

Essential reading for the London drug and alcohol sector

## “Tickbox” User Involvement Criticised

Service providers are critical of the way user involvement is being implemented in London. With DATs under pressure to show evidence of user involvement in planning and commissioning processes, drug agencies say some commissioners are “hijacking” the process and “parachuting” service users onto committees and user groups without giving consideration to their support needs or putting in place frameworks to facilitate consultation with other service users in the area.

Staff have told *User News* that they think this top-down approach is tokenistic and characterised by a “tickbox approach” rather than any concern to increase service users input. One provider said: “If you’re going to do this, it’s really important it’s done right and in order to do that you have to see what service users want to engage in. If you just have two people sitting on a committee. That’s not service user involvement, that’s two people involvement.”

At the time of writing, the National Treatment Agency was about to publish its long awaited guidance on user and carer involvement. This states that user involvement is “not about ticking boxes”. “It is about the treatment system, developing constructive relationships, building strong partnerships and communicating effectively”. But as the treatment plans for 2006/2007 which require evidence of effective user involvement are finalised, there is evidence this is not happening.

Alcohol Concern is currently undertaking research for the Department of Health into service users involvement in the commissioning process and has looked at what is happening in the drugs

sector. Don Shenkar Alcohol Concern’s director of policy and services, says some DATs are guilty of a “slapdash tickbox approach”. “That’s not the case everywhere but where it is happening there’s a danger user involvement will be seen by providers as a tickbox for commissioners and they’ll become antagonistic to it. Providers won’t trust commissioners have service users best interests at heart”.

He continued that the structure does not exist in many areas to allow service user reps at borough level consult with service users in agencies. “It is a difficult thing to do and needs to be done in a thought out way. It will be a while before we get there.”

Providers are also asking questions about how to make user involvement representative and relevant to what is a very diverse group of people. They point out that some are in treatment for very short periods, and that some abstinent based service users do not want to mix with those on maintenance. There are also concerns about where alcohol service users fit in.

The NTA for its part says progress is being made and that the draft treatment plans for 2006/2007 show that 70 per cent of DATs are planning to employ a fully funded service user lead, a post considered crucial to making users part of DAT’s substantive business. It says some DATs have also been asked to invest more money in user involvement.

But Darren Garrett, development

officer of the Alliance, a user-led advocacy and training service, says unless user involvement is driven by users themselves, problems will remain.

“User involvement should not be top-



down driven. It should develop organically from a grassroots level with users deciding on their own needs and deciding what they want to do.” He adds that the problem with the current target-driven approach is that it stifles creativity. “People are scared to try things in case they don’t work.”

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**LDAN**  
**UPDATE**

by chief executive Shona Beaton

Service user involvement has quite rightly been moving up the agenda recently and in order to do justice to the many different issues involved, LDAN decided to dedicate this special edition to the subject.

In it, are covered some of the big issues, more recent developments and the different perspectives of service providers and service users. As I'm sure you have already been able to tell, it is a bumper edition that is longer and in colour (so please appreciate!).

Service user involvement has always created issues for providers. It can be difficult to engage, and consult with, a wide range of service users and ensure that the engagement brings about change and is fully integrated into all levels of the organisation. It takes time and planning, and needs to be balanced against the requirements of commissioners to be able to demonstrate user involvement within the borough. And it can lead to tokenistic user involvement and the pressure to tick boxes and accept a lower quality standard than we would usually expect.

As already mentioned the top-down way service user initiatives are being rolled out pan-London can potentially lead to tokenism. However, it does help highlight some of the less well developed and delivered areas of service user initiatives within drug and alcohol service provision.

It is also interesting to note that across the health and social care spectrum, user involvement is being built into the system and is becoming more a part of everyday life. It just seems to be taking longer to become an everyday part of ours.

## 3-year Study turns to Service Users Views

Initial findings from the second part of a research project into user involvement suggest service users want more say in their treatment and find the vast amount of jargon in the field off putting and disenpowering.

According to Derek Bunce lead researcher of the project, which is being carried out in the West Midlands, service users do not feel treatment providers listen to them enough and want more power in the relationship. They also want more jargon-less information about how the system works. "Users want more information and education so they can understand how things work," says Bunce. "But the vast amount of jargon is a huge barrier - how can they understand the process if they don't understand the language? - and is part of the disempowerment process."

The initial findings come as the three year project moves into its second year. Funded by the National Treatment Agency, its remit is to identify factors that help or hinder user involvement.

Last year quite a few barriers were highlighted when it concentrated on the views of service providers and DATs, and interviewed 41 senior managers. "What the first years findings show basically is that there is some way to go before treatment providers are convinced it is worth the effort," he says. "Those interviewed didn't think there was an effective need for user involvement and didn't know how to develop it."

A former treatment provider himself, he says a key issue will be whether providers can be won over to the argument that it is worth the investment. "Providers need to be educated in why they need user involvement because they are not convinced that they do yet. When they have a lot on their plate already they don't want to be taking on additional duties and risk losing staff."

Though providers views were gathered last year by more traditional methods, Bunce and his team have turned

to a different method called participatory appraisal to collect and assess service users views. This is typically used when surveying socially excluded groups and uses less formal methods and service users themselves to gather data. As well as getting the information required, it has the benefit of engaging service users and training them so they can go on to train others to gather information, says Bunce.

Service user views will be collected over the course of the year - the initial results mentioned are from the first sample - and the results fed back to the NTA. Next year the researchers will revisit the service providers questioned in 2005 to see if there has been a shift in their position.

Bunce who works for the Policy

Research Institute in Wolverhampton University and has worked in the substance misuse for over twenty years, remains



**Providers have yet to be convinced of the benefits of user involvement says expert Derek Bunce**

optimistic that despite the lack of much progress to date, the user involvement agenda will progress. "This isn't new. It has been around for the past twenty years and there are a lot of people involved who are frustrated by the lack of progress. But I'm optimistic because I think there are people in authority who are ready to run with it now."

