

## Contradictory NTA

I am writing in response to Paul Hayes' letter (*DDN*, 9 October, page 8), which seems to make some strange and contradictory statements.

He says 'unfortunately it is difficult for us to act'. But the NTA is acting. They are actively supporting the current process of allocating capital funding to increase capacity in the Tier 4 sector. I would suggest that this is possibly the 'bizarre' and 'ill-judged' behaviour that should be challenged and reviewed.

Throughout his letter Paul refers to opportunities to increase capacity, problems of ineffective commissioning and concerns about the use of existing provision. So concerns do exist about the use to which this element of the treatment system is put. He even makes reference to 'access to an adequate and reliable revenue stream'. Where is this additional revenue going to spring from in the current funding climate within the NHS?

Why is it in the face of apparent confusion around the use of existing capacity, the apparent reliance on data reported to Bedvacs, and the admission from Paul that there are problems with commissioning tier 4 services at a local level, that we are still looking at spending substantial amounts of public money on creating more beds that will be under-used and ineffectively commissioned?

As a professional care management company operating predominantly in the private treatment market, we come into contact with a number of Tier 4 providers who provide services across both the private and publicly funded market. It has been our experience that some of the highest quality providers in the country, providers that the NTA should be promoting nationwide as examples of practice to be mirrored, are struggling to engage with local commissioners, struggling to engage their NTA regional manager with their service provision and confused as to why they are finding it so difficult to maintain houses at a workable level of occupancy.

Anecdotally it would seem that as well as there being a lack of understanding about Tier 4 provision amongst community workers (the letter following Paul's) there is a great deal of ignorance of the Tier 4 provision among commissioners and, dare I suggest it, the NTA nationally and regionally.

Having worked in treatment provision,

DAAT management, commissioning and strategic planning arenas for the past 11 years, I have watched as the development of community services has been driven from the centre. I have watched as budgets have been increased and the NTA expanded to drive the message of quantity, quality and effectiveness – but with little focus on Tier 4 provision across the country. There has in fact been a noticeable lack of guidance, drive or focus on the provision of residential/in-patient services until very recently.

The blame does not lie solely at the feet of the NTA. However, as the 'performance managers' of the sector, surely there is a responsibility to address matters of capacity, quality and commissioning realistically? The Tier 4 sector is difficult for individual DAATs to engage closely with. Often provision is a distance from the DAAT and few DAATs have sufficient knowledge of it to be able to assess quality effectively. Surely the NTA also has an interest in ensuring that additional funding being made available is being used as effectively as possible.

£54.9m may not be a huge amount of money in the bigger scheme of things but I and many people I have contact with regularly are concerned that it is not being used effectively to address the issues that undoubtedly exist within the residential treatment arena.

Quality residential treatment exists. Capacity can be increased by ensuring that revenue is targeted at those centres of excellence that will then re-invest this revenue and expand naturally to cater for commissioners' needs, and ultimately a better understanding of the sector needs to be promoted by the NTA.

Spend the money where it is really needed. Commissioners will of course be developing bids that appear to indicate there is a need locally; the money is there and people are very well aware that if it is not spent it will be lost. I have sat in on a number of meetings recently where the nonsense of the whole process is frightening, as providers and commissioners paint a picture of juggling with revenue streams to justify bidding for something that already exists in neighbouring areas, or at least within reach.

Slow the process down, develop a clear picture of the system, educate the workforce (commissioners and community providers), consult far more widely with the Tier 4 providers, promote quality that exists – and

please ensure that patient need is raised to the fore when considering this extremely effective treatment modality.

**Ben Hughes, operations director, treatment-now.com**

## NTA: No Treatment Available?

I have tried to resist getting into a tit for tat argument with Paul Hayes but his response (*DDN*, 9 October, page 8) to my piece on the residential funding crisis (*DDN*, 25 September, page 9) was not entirely satisfactory. If you have known about a problem for five years or so, but done nothing about it, it does suggest that somebody should be asking why this should be so. Similarly, since the NTA's Business Plan for 2005/6 drew attention to the likelihood of disinvestment by social services departments and PCTs, why were steps not taken to minimise this identified risk?

Turning to another topic, it may be interesting for others to know about our experience in respect of the Tier 4 capital bids. I had already identified the problems around the so-called consultation process in the South West region and, in particular, the severe time limitations and partnership support requirements. Having been in a position where we were actually able to put a proposal together in the few days allowed for expressions of interest, we submitted to the North Somerset DAT our plans (fully costed) for improvements in the dining, catering and recreational facilities at Barley Wood. About a week later we received a rejection on the basis that our proposals did not fit with current DAT priorities.

