



Would patients in a residential detox unit see a total smoking ban on the premises as a logical part of treatment or a step too far?

Richard Curtis explains the campaign

Choosing life

With the smoking ban imminent, the team at Baytrees, a residential detox unit which is part of Portsmouth's substance misuse service, decided to introduce a smoke-free protocol. We chose 1 January – a day when people tend to make resolutions like quitting smoking.

Baytrees is a newly converted NHS detoxification unit that offers a choice of structured therapeutic interventions alongside a range of medical regimes, to provide supervised withdrawal from drug and alcohol dependency. Referrals are made by

community drug teams locally and across the UK.

We called the smoke-free campaign 'Choose Life'. At first there was a great deal of trepidation – would patients leave treatment early if they weren't able to smoke? Would they decide not to come in to treatment at all? Or would they just light up and ignore it completely?

The campaign's success depended on preparation. First, we gave stakeholders sufficient warning of the impending ban. We consulted service user and carer groups, and printed leaflets highlighting the dangers

of smoking and the advantages of quitting.

Keyworkers from community teams were invited to use care plans as a way of identifying smoking habits and treatment options to help patients take control of their treatment.

The smoke-free protocol made it clear there would be no smoking anywhere on the ward, and patients were only able to smoke when they left the hospital grounds during social hours. A key part of Baytrees' treatment regime is confining patients to the ward for the first four to five days, during the initial supervised withdrawal stage, so to help them comply with the smoking ban free nicotine replacement therapy (NRT) was made available under the supervision of the ward doctors.

A smoking advisor was recruited to offer one-to-one counselling, group work and advice to help patients cope with the problems of quitting. We also introduced complementary therapies in the form of yoga, aromatherapy and tai chi, to enhance the feel-good factor gained from abstinence.

An obvious challenge was to ensure the protocol had 'legs'. We realised from the outset that it was no good announcing a ban and then turning a blind eye to infringements. However, we were clear that breaches would not mean discharge before treatment had been completed, as we knew this would increase risk of relapse and work against the service's 'patient-led' philosophy.

Patients that try to smoke on the unit are challenged by staff. A contract is then drawn up, agreeing that they will attend counselling sessions to explore the underlying reasons for wanting to smoke and look at how to maintain abstinence. Further infringements mean more of these sessions, and the only time patients are discharged from them is if the therapeutic relationship completely breaks down. The aim though, is to work with relapse rather than against it.

One of the main challenges was changing entrenched attitudes of staff as well as patients. Smoking is very much part of the culture in substance misuse services and it was common to hear statements such as 'it's unfair to expect drug users to give up tobacco as well as class A drugs – one thing at a time.' Concerns were also raised that it would lead to violence and aggression towards staff. Others questioned the morality of 'forcing' people to give up cigarettes, and the potential threat to the therapeutic relationship – turning staff into enforcers to ensure compliance.

Overcoming challenges

The campaign addressed issues around the ban by focusing on evidence. Drugscope's 2007 research, *Tobacco control and the role of drug treatment services*, showed that tobacco control initiatives, far from being a distraction from the core business of treatment services, may actually improve drug treatment outcomes and reduce the risk of relapse.

Training was key to the campaign's success, as it allayed many concerns while providing vital knowledge. Training sessions were provided for the detox staff as

well as the community drug teams, service users and carers, to inform them of the damage caused by tobacco. It also dispelled myths around smoking: 'It doesn't calm people down. Smoking actually exacerbates stress, anxiety and sleep disorders – it is likely to be detrimental to mental health, not the other way around.' When faced with this evidence, attitudes started to change and a culture of support developed for the programme.

One year on

Fears that patients would not come in for treatment with the ban in place were groundless. In fact, Baytrees has seen an increase of 10 per cent in the number of referrals in the past 12 months. During this time, the retention rate has increased and the number of successful completions has improved by 18 per cent.

Over the past year, patients have reported tremendous gains in their recovery – such as a large reduction in smoking, with 262 patients on NRT giving up smoking for a total of 722 smoke free days. Six patients even quit during their programme.

Comments that we received from patients included:

'I found the smoking rules made my detox more stressful, but I have cut down significantly, so I can't really complain!'

'I forced myself to think of coronary blockages... excellent service.'

'I think the information is very helpful and the education aspect of the dangers was quite shocking.'

Taking advice from DrugScope's consultation paper on the future of tobacco control (published in September 2008), we wanted to incentivise efforts on smoking cessation by celebrating success. This was well received by patients, with feedback like 'awarding a certificate, keyring, or a mug is a good idea – small things but they can make a difference.'

