



**I am a recovering addict of nearly five years and I am interested in becoming a substance misuse counsellor once I have completed the final year of my BSc in Psychology. Would anybody be kind enough to recommend pathways into this area as there are so many courses available it is hard to know which ones are effective, accredited by the relevant governing bodies, at the level needed in this field and so forth. Any help would be most appreciated.
Scott, by email**

Common ground

Dear Scott
As you say there are many paths, but there are some commonalities:

It is generally agreed that to practise as a counsellor you need to have a minimum qualification of a Diploma in Counselling.

A degree in psychology is great but it's not a counselling qualification.

Some specialist knowledge or training is essential if you want to work with substance misuse or dependency.

You can approach the qualification framework by first getting a Diploma in Counselling and then specialising in addictions, or you can set out to qualify as an addictions counsellor from the start.

If you take the general counselling route, then you need to decide which 'model' of counselling you wish to study and take it from there. There are a myriad of possibilities and most colleges and universities offer counselling courses in a variety of packages.

If you decide to go direct to training as a substance misuse counsellor, there are relatively few options. There is still a bit of a divide between the harm minimisation school and the abstinence-based approach, which you might want to investigate. Below are a few suggestions:

Dedicated treatment centres which also offer 'in-house' counsellor training – eg Castle Craig.

The Hazelden Foundation – a well-

established American-based training unit.

Clouds House – offers a Foundation Degree, either full or part-time.

Leeds Addiction Unit – provides some distance learning courses which include addiction issues.

RAPt – one-year full-time Addiction Counsellor Training Course, RAPt Diploma plus CPCAB Accredited Certificates at levels 2 & 3.

Good luck with your route.

Jane Norton, Training Manager at RAPt

Many routes

Dear Scott,
There are as many pathways into this field as there are interfaces to work at. If you have the opportunity, choose where you'd like to be (setting) and then figure out what it takes to get there. A way to do this might be to consider the setting where you'd like to counsel substance misusers.

If you are unsure, visit as many agencies as you can, in as many settings... and talk to the clients. Ask yourself, are you interested in meeting them where they're at? Can you hear what they are saying to you? Could you make a difference? The agency will tell you what it requires with regard to competencies.

Try not to be influenced by the rubbish about counselling models you might hear in the counselling bazaar. There are hundreds of them, with new ones being invented every year. Why anyone would

want to spend another shilling or write another word comparing one against the other is beyond me when all they ever discover is the same thing: none is more effective than any comparable other. There is significant research which demonstrates that the most important factor in eliciting change is the resources the clients themselves take. The next most important factor is the therapeutic alliance.

So, models are crucial... to the practitioner. Among other things, they offer a lens through which to focus and make sense of the client's presentation. In my experience, if we can't see the client properly, it's because there's something wrong with the camera, not the client. We know they have the strengths and resources and choices that will make a difference. Find a camera you're comfortable with.

The organisation I work with has placements in training from the Clouds

foundation degree. We also have placements on a local integrative diploma and a local CBT diploma. All are excellent courses, but it is the individual qualities the placements demonstrate that make a difference.

Agencies have different employment policies. In a counselling position, we won't employ anyone with less than a recognised, accredited diploma. However we do employ a range of practitioners, addiction counsellors, Rogerian counsellors, CAT practitioners, psychodrama practitioners, systemic family therapists, CBT counsellors, and eating disorder specialists. Many cameras! And I'm bound to have offended someone by forgetting one.

You're welcome to visit here and meet with the clients and the staff, if you find it useful and practical.

Kind regards and bon voyage.

John Trolan, programme director, The Nelson Trust

Reader's question

I am nearing the end of a mandatory life sentence, having spent the best part of 18 years in and out of detention centres, borstals, prisons and institutions. During my time in prison I have learned to read and write and educated myself to GCSE level. I completed every course the education department had to offer and have over 50 certificates. I am about to do a diploma course on counselling children and adolescents, after which I would like to do some voluntary work. I really want to put something back into the community: please can anyone point me in the direction of any contacts, a company or organisation that might be willing to give me some voluntary work?

Terry, Parkhurst Prison

Email your suggested answers to the editor by Tuesday 9 January 2007 for inclusion in the 15 January issue of DDN. New questions are welcome from readers.

Reducing drug-related deaths conference: Debate

'This house believes that increase in abstinence services will result in more drug-related deaths.'

Proposing the motion:

Dr Chris Ford, GP in London

This is a very important debate. We know that many if not most drug-related deaths are preventable, and this includes overdose and deaths from bloodborne viruses. Both types are preventable with treatment.

Overdose is most common in opiate users after they've left prison, or left treatment prematurely, and often they're in a situation where they don't have clean equipment.

Since 1991 deaths have been going down. Why? Has there been an increase in drug treatment? Is it related to meth and buprenorphine

being prescribed? The reality is that the quantity and quality of treatment has improved, and we know that well-managed methadone treatment can improve prospects.

Detox can be dangerous and is not very often successful. Death rates are higher in recently detoxed patients. Even the wonderful NTA, who I sometimes disagree with, says the realities of detox must be discussed, based on research by John Strang and the Home Office.

