VOL 26 | ISSUE 3 | **MAY/JUNE 2011**

Druglink

REPORTING ON DRUGS SINCE 1975

DrugScope

- designer drugs
- white cider
- sentencing
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Druglink

Force of nature

Workforce development. Still awake? Good – because in such an era of change, it is easy to get wrapped up in positioning agencies to respond to government demands and expectations and developing strategic business models for the challenges ahead. But the people who actually deliver the hopes and aspirations we have all signed up to – are the people doing the job. So we make no apology for devoting the majority of this issue to asking the critical questions about whether or not we have a workforce that is fit for purpose. And that's not just frontline workers, but also managers – and ultimately organisations themselves.

The focus on recovery gives us an opportunity to revisit all the policies and practices that have grown up over the years, as the sector itself began to emerge from a Cinderella service of the NHS, to the multi-million pound medium sized industry it is today. Business practices have become highly professionalised. But can the same be said about the workforce? What makes a good drugs worker? What kind of training do they need? What kind of qualifications? Do we need to professionalise the workforce with the panoply of nationally-approved qualifications, standards and ethics that operate say in the fields of nursing and social work? And if we do, how would you mesh in the more qualitative skills of the recent ex-user working in a drugs agency?

In an era of austerity, the first strokes of the blue pencil go through training budgets – but simply sending people for a few days out of the office does not begin to lay the foundations for coherent and cross-sector workforce planning. This is the challenge set by the Skills Consortium and one that needs to be embraced.

Harry Shapiro,
DrugScope's Director of Communications and Information

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Druglink is for all those with a professional or occupational interest in drug problems and responses to them – policymakers and researchers, health workers, teachers and other educators, social workers and counsellors, probation and police officers, and drug workers.

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for those working to reduce drug harms. Our aim is to inform policy development and reduce drug-related risk. We provide quality drug information, promote effective responses to drug taking, undertake research, advise on policy-making, encourage informed debate and speak for our members working on the ground.

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News

Main features

WORKFORCE SPECIAL
Highlights

Also in this issue...

Regulars

Cocaine probe

The government's expert drug advisers have begun work on their first significant review of the harms of cocaine. The Advisory Council on the Misuse of Drugs will take oral and written evidence before reporting its findings in spring 2012.

Fentanyl warning

Police and drug charities are continuing to be vigilant after the death of an Aberdeen man who took the powerful prescription-only, synthetic opioid, fentanyl. The drug, 100 times more potent than morphine, appears as a white powder or in transdermal patches.

Watch your back

A cannabis farm bust carried out in a blaze of publicity backfired after cheeky robbers looted the spoils from the rear door while police stood guard at the front. "While we were waiting for the plants to be disposed of the thieves broke in," said a police insider of the failed bust in Merthyr Tydfil, Wales.

Nose out of joint

THE owner of a Midlands dog kennels has been cleared of allowing one of his outbuildings to be used as a cannabis factory – after a court heard he has no sense of smell. Prosecutors decided to drop the case against Russell Liddiatt, 64, after medical evidence showed he has had no sense of smell since he was a teenager and may have been unaware of the pungent cultivation.

Pieces of eight

The eight Payment by Results (PbR) pilot zones in England have begun designing their services in readiness to go live in October this year. PbR, whereby drug services are paid according to the achievement of agreed outcomes, will be tested out in Bracknell Forest, Enfield, Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield and Wigan.

Evidence shows drug policing leads to rise in violence

Increasing the policing of drug markets may cause a rise in drug gang violence, according to a study.

The authors of the report, published in the *International Journal of Drug Policy*, expected to find that increased law enforcement would result in reduced levels of violence. But they admit they were surprised by their own findings.

An in-depth review of 15 studies in America and Australia, *Effect of drug law enforcement on drug-related violence*, revealed 14 of them found increasing drug law enforcement intensity was associated with greater rates of drug market violence.

"From an evidence-based public policy perspective and based on several decades of available data, the existing scientific evidence suggests drug law enforcement contributes to gun violence and high homicide rates and that increasingly sophisticated methods of disrupting organisations involved in drug distribution could paradoxically increase violence."

The researchers, from the University of British Columbia, suggest that disrupting the status quo of a drug market can lead to violent power struggles. "By removing key players from the lucrative illegal drug market, drug law enforcement has the perverse effect of creating new financial opportunities for other individuals to fill this vacuum by entering the market.

Body count: Mexican police at the scence of another drug murder

"As dealers exit the illicit drug market, those willing to work in a high-risk environment enter, and that street dealing thereby becomes more volatile."

The report says that policy makers must find "alternative regulatory models for drug control if drug market violence is to be substantially reduced".

However, evidence from a series of interviews with high-end drug dealers in British jails carried out for the Home Office by the Matrix Knowledge Group and published in 2007 found that drug dealing organisations typically avoid the use of violence because it resulted in unwanted clampdowns and was "bad for business".

Drug services 'patchy' on domestic violence issues

Drug services should have at least one member of staff trained in domestic violence awareness and improve information sharing on the subject, a report has concluded. The research, carried out among 52 drug services in London, found that while most drug agencies asked service users if they were the victims or perpetrators of domestic violence, there were patchy levels of information sharing around the issue.

Research shows that while there is no causal link between drug and alcohol use and domestic violence, survivors and perpetrators of domestic violence are disproportionately affected by problematic substance use.

"In agencies where staff are rarely or never trained to identify high risk cases of domestic violence, no referrals to multi-agency risk assessment conferences (MARACs) had been made in the past six months," said the report by charities AVA (Against Violence and Abuse) and CAADA (Coordinated Action Against Domestic Abuse).

"However, in agencies where staff commonly received training, referral rates rose to 56 per cent. This suggests that even modest levels of training in domestic violence awareness and risk assessment may have positive impacts on referral rates to MARACs."

‘White cider more deadly than heroin’ says homeless charity boss

White cider and other super-strength drinks are killing more homeless people than heroin and crack, according to the director of a charity.

“Super-strength drinks are a breed apart. The cheap and strong white ciders are a problem drink which have devastated and cut short the lives of tens of thousands of people since they emerged onto the marketplace,” said Jeremy Swain, Chief Executive of Thames Reach.

“Astonishingly, they are killing more homeless people than heroin or crack cocaine. It’s time for the government and drinks industry to act so that they disappear from the country’s supermarket and off-licence shelves.”

Swain said 50 of his service users had died over the last three years from drinking super strength drinks, more so than from illegal drugs. He added that many service users also suffered from liver, brain and heart problems as a result of the “relatively recent” super-strength drink phenomenon.

His comments come in the wake of a report commissioned by Alcohol Concern which reveals how the drinks industry is using cheap culinary apple concentrate – often imported from abroad to make white ciders – whilst benefiting from the tax breaks and low duty intended to boost the development of traditional cider apple orchards. This allows the drinks industry to produce a potent 7.5 per cent drink which is cheaper than bottled water or lemonade yet still extremely profitable.

Bad apple: white ciders have caused deaths amongst street drinkers

The report, *White ciders and street drinkers* says products such as Carbon White, White Ace and Frosty Jack’s, all of which are 7.5 per cent, have a lower price per unit than lemonade or water. K Cider, which is produced for the C&C Group Plc – owners of Magners and Bulmers – is 8.4 per cent in strength.

The report urges the drinks industry to recognise the damage caused by super-strength white ciders and to act responsibly and stop manufacturing it, alongside a series of recommendations for the government: to increase tax on ciders above five per cent in a bid to get manufacturers to decrease the alcohol levels in white ciders and to link cider duty rates to super-strength lagers; to look at minimum pricing; for the Licensing Act 2003 to be amended to allow local authorities to ban the sale of super-strength drinks across their locality; and to end to the practice of selling cider above five per cent in two and three litre bottles and a one litre cap to be introduced.

Heroin heroes: Methadone Man and Buprenorphine Babe are to spearhead a new drive to raise awareness about the lack of access in some parts of the world to these life-saving medications. In many countries, despite having high rates of drug injecting driven infections such as HIV, the medications are either not sanctioned by governments or banned. The campaign is being developed by the Open Society Institute’s International Harm Reduction Development Programme.
For info go to www.methadoneman.org

DRUGS QUOTE

A mixture of *uninformed* and plain-clothes officers targeted Inverness Railway Station

The *Inverness Courier* with the inside story on a series of drugs raids which surprisingly netted ecstasy, cocaine and cannabis

Was Osama Bin Laden a pothead?

The question being asked on the internet after some wild cannabis was found growing in the vicinity of the dead fugitive’s compound

They drove around in Ferraris, Lamborghinis, they had a private box at the O2 Arena and a yacht called ‘Shaken not Stirred’

Drug detectives describe the ‘James Bond’ lifestyle of cocaine smugglers Timothy Eastgate and Paul Flisher

My advice to you is to give up drugs, go and learn English, go and get a job and do something useful

Judge Andrew Hamilton’s advice to a Pakistani immigrant caught selling cannabis from his Derby flat

Okay, you said you bought some drugs from them and they didn’t give you your change back?

Operator to a US man arrested after calling police to complain that his crack cocaine dealer had short-changed him

inside DrugScope

The Essential Guide to Problem Substance Use During Pregnancy available soon

On 1 June, the latest in DrugScope's series of professional resource books, *The Essential Guide to Problem Substance Use During Pregnancy* will go on sale. The text has been written for us by Anne Whittaker, a Nurse Facilitator working for NHS Lothian who specialises in drugs, alcohol and blood borne viruses, who wrote the best-selling DrugScope publication *Substance Misuse in Pregnancy* (published 2005) on which this book is based.

This fully updated edition establishes a framework for care, synthesising the latest good practice advice, official guidelines and research knowledge, so that all women who use drugs and/or alcohol can be offered appropriate support before and during pregnancy, as well as after the birth of their baby. Information and intervention strategies are provided on topics such as antenatal care, the management of substance use during pregnancy, Neonatal Abstinence Syndrome, breastfeeding, postnatal care and the management of risk and child welfare concerns during pregnancy. The book also features 11 downloadable leaflets and factsheets for use by professionals and service users.

Priced at £15.25 for DrugScope members and £16.95 for non members, the book can be ordered from HIT at www.hit.org.uk, by email at stuff@hit.org.uk or by phone on 0844 412 0972.

LDAN/DrugScope bids Esther Sample farewell

Esther Sample, who has led the work of the London Drug and Alcohol Network (LDAN) following its merger with DrugScope in 2009, is to leave the organisation in May to take up a new post as Women's Strategy Coordinator for St Mungo's, the homelessness charity. Esther joined DrugScope as a Policy Officer in 2009. Her many achievements include building and supporting multiple London networks, which have developed LDAN's policy work in areas such as breaking down barriers to employment and improving cross-sector collaboration around homelessness and substance misuse. Most recently, her efforts have contributed to the decision by Trust for London to provide funding to continue LDAN's work around pathways to employment. Everyone at LDAN/DrugScope wishes Esther well in all her future endeavours.

Another BRIC in the wall

Having held consultation events, forum and network meetings involving nearly 100 DrugScope members and a range of other stakeholders, we delivered a 20,000 word response to the Building Recovery in Communities consultation continuing our track record of making your voice heard in Whitehall and beyond.