Perhaps this is hardly surprising, since most providers were not involved in the consultation process. We thought we would enquire as to the reason for this instant rejection and subsequently received feedback from the NTA's South West regional office. This told us that our proposal for a gym/sauna would enhance client experience and promote health, but it was not supported by anybody. This left us a little confused, since we had not asked for monies to develop a sauna in the first place. To find also that questions were being asked about what difference the sauna would make to retention rates and outcomes, was even more perplexing.

On a more serious note, this is quite ridiculous and illustrates the

inherent shortcomings in the Tier 4 capital programme. It is rushed, poorly managed and, as far as the non statutory sector providers are concerned, can be pretty well self-defeating. If the agency cannot get the support of local bodies who have not consulted the agency in the first place about establishing priorities, the expression of interest, let alone the bid, will fail. Additionally, if the body responsible for managing these funds is capable of coming up with a bid that did not exist to start with (in our case, the sauna), this does not instil a great deal of confidence in their financial management.

There is a need for an immediate curtailment of the capital programme as it currently stands and the implementation of a properly thought-through and professionally managed system for assessing priorities and distributing the funds that the Department of Health has been persuaded to release for this purpose. In the meantime they might also wish to consider if this money might be better used to ensure the continuation of current services.

**Brian Arbery, chief executive, ADAPT**

## Victim of the 'Danos effect'

A huge round of applause for Kevin Flemen, for highlighting the 'DANOS effect' (*DDN*, 23 October, page 6). I have recently moved from my home town of Nottingham to a different city, after handing in my notice at a well known drug and alcohol rehabilitation clinic. My plan, or so I thought, was to find another job in the same field with ease, based on my extensive six and a half years experience in my previous role.

I have knowledge and practice (from scratch) in assessment of client suitability for treatment (detoxification and group therapy) using a variety of audit tools and common sense. I have knowledge and practice of motivating clients for treatment and also in mini-interventions, conflict resolution, family therapy, legislation, drugs and the effect it has on the client and society, care planning, keyworking, and liaison with relevant agencies – to name but a few.

But alas it would seem my knowledge is totally and utterly irrelevant, due to my lack of DANOS qualification. Until recently I was a member of FDAR. Again irrelevant! What am I to do? I have no job and

am unable to gain access into my chosen field because apparently I don't have that shiny piece of paper that gives employers a glint in their eye in assuming that all people must be employable because they have DANOS!

I have worked with some awful DANOS trained people who are (wrongly) safe in the knowledge that they are 'good' at their job because they learnt it from a book! Whatever happened to common sense, and in the words of Kevin Flemen, 'personal attributes'? It all counts for making a good employee and should not be based on the fact that you are DANOS qualified.

All people working in the drugs field should be given the opportunity to work towards DANOS and not be pushed into it. Its a case of 'teaching your grandma to suck eggs' for a lot of people and a bloody insult to be turned down for employment based of the misconception that you are 'unqualified' without DANOS.

So where does that leave me and my six and a half years experience working as a frontline employee? It would appear that I will now have to go back to the drawing board and re-evaluate my future career as it doesn't look very likely that it will be in my chosen field!

Regards to Kevin Flemen.

**Caroline Knight, Midlands**  
PS (Somebody giz a job.)

## Power struggles nothing new

It was with mixed feelings that I read Kevin Flemen's commentary (*DDN*, 23 October, page 6). There are a number of areas where I both share Kevin's concern, but also where I fear we may well disagree strongly.

The tensions that exist between qualification and competence; accreditation; and the freedom to practice, are not new. The power struggle to define who has the authority and expertise to deliver practice (and indeed who has the power to ratify what should be practiced) is one that has been experienced by our colleagues in most other fields. The accreditation and achievement of qualifications are central to the power struggle. They are, as Kevin recognises, the currency by which membership and inclusion can be purchased.

Establishment of competencies means that someone has to establish quality standards, so that expertise can be recognised and rewarded. The key issue is that expertise is recognised in

an inclusive way. The value of a formal system of qualification and standards lies in its ability to be inclusive and to be critical.

I have no expectation that the formation of this system will be comfortable. Everyone involved in the field has a significant investment in their current status, and this investment is both emotional and financial. Do I like the fact that financial investment dictates service provision and standards? No! Do I accept that this is the way it currently has to be until significant political change occurs (on a global scale)? Of course I do!