Another obstacle which will need to be overcome are differences among service users themselves, mainly between the harm reductionists and abstentionists. Bunce says: "There has been a lot of factionalism and that has had an impact on user involvement. Both sides have needs and requirements and valid arguments but they need to come together to take this forward."

**Many thanks to Awards for All for funding this newsletter**



## NTA PUBLISHES USER INVOLVEMENT GUIDANCE

The National Treatment Agency is set to publish guidance on user and carer involvement. The guidance, which is very general, is unlikely to satisfy those calling for a comprehensive strategy for implementing user involvement in the drugs sector. It does however identify six key areas of activity for service providers on information, feedback and influence. It says service users must be given enough information to make decisions about their treatment, and services should have a strategy for gaining feedback from service users about their services. Agencies should also provide service users with information about local service user groups, advocacy services and regional and national groups. The guidance says that service users should have influence over what treatment they receive, how it is delivered and "not have decisions made for them". The involvement of service users and their representatives should also be facilitated and supported in the service planning and delivery processes.

Download at [www.nta.nhs.uk/](http://www.nta.nhs.uk/)  
See also Allan Johnstone's interview p6

## NEW RESEARCH GOOD NEWS FOR ALCOHOL SERVICES

The draft findings of research into users perspectives on treatment suggests many are happy with the level of support they get from staff. A significant proportion of those who took part in the study, carried out by Alcohol Concern, said they found staff supportive and compassionate and identified this as one of the positive factors in their treatment. The draft findings also suggest that many are more comfortable working with staff who are ex-service users. GPs however are unlikely to come out of the report so well.



Read more about Alcohol Concern's research on service users on p13

## GLADA SET UP WOMEN'S ADVISORY GROUP



The Greater London Alcohol and Drug Alliance (GLADA) is setting up a women's service users advisory group. The move follows a conference held last year by GLADA, LDAN and the Stella Project which heard that women can face particular barriers to treatment. The group which is expected to set its own agenda, will help inform drug and alcohol policies for London as well as highlighting and helping resolve issues affecting women service users.

For more info email: [glada@london.gov.uk](mailto:glada@london.gov.uk)

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Drug workers have also been criticised for being slow to accept a new more inclusive way of working and some point to the need for service providers to address their resistance to user involvement. Nicola Matera, who works in the Stockwell Project, says resistance is often centred around an unwillingness to let go control. User involvement is happening right across the health sector so staff need to "get used to it", he says.

Sandra Machado, chief executive of EACH, says staff have issues to address but structures must also be put in place to improve communication with service user reps and better represent users diversity. "There's no doubt providers are threatened by what amounts to a change in working arrangements and not everyone is signed up to this. But if things are done in an open way with a proper structure in place, staff will be less threatened and it will become less of an "us and them" situation. It will take a real collaborative effort to change things".

## PROVIDERS ADVISED ON PAYING SERVICE USERS

The Department of Health has published guidance on paying service users. The guidelines are intended to help service providers put in place fair and responsible payment and expenses policies, something which given the benefits system is far from straightforward. The guidance suggests service users should be offered payment when they are involved in work at a decision making or strategic level or there is considerable input involved, and that legitimate expenses should be routinely be reimbursed. *Reward and Recognition* follows on from a report last year that criticised the way the benefits system actively discourages user involvement, because of concerns about having payments stopped and the very low amounts people are allowed to earn on top of benefits.

See *Navigating the Payments Minefield* p7



## NO END IN SIGHT TO DIAMORPHINE SHORTAGE

Service users say the Department of Health's response to the diamorphine crisis has been "wanting" - as there is still no sign of the shortage, now a year old, coming to an end. Alan Joyce, eastern regional advocate of the Alliance said not enough was being done to help the 400-500 drug users on diamorphine maintenance programmes. He said there was evidence from around the country that people were losing jobs and suffering a deterioration in their health because of the shortage, while others were relapsing into street using or other risk behaviours.

The shortage has been caused by problems at the Chiron manufacturing plant, the main supplier of the drug to the

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## Flagship Sanctuary Club looks to the future



Committee members (L-R): Hippo Grigg, Tony Westwood and Rhianna Bayton

Lambeth's flagship Sanctuary club is looking to the future after receiving £12,000 in funding from the DAT. The social club run by and for service users has gone from strength to strength since starting off in 2004 as a three month project funded by the Centre for Public Innovation.

Operating out of a community centre in Vauxhall, it has a membership base of 50-60 and counting, who come on Thursdays to play pool, use the internet, watch a video or just sit around and chat. A six member committee oversees activities and organise a members meeting every six weeks.

The club's success, as well as presumably its novelty factor, has attracted local and national media coverage.

For service users the attraction is straightforward. "It's a place where people can come to be normal," says committee member Tony Westwood. "It's purely a social club, somewhere we can enjoy ourselves and not have good done to us."

Running the club requires considerable organisation and input from committee members, coupled with anxiety from time to time about where next year's funding is to come from.

However, now that a successful application has been made for increased funding, Sanctuary devotees are looking at the possibility of opening the club's doors twice a week.

## LONDON ON COURSE TO GET REGIONAL ADVOCATE

London is on course to get a regional advocate for drug treatment service users next April. The Alliance, a national user-led advocacy service, has received funding from the Department of Health to appoint nine regional advocates and is recruiting and rolling out the service in phases. Though the funding only covers part-time positions, it hopes additional money will be forthcoming from drug action teams to make the jobs full-time. The National Treatment Agency is keen currently to promote advocacy services and expects DATs and providers to help users access advocacy. Darren Garrett, Alliance development officer, says though the London post is not yet operating, service users in London should still get in touch via its helpline with problems.

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## NO END IN SIGHT TO DIAMORPHINE SHORTAGE

UK market. The only other licensed supplier of the drug, which is used to manage pain relief in the terminally ill as well as treat heroin addiction, is unable to make up the shortfall.

Service users affected are concerned that they are being discriminated against in the distribution of limited supplies, and that more is being done to find alternative treatment for those in palliative care. They say those on diamorphine should have access to suitable alternatives such as morphine. The Department of Health has issued guidance to doctors about the use of methodone as an alternative but Joyce says this is not suitable for most people affected. He adds that not enough is being done to monitor the impact of the shortage on drug users.