DrugScope and LDAN members support the focus on recovery and social (re)integration and the recognition that delivering on this recovery vision requires a holistic approach, continuing to break down silos and bringing together a range of professionals and agencies, both nationally and locally. They want to see continued improvements to drug and alcohol treatment matched by a commitment of energy and resources to a genuinely 'joined up' approach to prevention and early intervention. The challenge for the BRIC framework is to identify, develop and describe local frameworks that will support the practice that can deliver on this vision.

In our response, we emphasised the need for the BRIC framework to recognise the distinction between those recovery resources that are directly controlled by local commissioners and treatment providers, and resources that may be largely outside their control (for example, the availability of suitable accommodation or training and employment opportunities), and therefore the impact on the ability of services to deliver recovery of spending and policy decisions other than those concerning the allocation of the pooled treatment budget.

Our response to BRIC follows hard on the heels of our response to the government's proposals on public health, Healthy Lives, Healthy People. We expressed our concern at the extremely limited discussion of drug and alcohol misuse in the White Paper and the risk this might pose for the sector as Public Health England finds its feet. With drug and alcohol treatment sitting prominently in other reform areas, including reform of the criminal justice system, we urged that, with the introduction of Public Health England, the priority is to ensure that investment in drug and alcohol treatment and recovery is maintained.

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THINKING OUTSIDE THE BAG

The suggestion that lower level drug dealers could avoid jail and that 50 bags of heroin is 'very small' has been met with predictable media outrage. **Andy McNicoll** reports on the ongoing, super-sensitive debate around drug thresholds.

In late March a *Sun* front page accused Sentencing Council judges of being 'OFF THEIR HEADS', while the *Daily Mail* blasted them for 'helping heroin dealers escape jail'. Why? The Council had opened a consultation on sentencing for drug offences. It included proposals to hand out community sentences, rather than prison stretches, to those playing "subordinate" roles in drug deals.

Two factors lie at the heart of the furore. Firstly, the Sentencing Council consultation outlines threshold levels of what constitutes 'very small' to 'very large' amounts of different drugs. Controversy was generated due to the Council's recommendation that up to 4.9 grams of heroin, enough for 50 wraps, is considered 'very small'. Secondly the Council suggests that sentences should take into account the role the offender has played. Judges could be asked to factor in whether the offender is a "leading" figure profiting hugely from the deal, or a "subordinate" character, such as a runner.

So does the tabloid charge of "heroin dealers escape jail" stick? According to Nigel Patrick, Senior Policy Officer at the Sentencing Council, a non-custodial sentence for Class A drug supply is technically possible but "highly unlikely". Patrick says such a sentence would only be recommended in low-level cases where several mitigating factors were evident, for example where the "subordinate" had been intimidated or coerced into supply, or if they have a mental disorder.

"The press hit out with the idea that people dealing drugs for profit could fall into a subordinate role, but that isn't true," Patrick told *Druglink*. "The guidelines are quite clear that if the supplier expects personal financial gain, regardless of the amount being dealt, then they are automatically categorised as playing a significant role – that has a minimum prison sentence of three years. There is no community sentence recommendation in those cases."

Yet the proposed introduction of threshold limits for drug offences has a controversial past. Section 2 of the Drugs Act 2005, introduced by then Home Secretary Charles Clarke, included 'prescribed amounts' of drugs for personal use with the provision that anyone caught in possession over those limits would be automatically deemed by police to have 'intent to supply.'

The clause was quietly abandoned by Clarke's successor as Home Secretary, John Reid, in 2006, after a barrage of opposition to the plans. Drugs charities, including Release and DrugScope, criticised the plans for being impractical, while the Crown Prosecution Service warned "many dealers will believe that if they carry just below the prescribed amount they will escape being charged with supply."

Legal experts in the drug sector are keen to stress that the Sentencing Council's proposal is radically different, and much more practical, than those which appeared in the Drugs Act 2005.

"The Drugs Act 2005 clause would have seen a threshold being established where the quantity of drugs in itself would be the determinant factor in what someone was charged with. It was legislation for police, whereas what we are dealing with this time is guidance for courts in sentencing," says Niamh Eastwood, Head of Legal Services at Release.

Eastwood feels that the Sentencing Council proposals could actually help improve consistency in the way courts handle drug offences, while allowing judges flexibility by the guidelines not being legal statutes.

Eastwood believes that the proposal for judges to consider an offender's role in drug supply, rather than simply the amount of drugs they were caught with, is a pragmatic approach – particularly as high level dealers are, in many cases, likely to ensure that the risk of possession of substances is transferred down the supply chain.

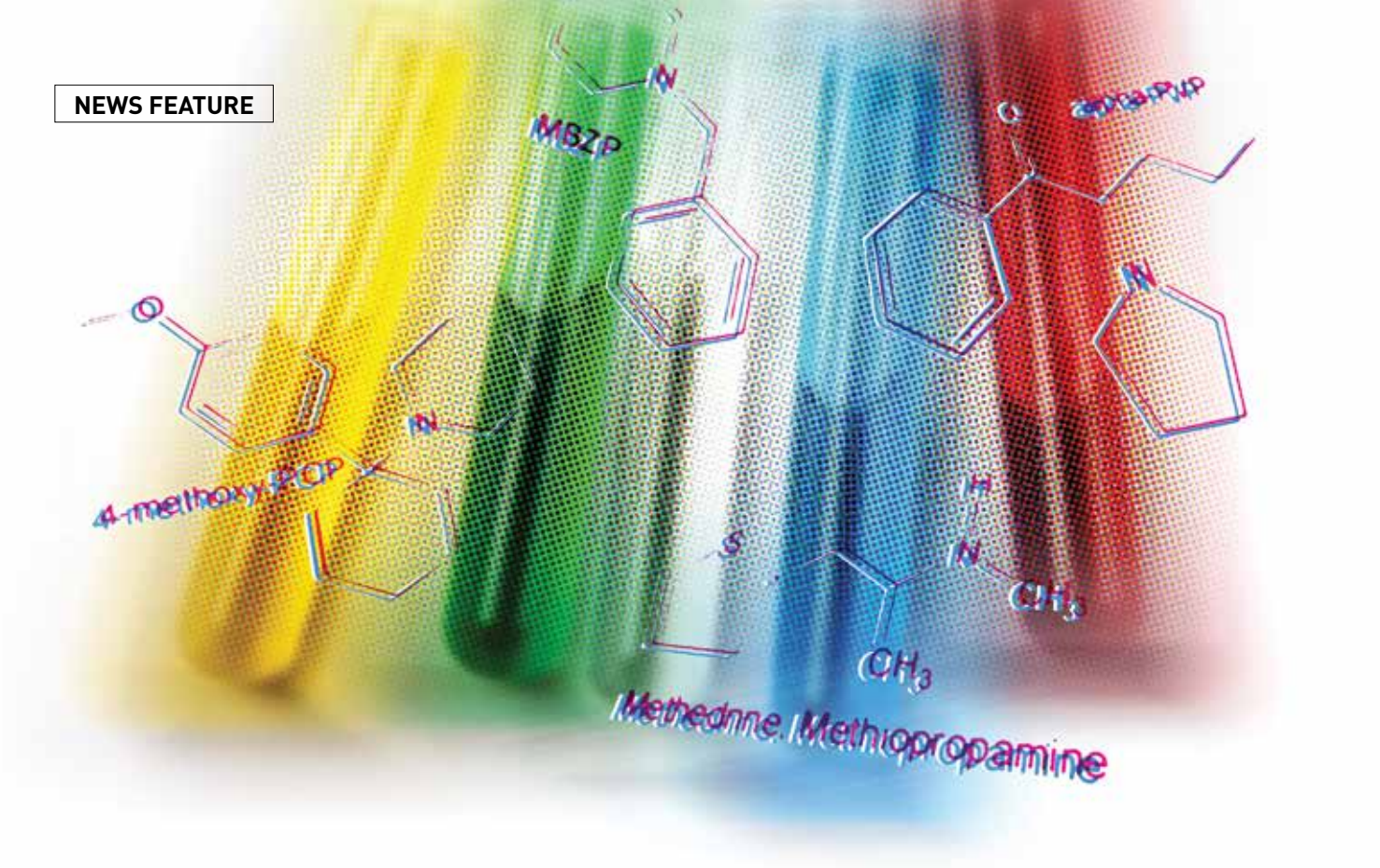
Sun stroke: the tabloid was shocked at the judges plans on drug dealing

But, Eastwood says, there are issues with the Sentencing Council's proposals around the thresholds for quantity. In the consultation document, for example, a 'very small' quantity of ecstasy is two pills – a situation that Eastwood feels doesn't reflect the realities of the drug scene.

"These days, a more realistic level for low level possession would be ten or fifteen tablets but in the current guidance they would say that 10 to 20 tablets is a large quantity and that could have a custodial sentence," she says. "The broad idea is positive but the numbers involved at the moment might need to reflect the social scene more effectively."

Release will be preparing a formal response to the Sentencing Council's recommendations. The consultation closes on 20th June 2011.

Andy McNicoll is a freelance journalist and former DrugScope Press Officer



ALPHABET SOUP

Identifying the array of chemicals now being sold over the internet as recreational drugs is a daunting task. But how much of a risk do these substances actually pose? By **Harry Shapiro**.

"There are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns – the ones we don't know we don't know." Former US Defence Secretary Donald Rumsfeld, explaining the lack of evidence linking Iraq and international terrorism, in 2002.

In its report in February, the International Narcotic Control Board (INCB) declared that designer drug production and distribution was "out of control". The situation has prompted increasing numbers of countries to reformulate their drug laws towards generic legislation to try and stay ahead of the chemists – or at least run side by side. In the UK, a Temporary Class Drug Order on new drugs has been proposed and according to the INCB, 51 new drugs have just been controlled in Japan.

In response to the phenomenon, two European Union-funded projects, the Recreational Drugs European Network (RedNet) and an early warning system set up by the European Monitoring Centre on Drugs and Drug Addiction, have been run to scour the internet in order to identify new and emerging substances.

So are we faced with the prospect of a multi-variant chemical virus raging unchecked across the internet – or is it a panic just as synthetic as the drugs themselves? Certainly the rate that new drugs have been identified is unprecedented. There was a time when years might elapse between arrivals of new drugs on the block; crack in the early 1980s in America; ecstasy in the late 1980s. But the during the 2000s we have seen a host of drugs – such as ketamine, GHB, stronger forms of cannabis, crystal meth and legal highs such as mephedrone – arrive on the scene.

All these drugs exert different levels of traction on the drug scene, some far more ubiquitous than others – while some, particularly in the alphabet soup of hallucinogens and amphetamines, such as DMT or 2CB, hardly register on the radar. But none of these could be called designer drugs – in other words deliberately created in order to circumvent drug laws – they have simply followed the pattern of drug users lighting upon different substances.

When it first became popular in the UK, ecstasy was dubbed 'a designer drug' – but although its unexpected appearance in a West Midlands amphetamine lab in the late 70s did trigger new legislation, it was not 'designed' – simply a new drug which (in

the tradition of most street drugs) had escaped the laboratory, hospital ward or therapist's couch.

