Clarity missing from coercion debate: what's really happening?

In response to the 'This house believes...', debate in *DDN*, 21 March: I sense another dialogue of the deaf amongst substance misuse professionals. The semantics and emotion surrounding the use of 'coercive' in the debate on DTTOs and what might follow in terms of treatment, clouded rather than clarified the issue.

What was missing for me in the reported debate, was a sense of what is actually happening in terms of the 'treatment plan' attached to individual DTTOs.

When I first heard about the massive investment (£500m) in the CJIP, aka DIP, initiative I hightailed it to a friendly senior probation manager I knew and asked what this was likely to look like in practice. The answer I got surprised me.

First, there would be an assessment against an offender profile to identify clients who were likely to stick with the order. Broadly these were defined as 'drug addicts who have fallen into crime', as opposed to 'career criminals who have fallen into drugs'. The latter group were seen to be more intractable and the former more likely to be facing a turning point and thus more likely to be seeking a successful outcome.

Second, the treatment plan 'could be as much as 20 hours per week'. Such treatment was non-residential and unlikely to move the client from their place of risk (neighbourhood where drug abuse and their crimes took place). Any therapeutic process was unit-cost managed.

Subsequent to that meeting, I learned from another contact that 20 hours was wildly optimistic and would more likely be three hours per week for a drug test and 'how's it going?' chat with the client manager.

Thus the business case for the treatment side of the DTTO is reduced to the unit cost difference between prison and DTTO. This distorts the real business case – the difference in life-of-crime costs associated with an individual and the costs of an effective programme of treatment leading to their recovery and rehabilitation.

If this is widespread, then it is no wonder that 'coercive' testing and treatment fails at even its most basic level – 'retention in treatment'. This in turn undermines the intent of the initiative, which is to get the 'drug addict referred by the criminal justice system' both out of their addiction and criminality. I am told that getting such addicts to address both their addiction and criminality is intensive, a '24/7 regime of therapy, diversion and support for three to six months, with a further six to nine months of regular ongoing contact and relapse prevention – all conducted away from their place of risk'.

It would be helpful to know just how much of the £500m is spent on treatment and how much is CJIP admin costs – one figure from the NTA suggests that just over £100m of this new money is being earmarked for treatment for criminal justice referred clients. I am happy to be proved wrong.

The problem is further compounded by the divide in thinking between service providers who seek abstinence focused outcomes and those who are content to just stabilise addicts through long term substitution prescribing. (Substitution prescribing in this context seems little else but a chemical prison.)

The issue is also marred by too flabby a definition of 'treatment'. (The NTA lumps six differing things together in terms of treatment places.) I appreciate 'client centric plans' make it difficult to generalise, but patterns do emerge and some standardisation is necessary to measure the effectiveness of approaches. For the criminal justice referred clients, there is a dual jeopardy at work; the bias of practitioners and the postcode lottery created by commissioning managers' prejudice.

What I would have liked to have seen in the debate, was a discussion of what an effective treatment plan and its outcome should look like, for people referred into treatment through the criminal justice and offender management system.

To help such clients agree the intensity and duration of their care plans, they should also be informed about the underpinning philosophy and success rate of the service providers they end up with.

It will however require the managers of the CJIP/DIP process to be more honest, or even informed, about the time needed to recover from addiction and the costs involved.

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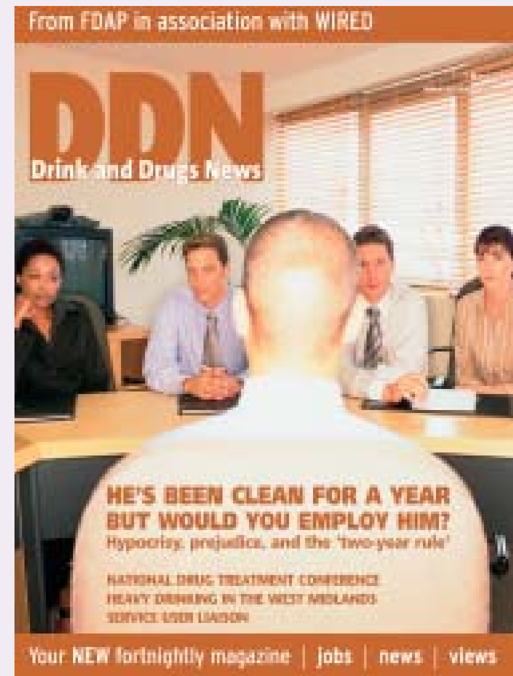

What constitutes 'risk' when employing former drug users?

Responding to your cover story: 'The two-year rule', *DDN*, 7 March: I work for the Shaw Trust offering employment related services to clients with addiction problems. The project is funded by the Essex DAT and Social Services.

I take each client as an individual case; I encourage further training and a life skills course for those who need it as part of their rehabilitation and to put some distance between their using and their criminal records – also to put something on their CVs. We offer host-client ongoing mediation and retention services. Substance use is dealt with as an occupational health issue and information is exchanged on a 'need to know' basis. No information is given without the informed explicit consent of the client. The client can withdraw consent at any point, in the course of our work together.

I have found small host companies more willing to employ. Bigger organisations are more reluctant, but employees benefit from superior employment policies and procedures. I have placed people in voluntary work in the addiction field as early as six months.

