

DEBATES

Do workers need qualifications? Should coercion be used to get people into treatment? Do talking therapies work? DDN heard the debates.

'This house believes you shouldn't need qualifications to work in this field.'

Proposing the motion: Kevin Flemen, KFx

Being competent shouldn't be entangled with being qualified.

We need to clarify what is meant by the 'drugs field'; it includes drugs workers, peer educators, youth workers, housing workers and teachers. So we need a community centric approach to drugs work.

There's a belief that by having a group of workers who are qualified, they are competent. There's also a belief that treatment can only start when you come into contact with workers who are accredited.

Some qualifications don't qualify anyone for anything. They show someone's attended something for the day and managed to stay awake.

When we demand accreditation, we start to restrict and exclude. I would be saddened by a field that lost its diversity. People need different interventions; I don't want everyone to be judged by the same yardstick.

Opposing the motion: Caroline Frayne, Central and NW London Mental Health NHS Trust

It's important to look at the quality of workers, at workforce strategy and at the range of qualifications – NVQs, degrees, diplomas and FDAP accreditation. We should think of qualifications as an equaliser, helping people to acquire skills.

Throughout huge changes in the NHS, staff are being supported through the training process. DANOS gives clear standards and our workers deserve support – we should be working to the highest possible standard.

We have to ensure people have done enough hours of training, as the safety of users and carers is paramount. How does a manager know their worker is working safely?

We have a duty of care. Would you want a member of your family entrusted to someone without qualifications?

From the floor...

For: 'People with qualifications can baffle you with science. What I wanted as a service user was people who'd walked in my shoes already and could inspire

me. Those people had no qualifications whatsoever.

Against: 'This is a crucial issue for the field. We are going to have to find a way of upskilling the field, giving service users the service they need, without excluding valuable people.'

Result: Motion carried

'This house sees no place for coercive treatment.'

Proposing the motion: Danny Kushlick, Transform Drug Policy Foundation

Coercive treatment is a product of prohibition.

Treatment should be available for all who need it, not just through the criminal justice system. Should there be coercive treatment for people who use tobacco, alcohol, tranquilisers? How far do you want to go with this?

Prohibition creates a Hobson's choice. It forces people to stop using and supplying drugs by giving treatment as a choice to prison.

It's time to look at ethics. Do we want to collude with prohibition? Or do we want to take a principled stand and replace it with a public health approach?

I'd like to see regulated control – coca leaves available from grocers, heroin from specialist pharmacies.

Against the motion: Brian Arbery, Adapt

My natural inclination is not to be coercive. But drug treatment always has an element of coercion.

Treatment is defined in so many different ways, but I don't consider receiving maintenance to be

The way forward for Tier 4 commissioning

The National Treatment Agency met with providers and commissioners at the 'Squaring the Circle' conference in Leicester earlier this month to tackle the future direction of Tier 4 commissioning. Here the NTA tell us about their next steps following a 'full and frank debate'.

As has been raised in *DDN* over the past couple of months, the residential sector has not yet benefited from the improvement in capacity and quality experienced by community based treatments since the launch of the Drug Strategy in 1998.

The Department of Health and NTA see the solution to the long-standing structural difficulties that have impeded growth and failed to guarantee income streams as the creation of a managed market in which an increasing proportion of Tier 4 provision, including residential rehabilitation, is commissioned rather than spot purchased.

The catalyst to bring about this structural change and enable the sector to expand to meet unmet demand is the Tier 4 capital programme, being rolled out across the country. The rationale for this approach was ably set out by Richard Phillips in his article 'Residential Futures: how do we build capacity?' (*DDN*, 23 October, page 10).

As part of this process, the NTA and the Centre for Public Innovation hosted a national conference in Leicester on 2 November to discuss with commissioners and providers what a managed market would look like and how we could make it work.

Results from the NTA's examination of the commissioning activity of all 149 partnerships in

England were also fed back to the conference delegates. Findings show that while there have been examples of DAT partnerships spending less than planned within the first six months of this financial year, there has also been overspend in other areas. In addition, analysis of the national picture did not show any discernable correlation between occupancy and cost; so it does not appear to be the case that commissioners have started to fund Tier 4 treatment simply on the basis of cost.

What has become increasingly clear is that there is no one specific reason as to why a number of providers (between six and eight on the basis of reports so far) have experienced a downturn in referrals. Similarly, there was no one reason why individual partnerships have invested less than they planned in the first half of 2006/07.

Key issues identified

One of the main activities of the conference was to consult with delegates on what a more sophisticated and robust model of Tier 4 commissioning may look like. The event itself was interactive and lively with a full and frank exchange of views and invaluable information and ideas were forthcoming as to how to

treatment. It's giving people something that'll make them more likely to reoffend and 'top up'.

There is over-criminalisation of drug users on one hand. But friendly persuasion is a better way than coercion. There are right ways of administering treatment where criminality is involved.

I'm not taking a stand against people's human rights. But to give people opportunities you may need to push them. Can they make the decision to go into treatment when they are in that frame of mind? They often can't make that decision on their own.

There's a lack of joined-up thinking and a rigid adherence to treatment modalities that makes this issue less than clear cut.

For: 'We spend all our time trying to gain trust... So a Drug Rehabilitation Requirement may have an effect, but not necessarily the one government wants.'

