

Blenheim



Good Practice within Stimulant Services Learning from experience

Blenheim CDP

**An Independent
Review**

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within Stimulant
Services
Learning from
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Introduction

What works with stimulant problems – notably cocaine and crack?

What innovative practice has evolved within services that have specialised in working with these populations?

Should we have similar expectations of specialist crack services to those we have for services that largely treat heroin problems?

To what extent can we rely on traditional treatment methods used with opiate problems?

How have specialist services developed in areas where cocaine/crack use is particularly high?

The philosopher George Santayana said, “Those who do not learn from history are doomed to repeat it”. This review examines the practice of a major, London-based organisation that has extensive experience of working with stimulant users – *Blenheim CDP* – and attempts to learn from its history of work with this population. The review uses a combination of description and analysis to: capture learning that is now embedded within *Blenheim CDP’s* services; identify features of good practice; and, approach some answers to the wider questions above.

Stimulant use in the UK

Stimulant use in Britain is not new. Associations between amphetamines and youth culture through northern soul, punk and then rave have maintained it as a feature of the UK drug scene continuously since the 1960s, when an increase in the use of amphetamines first triggered legislation to control their possession and supply [1]. Recreational use of cocaine has an even longer history, dating back to the early 20th century, when a largely London-based market emerged briefly, before being suppressed [2]. From then until the 1990s, cocaine use in Britain remained relatively rare; its high cost being one important prohibitive factor.

Towards the end of the 20th century, the saturation of the North American cocaine market triggered a surge in cocaine trafficking from South America to Europe and a corresponding increase in its use. This period was also defined by the diffusion of the smokable, free base form of cocaine – crack. In 1988, a high profile speech to the police by Robert Stutman of the Drug Enforcement Agency propelled crack into the media and greatly increased public awareness [3]. Although the use of ‘freebase’ was not unknown in Britain at the time, seizures and use of cocaine/crack have greatly increased since [4]. Today, rates of cocaine use in Britain are among the highest in the European Union [5].

Nationally, powder cocaine use now appears to have stabilised, with self-reported ‘lifetime’ use among people in their late twenties at around 15% with about 4% of people in their early twenties reporting cocaine use in the previous month [6]. The use of crack has also become a feature of

drug use across the country. Crack problems nevertheless appear to be very much concentrated in London, where it is reported as the ‘main problem drug’ by 16% of people in treatment. By contrast, the equivalent rates in other English regions range between 1% to 6% [7]. More recently still, there is some evidence that among injectors ‘speedballing’ (the combined injection of heroin and crack) is becoming normalised and may substantially be increasing risks and harm [8, 9]. It is also clear that whereas stimulants are the main problem for some people, for many others they are just one component alongside alcohol and a range of illicit drugs.

Against this background, stimulant use can best be understood as an enduring feature of problem drug use in Britain; yet one which has altered in important ways and intensified in recent years; and, which appears to be, in important respects, more serious in London.

Stimulant services in the UK: Guidance and good practice

Historically, British drug policy has been shaped around those drugs with which people have developed most problems and the treatments that have been available. As such, services have understandably focused on opiates and especially heroin. However, the recent growth in cocaine and crack use to levels that have never previously been seen has altered the picture in important ways. Patterns of cocaine/crack use and the problems that arise are different. For cocaine/crack there are no pharmacological treatments that correspond to methadone or buprenorphine. Although there are overlaps with the needs of the traditional treatment population,

it is also clear that responding to stimulant problems has challenged services to develop new skills and work in new ways.

The relatively recent development of specialist services for people with stimulant problems means that we are only gradually developing an understanding of what best practice might comprise. As has been noted, this is happening against a backdrop of shifting patterns of consumption. Nevertheless, there have been some noteworthy publications regarding

- a) our national strategic response
- b) practice guidance
- c) evaluating the way that specialist services are delivered, as follows:
 - Home Office - *Tackling crack: a national plan* [4]
 - NTA - *Treating cocaine/crack dependence: drug services' briefing* [10]
 - NTA - *Commissioning cocaine/crack treatment: commissioners' briefing* [11]
 - NTA - *Treating crack and cocaine misuse: A resource pack for treatment providers* [12]
 - Weaver et al. - *National evaluation of crack cocaine treatment and outcome study (NECTOS): A multi-centre evaluation of dedicated crack cocaine treatment services* [13]
 - GLADA - *An evidence base for the London crack cocaine strategy* [14]
 - Arnall et al. - *An evaluation of the crack treatment delivery model* [9]

From these publications, key messages for treatment services concerning good practice can be summarised as follows:

- Self-referral should be made easy and can reduce the impact of stigma and concerns about confidentiality
- Rapid access to treatment is especially important and practical help with attendance can enhance engagement
- Services should be provided within attractive, calm, relaxing clean premises with segregation and visible security measures minimised
- Workers should be welcoming, trustworthy, non-judgmental, pragmatic, flexible and respect confidentiality. A strong therapeutic alliance is essential
- Practitioners' role security is enhanced by having a good knowledge base regarding cocaine, crack and health
- Cognitive behavioural approaches including motivational interviewing and relapse prevention are core skills required by practitioners
- Proactive reminders are valuable and enabling easy re-engagement is important for the many people who are ambivalent about their drug use and drop out
- Tier 2 drop-in services that can be used informally have an important part to play in

promoting engagement and retention and should also be available to people receiving Tier 3 services