Kevin rails against money being fed into 'key bodies'; those of us who train, educate and accept the validity (not uncritically) of accrediting bodies. However my response to this is straightforward: I currently teach at both FE and HE levels; both courses are brand new, neither existed when I was a full-time rehab worker. It took me two years of 'learning on the job' to understand that which my students learn in a matter of weeks. How many clients lost out as the result of the lack of a formal training and qualification system when I was a rehab worker? I shudder to think!

The argument surely is not whether organisations and practitioners should be 'motivated' to attend the courses and achieve the accredited qualification; the argument should be how we ensure that the courses are delivered with appropriate rigour. For this to be achieved, an accrediting body is vital.

There certainly is a mechanistic quality to the DANOS we currently have, but that is not the only quality. If DANOS were conceived to be the one and only qualification without reference to any other, then I would agree with Kevin. However, my experience as a member of a workforce planning group, and my experience with FDAP (seeking accreditation for the HE course I lead) have given me no indication that this is the case. DANOS addresses core competencies but they do not preclude other skills. They are the starting points upon which (at last) wider skills and knowledge are being slowly constructed.

Expecting practitioners to know intimately the full range of interventions is a recipe for disaster! DANOS enables key basic knowledge to be put in place first. Once this has happened then practitioners can look at building deeper theoretical knowledge and practice skills. The

support by the Sussex regional DA(A)Ts for the course I lead at University of Brighton, is a clear indication that the developmental process aims beyond just DANOS.

Unfortunately it can be real, and sometimes wilful, lack of participation that limits the process. Will organisations and practitioners have to question their assumptions when they undertake DANOS? Yes! Is this for the purpose of creating unreflective, uncritical, limited and unskilled practitioners? Absolutely not – not on the courses I, or any of my colleagues, deliver!

**Daren Britt, Senior Lecturer in Substance Misuse, University of Brighton**

## Learning to tick boxes

Good luck to Kevin Flemen in his fight against so called qualifications that are more to do with learning how to tick boxes, than helping people to come off of drugs (*DDN*, 23 October, page 6). Training in assessment, and screening for alcohol, and/or drug addiction, whilst learning the differences between addiction and dependency, together with training in the application of the Cycle of Change, and the different models of therapy, including 12-step facilitation, that the authors recommend at each stage in the cycle, are what is required rather than politically correct psycho babble.

I wish Kevin well, and admire his integrity and courage in his endeavours.

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

## Anchor project clarification

I am replying to Dr Rupert White's letter 'Creating danger zones' (*DDN*, 11 September, page 9). I would like to clarify a few issues that may have been either misunderstood or possibly ambiguous in my original article.

First of all, in the case of risk, no pregnant woman, women with young children with or without social work involvement, would be discharged from the Red Zone or taken off a methadone prescription in our Tier 3 service, however badly they are doing in treatment. There have to be extreme circumstances. Everything possible is done to engage the extremely vulnerable, such as clients with physical health problems, those who are HIV positive and those with blood

borne viruses such as hepatitis B and C. Clients with a diagnosed mental illness can remain indefinitely in Red Zone and on a prescription and will also receive the support of MIND and assertive outreach CPNs from the Mental Health Services.

The probation service requires that criminal justice clients attend appointments with a worker twice a week in line with their own Drug Rehabilitation Requirement (DRR) or Drug Treatment and Testing Order (DTTO). This group remains in the Red Zone all though treatment. Some take a while to engage and still longer to give clean samples but if they drop out of treatment, they are likely to be breached. We still continue to work with people who have been breached and are expecting a prison sentence.

With regard to generic clients in the Red Zone, no-one who loses their prescription is left without treatment of any kind. After their prescription has been stopped, they are offered the services of Addaction, the Tier 2 Service. This provides one-on-one counselling support, enabling the client, after a period of four weeks or more, to re-engage with the Anchor Project, if appropriate.

The old model, of allowing all clients to come and go as they pleased in the erroneous and costly belief that 'something would stick one day' did the client no favours and caused horrendous bottlenecks and high caseloads for overwhelmed staff. In addition, methadone spilled over into the street and some years ago there were quite a few cases of methadone deaths in Sandwell. It was mooted that as clients were not on supervised consumption, a number of them were selling their methadone prescription for heroin.

As things are now, supervised consumption in Phase 1 of Red Zone limits the risks and is more focused on compliance with medical treatment. A comparison audit of the old and the new systems using the Christo questionnaire has indicated a considerable improvement in treatment compliance in the zoning approach and improved psychological and social stability. The reason that the NTA in the Midlands endorses the zoning system is because it is safer and because it works.

**Jane Benanti, chartered counselling psychologist/ lead psychologist in substance misuse, The Anchor Project, Sandwell Mental Health NHS & Social Care Trust**