



**‘Should you need qualifications to work in this field?’ (DDN, 20 November, page 6) provoked a decisive reaction on our online poll. Sixty per cent of you voted ‘no’.**

### Professional standards

I believe alcohol and drug workers should have a qualification and be accredited with a professional body. It is very desirable that counselling, advice workers and support staff maintain certain professional standards and subscribe to a code of ethics and standards.

We work with very vulnerable people – sometimes very vulnerable people indeed – and the first rule is ‘do no harm’. While ‘caring’ staff may not realise, however, that too much sympathy can kill, there is also the danger of negative labelling, which may eliminate any hope that the client may have for themselves.

Not understanding abuse or addiction to chemicals may also contribute to a carer becoming irritable, stressed and impatient when working with clients who are having difficulty achieving or maintaining their goals. Jargon and negative labelling are at best meaningless, and at worst self-defeating and very destructive.

Training ensures that carers remain professional, and accreditation ensures that standards and ethics are maintained and carers do not become burnt out or stressed unnecessarily. They also need to have good support and supervision within a team.

**Christine Wilson, by email**

### Proposer missed the point

I was dismayed to read the motion proposed by Kevin Flemen at the NTA/FDAP conference reported in the last issue (DDN, 20 November, page 6).

My dismay lies largely in the fact that a training professional of Kevin Flemen’s experience and renown has so completely misunderstood the point. I can only hope that there is some devil’s advocacy going on, but I fear not. It is enormously ironic that much of the argument laid out in support of the motion is precisely why the current line on qualifications has been taken, and if Kevin actually understood how these modern qualifications work he would realise that they are in fact the solution to most of the problems he outlines.

The motion ‘being competent shouldn’t be entangled with being qualified’ should really be turned on its head: ‘Being qualified should necessarily be based on being competent’.

The proposer goes on to say: ‘Some qualifications don’t qualify anyone for anything. They show someone’s attended something for the day and managed to stay awake’. I absolutely couldn’t agree more, such so-called qualifications are worthless – but these are not the type of qualifications people are being encouraged to obtain. In fact, the stipulation of competence

assessment in the qualifications framework serves to actively discourage any reliance on such worthless tat.

For the last 20 years the whole of the UK and quite a bit of Europe has been moving away from vocational qualifications that are awarded simply on the basis of the take-up of learning, and towards those based on the demonstration of safe, effective, competent practice.

This is why large amounts of work and brain power (not to mention a few English, Welsh and Scottish pounds) have gone into bringing about a range of qualifications which can only be awarded on the basis that an individual can perform effectively – and it is these qualifications to which the NTA treatment planning guidance refers.

With qualifications which are based on a course of learning and assessed on the basis of absorption, regurgitation and re-presentation of knowledge many have become ‘qualified’ while lacking the basic competence to engage with a substance misuser, let alone assess their needs. With that type of qualification, the ‘belief that by having a group of workers who are qualified, they are competent’ is indeed misplaced.

Perhaps it’s the term ‘qualification’ that causes the difficulty. But the type of qualification which the field has been exhorted to acquire is not that which Kevin describes: It is different in almost every respect. The substance misuse field has been asked to achieve competence assessed qualifications *ie* qualifications which are awarded without requiring any particular course of learning but depend entirely on the ability to consistently perform to the national standards that they (the field) agreed. In this case, one can be assured (as far as is possible) that the worker who is qualified is competent.

The inclusion of relevant units of these expert-devised competencies into the competence-assessed vocational qualifications for the hinterland of ‘peer educators, youth workers, housing workers... etc’ will help to ensure that their interaction with substance misusers also is safe, competent and informed by consensus good practice. That’s what the sector skills councils, arm’s-length bodies, government departments, and large portions of the field have been striving to achieve.

This approach is the antithesis of restrictive and exclusive. On the contrary it is aimed at recognising the diversity of the ‘substance misuse workforce’, at breaking substance misuse out of its silo and helping that diverse workforce to recognise and identify its substance misuse role.

Every time I hear an objection such as this to the value of qualifications in improving services, that objection is based on misunderstanding and criticism of something entirely different from reality.

Another ill-thought-out criticism is that people don’t only need competence, they also need learning – as if the fact that qualifications don’t require a specific course of learning means that learning and theory are not required. Of course they are. If one needs theory in order to practise effectively and one doesn’t have that theory, then one will not be able to perform competently and will not be able to become qualified.

There is simply a move from measuring the uptake of learning (which may or may not result in effective practice), to measuring the application of knowledge and skills (wherever they were acquired) at the business end. It’s really not rocket science and those who understand this fairly simple premise tend to agree that measuring the proof of the pudding rather than examining the ingredients is a good idea.

Perhaps the secret is in throwing out our old concept of qualifications as being necessarily about recognising learning. The qualifications which have been developed for, and recommended to, this field by the NTA/Home Office are about quality assurance of day-to-day work and professional accountability and recognition.

**Iain Armstrong,**  
alcohol and drugs advisor (workforce development), alcohol policy team,  
Department of Health

### For the sake of balance

I voted ‘no’. While I appreciate that there should be qualified workers within this field especially when it comes to recovery medication, I think there should be a balance.

I work as a project co-ordinator for an access service that provides help and support for people with drug and alcohol dependency problems.

I took on this role in February 2006

with no degree or qualifications in this field of work. (I have since done a motivational interview skills course and alternative therapy courses.) However, since I have worked with clients, I have found that compassion and empathy are among the most important parts of this job. Clients have confided their innermost thoughts and demons to me. If the clients want further help, I have been able refer them to the relevant local services.

At the access service, myself and a support worker colleague have set up an alcohol dependency self-help support group.