- Drug-free psychosocial interventions are currently the most cost-effective treatment option
- Some clients require access to a full, daily schedule of therapeutic and practical activities. Those with the most severe problems require residential treatment
- Group therapy can be effective but does not work well when stimulant users are mixed with opiate users or when people trying to achieve abstinence are mixed with others who are not
- Safety and confidentiality need to be managed carefully to ensure that: conflict is minimised, safety is ensured and, attendance/disclosure does not have detrimental consequences
- Carers (if supportive) and volunteers (including ex-users) can fulfil potentially important therapeutic roles, as can other current clients
- Client empowerment that includes: esteem building, an emphasis on self-responsibility, and a close examination of actions and consequences is important

Blenheim CDP: developing specialised responses to stimulant problems

The early adoption and diffusion of cocaine/crack use across London meant that the *Blenheim Project (BP)* and *Community Drug Project (CDP)* were each at the forefront of the development of specialised services for people with cocaine/crack problems within the UK. As cocaine/crack problems started to emerge in the early 1990s, BP and CDP staff visited services in the United States and were able to draw on the USA's experience of responding to cocaine/crack problems. With the introduction of the first specialist service in 1994, this shaped the development of some of the earliest specialist services for cocaine/crack across the UK.

Personnel from the *Blenheim Project* and *Community Drug Project* were also centrally involved in the establishment and development of COCA (coca.org.uk), which continues to operate independently as a valuable national network and resource focusing on stimulant problems. As services evolved, the Community Drug Project's day programme provided an especially important learning ground in which practitioners worked out how to provide effective services - much of which continues to shape our understanding of good practice today. The *Blenheim Project* was also one of the earliest services to produce guidance for professionals with its publication *What's the crack?* [15]. As members of an expert group on crack cocaine for the National Treatment Agency for Substance Misuse, personnel from each organisation have also made important

contributions to the development of the national guidance that has been summarised earlier.

The recent merger of the *Blenheim Project* and *Community Drug Project* into a new organisation - *Blenheim CDP* - in 2007 has further concentrated the expertise contained within these two services and provides a unique opportunity to take stock of the way that specialist services for people with stimulant problems are provided. By using a case-study approach to examine the work of a leading, national, treatment provider, this report aims to contribute to the evidence base concerning the way that:

- different models of provision have developed in response to differing local needs
- services have been organised to attract and retain stimulant users effectively
- the performance of services for stimulant users compares with treatment services in general.

Responding to local needs

At the time of writing, *Blenheim CDP* provides services from sixteen different centres in ten different boroughs across London. These comprise programmes that are a) either community based or residential b) either specialist stimulant services or generic (i.e. working with stimulant, opiate and other drug problems). Most of *Blenheim CDP's* services also provide a combination of Tier 2 (low threshold) and Tier 3 (structured treatment) services.

Populations vary both culturally and ethnically between boroughs and with regard to their patterns of drug use. For example, across London, the prevalence of crack use varies dramatically, as does the rate of injecting (see Table 1). The Greater London Alcohol and Drug Alliance also identify crime hotspots that largely mirror these variations in prevalence of use [14]. Although

these borough differences are revealing, many of the more meaningful differences arise within boroughs at the level of the local community or even the neighbourhood. *Blenheim CDP's* services reflect these differences. There is no 'one size fits all' solution to drug problems and *Blenheim CDP's* services have developed in response to these diverse needs. Whereas one area might require a service that specialises in work with people who mainly smoke crack cocaine; crack cocaine use may be better addressed within generic services elsewhere because the local need would not sustain a viable specialist service. At the micro level, services also need to be tailored to fit the requirements of service users at any given time. This sometimes means that new groups are developed or other activities are introduced within the therapeutic programme. Conversely, other aspects for which a need no longer exists may be dropped.

Services also have their own momentum that derives from factors such as the knowledge and skills of the workforce; specific opportunities or constraints – such as the availability of a building in a particular location or an inability to get planning permission; and, the commissioning environment - including the availability or lack of resources.

It is probably over ambitious to suppose that services can ever be perfectly calibrated to local needs; nevertheless, it is evident that *Blenheim CDP's* services have been developed in response to them and are delivered and organised accordingly. This review attempts to make some of these differences visible by looking in more depth at a sample of *Blenheim CDP's* services that have been developed in different ways to meet different needs.

	White %	Asian %	Black %	Current Injector %	Previous Injector %	Crack main drug %	Crack Any drug %	Cocaine main drug %
Greenwich	73	8	14	38	14	40	10	15
Hackney	60	9	24	33	20	55	19	3
Haringey	67	6	20	17	1	39	21	11
Harrow	52	34	7	26	3	2	1	36
Hillingdon	75	16	4	17	6	26	7	24
Kensington & Chelsea	77	5	7	41	8	26	16	19
Lambeth	65	4	24	33	16	54	20	6
Lewisham	64	4	25	31	17	41	14	13
Southwark	62	5	26	26	20	60	24	7
Wandsworth	80	6	9	26	16	55	31	15
ALL	69	13	12	27	13	37	15	14

Table 1 - Populations compared (adapted from the NTA's NDTMS 2005/06 Borough Factsheet for London)

Training and Workforce

Blenheim CDP have shown a commitment to ensuring that all non- professionally trained practitioner staff have the opportunity to work towards NVQ level 3 or equivalent qualifications. The expectation is that in the future all non- professionally qualified staff will have or are working towards such qualifications. Similarly the organisation expects its managers to have or be working towards relevant management qualifications. *Blenheim CDP* has made a decision that all the organisations practitioner staff will become members of the Federation of Drug and Alcohol Professionals (FDAP) professional certification scheme. The Federation of Drug & Alcohol Practitioners is the professional body for the substance misuse field and is working to improve standards of practice across the field. Their Certification Scheme provides practitioners with external verification of their competence and is also widely recognised as meeting the NTA's target of staff working towards an NVQ Level 3 or equivalent qualification.