Against: 'I don't just see coercion as coming from the criminal justice system; I was coerced by family and friends. And it worked for me.'

Result: Motion defeated

'This house believes talking therapies don't work with drug and alcohol users'

Proposing the motion: Dr Michael Farrell, National Addiction Centre

I am not arguing that treatment doesn't work; I am arguing that the evidence base for certain talking therapies is very weak.

improve Tier 4 commissioning and provision. The conference helped to clarify the following issues:

- The interface between local authority community care teams and local joint commissioning is poor in some areas and requires improvement.
- DAT partnership-level commissioning would not appear to be the most efficient model in the majority of cases. Rather, 'cluster-commissioning' where a number of partnerships in a region or sub-region act jointly to commission treatment from common providers may be more effective.
- A move to local partnerships tendering for and commissioning preferred providers of known quality is recommended.
- A mixture of block contracting (with payment in advance) and spot-purchasing may give more security to providers and improve access for service users. Timely payment should be the norm.
- Providers will need to be more compliant in submitting monitoring data including NDTMS and occupancy data, and more transparent about the quality of programmes they provide.

Next steps

Two sets of guidance launched at the conference (*Models of residential rehabilitation* and *Commissioning Tier 4 drug treatment*) are designed to assist partnerships in focusing their thinking on current activity, as well as planning for the coming financial

Studies on smokers are very useful as the outcomes are clearest. A study on motivational interviewing with smokers saw no increase in their ability to quit. People change for far more complex reasons than the therapy. A similar study showed those who quit smoking suddenly in an unplanned manner did better than those undergoing treatment.

Talking therapies don't work. Treatment works when you look at the whole and work on developing people's lives, as well as providing throughcare and aftercare.

Opposing the motion: Simon Shepherd FDAP:

There is no evidence of one therapy being more effective than another. What is important is how good the therapist is and how they relate to people.

An Australian study on cannabis smokers showed that the group receiving cognitive behavioural therapy for the longest had the best outcomes, and a RAPT study, showed those receiving treatment did slightly better than those who did not.

Unfortunately there have not been enough proper controlled trials. However the small amount of evidence we do have is broadly supportive.

From the floor...

For: 'Some therapy works, some doesn't. It is the participation of the client that makes the difference.'

Against: 'You need to deal with the reasons behind the drug taking. If you don't use talking therapies how do you find out?'

Result: Motion defeated.

year. The guidance was sent out with a covering letter, the day after the conference, to DAT and commissioning group partnership chairs and heads of adult social services, flagging up the importance of Tier 4 Commissioning for the Treatment Effectiveness Strategy. It signalled a clear direction of travel towards regional or 'cluster commissioning' models.

NTA regional teams will have an additional focus on Tier 4, with a case-by-case approach being taken to examine local partnerships and establish the reasons behind any shifts in funding where they have occurred. The regional teams' objective is to ensure that individual clients receive the level of service appropriate to their need, not to ensure that certain providers are funded. NTA staff will also liaise with particular providers who report they are having difficulties.

It is the DH and NTA's intention to work towards more coherent and efficient models of 'cluster commissioning' during 2007/08. The NTA will now convene a national steering group made up of commissioners (at both a strategic and community care level), providers from all sectors and service users to help future commissioning models. We hope to build on the excellent steer we got from this conference, which was robust throughout but remained positive and focused on solutions.

The NTA will issue a conference report shortly. The new guidance documents are on the website at www.nta.nhs.uk

FDAP News in brief

Services for stimulant users

How can existing drugs services engage better with stimulant users?, Michael Bird from South London Drugs Project, a specialist crack and amphetamine service, challenged delegates. Approaches using stress relaxation techniques, acupuncture, offering dietary advice, as well as round the clock telephone support are all useful to support this particular client group. It was concluded that while not all services could offer all of these things most could offer at least some of them.

Young people's needs

How do you fully address the needs of young substance misusers?, Dr David Bee from Middlegate asked. For many young people, drug-taking is part of natural youthful risk often exacerbated when the young person's parents are themselves substance users who may not be providing a clear role model. More resources are required to tackle the problem and increase the amount of young people's rehabilitation facilities as well as a clearly defined protocol for prescribing methadone to this vulnerable group.

Clients with co-occurring gambling problems

What are the differences and similarities of people addicted to gambling to those addicted to drugs?, asked Kevin Farrell Roberts from Gordon House. Both need the buzz, whether on gambling or drugs; both groups enjoy the rituals surrounding their addiction; and each suffers withdrawal symptoms when it is not available. The one big difference is that there are no physical limits stopping a gambler feeding their addiction, and as a result many find it easier to keep hidden and deny the problem.

Self-help groups

What are the great benefits of the self-help fellowships movements?, discussed Peter Smith from Broadway Lodge and Simon Shepherd of FDAP. They are free; there aren't any waiting lists, entry requirements, referrals or bureaucracy. There is just one criterion: the desire to change and stop using. The problems lie in people's perception that these groups are religiously motivated and a dislike for the self-labelling that is part of the programme: 'My name is ... and I am an alcoholic'. While these groups do not work for everyone they do work for many as attested by the large number of groups meeting all over the world, and the longevity of organisations such as Alcoholics Anonymous.

Presentations and contact details for some of the speakers are available at www.fdap.org.uk/fdapevents/conf2006.html