

**Your clients will die of alcohol...**

To be under-quoted is sometimes to be misquoted and such it was with the report in *DDN* of my talk to the ANSA conference, which began with me saying 'most of your clients will die from alcohol'. I would like to use the opportunity of correction to expand a little on the statement in its more realistic entirety:

'Of the clients who die whilst under your care, most will die because of alcohol, in combination with other drugs such as benzodiazepines.'

Depending on the service you work in you might quibble with this statement; for most services however, drinking clearly has a huge impact on drug related deaths. I raised this issue in response to a practitioner claiming that alcohol was not his concern as he worked solely with drug users. This may be, but it is pretty unlikely.

Excessive consumption of alcohol amongst in-treatment drug users is widespread and often not addressed by treatment services. This failure to respond has a detrimental impact on treatment outcome, raises the mortality of clients and leaves them ready and primed to take up a full blown alcohol problem if they successfully graduate the drug treatment system.

Most people who approach alcohol treatment services do not use drugs; the reverse is not the case. With the legality of alcohol and the illegality of drugs, people with dual problems will tend to arrive at drug services. They will also tend to understate the severity of their drinking and even not raise it at all if workers fail to conduct adequate screening.

I would suggest that it is a mistake to see excessive drinking as a distinct problem, separate in nature from the presenting drug problem. For drug users who drink, the difficulties in controlling consumption of both substances are likely to be deeply interwoven; perhaps to the extent that the option of referring on to another agency is facile and against the client's best interests. The psychotherapeutic interventions we need to encourage change in drug use are pretty much the same as for alcohol; a priority must be in enabling existing drug workers to respond to the drinking of their clients.

The NTA has raised the issues in their briefings on drug related deaths and promoting safer drinking amongst drug users, though neither document offers remotely sufficient guidance on how the drug treatment sector should respond. We can only hope that both Models of Care for Alcohol Misusers and the revised Models of Care for Drugs Misusers will provide a stronger framework for both services and commissioners; including alcohol in the NDTMS would be a good

place to start in providing some perspective on the problem.

**Richard Phillips, Director of Services at Phoenix House.**

(Richard Phillips has previously worked in both the drug and alcohol field and recently moved to Phoenix from Alcohol Concern.)

**Facing the demons of addiction**

I do like a thoughtful article about Addiction and what it is – it is a bit like trying to find the ideology in the third way – slippery stuff. But I agree with William Pryor when he says it is painful to be human. For some, life is actually more painful than for others, and the drama can be knife-edge, threatening some with a youthful death without help. Pryor is quite free (as he does) to call himself a junky, but I would feel uncomfortable about labelling him. I am quite convinced that that labelling perpetuates prejudice experienced by the vulnerable. That's you tagged then – junky troublemaker!

But whatever addiction is, an attachment to things or brain changing chemicals that help humans avoid reality and pain, or a mixture of both – there is plenty of evidence that shows that the brain chemicals have something to do with it. I have low levels of serotonin, which in me trigger depression. I swim a lot and this produces endorphins, which make me feel better. But this does not explain why I have low levels of serotonin. I think it is because I drank a bottle of vodka plus a day for five years of fifteen years of heavy drinking; that I was beaten up by my father who drank more than I, when I was very young, (fear and feeling unloved by someone I loved hardwired my brain responses perhaps?).

What I think matters, because I stopped drinking through AA help and my own capacity to face fear, so have something to measure my progress by. I faced the demons that made me feel worthless and that threatened me with death at the age of 34. That's the point. Facing the demons, facing reality, that life is painful but that it is possible to live well without recourse to a drug or drink that was doing my liver in and making me behave in harmful ways.

Knowing why we drink or drug is important but nowhere near as important at the beginning of recovery as finding ways to stop. Demons need to be faced sober or they drag you down into the undertow. When you are on dry land you can better afford to be a roving philosopher – and consider the existential angst that may assail all of us as we ponder the meaning of life.

Meanwhile, drug and drink free I can better act to challenge the evil that others do in my name and actually allow

myself to act to help myself and others. In this way I become and grow. That is the true metaphysic – the act of becoming and reaching for the light, where I stand up to fight real monsters, not drug induced ones, and find the courage to do so.

**Name and address supplied.**

**'If you ask any patient... if they would prefer a treatment which cures or contains their condition, they will plump for cure every time. Many patients perceive a detoxification as a curative solution to their dependence. We all know it's not as simple as that.'**

**Is maintenance really an insane option?**

Jon Royle paints himself as a marginalised 'heretic' whose freedom of expression is being stifled by what must be some kind of methadone 'inquisition', presumably unexpected and non-Spanish (A Balanced Approach, *DDN*, 3 October). However, I don't buy it. The abstinence-oriented approach he represents is getting an increasingly reasonable crack of the commissioning whip these days. As it is, we're going to see more of this as the NTA Effectiveness Strategy begins to bite. So Jon shouldn't fret, his time will come.