In a briefing on the shortage last year, the NTA said it found "no evidence" of the Department of Health "favouring any particular group of patients" for access to available supplies of the drug "whether for opiate dependent patients or for those who need diamorphine to treat pain in terminal disease". It said while "frustrating and very unsatisfactory ... everything is being done to resume supplies at the earliest opportunity".

## USERS HELP KEEP NEW CRACK SERVICE "REAL"

A new crack service that was co-commissioned by service users is set to open in Merton. The project, the only stimulant-based service in the borough, will be run by the Community Drug Service for South London and based in Wimbledon Chase. Funded by Safer Merton over a 5 year period, it will have a staff team of seven and will deal with all stimulant use with a special focus on crack.

According to Gary Seaman, Merton's service user representative, service users involvement kept the tendering process "real". "One of the things that struck us during the tendering process was that only a few tenders contemplated being open at the weekends and evenings. They didn't seem to think users would have to be out working to get their cash," he says.

Merton's service user group was consulted initially about what they would like to see in the service and then elected three representatives to take part in the tendering process. These received training on tendering and commissioning before putting their heads down and examining the bulky tenders.

Commissioning Manager Mark Robertson said service users input was very useful because they were aware what users need. "I haven't the experience of using a crack service. It was really good to be able to turn around and say does this make sense to you?"



Mark Robertson



(L-R) Chris Robin drop-in coordinator at the new project, James Rose one of the counsellors and Gary Seaman Merton's service user rep

Ask drug and alcohol workers about user involvement and you will get a range of responses. Below six people working in the field give their perspectives on the subject

**Bernadette Cahill**  
Operations Director  
Drug and Alcohol  
Foundation



At DAF we have had ex users on our board of trustees for some time but are really just getting on board with service user involvement as an organisation. We have a working party putting together a policy which is a big task involving a major cultural shift. We are planning service user forums but at this point don't know how successful they will be. We have heard from other agencies that there have been problems with service users showing up and expecting too much too quickly. We are anticipating some resistance from staff as we are small and caseloads are high. There's also a lot of anxiety around boundaries as we're a therapeutic service. I think it's all inevitably challenging at first but once we start, anxiety will reduce and the creative process will develop a life of its own. I think we will get there in fits and starts!

**Chris Ford GP**  
Alliance Chair  
LDAN Trustee



When I started out in my career a young man came to me and told me he used drugs and asked for help. He had been to the local specialist service where there was a 6-month long waiting list. He said he needed help now. I had no training as a doctor about drugs and didn't know much about treatment but I agreed to try and help and suggested "we both learn together". We did. That's where I stood when I started working with people who use drugs 20 years ago and that's where I stand now. It's an equal relationship and not a case of "I'm the doctor and you're the patient". I think a lot of drug services think people who use drugs aren't to be trusted and are the problem, but I think the only way to work is risk it and trust people. That's our approach at the surgery and we've never had a problem with anyone requesting help for a drug problem. People who use drugs need to be treated with respect like all human beings, or as my dear friend Bill Nelles founder of the Alliance said "let's take the morality out of drug treatment and put the humanity back in."

**Kevin Patton**  
Volunteer Coordinator  
Harbour Project



Since being appointed to the post I've set up a user group that meets on a regular basis and is involved in the planning of services. We've also begun to delegate responsibility for service delivery and users are involved in cooking and shopping. They get their own budget and how they deal with it is up to them. It's a small step in terms of delegation but a big leap for some of the clients who are crack users. The substance misuse field does have a lot of issues with user involvement particularly around boundaries but I think if you keep promoting examples of good practice and staff see it working they will become champions eventually. User involvement challenges internalised failure and normalises users as people. People aren't service users and providers all of the time so why make out users are any different?

**George Budge**  
Client Coordinator  
Addiction Support  
and Care Agency



I started the day programme here five years ago and began working afterwards as a volunteer. I became full time in 2003. As client coordinator I am the first point of contact for 95% of clients. The system works well because I can empathise with clients having gone through treatment myself. User involvement is obviously a good thing because users or ex users bring a perspective others won't have thought about. But I do think it's very easy to talk about it and not so easy to do it in practice. I get annoyed when I hear services being told constantly to increase user involvement because I think where are the resources to implement it? User involvement requires funding for training and user reps should be paid for their time and expertise. Yet alcohol services in particular are stretched to the limit because of Government neglect.

**Jo Roebuck**  
NTA London  
Deputy Regional Manager  
User Lead

As the NTA's London lead on user involvement, I have been inspired by the level of commitment and hard work service users bring to the agenda in the face of ill-health sometimes, criminalisation and poor personal resources, as well as general stereotyping. Drug service users often describe a history of consultation and tokenism that has rarely resulted in change. For this reason one of the main barriers to user involvement has been generally poor relationships between service users and services themselves and despite good models elsewhere, the lack of a genuine users stakeholder voice in strategic delivery structures. Building up the confidence of service users to revisit and rebuild these relationships is very important.

**Martin Delaney**  
Operations Director  
Axe Street Project



I'm a great believer in service users being part of staff teams. They have a lot to contribute because of the first hand experience they have. They know what it's like to walk through that door and can help change the culture of services and make projects more accessible. But I do think we need to keep some perspective on this. We have ex-service users on our staff team but they are people who have dealt with their issues and have the skills to do the job. I think some people coming into the workforce come back too soon, are not properly managed and supported and are open to exploitation. I have seen ex-service users in these situations, scared to say no, being asked to do too much too quickly and going out and using again.

# Nothing New : Just Mainstream NSH Policy



The guidance just published by the National Treatment Agency on user involvement is nothing new. **ALLAN JOHNSTONE, NTA USER AND CARER MANAGER** says there's lots of guidance out there, that should already be being put into practice at a local level.