The FDAP professional certification scheme operates at two levels:

- **Registration** – this is based on an assessment of competence in the workplace by the workers' line manager against 10 core DANOS units
- **Accreditation** – this is where the above competence is verified by externally accredited qualifications such as the NVQ or Open University

All *Blenheim CDP* workers are expected to meet the standard for registration and to work towards accreditation either by doing the NVQ L3 qualification itself or by the different routes. Additionally, to support staff *Blenheim CDP* have put in place a joint venture with Quay Assessments to offer the NVQ Level 3 and 4 in Health & Social Care for staff and volunteers and provided support for managers to work towards NVQ level 4 or equivalent management qualifications.

The current position in the projects in this report is as follows:

Out of seven managers, two have management qualifications and four are currently undertaking them. The remaining post is currently being covered on an interim basis whilst a manager is recruited.

Starting from a position in April 2007 of only four staff having a recognised qualification the current position is that fifteen out of forty-one project workers have recognised qualifications, and a further ten staff are working towards NVQ level 3 in Health and Social Care. The remaining sixteen will become part of the FDAP scheme and be expected to be working towards accreditation in 2008/9.

This clearly evidences the commitment to training and workforce development of the new organisation.

	M A N A G E R			W O R K E R S		
	Started Qualification	Has Qualification	Neither	Started Qualification	Has Qualification	Neither
Hackney	1	0	0	1	1	1
Lambeth Harbour	0	1	0	2	2	2
Source	1	0	0	1	1	4
Evolve	0	0	1	0	2	8
Quantum	1	0	0	3	4	0
Kappa	0	1	0	2	3	0
Latch	1	0	0	1	2	1

Methods

This review uses a case study approach in which a sample of services has been selected. Seven of *Blenheim CDP's* Services were sampled purposively to include the organisation's only residential service, four specialist stimulant services and two generic services – highlighted in Table 2. The choices were guided by a desire to include services with differing operational models and serving diverse communities. Service details are summarised in the appendix.

Each service was visited and the relevant service manager interviewed about a) the way the service operated b) distinctive features of the treatment programme. This qualitative information was augmented by the collation of a standardised set of treatment data information that adopts a similar framework to that used recently within the national evaluation of crack cocaine treatment and outcome study [13].

Service	Borough		Tier 2	Tier 3	Residential
Portobello Road Project Portobello Road	KENSINGTON & CHELSEA	Generic	YES	YES	
Southwark Contact Great Guildford Street	SOUTHWARK	Generic	YES	NO	
Directions	HARROW & HILLINGDON	Generic	NO	YES	
Evolve Camberwell Road	SOUTHWARK	Stimulant specialist	YES	YES	
Hackney Day Programme Lower Clapton Road	HACKNEY	Stimulant specialist	NO	YES	
Eban Bruce Grove	HARINGEY	Stimulant/poly drug use specialist	YES	YES	
Healthy Options Team Portobello Road	KENSINGTON & CHELSEA	Generic	YES	YES	
Kappa Project Old Kent Road	SOUTHWARK	Generic	YES	YES	
Lambeth Harbour Coldharbour Lane	LAMBETH	Stimulant/poly drug use specialist	YES	YES	
Latch House Clapham Road	LAMBETH	Stimulant specialist	NO	NO	YES
Linx Angelsea Road	GREENWICH	Generic/Stimulant Specialist	YES	YES	
Quantum Project Dartmouth Road	LEWISHAM	Generic	YES	YES	
Novo Creek Road	LEWISHAM	Stimulant Specific	YES	YES	
Rise Day Programme Camberwell Road	SOUTHWARK, LAMBETH & LEWISHAM	Generic	NO	YES	
Step Garratt Lane	WANDSWORTH	Generic	YES	YES	
The Source Palmerston Way	WANDSWORTH	Stimulant specialist	YES	YES	

Table 2 - Services provided by Blenheim CDP

 Projects included in study

Tier 3 activity data - Community-based services (February 2006 – January 2007)

Service	New clients	Completed treatment episodes	Retention as per NDTMS definitions	Waiting times - % seen within 3 weeks	Waiting time-average n of days	Gender F:M
Evolve	124	65	88%	100%	5	25:75
Hackney Day Programme	54	24	67%	98%	9.8	20:80
Kappa Project*	82	84	79%	95%	5.81	29:71
Lambeth Harbour	124	65	88%	100%	5	25:75
Quantum Project	193	185	77%	91%	9	36:64
The Source	123	165	69%	100%	9	30:70

* Kappa made 311 new tier 2 contacts and 3,688 tier 2 interventions

Activity and client profile - Latch House residential service (February 2006-January 2007)

Service	New clients	Completed treatment episodes	Retention as per NDTMS definitions	Gender F:M
Latch House	25	16	75%	0:100