The earliest stories of underground chemists actually trying to manipulate formulas were also the harbingers of the dangers inherent in the process of producing designer drugs. Fentanyl was (and is) a very powerful opiate drug about a hundred times stronger than morphine. But because of its very short action it never found favour with heroin users. In the mid 1980s, underground chemists started playing around with the molecular structure and came up with 3-methyl fentanyl, (known on the street as 'China White') which, depending on the isomer used, could be up to a staggering 6000 times stronger than morphine according to Gary Henderson, a pharmacologist at the University of California who first coined the term 'designer drugs'. This had a reasonable duration of action and so produced the necessary high for it to become a ready replacement for heroin on the streets.

Not surprisingly however, in the immediate aftermath of its street use, overdose deaths soared, 100 in California alone. But worse was to come. An attempt to produce MPPP, an analogue of another opiate, meperidine, mistakenly created MPTP, a seemingly innocuous production slip which induced irreversible symptoms of Parkinson's disease in those users unfortunate enough to try it.

In the UK, we first began to hear about what were now termed 'legal or herbal highs' in the late 1990s. These were not laboratory-derived designer drugs, they were often naturally occurring plants which delivered a psychoactive effect and were marketed as 'legal ecstasy' or 'legal cocaine' under names like Love Doves, Druid's Dream and Mind Bandits. They contained ingredients such as morning glory seeds, ephedrine, kava kava and guarana (also known as Paullinia cupana) resulting in relatively mild versions of controlled drugs.

One supplier was Dr Herman's Head Shops which back then had one shop in Manchester, but now has a number of outlets across northern England. Interviewed in 1997 by *Musik* magazine, then owner Charly Hughes claimed to have sold 25,000 Love Doves, 'that's 25,000 people who haven't taken an illegal pill on a Saturday night'. The interviewer Ben Marshall and some friends including two biochemists decided to try out a range of these products. While his friends suffered no ill effects, Marshall concluded: "The predominant feeling was nausea. Legal highs had a negative effect on me. I was unable to work the following day and even suffered a mild fever as my body attempted to sweat the rubbish out. So much for no come downs."

Dr Herman has since spread his wings with outlets across the north of England selling legal cannabis seeds and some herbal highs. Last year, current owner Sean Ellman, son of Liverpool Labour MP Louise Ellman and a local media hate figure, was served with an ASBO to prevent him selling cannabis seeds and a plant material containing DMT, which in its pure form is a Class A drug.

THE CLUE THAT THE NEW DRUGS ON SALE HAVE BEEN SUBJECT TO NO TESTING AT ALL IS IN THE PHRASE 'RESEARCH CHEMICALS'

It was this idea of safer alternatives to illegal drugs that sparked more recent developments, which have focused more on the products of the laboratory than the jungle. The story of BZP is a model for much of what was to follow. It started life back in the 1950s as a laboratory compound, investigated both as a potential anti-worming agent and later in the 1970s as an anti-depressant. It was abandoned on both counts because of side effects and abuse potential. It took off in New Zealand in the late 1990s as a response to the high use of methamphetamine (itself reportedly the consequence of a heroin drought in the region). Former meth user Matt Bowden began promoting and supplying BZP as a safer alternative to methamphetamine, which in all truth it probably was. He found himself at the head of a very lucrative business which began supplying BZP worldwide. In the process , the sales pitch now claimed that BZP was a safe alternative to ecstasy and amphetamine , which the growing clinical literature and anecdotal reporting challenged.

What turned the localized distribution of so-called 'Party Pills' into an international business, was the internet, whose importance in all of this saga cannot be underestimated. Until the turn of the century, the Dr Jekyll of designer drugs was Alex Shulgin, whose two massive tomes (a third, The Shulgin Index, has just been published) became recipe books for the intrepid chemist (although also helpful to enforcement agencies on what to ban next).

More recently however, says Dr John Ramsey from St George's University of London, "those who retail these drugs know people who know the scientific literature, who know about patents and can scour the net for compounds which have been abandoned by pharmaceutical companies". But this presents real problems for legitimate research which obviously needs to use the internet for information exchange and publishing.

Professor David Nichols who holds the Distinguished Chair in Pharmacology at Purdue University, Indiana spends his life working on psychoactive compounds and first noticed about ten years ago that amateur chemists were watching his papers. He synthesized a version of MDMA, called MTA which he thought might be helpful in his quest for new drug treatments for depression. It was clear to anybody who knew what they were doing that this drug had the potential to release dangerous doses of serotonin. Nevertheless, MTA tablets hit the streets as 'Flatliners' and by 2002, six people had died because they had either mixed this with other drugs, taken a huge dose or been unlucky.

Writing in *Nature* in January, Professor Nichols said he wasn't just concerned about lethality; he posed the question about a seemingly benign drug he had developed which gets out of the laboratory, becomes wildly popular but turns out to cause a rare type of kidney damage which is difficult if not impossible to treat. "That would be a disaster of immense proportions. This question which was never part of my research focus, now haunts me," he said.

Once a potential compound has been identified, chemicals can be ordered online, often from China. The country has a vast chemical industry, with an estimated 3,000-6,000 manufacturing

companies and thousands more distribution outlets. According to industry experts, China is set to become the third largest pharmaceutical market in the world. With such capacity and the need for outlets, legitimate or otherwise, retailers around the world have no trouble sourcing the chemicals they sell. The internet then becomes the main conduit for sales and a world wide information exchange among users, although this is not to say that the chatter on these drugs is always positive. Often these informal networks provide the only information available to official sources on the side effects of new drugs.

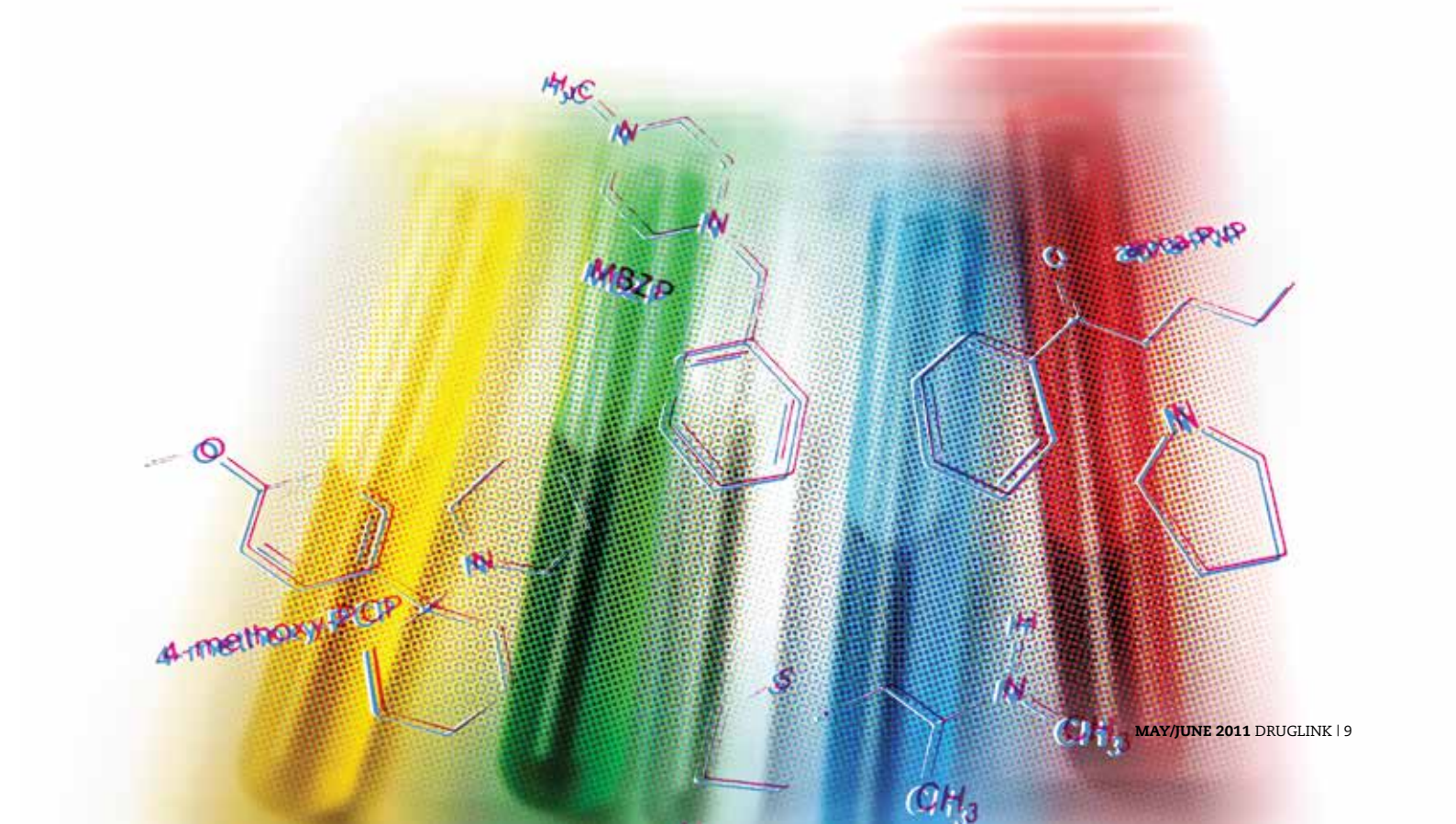
In order for a pharmaceutical company to bring a drug to market, it has to spend millions on taking the drug through a battery of tests in labs and on animals long before its tentative administration to humans. The clue that the new drugs on sale have been subject to no testing at all is in the phrase 'research chemicals'. It may be a term that is part of the fig leaf of legality that cloaks these drugs along with declarations of 'not for human consumption', 'use as bath salts' etc – but it is also a warning to buyers that 'you pays your money and you takes your chances'.

Dr Ramsey observes that a lot of what goes on in the Chinese labs, "is quite simple chemistry, but nonetheless it is chemistry not cookery. It isn't the conversion of cocaine to crack that you can do in the microwave at home. It is pretty sophisticated chemistry which requires precursor chemicals and a competent chemist." Although he adds that suppliers are quite capable of swapping one chemical for another if they have run out of the ordered stock and the chances are that the vendor would not notice the difference, although the user very well might.

Dr Ramsey regularly test purchases new drugs so he can analyse them and determine their content. He showed this author two identical packets containing white powders with the same markings on the packets – except one was mephedrone and the other naphyrone, bought either side of the mephedrone ban. Sometimes he buys what turns out to be caffeine powder. And here is where the information in online fora cannot be relied upon. If users discussing a drug have wildly different experiences, it could well be that they are not talking about the same substance. Dr Ramsey's online buys also reveal the challenge for enforcement; "you might buy from a UK website, but you pay in euros and find the goods have been dispatched from Belize".