Many people request detox but we need to recognise that maintenance is a very worthwhile option. Maintenance patients need our support –

including psychological support – and harm reduction has to be our goal.

The NTA says rehab providers have to provide mechanisms for rapid referral into maintenance programmes. Getting people off drugs is dangerous.

Bill Nelles, founder of The Alliance, said: 'Let's take the morality out of drug treatment and put the humanity back in'. Judy Bury [GP] said it is our job as GPs to keep people alive until they are ready to change.

There's not much evidence for long-term effectiveness of detox, but it can reduce tolerance. People



Working lives:

John Fox, young people's service worker, Kirklees

John Fox's dream job at Lifeline Kirklees gives him the chance to give young people the help he couldn't find in his own teenage years.

When I took my role within Kirklees User Forum (KUF) in September 2004. I had been accessing treatment through Lifeline Kirklees' structured day care service Outlook, which offers educational and structured activities for people wanting to return to mainstream society. I became involved with the KUF because of the problems I had in the past with my years of substance misuse and the hardships I experienced while trying to access a service for my heroin addiction, when I was 21.

The service I had contacted had such a huge waiting list I could not wait; and so I did my cold turkey, which was a nightmare. But it helped me to turn my back on smack and I have been clean for nearly ten years. I then developed a problem with cocaine, which ripped through my life and left me with nothing – not even any self-respect. This was not crack addiction, but a drug every one thinks is fun and manageable. It's seen as even more socially acceptable now, rather than a life-destroying experience. KUF gave me a passion, a role, and a movement that could make a change. It could give the user a voice and, also help the services to become more user-friendly and more accommodating to their needs.

Lifeline and our local DAT invited us to meetings, which helped us all to improve services. We attended national and local meetings to shape policies and procedures in our local services. We also took part in producing two pieces of research, one for adults and one for young people, around services and substance misuse issues. I started to volunteer for Lifeline's young person service, Drug Sense in Kirklees. It involved doing outreach around the Huddersfield area, engaging with groups of young people, delivering advice around substance misuse, and taking part in and organising diversionary activities. I kept my role within KUF and attended my treatment programme, keeping myself totally motivated and on the road to recovery.

I continued with all my ongoing responsibilities and a post came up as a trainee support worker for Drug Sense – a job I had always wanted to do. Although I thought I had no chance of getting it, I sailed through the interview and got the post. I then stood down from KUF, as I could not manage a full-time job as well as my responsibilities there. My time with KUF ended a year to the day I joined – and what a fantastic year it had been for me all round, personally and professionally.

When I started my new post, I had a structured training program which involved working with a fantastic team of individuals with different qualities and working styles. I worked within multi-disciplinary agencies and held a small caseload. I had training around clinical interventions and prescribing for young people and was able to cover the young person's clinic.

My contract ran out and a Tier 3 generic worker post came up, which I applied for successfully. Working with young people has made me so positive about being able to deliver the help that I found so hard to find in my teenage years. So being promoted and winning another year contract has been amazing.

Working in the field has brought out something in me that I thought I had lost years ago, and it's installed in me a pride and passion for the job I do. Not many people can say they like a Monday morning.

I hope that other ex or current users can find some hope in this story and also know that our field need hands-on experience. I want to thank Lifeline for giving me the chance to express my dedication and passion for the job, and also for helping me out of my nightmare of addiction to live a clean and passionate life.

John would like to thank Kirklees User Forum and Kirklees Drug Action Team for all their much-appreciated support over the past two years.

cannot do abstinence when they walk in the service. The move toward abstinence-based treatment is dangerous and will increase drug-related deaths.

Opposing the motion:

Dr Gordon Morse, GP in Wiltshire

Healthy drug treatment should be about choice. There's an enormous – and justified – enthusiasm for harm reduction. But I hear of many services that begin and end with a script, and that is wrong. There are two sides of the coin. People have to have both; a choice.

The debate's wording is not proposing that we disinvest in harm reduction services. We desperately need more services for alcohol and crack cocaine.

But disinvesting in abstinence services and

shoving all our money into harm reduction would be a terrible derogation. Would we tell people in this room who have achieved abstinence that they've taken an unnecessary risk? It's preposterous!

Where does personal responsibility come into the equation? Drug-taking is risky, but we should have both options. Our patients want abstinence. Sixty per cent arriving at services ask for abstinence, but 95 per cent get harm reduction. We owe it to our patients: It's about offering them choice.

It's not schizophrenic to entertain both. There are far too few abstinence-based services available because of the predilection for harm reduction services.

We're seeing the answer in a prescription pad; it's easier than the alternative when you won't go

down a more difficult route. But we'll get more and more methadone patients in their sixties.

If that's the only act in town, it sucks!

Seconding the motion: Dr Tom Carnwath

Abstinence isn't an appropriate goal for therapy. You get premature abstinence which leads to relapse. Be pragmatic. Go for harm reduction.

Seconding the opposition: David Marteau

Lots of young people drink methadone without any idea of how much is enough to kill you. It's not particularly safe stuff. It seems safe – but it depends on how you read the figures from studies on safety.

Result: Motion defeated.