	Ethnicity	% of all clients seen	% in catchment area	Drug	Primary drug %	Additional drug %
Latch House	Asian	0%	5%	Alcohol	0%	32%
	Black	68%	23%	Cannabis	0%	52%
	Mixed	16%	5%	Cocaine	0%	0%
	White	16%	65%	Crack	100%	0%
	Other	0%	2%	Heroin	0%	24%
			100%	100%	Other	100%

Note 1 – All percentages are rounded to nearest whole number

Client profiles compared (Community services)

	Ethnicity	% of all clients seen	% in catchment area	Age	%	Drug	Primary drug %	Injecting status	%
Evolve	Asian	1%	5%	19-24	8%	Alcohol	2%	Current	5%
	Black	43%	23%	25-34	31%	Cannabis	2%	Previous	29%
	Mixed	6%	4%	35-44	40%	Cocaine	16%	Never	66%
	White	45%	64%	45-54	17%	Crack	72%		100%
	Other	5%	4%	55+	4%	Heroin	6%		
					100%	Other	2%		
Kappa Project	Asian	7%	5%	19-24	2%	Alcohol	1%	Current	40%
	Black	10%	23%	25-34	26%	Cannabis	0%	Previous	36%
	Mixed	12%	4%	35-44	53%	Cocaine	0%	Never	16%
	White	71%	64%	45-54	15%	Crack	3%	Missing data	8%
	Other		4%	55-65	4%	Heroin	79%		
				65+		Other	17%		
Quantum Project	Asian	5%	5%	19-24	10%	Alcohol	1%	Current	8%
	Black	30%	22%	25-34	36%	Cannabis	11%	Previous	22%
	Mixed	6%	4%	35-44	37%	Cocaine	12%	Never	70%
	White	58%	66%	45-54	14%	Crack	25%		100%
	Other	1%	2%	55+	3%	Heroin	39%		
					100%	Other	11%		
The Source	Asian	4%	7%	19-24	12%	Alcohol	2%	Current	9%
	Black	36%	9%	25-34	36%	Cannabis	2%	Previous	7%
	Mixed	6%	3%	35-44	41%	Cocaine	25%	Never	84%
	White	54%	79%	45-54	9%	Crack	61%		100%
	Other		2%	55+	2%	Heroin	4%		
					100%	Other	7%		
Lambeth Harbour	Asian	1%	4%	19-24	8%	Alcohol	0%	Current	1%
	Black	52%	25%	25-34	34%	Cannabis	2%	Previous	9%
	Mixed	9%	4%	35-44	37%	Cocaine	13%	Never	90%
	White	28%	65%	45-54	19%	Crack	81%		
	Other	10%	3%	55+	2%	Heroin	0%		
						Other	4%		
Hackney day programme	Asian	0%	9%	19-24	11%	Alcohol	0%	Current	Unavailable
	Black	52%	24%	25-34	41%	Cannabis	0%	Previous	Unavailable
	Mixed	6%	4%	35-44	28%	Cocaine	0%	Never	Unavailable
	White	41%	60%	45-54	17%	Crack	100%		
	Other	2%	3%	55+	4%	Heroin	0%		
						Other	0%		

Note 1 – All percentages are rounded to nearest whole number

Discussion

The data summarised has described the main features and key indicators of the performance of a range of divergent services that are provided to cocaine/crack users in different parts of London. For comparative purposes, the discussion considers how they perform with reference to features selected by Weaver et al [13]. Attention then turns what may be learned from the distinctive features of the services and the way that these are intended to address the particular needs of stimulant users within the local communities served.

As with any other study, this report has its limitations. Essentially, it presents a snapshot of services using readily available data. As such, more probing questions concerning detailed clinical outcomes and the way these are influenced by different approaches cannot be fully assessed until data from the TOPS system becomes more widely available. However, given the formative nature of our understanding as to how to respond to stimulant problems, it is still important to attempt to learn from practice, as it unfolds, and the services provided by *Blenheim CDP* provide a valuable opportunity for doing so.

Performance on key indicators

Weaver and colleagues identify considerable problems concerning the speed with which treatment is offered and the retention of stimulant users.

Within the six community-based services examined waiting times were all low. Four services saw all clients within the three week NTA standard and the two other services met this standard in more than 90% of cases. Given the importance that current guidance attaches to rapid intake into treatment, a three week wait may still be experienced as unacceptably long for someone with a stimulant problem and the average number of days waiting can be a more telling measure of accessibility. It is therefore of note that for four services average waiting times are in the order of one week and for the others this is less than two weeks. The opportunity for people to commence treatment within 48 hours in services such as the *Hackney Day Programme* seems especially impressive.

In contrast to the services described by Weaver and colleagues, retention within *Blenheim CDP's* services (as per NDTMS definitions) appears to be high. Only one service has a retention rate below 75% and the highest rate (88%) is achieved within two of the specialist stimulant services – *Evolve* and *Lambeth Harbour*. Given the pessimism that often surrounds expectations of services working with stimulant users, this is a noteworthy observation. Within the constraints of this report, it is not possible to disentangle the factors that contribute to this finding with any confidence;

however, it strongly suggests that the overall organisation and provision of treatment within these quite different services is working effectively to retain stimulant users.

Within the six services that work with both men and women, treatment uptake broadly occurs in the proportions typically found within drug services nationally i.e. women comprise between a fifth and a third of all clients. Although some services have elements that directly address the needs of women, these do not relate to service accessibility in any simple way. It seems likely that although these may encourage the use of services by women, there are a number of other determinants about the general provision of treatment that are also of importance.