With substances that might (if only for a brief period) be legal, comes the tricky question of early warning. The mephedrone experience in the UK was salutary. More so than ketamine or GHB, mephedrone was a psychoactive drug that shot to unprecedented popularity while still being legal. How popular we can't tell. But anecdotally, the publicity around the drug attracted significant numbers of young, relatively naive drug users, as well as regulars, disappointed by the quality of drugs like ecstasy, amphetamine and cocaine. Then again, the many accounts of side effects – and the initial, although at the time unproven, reports of the number of deaths caused by mephedrone – may have equally dissuaded people from trying it.

And one final major unknown – how many of these compounds are there? Can the chemists go on tweaking forever? It is easy to whip up a media feeding frenzy by declaring there are hundreds of new drugs out there, all legal and just waiting to wreak havoc. Dr Ramsey notes: "We've seen the piperazines, the cathinones, and there are benzofurans and aminoindanes. The number is not infinite, but there an awful lot of them. And even if the substance is legal, suppliers are selling untested chemicals to young people to use as drugs – and that's just wrong." ■



CULTURE SHIFT

Joy Barlow on the impact of the recovery agenda on workforce development.

The drug policy landscape and its focus on recovery, enshrined initially in the Scottish drug strategy in 2008 and then the UK strategy in 2010, required a sizeable shift in workforce development. For the first time in many years, workforce development in the drug and alcohol field is properly on the agenda. Thus it is imperative to ask what we mean by workforce development and how it supports the recovery focus.

Workforce development is more than training courses and academic programmes. Professor Anne Roche and her colleagues at Flinders University have defined it as: "A multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individuals, organisation and structural factors, rather than just addressing education and training of individual mainstream workers."

If this is the case, then service design, organisational systems and 'setting' all need to be part of a broad, comprehensive and multi-faceted approach. The workforce is already multi-faceted and multi-professional. It should include strategic and comprehensive planning, organisational change, personal development, entrepreneurship and innovation. We still have a long way to go in this regard, after all this is a far cry from a few days of training on a specific topic.

The refocusing on recovery as the main plank of drugs policy requires major service design and re-design, a substantial investment in partnerships between organisations on the continuum of recovery focussed interventions, and an understanding from commissioners about what kind of services are truly recovery focussed. Such services would express hope and possibility for change, identify strengths and value the person's wishes, hopes and dreams.

THE TRUTH IS THAT THE RECOVERY FOCUS DEMANDS A MORE COMPLEX RESPONSE FROM WORKFORCE DEVELOPMENT THAN HAS BEEN APPARENT PREVIOUSLY

Staff should no longer see themselves as the 'experts' but a resource to harness information and support. Relationships are key in any recovery-focussed intervention. Relationships with professionals and the relationships an individual is able to build or regain with family and the community. Other areas of the recovery focus should concentrate on training, education and gendered responses to service delivery – women and men may require different interventions, and they may have different goals. At every point of an intervention, professionals should be able to evaluate effectiveness and be willing to change. An individual will define the integration of all outcomes of interventions into a model of recovery. If personalisation means anything at all, it means exactly that – interventions are personalised, not part of a 'sausage machine' like approach to treatment and rehabilitation. Recovery, at the earliest opportunity, becomes the focus of all treatment modalities, and through the establishment of an expert care management system is the single integrated gateway to treatment. This may conflict with a 'payment by results' culture, but if we are truly wedded to a recovery approach, which is person-centred, the principles of practice will need to be defended.

All of this means that we need to lay a much greater emphasis on attitudes, values and principles of practice. Of course, staff still need to have skills and some very specific knowledge, but

we do need people who, to quote Mike Ashton speaking on the Film Exchange on Alcohol and Drugs site, are "socially skilled". The fostering of empowerment and engagement with users of services is a prime prerequisite in a recovery focussed workforce. Relationships, cultures and issues of identity are fundamental to change and development for individuals. Staff need to recognise and be sensitive to the potential 'tipping points' which will be the prime factors to the beginning of any recovery. Skills in action planning and the ability to help users of services in self-management will be vital. Assertive outreach to those who remain ambivalent to the recovery focus will be needed as motivation may change over time (what William White has called "supportive stalking"). Thus contact with agencies is vital to support and enhance motivation.

Staff will be key to all of this. But who are the staff we are talking about? We have established that the workforce is multi-faceted and multi-professional. It includes those in universal services (such as health, social care and education) because they have a key role in identifying a problem or concern, in assessing it, or making an appropriate referral. The importance of this role cannot be over estimated. The specialist workforce will include those in health, such as medical, nursing, psychology, those in social work, and those providing specialist services. One does wonder about the definition of the job 'drug worker' these days.

Into this mix we now bring those who are entering the workforce in a less traditional sense, for example those who are in recovery themselves. They must be appropriately accommodated into workforce development. Peer support and mutual aid along with family members, may have as much impact on the recovery of an individual as the

traditional workforce. Also, if we accept the tenets of Biernacki's research in the USA in the 1980s, that those who recovered from heroin use without formal treatment did so because, to paraphrase, they "saw themselves differently", then a lot of different people will help support that way of thinking.

The truth is that the recovery focus demands a more complex response from workforce development than has been apparent previously. This is not about 'necessary competencies', and I for one am grateful that we no longer have a focus on competency frameworks and occupational standards. I know some will shout me down, but workforce development has always been more than having and showing competency in certain domains of skills. Workers in the field of drugs and alcohol have always required empathy, confidence and the ability to think beyond their own profession and agency boundaries.

The work we expect people to be competent in is complex, requiring a wide range of skills and knowledge. For some, these are reflected in levels of qualifications and accreditation. The work is challenging and it is often difficult to achieve success with and on behalf of individuals. It is frequently ethically fraught, involving hard decisions between the interests of the users of services and those of their families and communities. The work requires sound, professional judgment, often to be exercised autonomously. It is about recognising the theoretical base for practice. It is not only about how you do your job, but how doing your job makes you feel. Nowhere is this more obvious than in the learning and development for those who deal with the impact of parental drug and alcohol problems on children. This is the 'problematic underside' of drug misuse that has unavoidably moral connotations which impinge upon practice.

The work of STRADA (Scottish Training on Drugs and Alcohol) has been progressing for ten years now. We have seen the growth of the wider workforce, as drug and alcohol misuse permeates most professional practice in the 'helping' professions. We have seen a significant recent policy shift, and have always had to take cognisance of other wider policy shifts, particularly around the protection of vulnerable children and adults.

For the first time in Scotland we now have a statement from the Scottish government and the Convention of Scottish Local Authorities (COSLA) on 'Supporting the Development of Scotland's Alcohol and Drug Workforce'. Published in December 2010, it is addressed to anyone who has a role in implementing outcomes for an individual, families or communities experiencing problematic drug and alcohol use.

It acknowledges the need for strategic leadership and indicates the responsibilities of those who make decisions at a national and local level. It requires alcohol and drug partnerships to carry out training needs assessments and to take account of the capabilities of the current workforce. It gives roles and responsibilities to commissioners of services, professional bodies and education and training providers and managers and individuals. Most importantly, it sets out learning priorities for all levels of the drug and alcohol workforce. The statement also includes a Training Needs Analysis guide – provided on the NHS Health Scotland website and based on a template used by STRADA since 2005 – and a report on service users' views of workforce development needs.

All of this is very reassuring and should assist in the development of all involved in drugs and alcohol work, to provide better services to support individual, family and community recovery. However it is pertinent to record the final sentence of the introduction to the statement: "The whole of the public sector in Scotland will be looking to reshape services to deliver better outcomes with potentially smaller budgets and we need a skilled workforce to do this effectively." At least it's honest.

This leads to me consider what works in learning and development in alcohol and drugs. This is not an easy question to answer as robust, independent evaluations of learning and development courses are few and far between. A European-wide survey undertaken in 2006 for the International Think-tank in Education and Training in Addictions (I-ThETA) found that evaluation is mostly done by providers themselves. Only exceptionally are the effects of educational inputs researched. In a book I edited in 2010, Donald Forrester lays great stress on the commitment to evidence-based practice and on the importance of reflection, high quality supervision and the link to reflection on practice. All of this is based upon evidence that it would work, if it were put into practice.

In 2010, the Independent Inquiry into maximising recovery from drug and alcohol misuse in Scotland, called 'Melting the iceberg of Scotland's drug and alcohol problem', notes the challenges facing all of Scottish society, particularly those professionals involved in drug and alcohol misuse prevention, treatment and recovery. In the Inquiry we called for people to work more closely together, co-operate and undertake through mutual learning how they fit into the continuum that supports recovery. We wished that all professionals might feel released to "bring themselves to work". This means that they are not hidebound by professional dogmatism, silos and entrenched thinking; that they can truly support the achievable ambition of recovery.

So in conclusion it is not all about changes in systems and strategies. It is also about changes in culture, relationships and identity. 'No changed structures without changed cultures': it is very similar to what we are saying about recovery for users of services. The workforce and those whom it supports travel the same road – together.

Joy Barlow is the Head of STRADA (Scottish Training on Drugs and Alcohol)

Agents of change

Little can be achieved in improving the way drug workers do their job without the help of their managers, says **Carole Sharma**.

The one resource that actually delivers treatment, the workforce, is at long last being given some prominence. The 2010 government drug strategy acknowledged that those in the drug field are working together to "develop an inspirational recovery orientated workforce; promoting a culture of ambition and a belief in recovery". We are working on national standards, competency requirements and making as many staff development resources available as possible.

After all, it's pretty grim coming to work each day if you don't believe that what you do is making a difference. It is time to fully develop these aptitudes and competencies so that drug and alcohol users can have confident, able, knowledgeable practitioners who can work in partnership with them on their recovery journey.

One of my concerns is that we are focussing too much on practitioners without consideration for the framework in which they practice. Concentrating solely on the competencies of the face-to-face practitioners will not deliver the required outcome. It will be unsustainable if we do not at the same time ensure that we develop managers to support and guide the practitioners. A wonderful practitioner may quickly become jaded and operate below par if they are not challenged, supported, praised, and valued for what they do. So if we are going to deliver recover then we urgently need to consider the development needs of managers and team leaders.

Yet this is a difficult task in an environment where the rhetoric is all about maintaining front line services and cutting so-called 'back office' functions. Those in a management role already have a lot on their plate, but for services to be effective, managers will need to prioritise the support and supervision of the practitioners.

I feel the agents of change in the culture of treatment services are the managers. And they do this by leadership and providing a learning environment within the workplace. They are able to nurture development by good quality case management, examination and audit of practice and ensuring that practitioners are working in a viable and meaningful partnership with their clients.

THE DRUG AND ALCOHOL SECTOR SHOULD CONSIDER DEVELOPING THE ROLE OF 'SENIOR PRACTITIONER' TO PROVIDE MENTORING, TEACHING AND SUPERVISION TO OTHERS

So do we need specific drug and alcohol service management qualifications? In a nut shell, no we do not. But we do need managers who are trained to manage and who can be liberated from case work to concentrate on overseeing the delivery of services and the needs of the practitioners in those services.

There are plenty of nationally recognised qualifications in management for health and social care (see below), which will prepare individuals to manage teams or organisations. Most universities provide management courses which are relevant. But a need does exist for the development of additional training for qualified managers to contextualise their skills, in terms of delivering a recovery-focussed workforce. This would be a useful piece of work for the newly constituted Skills Consortium to undertake.