But is it really 'insane' to provide substitute opioid medication to heroin-dependent patients? After all, they've pitched up for that hour-long interview and are explicitly asking for – yes, they ask for – the physical, psychological and social relief that methadone or buprenorphine (Subutex) will provide for them after they walk away from the clinic. The logic of his own argument (that the patient should get what the patient wants) is inescapable.

On abstinence, he notes that 'surveys have shown if you bother to ask drug users, it's what most of them want anyway'. Well yes, of course they do. If you ask any patient with a severe and

chronic condition if they would prefer a treatment which 'cures' or 'contains' their condition, they will plump for cure every time. Many patients perceive a detoxification as a curative solution to their dependence. And, I think we all know, it is not as simple as that.

I'll debate the long-term efficacy of methadone maintenance treatment with anyone, although one would have thought that the abundance of international research evidence from systematic reviews, randomised controlled trials and other studies would count for a bit more than the 'faith' in some individual success stories upon which Jon appears to rely. Unfortunately, the NTA Effectiveness Strategy, as Mike Ashton pointed out in his highly enlightening letter (NTA strategy: raising expectations, but heading for a funding crisis, *DDN*, 5 September) also appears to be predicated on a number of articles of faith: that the optimum length of treatment is six years or thereabouts; that the generic support services that have consistently failed drug users in the 10 years since the first national drug strategy will somehow come good; and that, ultimately, patients can be assertively managed through and out of treatment services successfully.

**Simon Morton  
Tameside Substance Misuse Services**

**Can you help student project?**

We are currently researching the effects of media influence on young people to do with crime and in more detail, from films such as *Snatch* and *Layer Cake*.

Does our issue have any links to drugs and drinking from influences that films may provide, such as stereotypes or role models?

We are doing an educational project in our media course at John Leggott College. If any *DDN* readers can help by providing us with any information that might be of interest, we would be very grateful.

**Sara Williamson and Carly Temperton  
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**Should services inform DVLA about users' fitness to drive?**

Our Trust is developing guidance for practitioners regarding Fitness to Drive and responsibility for reporting to the DVLA.

Specialist Drug and Alcohol Services (SDAS) developed *Guidance for Staff and Information for Service Users regarding Fitness to Drive* some time ago, summarising DVLA guidance (available at: [www.dvla.gov.uk/at\\_a\\_glance/AAG\\_SEPT\\_2005.pdf](http://www.dvla.gov.uk/at_a_glance/AAG_SEPT_2005.pdf)).

This guidance makes it clear that it is

the drivers' own responsibility to inform the DVLA of relevant medical conditions; these include 'drug and alcohol misuse and dependency'. Medical staff, and by extension in multi-disciplinary service settings other practitioners, have a duty to advise service users accordingly.

However, in cases where service users (a) do not inform DVLA, (b) continue to drive and (c) their condition is such that their driving is likely to place others at risk, practitioners will have a responsibility to inform DVLA themselves:

'It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving. On occasions however, there are circumstances in which the licence holder cannot, or will not do so.

The GMC has issued clear guidelines\* applicable to such circumstances, which state:

**1.** The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may, now or in the future, affect their safety as a driver.

**2.** Therefore, where patients have such conditions, you should:

- Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.

- Explain to patients that they have a legal duty to inform the DVLA about the condition.

**3.** If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained.

**4.** If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin. If they agree, you may do so.

**5.** If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA.

**6.** Before giving information to the DVLA you should try to inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.'

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*At a glance Guide to the current Medical Standards of Fitness to Drive (DVLA, September 2005, p.4)*

There seems to be a change of emphasis from point 2: 'may impair their fitness to drive...' to point 4: 'if patients continue to drive when they are not fit to do so...' implying that assessment of fitness to drive has already taken place by virtue of the service user having a particular condition.

The DVLA guidance makes it clear that most, if not all, service users in treatment for drug or alcohol 'misuse' or dependency would be likely to have their licenses to drive revoked for a minimum period of six months.

All of which is a long preamble to a central question: should drug and alcohol services routinely inform the DVLA about those service users who meet DVLA criteria and who don't do so themselves, breaching confidentiality if necessary? Do they do this?