Much attention now focuses on the ethnic diversity of clients and the extent to which different groups use services. Local prevalence data on the extent of stimulant problems within different ethnic groups is generally unavailable and cannot be assumed to occur proportionately; nevertheless, some assessment of the accessibility of services can be made by examining the diversity of clients relative to the general population within the locality. A complex picture emerges across the services considered. The proportion of people of mixed race in treatment exceeds that of the wider community in every service. In all but one service, the proportion of black service users also exceeds the general population: the exception to this is a long-established generic South London service that has very high needle exchange activity i.e. that has a strong tradition of working with white, injecting drug users. Even so, 29% of this service's clients are black, Asian or mixed race. Penetration of the Asian population appears to be poorer and occurs at a lower rate than might be expected in five of the seven services. Whether this is because stimulant problems occur with less frequency among people of Asian ethnicity in the particular areas examined, or because services are less accessible to this population is unclear. However, recent NDTMS data suggests that this well may be because stimulant problems are indeed less frequent among this group, and that this reflects a general trend across London [16, 17].

Distinctive features of the services' responses to stimulant problems

Based upon the fieldwork observations and interviews with the respective managers, each of the services examined seemed to have developed distinctively and in ways that were linked to local needs, the wider mix of services within localities and, local commissioning priorities. Repeatedly, the services reflected many of the features of identified good practice as described within national guidance. Given the historic role that *Blenheim CDP* projects have had in the

development of good practice guidance, this should come as no surprise. Consequently, the discussion here largely considers the way that aspects of this guidance were translated into practice and identifies several specific issues that may warrant greater attention in the future.

The physical environment

Four of the community services were provided from anonymous shop fronts within centrally situated, mixed commercial locations. These enabled immediate discrete access for clients. Two of these had an especially striking modern design, using obscured glass and open access into an entrance lobby, from which access was then negotiated. These enabled quick access to the building for people who may be nervous about being seen there, whilst members of the wider community were given few clues as to the nature of the service.

Five of the six community services benefited from notably clean, modern interior design with good levels of light and space. Each had good provision of space to accommodate group work, individual therapy and clinical treatment (including complementary therapies); as well as space for treatment staff. In each, the space was also designed to provide a social milieu in which clients could mix easily during drop-in sessions, yet had unobtrusive staff supervision. The buildings and clinical environment within *Evolve*, *Lambeth Harbour*, *Quantum*, and *The Source* can reasonably be regarded as providing examples of excellence. The fabric of the sixth, long-established service, provided from an older building - *Kappa* - seemed more 'fatigued', but was still divided effectively into spaces that enabled a similar range of activities. Some clients commented on this favourably, as they found its 'lived in' character welcoming.

The residential service was provided in temporary facilities whilst the building in which the permanent service was provided was modernised and extended.

Assessment

All community services emphasised the importance of a structured assessment that could be tailored to the attention span and needs of the client. It was generally noted that although the range of information sought at assessment had - largely for good reasons - progressively increased; this was not allowed to distort the assessment process unreasonably. Tensions between gathering more and more information and developing a therapeutic alliance were evident, but engaging the client was prioritised over completing all assessment information on a first encounter.

Immediacy and comprehensiveness of responses

All community services discussed the importance of providing an immediate response to the client's needs - as the client perceived them. Without exception, services saw their role as being to help the client address both their immediate drug-related needs and their wider health and social concerns. Although the detailed arrangements varied, services had well developed connections to services addressing: maternal and child health; housing; education, training and employment; legal advice; mental health services; domestic violence, welfare assistance and family support. This is probably best exemplified within the *Kappa Project*, which has deliberately developed its services to include a wide range of part-time workers with strong links to other agencies and who can provide weekly clinics the service. Here, the principle of being a 'one-stop shop' for almost any need the client could have seemed especially strong and serves as an example of good practice.

Evening services

Flexibility was discussed consistently, both with regard to the accessibility of services and their content. Each of the community services provided at least one evening clinic and it was noted that the client group using evening services overlapped but differed from that of the day time. In particular, these services seemed important for engaging employed cocaine sniffers as opposed to crack users and poly drug users who were more often unemployed.

Specialised materials

Treatment was supported by a range of printed materials that had been developed in direct response to the needs of the client group - always with a degree of direct involvement from clients. Client information booklets for each service give clear information about the operation of the service, the expectations the client should have and the expectations that the service has of the client. Alongside this information, *Evolve* had included a wide range of harm reduction information, exercises and advice geared specifically to stimulant users, which seemed likely to function well as a brief intervention for people, even if they did not remain with the service. These might usefully be emulated.

Adapting groups to immediate and wider needs

There was much evidence of group content being adapted to the needs of client: a process that appeared to be dynamic and ongoing. Services generally described core groups that were well established alongside others that were in development as a response to an evolving understanding of need. The case descriptions illustrate the breadth of these groups. It seems important to note that alongside those groups that focused specifically on drug problems, each service

running groups operated others relating to wider issues including leisure skills and cultural identity: the latter being especially well-developed to meet the needs of black clients. Again, the emphasis was on a holistic programme, which was in turn thought to enhance engagement and retention.

Complementary therapies

To a greater or lesser extent, each service provided a range of complementary therapies. Although the evidence base concerning their capacity to directly produce abstinence from stimulants is not encouraging, services consistently discussed the value of complementary therapies for engaging and retaining clients. Demand for complementary therapies appeared high, sessions were invariably well attended and client feedback was reported to be very positive. This conundrum raises the possibility that the evidence base to date has focused on outcomes other than those that are being achieved. Their effects may not directly arise in the way that is generally described, but complementary therapies may still function effectively to engage and retain people in services that exert a positive influence through other mechanisms: this possibility seems deserving of further study.