Workforce development is a tall order for service managers to take on – so the time is right to look at how we can best achieve this. Our sector tends to have relatively flat career structures, where you are either a manager or a practitioner. This has been an historical problem across health and social care. The nursing sector has tried to alleviate this by having such roles as 'clinical nurse specialists' in an attempt to reward very good practitioners and keep them in touch with clinical work.

The drug and alcohol sector should consider developing the role of 'senior practitioner' to provide mentoring, teaching and supervision to others, as well as good quality case work. Senior practitioners should also play an important role in maintaining the positive culture within the service.

We are facing hard times in the near future where we are all going to have to do more with fewer resources, so we need to be smarter with the resources we do have and make sure we use them effectively. I believe that time spent building a management system which truly supports the practitioners will give us the dividend we require, namely, services which are recovery-focussed and are valued and cherished by drug and alcohol users, their loved ones and the communities in which we work.

Carole Sharma is Chief Executive of the Federation of Drug and Alcohol Professionals

Awarding bodies for qualifications in management appropriate to the sector are: www.city-and-guilds.co.uk; www.ediplc.com; www.ocr.org.uk and www.open.ac.uk/shsw

Not so secret services

Drug workers have to walk a fine line over what they can tell the authorities and even family members about clients. But now they are under increasing pressure to share confidential information with the external agencies. **Esther Sample** reports.

After fleeing the war in Iraq, Ali became an asylum seeker in the UK and was put in dispersal accommodation in Bradford. With little access to support or healthcare and coping with traumatic memories of conflict, he developed a serious heroin problem. After two years, he gained refugee status and with increased support and access to public funds was referred to a drug treatment service.

At the same time, the Red Cross International Tracing and Messaging Service had been contacted by Ali's parents who were desperate to find their son and thought he could be in the UK. The Red Cross were able to track Ali down to the treatment service through his refugee case worker. When approached, the service said that they couldn't confirm whether he was there or not, but if he was, they would pass the contact details on.

Months passed with no news and more and more tracing requests were submitted to the Red Cross by Ali's parents, who did not know whether he was alive or not. When contacted again the drug worker agreed to pass the message on, explaining that he was there but that this information could go no further. Ali never contacted his parents and the Red Cross could not disclose that they had found him. He did, however, have the contact details if he ever changed his mind.

Drug service confidentiality policies vary depending on client groups and service aims, but managing risk is a core element of all policies across the drug and related support sectors. For workers these policies provide legal protection and security, and can also be a way to establish trust: "Only in these extreme circumstances will I break confidentiality". For service users, having privacy and personal space is often an essential part of recovery.

A key question all drug workers ask themselves about their clients is "do they pose a serious risk to themselves or others?". If the answer is yes then a worker must override confidentiality, and in some cases they are legally obliged to do so. "Disclosing someone's drug use or treatment without permission could really destroy someone's recovery. Disclosure can be a personal disaster for someone who is trying to get help, ultimately it could kill someone," says Lucy, a client of London treatment service Blenheim CDP Rise.

Negative judgement from family or wider society is often a key concern. "I would be very sceptical of my details being shared with external agencies, because I feel like I may be judged and I am not there to defend myself," says Lucy. "I would want to see anything written about me. I think how things are worded can have a big impact."

Another client at the project, Helen, says that "confidentiality is paramount for me. My partner knows I am here but I would not want my information shared

further, letters could go wandering and someone else could know about my drug use that shouldn't". At the simplest level, confidentiality policies can prevent drug workers from sharing information about clients or force them to do so. It is often a fine balance, and if not managed correctly, it can inhibit effective joint working or damage the relationship between drug worker and client.

The new drug strategy's push towards holistic recovery services requires a heightened level of joint working, which inevitably brings information sharing and confidentiality issues to the fore. There is concern in the sector that workers are increasingly being forced to break confidentiality. And the dispersal of data, whether it is between police, probation or social services, can be difficult and distressing for service users and workers. "Drug workers are certainly getting less control over what is confidential," says Sean, a drug worker at Rise.

Drug workers have also expressed concerns over the effect that welfare reforms and payment by results could have on confidentiality. With so much policy change, not least following a change of Government and the abandonment of key proposals in the Welfare Reform Act 2009, it is not surprising to find that there is confusion and anxiety over what information, if any, will need to be shared with JobCentre Plus, and the impact this could have on a client's benefits.

Tensions about information sharing between substance misuse service and social services or police have always existed. In recent years, however, there have been more reports of services feeling under pressure to introduce policies of automatic referral in order to maintain good relations, despite no legal obligation to do so.

Kevin Flemen, a housing and substance misuse consultant, told *Druglink* that drug policies in homeless hostels, developed in conjunction with the police, now often include automatic referrals for any "suspicion of dealing". He says this is "fundamentally dubious" and can be a slippery slope of giving away more and more information.

THERE IS CONCERN IN THE SECTOR THAT WORKERS ARE INCREASINGLY BEING FORCED TO BREAK CONFIDENTIALITY. AND THE DISPERSAL OF DATA CAN BE DIFFICULT AND DISTRESSING FOR SERVICE USERS AND WORKERS

Supported housing protocols developed in Newcastle now include blanket referrals to police for any suspicion of drug-related illegal activity. And in Brighton last year, police seeking to clear up scores of unsolved shop-lifting crimes approached supported housing workers to go through shop CCTV tapes to identify any clients they knew. The workers understandably felt compromised.

Flemen says that crime and disorder legislation creates a "willing spirit of cooperation", rather than a legal obligation. But he says it is often used by police as leverage to fish for information. As a result, some organisations break their confidentiality agreements with clients by sharing too much information, either because they think they have to, or just to maintain good relationships.

Drug services are also finding themselves increasingly under pressure to hand over previously confidential information to social services. A young people's drug service manager in the South East

TESTING TRUST

A young people's treatment service manager on how new information sharing policies are weakening the bond of trust between clients and services:

"A 15 year old boy shares with us he is heavily involved in dealing crack, and being exploited by adults to do it, although he doesn't yet recognise the exploitation. To our knowledge he hasn't shared this with other services. He was assessed to show that he was competent to make his own decision about receiving services without parental consent. Our aim would previously have been to work with him to get him to recognise the exploitation and to gain consent to share, while maintaining the relationship. Our new policy says we should share immediately with or without consent. My concern is that this will damage the relationship, not only with us, but with services more generally, and that he will disengage and become harder to reach and more at risk. The ripple effect may also mean that services' reputation for providing confidentiality will be compromised and young people in general will become less likely to share."

FDAP CODE OF PRACTICE: CONFIDENTIALITY

- Personally identifiable information about clients should normally be disclosed to others only with the valid informed consent of the person concerned (or their legal representatives) – and the boundaries and limits of confidentiality should be explained clearly before any service is provided.
- Where a practitioner holds a sincere belief that a client poses a serious risk of harm to themselves or others, or where obliged by law, a practitioner may be required to disclose personally identifiable information without the client's consent. Before breaking confidentiality, however, practitioners should still seek to secure valid consent for disclosure from the person concerned and should consult with their supervisor or a senior colleague where this is not provided – except where the practitioner judges that any delay this might cause would present a significant risk to life or health, or place the practitioner in contravention of the law.
- Information identifying clients must never be published (for example in an article or book) without their written agreement (or that of their legal representatives).
- All reasonable steps should be taken to ensure that any records relating to clients are kept secure from unauthorised access and the requirements of the Data Protection Act should be complied with at all times.

of England said she was surprised when her local authority introduced an 'automatic referral' system for her drug service clients to social services. She says it is a policy that disregards the four parameters traditionally used by the drug service to assess whether they should refer young people to social services: age/maturity; severity of the problem; continuing/increasing risk; and context. She says the new system is already acting as a barrier to young people seeking help, who no longer see the service as confidential (see box on p15).

Since the case of Baby P, social workers have been encouraged to be more open to sharing information. "The key cause of confidentiality tensions between substance misuse services and social services are caused by a lack of training on both sides about the pressures and duties of each other's roles," says Sarah Galvani, an expert on social care and substance misuse from the University of Bedfordshire. "For example, a children's social worker may approach a treatment service to find out the details of a counselling session for a child's parent. This isn't necessarily an appropriate thing to ask as confidentiality is a key part of the therapeutic process. It is appropriate to ask whether a person has attended and if anything has been discussed to suggest the child is at risk – that is, providing the social worker isn't making a decision based on that alone. People can be bad parents with or without drug and alcohol problems."

Galvani says that as well as training, the easiest way to overcome these barriers is for workers to always seek permission from the client to share information and be clear under what circumstances they can go ahead without permission. The Federation of Drug and Alcohol Professionals state that before breaking confidentiality, practitioners should inform the client this is going to happen and whenever possible "seek to secure valid consent for disclosure".

But this does not always happen, as Blenheim client Helen explains. "I am going through a court case with the little one. At a previous service, my drug use got disclosed to social services without my knowledge. They should have spoken to me first. Social services were judging me because at that stage I was still using. They said, "if you want your son back you will have to stop now". I was so angry because I didn't know anything about it, and it is part of my treatment and recovery."

Services sharing information appropriately and working closely together can make service users feel supported and prioritised. But confidentiality policy can often act as an obstructive form of red tape between different drug services.

"It can be so monotonous going from one place to another, having to give your details and life story over and over again because they cannot share the information," says another Blenheim client, Lucy. "Believe me, when you are in early recovery it is so hard to go over your life story. Frustration sets in and before you know it you can relapse."

Another client, Robert, says: "If drug services have better links and so they have a vague idea who is walking through the door, they have got a heads-up. If services have a rapport with each other then they can choose an appropriate key worker. When I moved to this agency it was like my key worker knew me already, which was great."

Although privacy and freedom from stigma and judgement are key concerns for people accessing treatment, between trusted support services, many service users are happy with information sharing. Lucy agrees: "I have had information shared but it has been for my own benefit. I had depression and suicidal thoughts and that has been disclosed. I can accept that though because it is coming from a caring place."

Confidentiality policies need to reflect personal preferences, something that Blenheim has built into their procedures. Drug worker Steven explains that at assessment stage, service users will create their own sections of the policy. For example, allowing drug workers to talk to specific members of a family about attendance and drug test results, but nothing else. Treatment agencies are often particularly careful to follow client wishes on family members, as is shown in the case of Ali and his parents, described at the start of this article.

Sean explains that a typical example of when confidentiality policy can get in the way is when a client goes missing. If that person has not given permission to speak to family members, it can be extremely difficult to track them down. Just as many drug workers can feel uncomfortable sharing information with social services, the criminal justice system and Jobcentre Plus, these agencies were also highlighted as the ones from which it is most difficult to get information on their client's situation or history.

Policies on confidentiality are an essential protection for both drug workers and service users. However, as far as possible, they need to be personalised and consensual. The challenge is not to allow policies to inhibit joint working between support agencies. Where information is shared, both workers and clients need to be fully informed and understand why a breach of confidentiality is necessary.