**Q. Given the high profile user involvement has been given by the NTA for some time should this guidance not have come out sooner?**

**A.** This guidance is not new. It is a restatement of existing responsibilities. All health agencies have a statutory responsibility to implement patient and public involvement or user involvement, and as the majority of the sector is commissioned by the NHS this should have been picked up on and in place at a local level. There's also plenty of guidance out there already. I counted 9 separate pieces of generic guidance to health services on user involvement. The problem is it just hasn't been noted and picked up on enough by the drugs sector.

**Q. Why is this guidance so general when many services are confused about user involvement?**

**A.** When I started working on the guidance 16 months ago I did a regional tour and the message I took from that was that noone wanted very prescriptive guidance. It's up to each local area to come up with their own plan. The guidelines do however identify six areas of activity on user involvement providers must act on. There is also more practical information on the way - a user involvement self-assessment toolkit and examples of good practice. These will cover areas like setting up user groups, constitutions and bank accounts.

**Q. What do you think are the main issues here for providers?**

**A.** Historically, the main issue for providers and by that I mean providers generically, not just those in the drugs sector, has been whether they have been willing to let go and involve service users in a meaningful way rather than doing it in

a tokenistic way. The other big issue is the need for providers to listen to service users, even when that involves listening to things they may not like, and being willing to act on what they hear.

**Q. How can services judge whether they are implementing user involvement?**

**A.** The guidelines outline a framework for involvement which sets out 6 key areas of activity – information, feedback and influence at both an individual and collective level. Providers must be able to show activity in each of these key areas. They should be working with their users and user groups to see how best to achieve this.

**Q. The term “meaningful” user involvement comes up a lot. What is meant by this?**

**A.** Take the area of recruitment. Some services have service users sitting on interview panels for staff jobs and yet the service user isn't involved in other parts of the process like defining the job description, drawing up the person specification and short listing. Most of the decisions have been made without them in other words. They need to be involved at all stages of the process.

**Q. What about the resources to implement this? Many smaller agencies have none to spare.**

**A.** DATs are key. Their treatment plans should include funding for user involvement and they should have a user strategy. It's up to providers to go and make their case to the DAT and say we can't realistically do this without resources.

**Q. Why do you think the 2 year rule**

**still operates in the sector?**

**A.** There isn't a two-year rule. It exists simply because organisations choose to have it. People should be considered for job vacancies so long as they have the competencies to do the job and organisations should have appropriate drug and alcohol policies in place for all staff including ex-service users. These policies should be clear about supporting and managing people who are current or ex-service users. Frequently they are left out, isolated and highly vulnerable. Organisations that have a 2 year rule are excluding people unnecessarily rather than working through some of the issues with existing policies.

**Q. There is considerable scepticism in the field that the current high profile being given user involvement won't last. Isn't it inevitable that attention will soon move on?**

**A.** The concept of public involvement and active citizenship is becoming more mainstream right across public services. In a way I hope we do move on and can concentrate on other issues because that will mean user involvement has become part of the process not just an add-on.

**Q. How will you judge whether this process has been a success in say five years time?**

**A.** I'd want to see services that are user led in line with the current thinking on a patient-led NHS. Services need to cater for the groups they work with and not discriminate against some people which we know does happen. On the individual level I'd want to know that each service user knows and understands their care plan. At the moment a lot of service users don't even know they have a care plan let alone the detail of it. That needs to change.

# Navigating the Payments Minefield

The question of payment for service users has become a big issue. Should service users be paid? In what circumstances? And how, given the impact even risibly small amounts of money can have on benefit payments? These are some of the questions drug and alcohol agencies are having to grapple with as the user involvement agenda is pushed forward.

In January the Department of Health published guidelines which should at least help providers navigate what can be accurately described as a minefield. The guidelines *Reward and Recognition* cover when service users should be reimbursed expenses and when they should be offered payment, as well as looking at the implications of paid and voluntary involvement on the benefits and tax systems, and on employment law.

The guidelines follow on from a report *Contributing on Equal Terms* published last year by national service user organisation Shaping Our Lives. This criticised the way in which the “inflexible” and inconsistently applied benefits system hampers user involvement and identified instances of service users getting paid very small amounts of money for work professionals working alongside them were getting well paid for.

So should service users be paid? The answer according to the Department of Health's guidelines is yes when they are being asked to make a substantial contribution to the running of a service. It defines this (unhelpfully) as involvement that can be classed as “deciding together, acting together and encouraging independent initiatives”.

What this appears to mean is involvement at a decision or strategy making level or when the work involves a considerable level of commitment, skills and reliability. It cites examples of a user rep attending a regular service planning meeting or someone involved in the recruitment process. In these instances service users should be offered payment, it says, though they might prefer not to take it. It continues that payment should not be expected when someone chooses voluntarily to go along to a meeting or when they have chosen to work on a voluntary basis.



Paying service users is far from current practice in the drugs and alcohol fields where the principle of payment has yet to be established. DATs however are beginning to pay reps involved in work at borough level (in some instances they are also paying service users to go along to local user groups as a way of generating interest in them). The problem is it is happening on an ad hoc basis and there is confusion about what policy should be which leaves service users vulnerable.

Although it has published its expenses policy, the NTA has not issued guidance on payment and does not itself pay service users, because says Allan Johnstone User and Carer Manager this would disadvantage those on benefits. He adds that this position may change. Meanwhile, some look to the National Institute for Mental Health in England's (NIHME) guidelines for direction.

Service users too have different opinions on payment. Some say it is simply a fair acknowledgement of their input (or as one service user put it quite reasonably at a recent forum held by the NTA “why should we be the only ones sitting around the table not being paid?”) while others eschew payment *on principle*.

Paying people for work with gift vouchers however is not now considered good practice. “The official reason for their popularity was it less problematic in terms of benefits,” says one observer. “But the subtext was “we don't want to be

responsible for someone buying a bag”.

On the less troublesome area of expenses, the guidelines say service users should be reimbursed expenses when asked to attend a meeting, training event or to undertake work and that smaller costs like phone calls should be reimbursed as well as travel, refreshments and childminding expenses. It advises providers to have a clear policy on expenses available to service users and where possible to reimburse expenses on the day in cash as some people may not have much disposable income or a bank account.