International Treatment Effectiveness Project (ITEP)

ITEP is an NTA-supported programme for improving the effectiveness of treatment. Trained keyworkers use a manual-based, care planning approach (referred to as “node-link mapping”) with their clients. Previous research had shown that these psychosocial interventions had a number of positive outcomes in terms of clients’ treatment experiences and reductions in illicit drug use. Node-link mapping as an evidence based intervention is referenced in revised Clinical Management guidelines [19].

Several *Blenheim CDP* services were participants in the ITEP evaluation. Staff perceptions of the programme were reported as mixed. Most staff had embraced it enthusiastically and found it valuable within their work; however, a few of the more experienced practitioners felt it added relatively little to their existing practice. It seems possible that more experienced workers already integrate many of the principles of the programme into their work and have less need for what is perceived as a different model, whereas newer practitioners may value it more as a framework for developing practice.

More generally, within the NTA’s ITEP evaluation the programme was regarded very well by practitioners, who found the interventions relevant to client needs. Mapping was associated with improved rapport with clients, better treatment participation, peer support and engagement [20]. As a pilot service, *Blenheim CDP* is well-positioned to build on and integrate this programme across its services.

Combined provision of a day programme with residential services

Latch House is a distinct and innovative service with few, if any, parallels. In many ways its group programme is similar to those in *Blenheim CDP*’s community services; however, linking hostel accommodation and treatment in the way that it does means that there is less possibility for some of the most marginalised stimulant users to fall into the cracks between services. Its high retention rate with a client group who have such complex needs is noteworthy and this model of service provision warrants further study in terms of both effectiveness and value for money. One especially important observation concerns the way that joint working between *Blenheim CDP* and NACRO has led to a progressive process of learning for each organisation. *Blenheim CDP* staff have gradually acquired improved knowledge and understanding concerning resettlement issues and NACRO staff have developed a deeper understanding of treatment processes, in a way that seems reciprocally beneficial.

Independent research elsewhere has identified *Latch*’s strength in engaging crack cocaine users and providing a programme that is valued as distinctive by its clients. One of the main problems faced by the service is a lack of capacity relative to the need (as measured by referrals).

“To me, rehab was just like prison, here is totally different” [21]

Contingency management

Contingency management operates by providing a variety of incentives in the form of vouchers, privileges, prizes or modest financial incentives to modify a person’s drug misuse or to increase health promoting behaviours.

There is a strong, largely North American evidence base for contingency management and it is now recommended as an appropriate intervention with drug users by both the National Institute for Health and Clinical Excellence [22] and within the most recent national clinical guidance for drug misuse and dependence – the ‘Orange Book’ [19]. A growing number of studies have found contingency management to be effective in promoting abstinence in stimulant misusers. It has been identified in the NICE guideline as having the strongest scientific evidence base for the most effective outcomes. The use of simple one-off incentives has proved to be highly effective in promoting engagement with and concordance with hepatitis B, hepatitis C and HIV testing, and hepatitis B vaccination programmes.

Contingency management is not commonly used formally in the UK and *Blenheim CDP* will need to identify and evaluate appropriate, incentives and the behaviours upon which incentives are

contingent. The organisation will need to provide significant training for staff in the concepts of contingency management which potentially has much wider implications than simply the adoption of voucher based incentives.

Many of the *Blenheim CDP* services currently offer a range of incentives designed to attract and retain service users, these include, access to showers, internet, washing facilities, food and drinks, and complementary therapies. These are specific incentives to attend the services and could be legitimately re-assessed in the context of contingency management. The required behaviour (attendance) is followed by an immediate incentive and failure to attend results in the incentive not being available. However staff will need to be trained in the concept of contingency management and the incentives clearly identified by the organisation to service users as incentives aimed at enhancing compliance with the desired behaviour (attendance). There is a need to evaluate further the extent to which these incentives impact on service users decisions to attend initially and subsequently.

Blenheim CDP, in partnership with the Institute of Psychiatry, the South London and Maudsley NHS Trust and Lambeth PCT, is undertaking the only NTA-funded randomised controlled trial of Contingency Management. The study will contrast voucher-based reinforcement therapy (based on principles of contingency management), group based cognitive-behaviour therapy, and standard care-plan based key working.

Conclusions

One of the strongest impressions that emerges from this review is of the diverse ways that services have evolved to meet local needs, and reflect opportunities and constraints within differing localities.

On the basis of conventional measures of effectiveness, each of these services performs well: an observation that holds irrespective of whether the service is designed for users of all drugs, or stimulants specifically. This suggests that when planning the provision of services for stimulant users, there is no substitute for thoughtful, needs-led commissioning that examines the gaps in current provision at the local level and meets these creatively and with reference to existing best practice, whilst resisting a doctrinaire approach.

The performance indicators for the services examined are encouraging and suggest that much is being done right and might therefore be learned from. However, it should be noted that although they are widely used, indicators such as waiting times and retention are relatively weak proxy measures for effectiveness, and tell us little about end outcomes and the ultimate well-being of the people for whom services are provided. To this end, the forthcoming TOPS outcome system may, in time, become a valuable means for better understanding the outcomes achieved by different services for different groups of clients, including stimulant users.