Esther Sample is a former Policy Officer at LDAN

UP TO SPEED

What is the role of doctors within the government drug strategy? **Dr Linda Harris** on two new projects set to change doctors' approach to drug and alcohol use.

What kinds of contribution can doctors make to supporting drug users within a collaborative, multi-disciplinary team? And what skills and competencies do they need to take on the various tasks that may be asked of them within an integrated, recovery-oriented treatment system?

The medical Royal Colleges (which have a key role in overseeing the training, professional development and regulation of doctors) will this summer launch two projects to address such questions. The decision to take a fresh look has come in response to the changing needs of service users and recent trends in drug use. It has come in the wake of new patterns of commissioning and service design and to changing configurations of the workforce within the treatment system.

The first is a joint initiative of all the Colleges to define a set of core competencies that all doctors should have in working with people who use drugs or alcohol – whether they are local GPs, A&E doctors, general hospital doctors or specialists such as paediatricians or obstetricians. The result is a consensus across all medical specialties, the GMC and other stakeholders, on what every doctor should know and be able to do to support, health and wellbeing in this area. It will also be a required part of medical training for all doctors.

The second project looks in more detail at the roles and competencies of doctors who specialise, to some degree, in working with people who use drugs and alcohol. It will define three levels of competency for doctors – specialist, intermediate and generalist – based on their training, qualifications and experience. It will map competency levels against the roles and responsibilities that these doctors may carry out. Intended for commissioners, managers and clinicians, it is a collaboration between the Royal Colleges of General Practitioners and of Psychiatrists to thoroughly revise and update their 2005 guidance document on this subject.

Part of the project's aim is to define the important role that specialists have in delivering high quality, cost-effective care that achieves positive outcomes and successfully manages risk. It will ensure that drug and alcohol users have access to the medical expertise they need in order to recover.

The project will address the need for more specialist doctors to have a full range of skills to provide psychological and social support as an integral part of working towards optimal health and wellbeing. The new document will aim to develop and spread best practice, by clarifying for commissioners and others what they can expect of doctors working in the treatment system. Importantly, this should include the ways in which doctors can and should contribute to ensuring that a high quality service is being delivered and is providing the right support and care to everyone, especially those with the most severe and complex needs.

Dr Linda Harris is Chief Executive, Spectrum Community Health in Wakefield

Co-authors on this article are: Dr Emily Finch, Clinical Director for Addictions, South London and Maudsley NHS Foundation Trust; and Julia Sinclair, from the University of Southampton School of Medicine

THE WHOLE NINE YARDS

A good drug worker is not necessarily someone who has used lots of drugs, has great charm or is extremely efficient. They are someone best equipped to help people off drugs. By **Leon Wylie**.

Quality in a product or service is not what the supplier puts in. It is what the customer gets out and is willing to pay for. A product is not quality because it is hard to make and costs a lot of money, as manufacturers typically believe. This is incompetence. Customers pay only for what is of use to them and gives them value. Nothing else constitutes quality.
Peter Drucker (1909–2005)

The substance use treatment sector is in flux. Political and policy changes and squeezed funding have led to greater bickering about the direction services need to go. Therefore, let's cast an eye over a key area that will heavily influence our response to those challenges. Do we have a workforce that is capable of doing its job?

If someone asked, "what makes a good drug worker today?", it's likely your answer will be largely based on your own view of the world, with a sprinkling of any evidence that backs up your argument. Although a drug worker is not a product, if you apply Peter Drucker's thoughts (above) to the core components of a drug worker's skills, the logic behind the quote seems to apply.

Drucker was often lauded as a management guru, but it was his interest in getting the best out of human relationships that was core to his work and writings. Evidence-based best practice has been defined as a combination of best research evidence, clinical experience and patient values – three elements that when melded together form a good drug worker

Services still tend to judge staff quality in organisational terms, such as knowledge or service orientation, but recent evidence from a review of literature regarding users suggests that many rate a positive attitude towards the user as the key staff attribute to enhance quality of care. Interpersonal skills such as empathy, being non-judgemental, quality of interaction and staff availability are seen as very important. And although users wanted knowledgeable staff, a positive attitude towards them will often overcome a staff member's knowledge deficit. Another key value identified by users is a staff member's self-awareness. It is thought that being in touch with one's personal vulnerability in many aspects of life increases the likelihood of an empathic response to someone from beyond one's usual circle of humanity.

Evidence from service users is backed up by treatment data which seems to confirm that it is the relationship between client and worker which is most important, rather than the type of treatment provided. Across a number of studies, treatment outcomes were enhanced by the therapist displaying empathy, where the client felt they were being understood.

Good practice is not just about substance use treatment protocols, it is about stability, security and enhancing confidence in support services. It's about working 'with' rather than 'for' clients, thereby enhancing a person's self-image and supporting the ability to change. Interpersonal skills enhance interaction and the therapeutic alliance between users and staff, increasing the potential for positive change. When staff gain a greater empathic understanding of their client's needs they are more likely to produce the positive environment necessary for change. The evidence points to the fact that positive treatment outcomes are influenced by positive client-worker relationships.

Matching clients to therapists who use a treatment style that suited their particular problems enhances outcomes: it is the style of the therapy, rather than the content, which is the key indicator in matched treatments. Bringing matching and empathic relationship-building together requires the ability of staff to perceive not only their client's perspective, but how their own mode of communication may be a positive or negative influence on treatment outcomes. Assessing where a client is currently at and what treatment style is most likely to benefit them is not an easily developed skill. However, validated assessment questionnaires can partly fill this treatment gap. Workers who are able to adapt their treatment to the client, but not stray too far from the treatment framework, often have more consistent results than those who operated under a laissez-faire style or stuck rigidly to the manual.

There continues to be a strong level of debate about the pros and cons of ex-user involvement in drug services. Service users often feel that ex-using staff members can be superior in displaying empathic skills. Ex-users may, through their personal recovery process, sometimes garner a greater insight into their own and other's reasons for use and therefore perhaps gain a greater

empathic understanding of another user's current situation. However, there is also evidence that ex-users who are untrained or lack self awareness can have aversive impacts on clients.

With the various mythologies also attached to substance use it is important that the ex-user has had the opportunity to get to grips with the scientific nuts and bolts of treatment. With the policy focus on recovery and localised solutions, it seems important that training and reflective practice is encouraged across all service delivery areas. As the staff that come into contact with service users are many and varied, it may be more effective to teach the tools and attitude of acquiring knowledge, rather than the many strands necessary to be the 'complete' worker. There are, however, skills in various specialised areas, such as alcohol detoxification or initiation of substitute prescribing, that will still require procedural, rather than attitudinal, orientated skills development – as user safety could potentially be compromised by under-trained staff.

Unfortunately, negative perceptions may influence the level of care deemed appropriate for a particular user's circumstance. A Northern Irish study by McLaughlin and colleagues noted that staff with low levels of knowledge and skill levels show a low regard for substance users and feel unable to cope with regular contact with them. A recent Scottish user's study commissioned by Health Scotland found the main service delivery criticism focused on stigmatising attitudes, especially towards drug users with a lack of choice of and control over treatment and care. Professional staff with a longer history or further studies in the substance use area tend to have a greater understanding of the aetiology behind problematic use. There is a varied mix of evidence that shows these staff can often have an ability to be more empathic than new untrained staff however this can vary greatly, perhaps often due to the organisational culture that the staff work in.

Management has a major role in the development of staff culture. A US study suggests that services that base their delivery around quality rather than cost management will produce better outcomes. A recent review of UK services by academics from the US and UK found that services that reflect an openness to change are more likely to have staff with

an ability to enhance engagement with clients, therefore improving outcomes. Whatever the individual qualities of staff, whether new to the field or old hands, the organisational culture in which they work has a key role in how they use, or do not use any knowledge they may acquire. A London School of Economics discussion paper, although focused on the banking sector, explored some interesting areas relating to organisational culture, training and attitude.

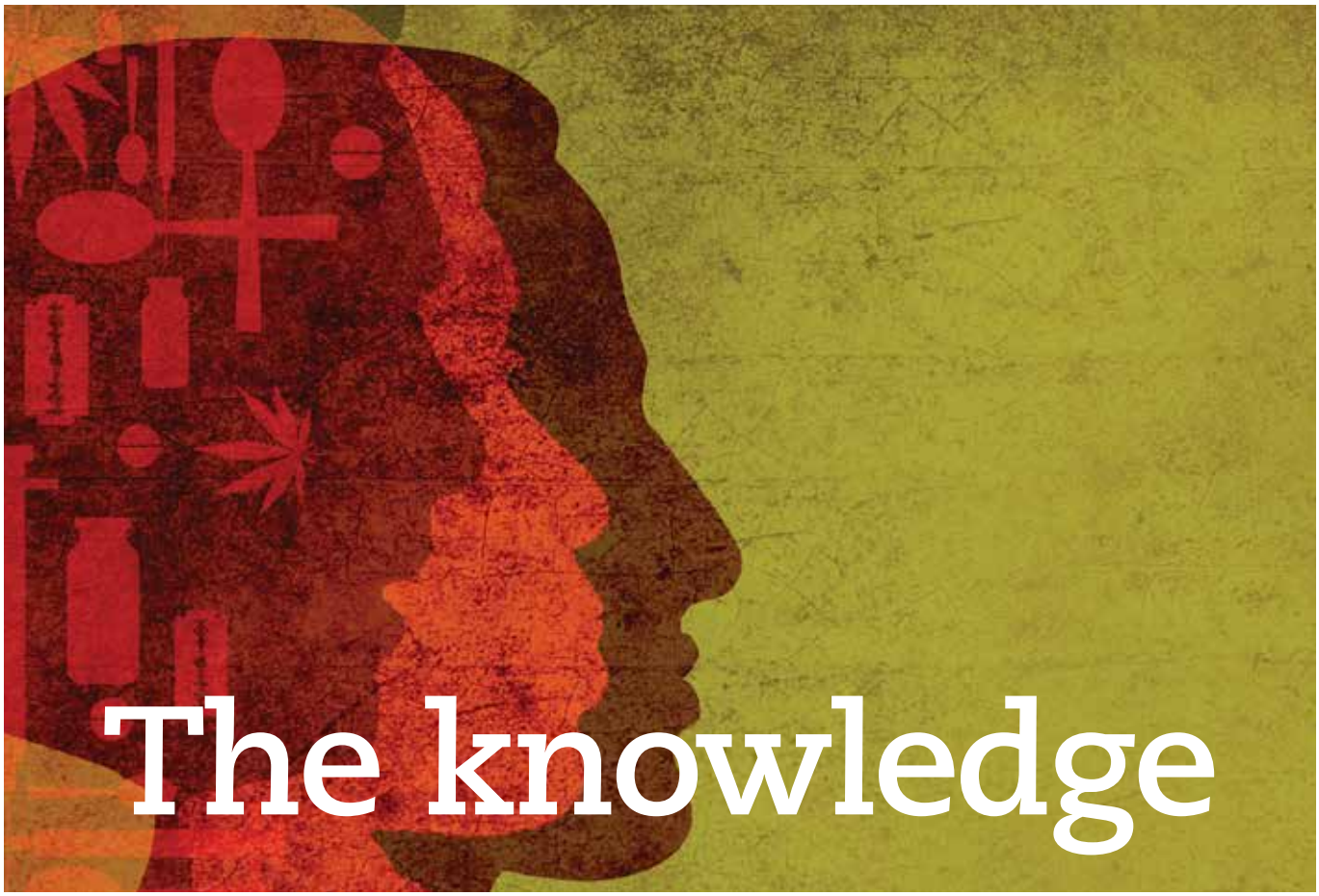
THERE IS GOOD EVIDENCE THAT IT IS MOST OFTEN THE WORKER, NOT THE TREATMENT MODE, THAT MATTERS MOST WHEN IT COMES TO WHAT IS BEST FOR THE CLIENT

The study, based on an American bank with hundreds of branches across the United States, explored the link between organisational attitude and economic performance. Unsurprisingly, it found that the branches with better staff attitudes performed better economically. But the study also found that a poor organisational attitude impacted on staff attitudes, irrespective of their level of training prior to joining that branch. This negative culture also affected attitudes towards current training as staff who received external training were unlikely to use it once they returned to their branch.