*Reward and Recognition* gives quite detailed information on the benefits system in an attempt to bring some clarity to a very complex area. Basic rules and their implications for benefit recipients engaged in voluntary or paid work are outlined. This is in response to the concerns raised in *Contributing on Equal Terms* which pointed out that service users right across the health and social care sectors are opting out of involvement, because of low disregard levels, concern that their benefits will be stopped or that it will trigger a case review. The fact that JobCentre Plus staff themselves are often unsure of the regulations, and the rules are inconsistently applied, compounds problems.

While things are unlikely to change substantially unless the benefit rules do, the guidelines say that it is important that providers make sure expenses and payment policies comply with benefit rules, and do not put clients welfare at risk. In this regard, the guidelines suggest that agencies should get prior agreement from the JobCentre Plus Business Development team for the district, rather than their local office, as staff here are aware of the user involvement agenda and have the authority to resolve any problems at local level.

Download *Reward and Recognition* at [www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance)

*Contributing on Equal Terms* can be found at [www.shapingourlives.org.uk](http://www.shapingourlives.org.uk)

For the NTA's service users expenses policy go to [www.nta.nhs.uk/](http://www.nta.nhs.uk/)

**More and more services are setting up user groups. Here User News looks at two well-established groups and gets some opinions on how to make it work**

## Walthamstow Group Provides Safe Haven and Fun - Without the Alcohol

One North East's service user group dispels the notion that service user forums just want to sit around and criticise services when they meet up. Questions about any tensions or disagreements between the group and staff are met with a perplexed look. They explain that the group is about providing support and a focus for current and ex-service users and raising funds for the project, an abstinence-based day programme based in Walthamstow.

"It's corny to say this but we are a big family. This is a safe place for us to come," says one member of the group. An ex-service user agrees saying the group is popular among former as well as current service users. "It's important to be able to stay involved in the project. It can be a bit of a wrench after treatment to cut off contact." "Alcoholics can lead pretty useless lives sometimes. Taking part in activities here provides us with a purpose," says another member. "It's somewhere where we can come to have fun, without the alcohol," says another.

The group called Friends of One North East was set up six years ago and became an independent association last year. As well

as holding regular meetings, it sends out a twice-yearly newsletter to 400 current and ex-service users and holds a number of fundraising events including quiz nights and an annual barbecue. Last year the group raised £2,500 for the project. An elected committee, whose members must be



**One North East's successful user group**

abstinent for six months prior to joining it, oversee its activities.

Though group meetings, which are attended by a staff member, primarily have a social and support focus, its activities mean lines of communication with staff are kept open and any concerns are more likely to be fed back. Two client reps also sit on the project's management committee. "The fact

that relations here are so good is because a lot of the management committee are ex-service users," says trustee Cluny Macpherson.

Infact far from criticising the service, much of the conversation around the table would not be out of place at a staff meeting as it turns to the services changing client base - about 50 per cent now also use drugs - the need for better identification by the local hospital of patients who drink problematically so they can be signposted to treatment, lack of resources for alcohol services and the fact that Government policy around alcohol is increasingly dominated by antisocial behaviour initiatives.

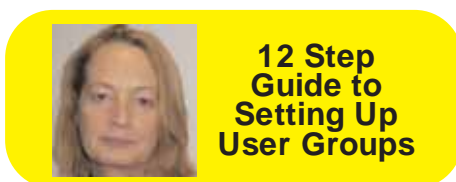
Service users at the project are also tapped into Redbridge and Waltham Forest DATs and representatives take part in local planning consultations. But they have noticed a bias in the attention being given drug service users as compared to those using alcohol services. To illustrate the point, they laugh recalling the venue chosen for one consultation event they were invited to attend by one DAT - a local pub." Charitably, they point out the DAT subsequently apologised.

### **"Encourage and Congratulate!" Rosie Flexer, Lambeth's Client Involvement Coordinator, gives some tips on setting up a sustainable group**

1. Identify a staff champion who can lead on service user issues and look at what support they will need.
2. Identify service users who are likely to be interested. Have one-to-one meetings, explain what their time and commitment will entail, develop interest.
3. Develop a consultation tool, like a questionnaire, to get feedback from service users and a clear idea about big issues.
4. Choose an appropriate setting for the first meeting - it's important everyone feels comfortable - and publicise the meeting well.
5. At the first meeting explain what's

happening clearly and outline the group's aims and objectives. Be honest and realistic.

6. Focus on the wider picture but make sure people know individual concerns will not be ignored and a



complaints procedure is in place in the service.

7. Consider the nuts and bolts of meetings - chairing, taking minutes, setting agendas - and how to support service users develop these skills.

8. Recognise broader training needs and encourage service users to access available opportunities. Look at people's individual strengths.

9. Provide resources to help sustain the group - computer access, use of a designated space.

10. Think about the wider picture. Inform the group about linking into the DAAT team and national and regional user forums run by the NTA.

11. Remember user groups are just one part of user involvement. It should be integrated into all aspects of service planning and delivery.

12. At all times encourage, boost confidence and congratulate!!

## Equality Drives the Stockwell Project's User Involvement Success

When community groups in Brixton objected to the Stockwell Project's proposed move to premises just off the High street, service users played an important part assuaging local concerns. "When the objections began, people using the project were faceless so far as local residents were concerned which allowed them buy into stereotypes about drug users," says Clive Diedrick. "Once we got involved and started going to meetings in the town hall, community reps had to at least acknowledge us and begin engaging in discussions."

Now that the move is definitely on, Clive and Steve Burroughs, co-coordinator of the project's service user group, are discussing how to consult service users about what they would like to see in the new premises.

"We are putting our heads together and thinking about the best way to engage people. Is it a questionnaire, an audit or holding meetings?" says Clive. "It's important not to lead the consultation so we can get as much information as possible about what people think." The consultation will be carried out by service users themselves and then sent to external consultants.