Despite these limitations, this review has identified a number of features of the services examined that both reinforce existing understandings of good practice, and point to areas for consideration and further research as services evolve in response to stimulant use - a problem that itself continues to evolve.

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Appendix - Case studies

Case 1 - Evolve

Location

146 Camberwell Rd, London SE5 0EE

Type of service

Community based, Tier 2/Tier 3 service, Stimulant specialist service

Services provided

A Tier 2/Tier 3 service that specifically targets cocaine/crack users. Services include a low threshold drop-in service and structured treatment (keyworking and groups), hepatitis B immunisation. Interventions include motivational enhancement, relapse prevention, and brief solution focused therapy. Keyworkers have an advocacy and support role regarding access to mental health services and the local substance misuse team. Advice and information services include housing, legal advice and welfare advice. Complementary therapies include shiatsu, homeopathy, therapeutic massage and auricular acupuncture. Facilities include refreshments, washing and shower facilities, leisure facilities (pool and table tennis). NA meetings also operate from the service.

Staffing

Role	WTE
Service Manager	1
Team Leader	2
Project Workers	4
Administrator/Receptionist	1
Outreach Workers	2
Crack/Alcohol Worker	0.5
Women's Worker	1
CDP Trainee Worker	1
Addaction Smartscheme Volunteer	1
Sessional Complementary Therapies	3

Opening hours

Mon	09:30-17:30
Tues	09:30-19:00
Wed	09:30-19:00
Thu	09:30-17:30
Fri	09:30-17:30
Sat	N/A
Sun	N/A

Distinctive features of the service

A modern-looking shop-front service offering easy and discrete access to the building. The service is currently included in an evaluation of the International Treatment Effectiveness Project (ITEP), an evidence-based cognitive behavioural programme developed by the Institute of Behavioral Research, Texas Christian University and supported by the NTA and National Addiction Centre.

Clients receive a highly individualised care plan that includes access to a number of specialist groups. The group programme has been developed around the assorted needs of the local population of stimulant users and includes: effects of crack/health; relapse prevention/lapse management; anxiety management; motivation; comfort zones/masks; patterns of behaviour/goal setting; art group; women's space; black culture group; and, a service user group

The service includes an outreach team that focuses on engagement.

Case 2 - Kappa Project

Location

231 Old Kent Rd, London SE1 5LU

Type of service

Community based, Tier 2/Tier 3, Generic client group

Services provided

Drop-in, needle exchange, hepatitis B immunisation, hepatitis and HIV testing, wound care, complementary therapies (auricular acupuncture/shiatsu/reflexology), low threshold prescribing, shared care prescribing, liaison and referral to mental health services, antenatal services, a satellite clinic, training and employment advice and a housing clinic.

Staffing

Role	WTE
1 x Project Manager	1
1 x Team Leader	1
4 x Project Workers	4
1 x Administrator	1
2 Complementary Therapists	0.2
GP Specialist	0.1
Specialist Medic	0.2
2 x Senior Substance Misuse Workers	0.2
Specialist Prescribing Nurse	0.1
Housing Specialist	0.1
BBV Nurse	0.1
Employment /Career Adviser	0.1

Opening hours

Mon	2.00pm - 17.00pm
Tues	9.30 - 13.00pm & 2.00pm - 17.00pm
Wed	9.30 - 13.00pm & 2.00pm - 19.00pm
Thu	9.30 - 13.00pm & 2.00pm - 17.00pm
Fri	9.30 - 13.00pm & 2.00pm - 17.00pm
Sat	N/A
Sun	N/A

Distinctive features of the service

A shop-front service offering immediate and discrete access to the building. The service places great emphasis on being a 'one stop shop' for its clients whose poly-drug use generally includes stimulants, opiates and a variety of other drugs. Responding to the entirety of clients' needs rapidly is central to the ethos of the service. Consequently, alongside a comprehensive team of practitioners providing diverse specialist skills, the service has developed strong links with other services that complement these services catering for domestic violence, legal advice, bereavement, hostel provision, employment and welfare assistance, family support and support for people who are abstinent (AA and NA).

Case 3 - Latch House

Location

112-114 Clapham Road, London, SW9 0JU

Type of service

Residential, stimulant specialist service

Services provided

A joint residential project between *Blenheim CDP* and NACRO that offers hostel accommodation and a day programme that is run by *Blenheim CDP* within the same building to male, primary crack cocaine users. Although clients may be subject to a probation order the service does not have people who are on DTTOs/DRRs.

Staffing (Blenheim CDP)

Role	WTE
Project Manager	1
Team Leader	1
Project Workers	2
Family Service Worker	1

Opening hours

Mon	9am - 5pm
Tues	9am - 5pm
Wed	9am - 5pm
Thu	9am - 5pm
Fri	9am - 5pm
Sat	N/A
Sun	N/A

Distinctive features of the service

Established in 2004, this unique service was developed to meet the needs of people with a need for both an intensive treatment programme and housing. It aims to reduce the problems that arise when communications fail between treatment and housing services. The progressive development of a shared working culture between the two organisations has been an important feature of the service.

Treatment revolves around a rolling group programme that includes sessions on:

- Emotional intelligence
- Self care skills
- Music
- Black culture
- Stimulants – aiming to refocus people's relationships from object relations (the drug) to human relations

A Family Service Worker focuses on enhancing damaged family relationships and each Friday there is a community lunch with invited guests.