How does this all relate to the new focus on recovery? Does this mean a change in direction for staff? Well, one could hazard a guess that, if a staff member displayed the positive traits so far discussed, there is a high possibility that their current treatment mode embraces the core ethic of recovery. In other words, true, client-focussed care. Leaving aside visions of new methods of service delivery, there is good evidence that it is most often the worker, not the treatment mode, that matters most when it comes to what is best for the client. A worker who is truly client-focussed would seek out recovery-based opportunities for their client, whether that be knowing how to access all local services or engaging clients with those other services as they move through treatment.

The good drugs worker can engage and motivate, is self aware and enhances self belief, respects themselves and others, can match care to clients, knows and updates their subject matter and adapts to the system they are in. They can be an ex-user, a new recruit or the gnarled old pro. Dear reader, they could even be you.

Leon Wylie works for NHS Education for Scotland. Before that he worked at the Scottish Association of Alcohol and Drug Action Teams and at frontline drug services in Scotland and Australia



The knowledge

The Substance Misuse Skills Consortium is a sector led initiative tasked with delivering 'an inspirational, recovery-orientated workforce'. The Consortium's chair, **William Butler**, describes how it came about and why it is vital that treatment providers now step up and demonstrate their support for its work.

Delivering the recovery ambitions of the drug strategy will rely heavily on the skills and abilities of staff to engage with people in a meaningful and effective way and support their integration within broader society. We established the Substance Misuse Skills Consortium in 2010 to ensure that services and their staff can grow and sustain these abilities.

The Consortium is an independent, sector-led initiative seeking to harness the ideas, energy and talent within the substance misuse treatment field. It has nearly 150 voting member organisations, and another 100 associates benefiting from its resources. Its work is managed by an executive representing a broad range of service providers, membership organisations, service users, training and education organisations and professional bodies. Recognition of the Consortium's drug strategy role in supporting the delivery of the recovery agenda gives us a sound endorsement on which to build. But it also sets a challenge to which we – and by that I mean the entire treatment sector – must respond.

It was the many challenges facing the workforce which prompted the establishment of the Consortium. The last decade saw a huge – and welcome – expansion in the size and diversity of our workforce. The system focussed on the reduction of waiting times; engaging service users and reducing harm. We are now faced with a substantial and challenging transformation of the agenda, which focuses on people's individual recovery journeys with the goal of leading to them leaving treatment free of dependence. Many of the skills required aren't new: motivating

people, supporting change, working collaboratively with service users and effective care planning. But just because they aren't new doesn't mean that all staff are able to use them or are doing so successfully. We need to be honest about this and work hard to address any shortfalls.

The renewed focus on recovery is also generating a wealth of fresh and innovative thinking, in particular how to foster and work in harmony with recovery communities. But we have to embed recovery frameworks in a way that both delivers results and develops evidence to support our practice. Since many of the challenges to our current practice have come from service users themselves, it is vital that we work with them as genuine partners to build treatment and recovery systems we can all be proud of. And we have to support the workforce in regaining the positive sense of itself required to deliver the changes.

But as we make progress we need to be careful not to generate new problems or undermine previous gains. There is always the risk of rushing people out of treatment before they are ready or neglecting the skills required to reduce harm. The drug strategy seeks to build on the foundations of the last ten years – we need to ensure our skill set does the same.

The Skills Consortium's broad aim is to support managers and practitioners to deliver services and interventions that are purposeful, evidence-based and effective. Our opening offer to the field in November 2010 was the Consortium's website and the 'Skills Hub': an online gateway to nearly 200 resources to support effective drug treatment practice. These include guidance, toolkits, manuals, training and the evidence base for interventions. It is all built around a framework for skills in drug treatment, drawing the mass of different interventions and techniques together into one model built around a treatment journey. This free resource will help services, managers and practitioners to deliver purposeful and effective interventions. But the Skills Hub is far from complete. We need people to share resources they have found useful and lessons they have learned from implementing 'new' interventions.

There are three broad strands to our current work programme. First, we will continue to develop the Hub, establishing priorities for new resources and improving shared learning about the implementation of 'new' interventions. Second, we will seek to develop a consensus and sector-led approach to training, continuing professional development and qualifications, based on an understanding of the appropriate roles and responsibilities of staff across the treatment spectrum. We will work with the relevant sector skills councils, further and higher education providers and awarding bodies to ensure that the sector has a progressive qualification and accreditation framework that meets its needs.

THE LAST DECADE SAW A HUGE – AND WELCOME – EXPANSION IN THE SIZE AND DIVERSITY OF OUR WORKFORCE

Third, we will foster a sector-led consensus and approach to developing the evidence base and the body of research to support effective treatment systems, focusing on emerging thinking about recovery-oriented treatment systems, practice and communities. This means working with relevant research bodies, government departments and clinical institutes to inform their priorities and approach.

We are holding our first national conference in London on 6 June 2011. The larger part of this event will be an opportunity for members to present their responses to the recovery agenda. They will learn more about what the Consortium can do with their involvement, and consider how the Consortium can become self-sufficient.

In this time of increased competition and innovation it is vital to share clear examples of effective practice. The establishment of an independent sector-wide and led Skills Consortium is a major opportunity and a substantial challenge to enhance the reputation and quality of our field. Together, our joint endeavours can produce something outstanding, potentially far outstripping any single organisation's workforce offering. So it's time to get involved!

www.skillsconsortium.org.uk

William Butler, chair, Substance Misuse Skills Consortium

COMMENT BY PAUL HAYES

The Substance Misuse Skills Consortium is a welcome innovation by the drug treatment field, for the drug treatment field.

The skills of the treatment workforce are crucial to delivering a recovery-oriented agenda. That is true not only for practitioners but for their managers too.

Neither national guidance nor local commissioning is any substitute for concerted efforts by the providers themselves to ensure that their staff can promote and sustain change for their clients.

The NTA has been proud to support the initial stages of establishing the Skills Consortium. However, the initiative has now reached the point where it can be self-sustaining. So we are equally eager to step back and allow members themselves to press ahead under their own steam.

The key to the success of the Skills Consortium is that it is sector-owned and sector-led. It is genuinely representative of the broad range of those who provide drug and alcohol treatment and recovery services.

Whatever changes are being made to the structure of the healthcare landscape through the government's reforms, it will be these member organisations that are commissioned to provide effective services on the ground.

It is therefore vitally important that individual employers take responsibility for ensuring their employees can deliver on their contracts.

It is also through these providers voluntarily working together to create a recovery-oriented system that we will ensure there is a national framework for drug treatment services that gives consistency across the country.

The Drug Strategy gave a clear role to the Skills Consortium to develop a skills framework that supports the recovery agenda. I am heartened to see so many providers step up to that challenge, ready and willing to exploit the opportunities they have been given.

Paul Hayes, chief executive, National Treatment Agency for Substance Misuse

RELATIVELY SPEAKING

One of the Britain's largest drug agencies has trained its workforce to look into the delicate matter of drug users' families. By **Elliot Elam**.

Only by looking past the label and focusing squarely on the individual can drug treatment workers understand a person's concerns, their predicament and the issues underlying their use. But focus on the individual can be too tightly drawn. Drug services have not always considered service user's families, and that they may also need support. But asking people about their family is a tricky business.

For the last two years, Scott Haines, and another Family Development Manager, have been training Addaction's 1,000-strong workforce to ensure they take into account the needs of families when helping people with drug and alcohol problems. "Some staff had concerns," says Haines. "The main fear was of alienating service users.

"Imagine if they asked someone about their children, for example. And imagine if that person responded aggressively – 'what do you want to know that for?' There were concerns about where that could lead; perhaps the service user would drop out of treatment, with a fear that, now their kids were in the picture, social services would be called to take them away," says Haines.

"So, we had to work hard to dispel those fears. And we did that by giving staff the skills and the confidence to broach these kind of subjects. We built a framework of training and guidance, so staff understood why they were asking these questions in the first place, and how by asking them they weren't jeopardising their client's treatment, but actually supporting them further. And of course, having a drug problem isn't a cast iron guarantee that your kids would be taken away from you. Far from it."

There is certainly a need for this support. In its 2003 *Hidden Harm* report, the Advisory Council on the Misuse of Drugs outlined the dramatic consequences that a parent's drug use could have on their children. Children were, it claimed, far more likely to develop drug problems themselves in later life and that preventing this was of the utmost importance. The Social Inclusion Taskforce expressed similar sentiments five years later, and called for adult drug services to prioritise partnership work with children and family services, in its *Families at Risk* report. Over the last two years, Addaction's 'Family Focused' project – supported by a £240,000 grant from the Department for Education – has meant an overhaul of the charity's policies and the way it records data. "We already had family-specific projects," says Haines, "but this was something different." Haines and his colleagues started by appointing 'Family Leads' in each of the charity's services to champion the new changes. After they had been trained themselves, they trained their colleagues.

As well as helping staff recognise and deal with the stresses someone's misuse could be placing on their family, for example financial pressures or feelings of shame and guilt, the training also helped staff speak to those families. Getting staff to think about the way they used language was perhaps the most important part of the whole project, says Haines. "We work in a jargon heavy sector. 'Tier this', or 'intervention that'. It's all well and good if you're speaking to people who are familiar with those terms, but to the uninitiated it can be confusing, or even scary. We saw no point in our staff sitting down with someone's mum or dad only to confuse the hell out of them, or for them to leave feeling pessimistic about their son or daughter's recovery."

"Instead, by using positive, simple terminology, our staff can help that same mum and dad leave feeling as they should feel – involved in their child's recovery, and committed to helping.

"Now, we're asking a lot more questions", says Haines. "We're asking for more comprehensive information about our service user's children – their schools, how much time they spent with them, whether they have a GP, whether they have a Common Assessment Framework. Before, it was all too common to ask 'have you got kids?' and when they said yes, 'how many?' It was pretty basic."