Service users have also had discussions with the architect designing the new centre about a dedicated room for service users planned for it. As well as providing them with their own space, this will give ready phone and computer access.

The extent of clients involvement in the premises move illustrates why the

Stockwell Project, part of the South London and Maudsley Hospital Trust, is considered to have good practice in the area of user involvement. "It is quite unique the amount of involvement we have here," says Diedrick. "But by doing this in a user-led way the project manager knows that



Nicola Matera and Clive Diedrick  
Service users at the Stockwell project  
are playing a key part in the move to  
Brixton

he will have service users on board and it will help assuage clients concerns about the move."

The project's service user group meets every 6 weeks but a core group of users are involved in activities throughout the year. A user representative attends the weekly staff meeting - apart from the discussions on clients cases - and feeds developments back to the group. User reps also liaise closely with the project manager

and its service user lead, Nicola Matera.

Matera says the fact that the project is so client centred is down to the philosophy of its founder Lorraine Hewitt, a well known advocate of drug users rights, who died four years ago. The new centre in Brixton will be named after her. "There is a lot of tokenism about when it comes to user involvement but the philosophy here has always been we are on the side of the client and they are involved in all aspects of the service."

Matera says resistance to user involvement is often driven by the stereotyping of drug users as untrustworthy and practitioners unwillingness to let go control. The problem with much of drug treatment is it is based on the medical model where medication is used as a form of control, he says. "Here the relationship between worker and client is one of equality. We are not here to dictate."

A key worker himself, he says relations with clients have improved since the service user group was set up and he has had no problems with boundary issues.

Diedrick acknowledges that staff can be put off user initiatives because of the work involved but says if projects are supported adequately to begin with, users will take increasing responsibility themselves. "Drug users are often frustrated and fed up with their lives and want distraction. Many are just crying out to get involved in things and they will, so long as they can they see they are constructive."

## Tackling User Disinterest by Darren Garrett Alliance Development Officer

One of the criticisms often levelled at user involvement is that it doesn't work because service users aren't interested. This may well be the case particularly if a group or initiative has been set up without users being a central component in its planning and development and it doesn't serve users agenda or address their diverse needs.

It's important then for services to understand what they mean by "user involvement" and what users want to get involved in - whether a self help group, peer-led advocacy, activism, promoting user representation on strategic groups, developing employment options, establishing peer-led health promotion initiatives or

getting an amber light from the NTA. Pursue the wrong agenda and you'll get little return for your efforts.

Another question is who are you looking to involve? Is it current "street" drug users, long-term stabilised users in treatment, users still adapting to treatment, ex-users and/or abstainers? Once again this question needs to be addressed and effectively managed from inception as it will greatly influence the success of the project's implementation. This is because the field is rife with politics and division. How many of us for instance know of users who have found that they're unable to work with their local user group because their own status or

philosophy is at odds with its core members?

Finally services also need to look at how they are going to engage users in initiatives. Is it via task oriented contracted work, group consultancy, peer support, allowing users to attend training sessions or sending a couple of compliant ones to a conference and covering their expenses? Different approaches will invariably signal to users whether user involvement is an act of tokenism or a desire to deliver an effective intervention.

At the end of the day, if it's to be successful and worthwhile it has to have at its essence the basic principle: "Nothing about us without us".

## Service Users and Ex-Service Users are involved in drug and alcohol treatment in London in different ways and have many perspectives on the subject.



### TOP TABLE

Tiras  
Newbould

I was appointed to the Alcohol Recovery Project's board as part of a programme to appoint more service users to the board. I did training first, along with 12 other candidates, which looked at things like governance, confidentiality, minutes and agenda items, anger management and equal ops. At the end of the training, I had an interview with the acting chair and two trustees. I was the only candidate appointed.

Being on the board was difficult at first. Initially I introduced myself as a client trustee until the chair of the board put me right and said "you are not a client trustee, you a trustee. You have an equal voice". At the same time clients said to me "who's side are you on?" because I felt I had to take a back seat in terms of client involvement and distance myself from service users. That was tough. It made me think where do I stand? I felt a bit isolated but gradually things did fit into place.

I get a lot of support from the board and think I contribute as much as anyone else. A lot of my input is centred on issues around addiction, core services and the welfare of clients. These interest me more than five-year organisational plans. I am a hands-on person and look at things differently. I also think I bring a grounding aspect because I make it clear I know where I am coming from when it comes to addiction.

I am very strongly supportive of user involvement but think the statement "the client is expert" needs some qualification. Someone does get to a place in their recovery when they know what is best but that is only after being exposed to some soul searching. Someone coming into a service, vulnerable and angry about not being able to drink, is not an expert. I think it has to be acknowledged they're accessing a service because they have a problem and they are going to have to accept help from professionals.

I am now training to be a counsellor and find the training I am doing around

boundaries very helpful. It has made me more and more confident that I do not need to stay away from people to keep appropriate boundaries. Now I go to the Sanctuary social club for service users, whenever I can and if I have to, say "Sorry there are some things I can't talk about" and it is not a problem.



### CLEAR STRATEGY

Gary  
Seaman

I've been the development worker for service user involvement in Merton for just over three years. My job is to bring service user perspectives directly into the DAAT's and its partners strategic agenda - a job that is not easy nor historically one that drug action teams are comfortable with. That is now changing for the better. Better engagement means cost effective services that clients want to engage with.

More DATs are now putting service user coordinators in place. This is positive but I think it's important their role and responsibilities are well thought out and broader policies are in place to support them. Some job descriptions are too slack and those appointed are not being given appropriate training or developing targets that facilitate real service user input and empowerment. Service user involvement is not just about appointing a service user rep. It's about a whole package of support and development. I also think it's important the service user coordinator is located in the DAT and not in a provider agency where they can be isolated and less independent.

Often user groups don't work because their remit is too vague and service users don't think they are being listened to. One way around this is for services to have a service level agreement with their user group that makes it clear what the role and functions of the group are. This could set out for instance that 2 meetings a year will look at treatment planning and another 2 qualitative assessments. This can be fed into the running of the service and would help remove the tokenistic element.