Our present guidance suggests that each person's circumstances are assessed individually and discussed in a multi-disciplinary meeting; if it is deemed that the person continuing to drive will place others at serious risk of harm, and they will not inform DVLA themselves, then confidentiality will be breached and the DVLA informed (immediate action would be taken in respect of imminent risk such as that posed by someone who is clearly intoxicated).

However, we are now reviewing this guidance through our Clinical and Practice Governance frameworks as it seems that it may contradict the DVLA guidance cited above.

On the other hand our discussions have also considered the likely impact on retention and engagement in treatment of a policy of routinely informing the DVLA.

I would be very interested in hearing how other services approach this issue.

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# Comment

## Women, cocaine and media morality Shock horror! Media outraged as model Kate Moss is discovered to be using cocaine! It's all a bit familiar, says Kevin Flemen.

In the acres of newsprint that have been devoted to Kate Moss, and her very public trial by media, I've been looking out for one name: Billie Carleton.

The stories of Billie Carleton and Kate Moss share a strange similarity, and it's perhaps surprising that more savvy media pundits haven't looked into their celebrity history to make the comparisons.

For those who haven't heard of Carleton, she was born Florence Leonora Stewart in London in 1896. Changing her name to Billie Carleton, she worked her way up as a showgirl, firstly with bit-parts in the chorus and later as a lead. As she became more famous she became one of the glamour girls for London during the First World War, appearing in the pages of *Tatler* and other publications, a photo-portrait starlet.

On the one hand, Carleton was lauded for her looks and talents, described as 'a young girl of flower like beauty, delicate charm and great intelligence'. Her career was dogged, however, by allegations of drug use. It was alleged that she had been using opium in her early twenties and as her career escalated, the rumours became louder, focussing on her cocaine use. By 1918, although she had become increasingly well known in the media and on the stage, her drug use had escalated, with the drugs and the attention hurting her personally and professionally.

Tragically, Carleton died on Armistice Night, 1918. Following a celebratory party, she had retired to bed. She never woke. While the media widely blamed her death on cocaine, it seems more credible that she actually overdosed on the barbiturate Veronal, which may have caused death through suppressed respiration.

Carleton's story has more than a superficial similarity to that of Kate Moss. The story of both is that of women, living a double-edged world of glamour, and of drug-related tawdriness. Whilst the *Tatler* and the other papers were putting Carleton on the front pages, selling copy with slightly risky images, the fact that she was using cocaine had become common knowledge; in the same way the media have been happy to trade off Moss' glamour whilst aware of her drug use.

The story of every woman fallen from grace needs a manipulative male figure in the background. The 'classic story' is of the woman, vulnerable and weak, tempted and led astray by the man, with tragic consequences.

In the case of Billie Carleton, this role was played by Reggie De Veulle. He was a

fashion designer who created costumes for Carleton. He also used cocaine. Following her death, De Veulle was charged with manslaughter. Responsibility was his, the prosecution argued, because as a man, he led the vulnerable Carleton astray.

In today's drama, Pete Doherty plays the role of De Veulle. As the 'junkie boyfriend', friends of Moss and some media commentators blame him for Moss' current situation.

In De Veulle's case, he was acquitted of manslaughter. It seems that, despite prosecution attempts to paint the worst possible picture of De Veulle – 'somewhat foreign appearance and accent...[with a]...effeminate face and mincing little smile...' the Jury still accepted that Carleton had made her own choices and decisions.

It is a shame that Carleton has been forgotten by the media and commentators. In neglecting to tell Carleton's story alongside that of Kate Moss, we have lost the historical and social narrative that underpins both stories.

Over 90 years, so much has changed and yet, amazingly so little. A famous, glamorous woman using cocaine draws the same two-faced attention from the media. There is the craving for the sensational story, observed through the critical morality that sermonises and moralises.

The decline and death of Billie Carleton came only two years after legislative changes had been introduced to restrict the sale of cocaine. Changes to the Defence of the Realm Act (DORA) in 1916 restricted the sale and possession of cocaine. Yet opium and cocaine were still widely available around the West End of London.

Then, Germany was the world's biggest manufacturer of cocaine from cocaine. This trade had initially been via pharmacies, and then, as the new restrictions under DORA came in to force, a new wave of street hustlers emerged, selling on drugs on the streets, bulking out drugs and selling at increased cost.

Ninety years later, the laws have been made stricter, the penalties have increased, and opiates and cocaine are still widely available – not just in the West End but across the UK.

The price has gone up. But otherwise the story seems to have changed very little.

*For a more on women and drug use through the first half of the 20th Century, see 'Dope Girls: The birth of the British Drugs Underground'. Kohn, Marek: Granta: 1992). Kevin Flemen runs drug consultancy KFx.*