Karen Morris, Baytrees' clinical manager, sums up: 'The campaign has been a real challenge, which at times we could have done without. Full of apprehension and foreboding to begin with, it has turned out brilliantly. Nicotine addiction has the same characteristics as the other addictions we treat in the unit, so drug services are best placed to provide treatment.

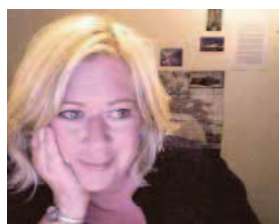
'There is a real sense of holistic care on the unit,' she adds. 'And this has only been possible with commitment, preparation, proper investment, training, and a service that is dedicated to taking treatment provision to a higher level.'

Richard Curtis is service improvement and development manager at Portsmouth City tPCT

Policy notes

GOING DOWN

What could recession mean for the drug and alcohol field?, asks Sara McGrail



I came into the drugs field in Liverpool in the 80s as a needle exchange outreach worker for three large social housing estates. The links between poverty and drug use for the people I worked with were undeniable.

It wasn't just financial poverty but poverty of expectation, experience, ambition, and opportunity. In one area it was reckoned over 85 per cent of the 18-25 year old age group were using gear and it was exceptional not to be on heroin. When in 2007, I was asked to do some work to look at the potential impact of an economic recession, it wasn't clear that a recession was inevitable and I was glad of that. Sadly there's no denying it now – so what might it mean for our field?

There isn't much science to this, but what might happen is that those drugs that last a short time and make you spend a lot of money (like crack and other stimulants) may lose some popularity and those drugs that last for a long time, but cost less money, may increase in prevalence. Depressants – like heroin, some prescription drugs, alcohol and cannabis – are relatively cheap, eat time and give comfort, initially at least, and this is one of the reasons we think their use increased massively during the last period of high unemployment.

We know it's the people at the margins of society – the unemployed, people in unstable housing, people who've grown up in care – who suffer disproportionately from problems related to substance use. This is not necessarily because people in these situations use more drugs, but because they lack the protective factors like having a job, a home and a supportive family, that can help someone keep experimentation with drug use under control. At a time of economic recession, the margins of society get wider. More people lose their jobs and their homes – under the strain families break up.

When money gets tight in an already disadvantaged area, the informal economy booms, with more people wanting to buy things for less. Acquisitive crime and fraud become more attractive propositions for people struggling to keep their heads above water. This might bring more people into DIP schemes, but increased engagement in borderline criminal activity may also

increase people's vulnerability to developing drug problems. The relationship between crime and drug use is complex and difficult to map with any certainty. But living in poverty, engaging in crime or selling sex, are anxiety-provoking ways to live. For some people, taking drugs becomes a rational coping mechanism.

We know – and government acknowledges – that helping someone out of poverty saves money on drug treatment, crime and healthcare. We understand that treatment on its own doesn't 'work' in terms of helping people out of poverty – that it's just the first step and that poverty itself can undermine the gains from treatment. We also know that employment, housing and support for families and communities, critical as they may be, cost money.

And here's the rub. What have we seen so far in terms of investment in services for people with drug or alcohol problems, to help them survive the harsh economic climate? Nothing. The only new investment has been £9m for job centre staff to apply the convoluted benefit-sanctioning regime of the Welfare Reform Bill.

The strategy claims that new investment in reintegrative projects will come from efficiencies elsewhere in the system. But how? The reality is that DATs are commissioning more services against a budget that's shrinking in real terms.

If we don't spend on getting some better support in place now for the most vulnerable individuals and communities, we may see treatment services with diminishing pro rata budgets jammed to the rafters with people whose problems have become intractable. People whose problems need not have reached this point if we had the resources to intervene earlier and with more appropriate services. Waiting times could increase and we could end up with a larger out-of-treatment population than we had in 1998. With unemployment growing and social housing under pressure, drug users will be way down the list for mainstream support or jobs. And the problems will deepen.

Over the next few months, working with the London Drug Policy Forum, I'm going to be looking at how we can increase the financial security of people who have experienced drug problems. Some of the options we want to look at are access to credit unions and alternative sources of financial support, improving experience of the benefit system and the reality of routes back into employment. If you'd like to contribute, or have any thoughts about the likely impact of the recession on your clients or community, please get in touch with me via DDN or on sara@saramcgrail.co.uk

Sara McGrail is a drug policy specialist. Her website is at www.saramcgrail.co.uk