I don't think providers need be frightened of user involvement on cost or any other grounds. It's part of every service's remit so when providers put in bids they have to cost it in just like administration or staff training. Real user involvement takes time but improved outcomes will prove it's worth the investment.

### IN TRANSITION

Thea  
Cox

I am a service user rep on equality and diversity issues in Cranstoun's Community Drug Agency in Croydon. I approached the agency for help with an alcohol problem last year and became a service user rep in December. I thought if I could do anything to help people who have other issues to cope with as well as an addiction, I would, given my background.

I've had a gender change and have had huge difficulties getting people to accept me over the past 25 years. There is so much stereotyping and stigmatisation of transgender people out there. You think people have problems understanding someone with an addiction. They have real problems understanding someone who has undergone a gender change.

My role as service user rep will be to go out and talk to different communities about addiction and raise awareness about what help is available. I have a mentor for support and am also getting training on giving presentations. With the support of a staff member I am working out a strategy for going out and meeting people. I am planning on starting small and as I become more comfortable getting more ambitious. I hope my experience will help others deal with their issues.

I have had a lot of dealings with health agencies over the years but before I came to the Community Drug Agency I had yet to find one I was comfortable in. I was worried at first about being accepted but that hasn't been a problem. I think it's only because of this that I've been able to deal with my alcohol problem.

## Below six representatives explain about their work and main interests - and drop some hints for providers



### CAREPLAN LESS

Martin Saunders

I used to consider myself careplanless because when I came into contact with my first treatment provider in 1999, "care planning" did not have the profile it has since Models of Care. I realise now that the subtle guidance of my key worker (another term not used back then) provided me with my planned way forward. So I did have a care plan which I owned, though it wasn't written down (Thank you Cordelia).

Six weeks later the treatment provider lost its contract, and it was another month before another agency had the service up and running again. When the service did open I found my key worker worked for the new provider, the Alcohol Recovery Project in Camberwell. So I was lucky but suppose it had been different. A new key worker and I would have had to go over the same ground which I'm not sure I would put up with as I was wary of trusting services and felt I had already been let down once.

This is one good reason why service users should have ownership of their care plan. It provides us with some continuity and hence some continuity in treatment. It is also important in helping users engage in treatment in the first place, something which is especially problematic for those who do not self-refer but have treatment thrust upon them. For these I think engagement and motivation becomes far more achievable if the care plan is wholly, or at least partly, seen as the property of the service user.

While care plans need to be structured, they should also be flexible as changes made by service users, whether in their ways of thinking or lifestyle, can have a profound effect on them so the care plan and support structure will need to cater for this. Working together, the service user and key worker should set small but achievable goals focussed solely on the service users needs. The care plan should also go a long way to defining the shape of the all-important aftercare.

The care plan is the route map for a journey to an unknown destination for the service user. Yet talking to fellow service users at the NTA's London User forum recently many hadn't seen their care plan or know whether one existed.

*Martin Saunders is a long term activist on user involvement and helped found user group As If*

### INSIDE VIEW

Colin Standfield



At Battling Addictions Together we raise awareness about detox issues in Ealing and support those who have come through it. We have a good balance of people involved the whole time including some with recent treatment experience, so we know what the issues are and can raise them with the DAAT and providers. I'm on various committees and was on the DAAT until it merged with the Crime and Disorder Reduction Partnership, and they decided last year they weren't going to have a service user rep anymore. A pity given our contribution.

I find that most providers in Ealing are open to user involvement but I think some staff are worried we'll be noisy and disruptive. I've never found that to be the case. We've certainly never had any problems at BAT meetings. We can ask awkward questions though. I was once accused of being high handed at a meeting when I said to someone they didn't know what a detox was like because they had never stood inside a detox unit. Most people don't. They just assume all sorts of things.

It can be difficult to get service users involved and then to sustain that interest. A lot of people want to walk away when they come out of treatment. But you do need to try and strike balances with the people involved – have regular attenders but not a small clique. Also service users won't be involved unless there is something in it for them and I don't mean just money, I mean listening and responding to what they have to say.

I worked as a volunteer at BAT before we got funding for this position of development officer and I got the job. I was on the New Deal at the time and had to find work. If this hadn't come up the alternative was a job as a warehouse clerk in Heathrow. Had I done that, I would have been back drinking by Friday.

### SIDE LINED

Erin O'Mara



A lot has been happening on the drugs scene recently whether in terms of policy initiatives, changes in patterns of drug use or the push to implement user involvement. Drug using women though are still on the sidelines. This needs to change if we are to begin to tackle the impact of drug use on families and communities.

Our experiences as drug using women have given us access and specialist knowledge very few people have and left us well equipped to understand many of the complexities of drug culture. We know what's happening to women in crack houses and in the sex industry. We know what makes women come into treatment and what makes women leave and what makes support services empowering or disabling. We also know all about the fears and anxieties of bringing up children in a climate that excludes and fears drug users.

Getting women involved in the development of drug services is paramount if we are to tackle the cycle of drug use and its effects on families. Only by doing this will we gain the language and tools to improve the lives of women and children. But in order to do this we need some new thinking - courageous and creative thinking - that identifies new ways of engaging women and overcoming obstacles to their participation. Dismantling the barriers to women's involvement will require services to take the plunge and invest resources, trust, time and support. Without this, user involvement will remain a token gesture so far as women are concerned.

*Erin O'Mara is editor of Black Poppy Magazine*

## New York Provides Inspiration for Innovative Recruitment Project

Homeless shelters run by former crack users in New York were the inspiration for a London project aimed at increasing the number of service users employed in the homelessness sector

A fact finding trip to New York made a big impression on John Crowther Operations Director at Thames Reach Bondway. Visiting homeless shelters, he was surprised to find some run by former service users, mainly crack users. "It made a huge impression. User involvement was perceived in a very different way there. Here we tend to focus on the problems rather than looking at the many positives of service user involvement. It made us think if they've found ways to overcome problems so can we".