We run a seven-week programme on drink awareness, health effects, alternative recovery therapies and relapse prevention. Through our and the group's support, some of those members have cut down their drinking and some have had success in becoming abstinent.

When we started this I had very little knowledge in this field. But over time, through finding out information and the help of the members, I have learnt so much that I am able to give to future members.

Also, recovering addicts can be among the best support workers as they have been there and experienced the difficulties. They have knowledge of what can work and what does not, and can provide a lot of advice to other people that are struggling to recover.

While I said 'no' on the opinion poll, I think that a balance of qualified and non-qualified workers, with other life skills to offer, can bring a good balance to the service that we provide.

**Lorraine Green, Project Co-ordinator, Woodgrange Access Service**

## Hands-on results

To be of value, any route to effective training in the rehabilitation field must contain at least two main components:

The system of rehabilitation being studied must be effective *ie* it must have a finite end result in the form of comfortable long-term abstinence, and, it must be 'hands on' so that the student can directly prove for him or herself the viability of the system, and thus know with certainty that it works.

**Kenneth Eckersley, the Narconon Programme**

## More than just accreditation

I've worked in the addictions field for 16 years, I am accredited (NCAC) and I do possess qualifications – despite most of my significant influences being from 'unqualified' people, many who have inspired me through both their knowledge and experience. It would damage the creativity, openness, and acceptance of difference in this field to bar people without qualifications.

As a counsellor/supervisor I have actively campaigned against accreditation; it effectively bars many candidates, often because of cost issues. It is increasingly difficult to meet the costs of professional practice, and I know through experience that accredited and 'qualified' people don't always make the best practitioners. They meet the costs of training, accreditation etc and can put together a good portfolio – but some lack insight and empathy.

**Mike Robinson, by email**

## Tier 4 – Where is the law?

I have been following the debate in *DDN* about Tier 4 services with some consternation.

For ten years I was a commissioning manager in social services and was involved in the development of community care in the substance misuse field from the outset in the early 1990s. So I am constantly surprised about the framework for the debate about the development of residential care. Where is the reference to the law?

Little mention is being made of the legal framework of the NHS and Community Care Act. The Act and subsequent legal rulings gives a very powerful framework for improving the provision of residential care and in a way would reduce the costs to the NTA.

It is almost as if the drug and alcohol field is so used to working in a world where progress is made through negotiation and cajoling of reluctant partners, such as primary care or mental health, that we are unused to having the law on our side.

However, the law is on our side. Every local authority must offer an assessment to any drug or alcohol misuser who requests it. If this person meets the nationally established eligibility criteria then there is a duty to fund. This has been clarified by legal

judgements over the years.

The reason there is a problem in the provision of residential rehab is that local authorities are skirting round these legal duties. In my current role as a consultant, I have visited area after area where access to community care funds has become so obscure that no-one bothers to ask anymore.

A more effective and cost-effective way of developing the field is to:

a) Enforce the requirement that local authorities advertise their assessment procedures and eligibility criteria.

b) Require local authorities to publish figures on assessments and placements for drug and alcohol users.

If service users are not getting access to community care funds, then there should be encouragement for a legal challenge. If drug and alcohol agencies fail to appeal against decisions that are unfair or challenge processes that make access to community care funds difficult, then we are colluding with the local authorities' poor practice. By not subjecting community care to the legal challenges that have been relatively common in other care groups, the substance misuse field is failing to clarify and define service users' rights.

**Mike Ward, by email**

## Does anyone care?

'National and international evidence consistently shows that good-quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing-drug related offending.'

The above is stated on page 7 para 2.1 of *Models of care for treatment of adult drug misusers: Update July 2006*, published by the NTA. If that statement is true, then with re-offending now at 92 per cent of those on DTTOs, an increase of 3 per cent on last year, it would seem reasonable to ask what's going wrong.

Is it the models of treatment being used? The time that is devoted to individual cases? A failure to engage service users in the models being used? Worse still, given that in the latest NDTMS report, the contents of which were hailed as a success by both Caroline Flint and Paul Hayes, there is no reference to this deplorable state of affairs, does

anyone care?

It may be that the models of treatment being used are effective for those who simply misuse drugs, and for such people it may well be possible to find methods of persuading them to reduce their consumption. But there is scant evidence that what might work in such cases can ever be effective with those who are unfortunate enough to have become addicted.

There is no reliable evidence that those who are addicted can be 'educated' to use illicit drugs in a manner that could be described as safe. Attempts to cut down, no matter how sincere, simply do not work for any meaningful period of time; therefore, so called 'harm minimisation' in such cases, is as effective as a candle in a force 10 storm. With that in mind, perhaps the NTA would care to answer the following:

Does present assessment of those on DTTOs allow for screening of 'Drug Dependency Syndrome' as described in ICD-10, and/or DSM-1V?

How many of those currently in treatment have been screened for 'Drug Dependency Syndrome' within the specified criteria?

Given that both standards urge abstinence in such cases, what abstinence-based methods are being used in current treatment strategies?

What percentage of those who have been diagnosed as 'dependent' are being treated with abstinence based interventions?

If abstinence based treatment does exist, how many of the above have been continuously abstinent for a minimum of 12 months?

If, as it appears, attempting to get those who are 'dependent' off of drugs has been abandoned as a primary objective in favour of 'more realistic targets', is the escalation in re-offending included in such targets? If not, is there a target figure for re-offending – and if so, what is it? If not, why has such an important target not been included?

I do hope that the amount of taxpayers' money that has been spent on current treatment strategies is sufficient justification for expecting jargon and rhetoric free answers to the above, thus avoiding the necessity of seeking the answers via the Freedom of Information Act.

**Peter O'Loughlin, The Eden Lodge Practice**