cultures, race and background, I suggest that the evidence becomes compelling. In marked contrast, the opponents struggle to produce any significant evidence of a thousand or more people, who having been independently assessed as meeting either DSM-1V or ICD-10 criteria for addiction, successfully reversed their condition over any meaningful period of time, this being defined as a minimum of 12 months.

The suggestion by the opponents that the disease model can lead to people avoiding self responsibility is a gross distortion of the underlying principles of 12-step recovery, as indeed is the implication that the necessary inner (spiritual) changes essential to recovery are thus avoided. Those who seek to advance such a specious argument have either failed to understand the six principles underlying the 12 steps – *ie* acceptance, faith, personal inventory, change, restitution and helping others – or choose to ignore them; principles that are alien to those whose addiction is active, if only because the pursuit and consumption of their drug(s) of choice is their overriding priority.

What the disease model does suggest is that no-one sets out to become addicted, but that having done so, recovery is very much the responsibility of the individual, whilst ongoing support is offered simultaneously for as long and as frequently as the individual desires it.

The equally baseless hypothesis that

being 'labelled as an alcoholic or addict' whilst spending time in the company of others who have also experienced the terror of addiction is not conducive to a balanced lifestyle or 're-integration into society', is a further distortion of the principles of the 12 steps of recovery. First, all of the self-help fellowships stress that the only person who decides whether or not to consider themselves as addicted is the individual, and that no other member has the right to 'label' another as such. Second, those who have bothered to seek the evidence of the efficacy of self-help groups by attending a few hundred or so 'open' meetings, rather than just looking at the title of each step, soon become aware that many of those who attend these groups have been through the Criminal Justice System, and that a not inconsiderable number are initially homeless.

Further, it soon becomes apparent that many of the members have experienced, or are experiencing, severe psychological, medical, or behavioural problems, yet through the help, support and encouragement of other members, many of these seem to find gainful employment (a strange concept to those on DTOs and purportedly 'engaged' in 'treatment'), become self-supporting to the point of finding rented accommodation, and are encouraged to seek appropriate professional help for problems other than alcohol or other drugs.

Given the abject failure of the current government strategy, as documented in the research and report published by John Moores University, rather than the selectively edited recent report that has emerged from the Healthcare Commission and is published on the NTA's website, such a 'lifestyle' is far more normal and responsible, than those engaged in the revolving doors of 'harm minimisation'.

Insofar as other therapeutic interventions are considered, anyone who has studied and become skilled in implementing the transtheoretical model of change will be very conscious of how compatible the 12 steps of recovery are with the various stages in the 'Cycle of Change.'

Peter O'Loughlin, Eden Lodge Practice

Unhooked Thinking

I found William Prior's article Love and Baggage (DDN, 25 September, page 8) surprising and refreshing. While writing within the framework of addiction he says 'we get confused about love, so badly do we want it'. Obsessive 'love' is a drug

and, as with other addictions, can be seriously damaging to mental and physical health. Where powerful emotions are involved, we are all slow to learn.

Anthony De Mello in his spiritually wise book *Walking on Water* tells us love is not attraction or desire ('I love the way you make me feel') although it is eternally confused with these. He questions our thinking: 'I love you, I can't live without you'; the verdict here being this isn't love, it's hunger. We are told that when we get rid of our fear, attachments and illusions enough to see a person clearly, then we can love in the true non-addictive sense. Popular culture, lyrics etc lead us anywhere but here, however. They continue to brainwash and confuse.

With its theme of Love and Baggage, Unhooked Thinking 2007 sounds set to explore the myths and complexities of human relationship and promises a broad look at addiction and that most fascinating area, the frailties of the human heart.

Angela Bott, Bromsgrove

User group advice wanted!

We are setting up a new service user venture in Medway Kent, and would appreciate readers' advice.

A group of us who have suffered from drink and drug addiction and met through attending AA and NA meetings have been discussing the ongoing effects of depression. (I am still taking antidepressants and have been for about six years).

So often we have heard people say 'go out and join a club', that will cure you. This is not an easy thing to do in an area where the majority of social activities are based around pubs, which is not a very good idea for those of us in recovery.

A few of us who have shown an interest in doing something to raise the profile of our lives are starting a coffee get together to put our heads together on activities that we can participate in, and the formation of a drop-in centre for people in the same situation, who don't want to be talking about the drink and drug 'war stories' all the time, but need relief from the drudgery of depression.

If any readers have experience of similar activities, their suggestions would be most welcome.

Trevor, by email

Email Trevor at ts006q4169@blueyonder.co.uk if you can offer suggestions. The group's meetings will begin on Friday 13 October, 1-4pm at 55 Green Street, Gillingham. All welcome.

Comment

Learning the hard way The independent inquiry into the care and treatment of Michael Stone has outlined lessons on dual diagnosis that we cannot ignore, says Mike Ward.

Michael Stone's killing of Lin and Megan Russell ten years ago is entrenched in the public consciousness. The fact that he had a severe anti-social personality disorder sparked a public debate and led almost directly to attempts to re-draft the Mental Health Act.

Unfortunately various legal appeals and challenges to the inquiry process have meant that the report could not be published until September 2006. As a result some of the lessons are less striking now than they would have been when the report was completed in 2000.

Nonetheless, Michael Stone belongs to a group who are still among the most challenging to deal with: those with a severe antisocial personality disorder, drug and alcohol abuse, and occasionally, psychotic symptoms.

Stone came from a disrupted family background. He spent his adolescence either in care or in custody. He was using heroin by age 17 and was still using at the time of the killings.

He was 36 at the time of the killing and had had regular contact with mental health, substance misuse, prison and probation services. The inquiry found no evidence that the killings were directly due to failings in the provision of services; indeed in some areas services in Kent were to be commended. Nonetheless there are failings which provide important lessons.

The key message is familiar from other inquiries. From 1993 to 1997 Stone was in contact with the mental health and drug teams in Medway. The initial work of the drug service is praised: it was responsive and there were joint care management meetings between mental health, substance misuse and probation services. However, later in his care there are criticisms of inadequate care planning, ie poor implementation and review of a care package, poor coordination with other agencies, and inadequate sharing of information. These familiar themes run across all the main agencies working with Stone.

However, the most powerful passage of the report is that which talks about the challenge of working with drug using personality disordered clients. The report challenges those who take a defeatist attitude to this client group:

...there is no simple remedy, but that is not a reason for doing nothing. What has to be done is patiently to take all reasonable steps to reduce or remove the negative influences on the individual's life, build up the positive ones, and assist... in a return to a style of life and behaviour more consistent with survival in the community... There will be many reverses, failures and disappointments, but that is so of many conditions, physical, mental and social, which confront the caring agencies... The cancer patient is not abandoned because there is no cure.'

The report is almost 400 pages long and contains many other useful insights, such as a section on the application of the law on confidentiality. However, the greatest tribute to the Russells would be the application of its demands for a better response to those with a dual diagnosis of substance misuse and a personality disorder.

Mike Ward has been a member of both homicide inquiry and drug death review teams and provides training. He can be contacted at Michaeljohnward@btinternet.com