The Shaw Trust is currently working on creating a consistent policy across the Trust. The first questions to come up are:

A Disclosure Policy, *ie* when we present a client to host companies, should we encourage the client to disclose that they are in recovery? If so, how long in recovery before we do not encourage disclosure at all? Six months? One year?

> 'Many Clients want to leave our service on the point of going into work so as to avoid prejudicing their employment chances. If we know that they are putting themselves or others at significant risk how much onus is there on the Shaw Trust Officer to breach their confidentiality?'

Many Clients want to leave our service on the point of going into work so as to avoid prejudicing their employment chances. If we know that they are putting themselves or others at significant risk how much onus is there on the Shaw Trust Officer to breach their confidentiality? We are mindful that the boundaries of confidentiality have been explained to them on initial contact with the Trust and repeated during their time with the Trust, and that we are no longer in a professional relationship with them.

How do we establish what constitutes significant risk?

These will be the first of many such questions, and I would much appreciate any thoughts your readers may have on these matters.

Cathy Chabo, Shaw Trust

Can we protect young people from being stereotyped?

In *DDN*, 24 January issue (page 5), you printed a request by documentary filmmakers, to interview a young person, aged 11 to 14 years, who has a chronic problem with alcohol use over several years.

On hearing that such a documentary was to be made I became concerned that such public exposure could be damaging to a young person. This could be in terms of how others may come to view the young person within the school environment and in the future, possibly potential employers, as well as other young people or friends and family. I would also question whether someone as young as 11 could assess the impact of taking part in such a programme upon their own sense of self and the effect of public exposure in the future.

Secondly, where a young person is involved, I think thought should be given about how the substance use is described. The programme could be seen to label that young person as an 'addicted' substance misuser or problematic user – these are familiar terms to use with adults, but how useful are they for young people?

My concern is that by focusing on the individual child and their relationship to a particular substance, other issues will be overlooked – for example, the social environment, effects of poverty or the type of parenting the young person has received.

The label of 'substance user' or 'alcohol user' can be unhelpful for younger children. This is happening increasingly in the media. This drive to label children as 'suffering' from different conditions is occurring a lot earlier in their development than previously.

It may be more helpful to examine the following:

- Attitudes conveyed in parenting, for example the behaviour that is modelled by parents in relation to drugs and alcohol. If alcohol is made readily available to children how is it that this is happening? And who is responsible. Parents? Off licences? The wider community?
- Alerting behaviours: children who do not receive clear boundaries or love or comfort, and who are emotionally impoverished, will develop alternative coping mechanisms in the drive to get their needs met. These mechanisms or behaviours, however dysfunctional, are often a response to the lack of love and effective parenting. To give the child a label at this early stage based on the dysfunctional behaviour takes the focus away from the causal factors.
- Understanding the pressures young people are under. At the same time that young people are being seen as a marginalised group with unmet needs and pressures upon them, they are also being criminalised or burdened with labels inappropriate to their age and development. It is widely recognised that young people are frequently the victims of crime and often do not have a voice to speak out about what is happening to them.

There is increasing awareness of the anti-social behaviour of young people, but what about the causes? Often these are too painful to be revealed and, for adults, buried deep within our own childhoods. Often the causal factors are so ingrained in our society that we can only catch glimpses of the dysfunction of the system or the culture that perpetuates it. As adults, and as a society, we have learnt to internalise our distress whilst children enact or externalise their distress in more obvious ways.

This debate is relevant to many conditions and their accompanying labels which now are being used for younger and younger children; for example labels such as 'self-harmer' or 'anorexic' are being given to children as young as six or seven. This is not to say they don't exhibit characteristics of those conditions, but that they may be being burdened with unhelpful diagnoses too early on.

Possibly an approach could be to examine what intervention could have helped each time the behaviour occurred. Our attention should be drawn to the environmental or familial factors at play that allowed the behaviour in the child to take place. This would be relevant for any self-damaging behaviour a child engages in, from self-harm to substance misuse. I believe that paradoxically it would be more helpful to take the focus away from the child as a way to keep the 'adult style labelling' from them.

This is exactly the process we would use with a toddler that strayed to close to a fireplace – we wouldn't analyse whether the child is a risk-taker or addicted to danger; we would intervene in a protective manner and examine or change the environment. I believe this approach becomes subtly more complex as they get older but in essence the responsibility to provide safety remains the same.

At Brighton Oasis Project we use harm minimisation techniques and assess the young person's ability to access or make use of mechanisms that keep them safe. We also explore whether negative beliefs and patterns of familial substance use can be challenged internally and externally.

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Often the aim of such interventions is to enable young people to feel they have a right to access mainstream young people's services and support in the same way as any young person, rather than feeling that they are an outsider because of the problematic substance use. Minimising the negative stereotyping and stigma of being a substance user becomes integral to the intervention.

Many of us who work in the substance misuse field recognise the damaging effects of the stigma and negative labelling upon adult service users – what then is our responsibility to young people?

How do we focus on the problematic substance use without reinforcing the negative stereotyping this could lead to?

Could it be possible for drug and alcohol practitioners and the FDAP to take a united stand on this in order to protect young people from sensationalised stereotyping?

We are, after all, the professionals that day in, day out, work with the complex range of issues that young people present with and understand better than anyone how simplistic labels like 'addict' are unhelpful and damaging to the self-esteem of children and young people.

I would like to open up a debate and encourage other practitioners to respond via the pages of *DDN* and share their experiences of dealing with these issues.

Tania Soley, Young People's Services Co-ordinator, Brighton Oasis Project