Within Addaction's services, the Family Focused project is already reaping dividends. All staff have reported that they feel more confident discussing children and family issues with their service users, and the service users themselves feel more aware of the support available for them, their children, their parents and other loved ones. Prior to the training, 66 per cent of Addaction services were asking questions about families and the support they may need. Now, that figure has risen to 97 per cent – with staff understanding the importance of doing so, and vitally, supporting the charity's new approach.

By compiling this new, more detailed, information from its service users, Addaction hopes to build on the existing evidence around family-based working and, with it, influence the development of local and national approaches to drug and alcohol treatment by other drug service agencies. "What I'm seeing now", says Haines, "is the really positive effect the whole project has had. Frontline workers are telling me about the links they have made with children's services, social workers and others. And how the changes they we're making have improved things for their service users. They feel like they are really developing their own skills, adding more strings to their bow."

Elliot Elam is Communications Officer at Addaction

Stepping forward

Relative to other social care sectors, the drug field has a short history. But as this account of the last 40 years shows, it is a frenetic history dominated by the values of voluntarism and a complex, sometimes contradictory relationship, with the state.

Reviews

Karen Biggs is Chief Executive of Phoenix Futures

VOLUNTARY ACTION AND ILLEGAL DRUGS: HEALTH AND SOCIETY IN BRITAIN SINCE THE 1960S

Alex Mold and Virginia Berridge
Hardcover, 288 pages
Palgrave Macmillan, 2010
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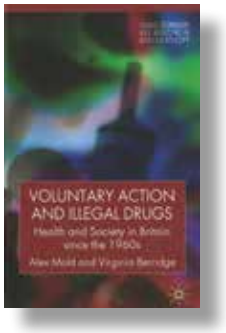

Voluntary Action and Illegal Drugs: Health and Society in Britain since the 1960s isn't the most inspiring title in the world but it belies a stimulating and informative book that tracks the highs and lows of the sector with insight and honesty. If like me you haven't grown up in the sector and weren't there at the beginning, this book makes sense of how the sector got to where it is and may help us make more sense of what should come next.

The questions Berridge and Mold pose are these: how can we explain the significant increase in the size and scale of the voluntary sector over the last 40 years? What do voluntary organisations actually do? And how important has been their contribution been? The seven chapters of the book are split into three parts. Part One describes how the drug sector was born by looking at two very different organisations, Phoenix House and Release, in the 60s and 70s. Unsurprisingly it was this chapter that brought me to the book.

It shows how voluntary organisations emerged to deliver something the state couldn't or wouldn't provide. There is an accurate and honest account of the first days of Phoenix, set up as a self-help organisation aiming to rehabilitate drug users, as I have heard. This is due I suspect to the many primary sources set out in the bibliography and not least the interview with the Phoenix House founder Griffiths Edward. Phoenix House worked in harmony with the state and the psychiatric profession, providing an alternative form of treatment for drug users facing the prospect of maintenance or withdrawal in a drug dependency unit. Release, more a civil liberty group than representing the rights of drug users per se, was steeped in the counter culture of the 60s. In its essence it was anti-state and its continued survival has proved its resilience.

In the final chapter of Part One, Mold and Berridge explain how the key tenets of the sector we recognise today came into being. Examples include the state and the voluntary sector working together in projects like City Roads, the development of street agencies like Lifeline and the establishment of SCODA – formed to better represent the voluntary organisations working in the sector.

Part Two looks at the 80s: the impact the Thatcher government had on the sector and the seismic shift in the delivery of drug treatment as a result of the onset of AIDS. Mold and Berridge argue that increased state funding of the sector through the creation of the central funding initiative (CFI) had a profound impact on the relationship between the voluntary sector and the state. It also allowed the government to support harm reduction services, shifting policy away from the rehabilitation focus of the 70s. The state no longer provided welfare services but instead oversaw the voluntary sector (as well as statutory and private sector organisations) to do the job, through a tight command and control approach. In this way, Berridge and Mold see the relationship between voluntary sector and the state as becoming closer, the "state forming a constituent part of an increasingly diverse mix of welfare providers". It was this closer relationship that proved essential in the battle against AIDS which proved to dominate the approach to drug policy for the next 20 years.

A CANTER THROUGH THE KEY CHAPTERS IN THIS BOOK CAN'T DO IT JUSTICE. IT READS LIKE THE 'WHO'S WHO' OF THE DRUG SECTOR

Part Three deals with the 90s and 2000s, and in particular the influence of drug users on the sector and the development of the 'user voice'. Mold and Berridge make the distinction between the 'service user groups' who want to influence the way services are delivered and 'the activist user' who sought to have drugs decriminalised or legalised. The distinction between these two groups leads Mold and Berridge to conclude that drug users didn't all want the same thing and that there was clearly ''not one user voice but many users' voices".

A canter through the key chapters in this book can't do it justice. It reads like the 'Who's Who' of the drug sector. Mold and Berridge somehow make sense of the febrile activity in the sector and show how the voluntary sector's relationship with the state has changed radically over 40 years. Berridge and Mold show how the voluntary sector has responded to change in drug use and policy. It is this "adaptability and flexibility" they say is one of the key values of the voluntary sector.

The only downside I can find in this book is that is stops at 2009, just as arguably another seismic shift is about to occur in the sector with the new drug strategy, from a new coalition government in the worst economic conditions the sector has ever experienced. At the end of the book Mold and Berridge look to the future and feel certain that as drug policy moves on, "voluntary organisations, however reconstituted or reconfigured, will play a key part in whatever is to come."

I agree and just hope Mold and Berridge are poised to record the next chapter in our history.

drugworld DIARIES

SARAH RILEY

Senior Lecturer in Psychology

Aberystwyth University, Psychology Department

With Easter falling late, last month culminated in the end of what felt like a long teaching term. As with many academics, my job involves teaching, research and administration. Last month for example, I gave lectures and ran seminars with first years, held various meetings with second years to help develop their ideas for their final year dissertation and submitted a proposal to run a new final year module for next year that I have pretentiously (but enjoyably) entitled 'the 21st Century Self'.

I moderated and coordinated marking for various courses, met personal tutees for pastoral care, co-edited a book on qualitative research projects and tried to learn the teaching-related regulations and administration systems for this university. I've just started this job, and a new institution means new systems.

A long teaching term means that I can now focus more on other aspects of my job, including my research. I've been involved in a range of research projects linked to drug use and youth culture. These tend to be one of two kinds of projects. The first are small-scale projects that address information agency needs such as tracking changes in patterns of recreational drug use. The other kind are usually larger and initiated within academia, exploring some aspect of theory.

I enjoy doing research with young (and not so young) people on their 'party cultures'. Part of the pleasure is hearing stories that would otherwise have little air play, and then thinking about these stories in analytical ways so that I can tell them back, locating at them within their wider psychological, social and political contexts.

PEOPLE GET AN INCREDIBLE SENSE OF BELONGING WHEN PARTICIPATING IN THESE FESTIVALS AND PARTIES, AND I THINK THEY ARE IMPORTANT SITES FOR COLLECTIVE EXPERIENCE IN AN OFTEN INDIVIDUALISED WORLD

A good example of when the two types of research I do merged was a project initiated by Crew2000 in Edinburgh about magic mushrooms. I did a survey and focus group study for them addressing 'what', 'why' and 'risks' questions (Riley & Blackman, 2008), and later I went back to the data, because I'd been intrigued by the way that the focus group participants had justified their drug use. This second analysis culminated in a paper only just published in which myself and colleagues argued that these magic mushroom users were drawing on (neo-liberal) government rhetoric to position their drug use as part of their management of being a good citizen (Riley, Thompson & Griffin, 2010).

I love the way people take up ideas that are in their social milieu and incorporate, challenge, or re-appropriate them in ways that are new, sometimes contradictory and always interesting. That's the underlying theoretical framework for the identity research that I do.

Recently I've been involved in a project looking at the relationships between consumption and identity in festival and free party cultures (funded by the Economic and Social Research Council). It was fascinating looking at the interview and fieldwork data collected. People get an incredible sense of belonging when participating in these festivals and parties, and I think they are important sites for collective experience in an often individualised world.

The role of consumerism in the creation of these experiences is also fascinating, and while youth culture and business have always been hand in hand, there's been a ratcheting up of this relationship that has some interesting consequences for how young people make sense of themselves.

The grant for this festival project finished last year, and so now we're working on what articles and book chapters – and perhaps book – we might write to further disseminate the work. For now though, we've just been invited to join a steering committee for a project on risk-taking behaviour at music festivals. It's nice being a festival researcher – it gives you a sense of belonging.

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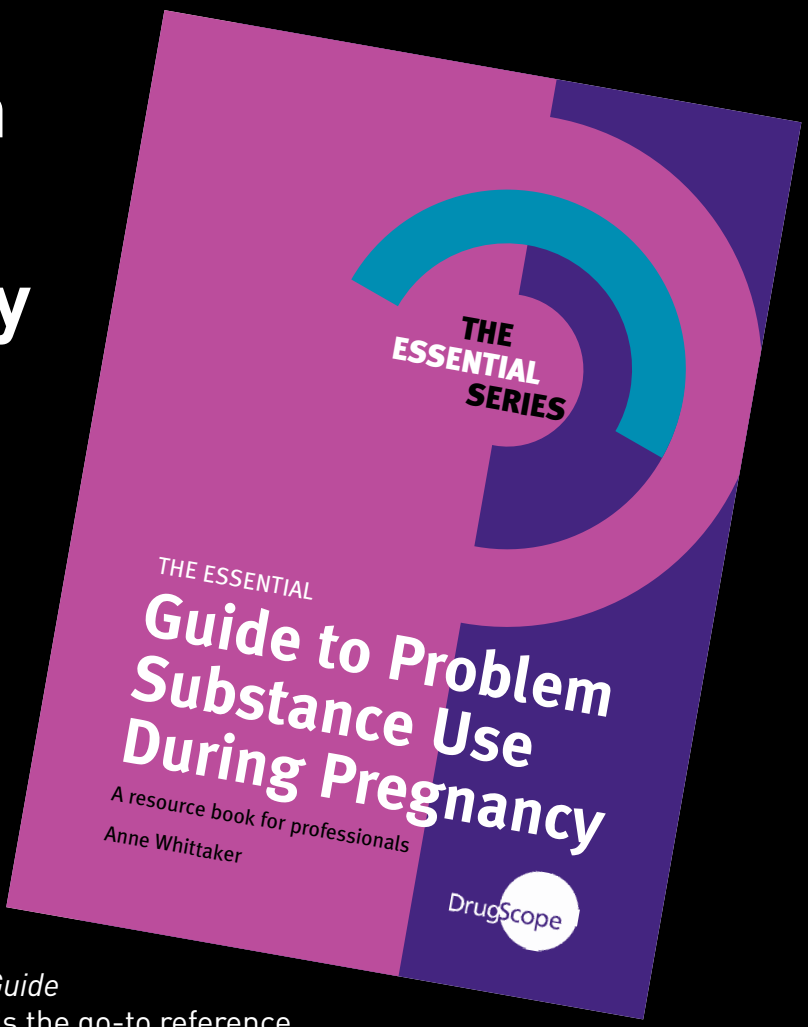
The Essential Guide to Problem Substance Use During Pregnancy



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