Case 4 - Quantum Project

Location

55 Dartmouth Rd, Forest Hill, London SE23 3HN

Type of service

Community based, Tier 2/Tier 3, Generic client group

Services provided

A tier 2/tier 3 service offering shared care to people whose primary problem drugs include both opiates and crack/cocaine. The service also offers an afternoon drop in service with needle exchange, hepatitis B vaccination, hepatitis and HIV testing.

Staffing

Role	WTE
Project Manager	1
2 x Team Leaders	2
5 x Project Workers	5
2 x DIP Workers	2
Project Administrator	1
2 x Complementary Therapists	0.2
BBV Nurse	0.2
Housing Worker	0.1
Dual Diagnosis Nurse	0.1

Opening hours

Mon	9.30am - 5.00pm
Tues	9.30am - 5.00pm
Wed	9.30am - 5.00pm
Thu	9.30am - 5.00pm 5.30pm - 8.00pm
Fri	9.30am - 5.00pm
Sat	9.30am - 1.00pm
Sun	N/A

Distinctive features of the service

A low threshold drop-in service, offered discretely from a modern shop front setting that provides easy access and confidentiality to people entering the building. Complementary therapies including auricular acupuncture. Specialised services include a housing clinic and antenatal clinic.

The service is currently included in an evaluation of the International Treatment Effectiveness Project (ITEP), an evidence-based cognitive behavioural programme developed by the Institute of Behavioral Research, Texas Christian University and supported by the NTA and National Addiction Centre.

Case 5 - The Source

Location

4 Palmerston Court, Palmerston Way, London SW8 4AJ

Type of service

Community based, Tier 2/Tier 3, Stimulant specialist service

Services provided

A tier 2/tier 3 service that works exclusively with crack, cocaine and other stimulant users who are currently using or in the process of stopping using. Interventions include keyworking, relapse prevention and peer support groups, hepatitis B immunisation, hepatitis and HIV testing, drop-in (including a women-only session), complementary therapies and self care and support facilities (shower/laundry/Internet/telephone/books/relaxation room). There is also a partnership service (Bumps) for pregnant drug users and their partners (with St George's).

Staffing

Role	WTE
1 x Service Manager	1
1 x Team Leader	1
4 WTE x Project Workers	4
1 x Administrator/Receptionist	1
1 x Addaction Smart Scheme Volunteer	2
2 x Complementary Therapists	0.2

Opening hours

Mon	9.30 - 4.30
Tues	9.30 - 7.30
Wed	9.30 - 4.30
Thu	9.30 - 4.30
Fri	9.30 - 4.30
Sat	N/A
Sun	N/A

Distinctive features of the service

The service is exclusive to stimulant users and is provided from a discrete, modern, well-fitted building. The drop in and self-care facilities are important for the most marginalised and disorganised stimulant users and give access to a range of ancillary services including housing advice, career advice, leisure activities (such as table tennis) and herbal teas. The initial assessment is deliberately brief to enhance engagement with stimulant users. Specialised materials have been developed e.g. the 'craving pack'. Service users are supported to produce their own magazine.

Case 6 - Lambeth Harbour

Location

245 Coldharbour Lane, London SW9 8RR

Type of service

Community based, Tier 2/Tier 3, Stimulant specialist service

Services provided

A partnership initiative between *Blenheim CDP* and SLAM Psychology that provides a tier 2/ tier 3 service that works primarily with crack and cocaine users who are currently using or in the process of stopping using. Interventions include keyworking, and peer support groups, motivational enhancement, cognitive behaviour therapy, ITEP, hepatitis B immunisation, hepatitis and HIV testing, drop-in, complementary therapies and self care and support facilities including shower and laundry.

Staffing

Role	WTE
1 x Project Manager	1
1 x Team Leader	1
4 x Project Worker	4
1 x DIP Worker	1
1 x Project Administrator	1
2 x Complementary Therapists	0.3

Opening hours

Mon	9.30am - 5.00pm
Tues	9.30am - 5.00pm
Wed	9.30am - 5.00pm
Thu	9.30am - 5.00pm 5.30pm - 8.00pm
Fri	9.30am - 5.00pm
Sat	N/A
Sun	N/A

Distinctive features of the service

In common with many *Blenheim CDP* services this service is provided within an older building that has been impressively refurbished in an inviting, modern style. Service users have immediate access to the building from off of the street. The service is situated particularly well as it is close to an active and long-established drug market. The service has developed link workers with allied agencies that undertake work with commercial sex workers, the criminal justice system, psychologists and dual diagnosis workers within local mental health services.

Case 7 - Hackney Day Programme

Location

128 Lower Clapton Rd, London E5 OQR

Type of service

Community based, Tier 3, Stimulant specialist service

Services provided

The specialist service provides a specialist day programme that works with crack/cocaine users. The programme is group-based and also incorporates complementary therapies.

Staffing

Role	WTE
1 x Project Manager	1
3 x Project Worker	3

Opening hours

Mon	10.00am – 4.00pm
Tues	10.00am – 4.00pm
Wed	10.00am – 4.00pm
Thu	10.00am – 4.00pm
Fri	10.00am – 4.00pm
Sat	N/A
Sun	N/A

Distinctive features of the service

The programme offers exceptionally rapid assessment and treatment entry. Referrals can be assessed with 24 hours and, if eligible, commence treatment the next day. The service also has close links with a project for commercial sex workers – Open Doors.

Blenheim



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