Six years on and Thames Reach Bondway has launched the Grow Project, a three-year initiative aimed at increasing the number of service users employed in the sector. Last October the first batch of 12 trainees started 9-month long placements. A second group started placements this year. Though the project will initially gear trainees to work as homeless support workers, there are plans to expand it to train people for jobs at all levels "up and across" homelessness organisations. Thames Reach Bondway itself has set a target to increase the number of service users it employs to ten per cent by 2007.

Given that user involvement is not that well developed in the homelessness sector, the Grow project is considered very innovative. Both the London Housing Federation and Broadway helped fund the groundwork, but Crowther admits reaction from other organisations has been mixed. "Some organisations think we're barmy. Others are quite interested."

According to Kath Dane, Grow's full-time project manager, before launching the project Thames Reach Bondway carried out research into existing barriers to employing service users. There were plenty of them at both a practical and cultural level she says, but all were surmountable.

For a start, the organisation had to look at recruitment practices. "We had to look at some of the issues which prevent service users being employed. For example we had to make it clear during the advertising process that gaps in employment history was not a problem and that applicants homelessness

experience and experience as service users was valuable."

The person specification for Grow placements is based on core competencies, motivation and experience of service use and the application form includes a section on homelessness history. The selection process also involves an interview and assessed visit to



*John Crowther was impressed with the shelters he saw in New York run by former crack users and Kath Dane Grow Project Manager*

a TRB project where service users give feedback on the prospective trainee.

Consideration had to be given as well to the support successful candidates would need. There were concerns in particular that some would find it too difficult to adjust to a structured nine-to-five day and would drop out. This resulted in trainees starting off on a three-day week giving them a couple of days off to attend to benefits or personal tasks and reflect on the training, and adjust to their new routine. Trainees are also paid their £15,000 salary on a weekly basis to help them budget and feel more financially secure.

Grow participants case files are anonymised and kept in central office so colleagues do not know their service history. But it is made clear to trainees that they can continue to use services. Initial indications however suggest that a

significant number choose not to and opt instead to make use of the life coach assigned to them for support. Dane sees this as an indication that they are making an important adjustment. "The hardest thing for trainees to do is to start thinking of themselves as a member of staff. But they need to make that transition. It's about a change of identity."

Trainees are bound by the same rules as all TRB employees though the staff code of conduct has been amended to take into account their background. It is accepted that trainees will continue to have friends and socialise with service users but they are expected to be bounded and manage their friendships and not to make new friends among clients.

The issue of drug and alcohol use is brought up at interview stage. "We don't have separate rules but we explore these issues and ask people to be honest. Some people aren't ready for the placement yet. They're worried about their physical health or if they've stopped drinking working in a hostel with drinkers. We explain if they're not ready, they can apply again."

By far the biggest barrier to the project however according to Dane, was staff resistance. Staff had many concerns about recruiting service users but the really big ones centred on the question of professional boundaries and danger of trainees over identifying with service users, and on their ability to maintain confidentiality when appropriate. The latter was based on prejudice she says, while staff had to accept trainees dual role as both delivering and receiving services and help them embrace this role.

"The cultural change required was the biggest," she says. "The us and them attitude – we're professional, they're different – needed to change. To do this people had to be honest and think through why they were resistant. They also needed to understand that by employing service users we'll be recruiting people who understand users homelessness experience, and experience using services, and that will help raise the standards of the organisation."

## New Research Highlights Benefits of Employing Service Users

Alcohol Concern is undertaking two research projects for the Department of Health that should increase the input of service users in treatment services. One project is focused on service users perspectives on treatment while the other is looking at their involvement in the commissioning process. Though neither project was complete at time of writing, both are likely to highlight the benefits of having service users or ex- service users involved, whether on staff teams or consultation work, as clients are more comfortable dealing with them.

### Service Users Perspectives on Treatment

This five month project is looking at service users perspectives on treatment - the pros, cons, barriers and suggestions for improvement. Five focus groups and 67 service users took part including service users from London projects ARP, ASCA and EACH. The research follows on from the publication of the Alcohol Needs Assessment Research Project (ANARP) last year, which looked at providers, DATs and GPs perspectives on treatment.

According to Kim Rezel, Alcohol Concern's service user project officer, the interim findings suggest many service users are happy with the support they get from staff during treatment and identified non-judgemental support as key to the recovery process. They were however more comfortable with staff who were former drinkers themselves saying they more likely to be open about their experiences with them.

Many of the service users questioned were also enthusiastic about becoming alcohol workers and wanted more opportunities to access training. The two year rule came up frequently in discussions in this regard and participants were unhappy with some agencies rules around this, which they considered unfair and overly cautious.

Barriers to treatment identified by those who participated in the research, were a lack of information about alcohol services available - many did not know any existed other than Alcoholics Anonymous - and GPs who were unhelpful and uninformative when approached for help.



*Juliette Hough (left) and Kim Rezel Both are writing up reports that will be sent to the Department of Health*

### Service Users Involvement in Commissioning

The second piece of research is looking at service users involvement currently in the commissioning process and identifying areas of good practice nationally across the drug and mental health fields. It will result in a set of guidelines for primary care trusts on involving service users in commissioning.

According to Juliette Hough who is overseeing the project, the findings so far suggest that a lot of work remains to be done if service users are to be substantively involved in commissioning. "Areas of good practice do exist -we found some in Southwark and Croydon - but overall service user involvement is often very tokenistic", she says.

Some of the points likely to feature in the report's recommendations are the importance of having a representative structure that allows commissioners consult with service user reps who can then go back to local groups; the need for representatives on commissioning groups to get training and support; and the need for a dedicated service user post to promote the agenda.

"There's not necessarily a right way of doing it. The important thing is that service users are involved in deciding what the best way to do it locally is", says Hough.

"But If it is to be done properly there's a lot of work involved and it takes time".

### Croydon Toolkit Spurs on Local User Involvement

One of the useful models Alcohol Concern identified during its research on commissioning was a toolkit developed by Croydon DAT. The toolkit is aimed at facilitating user involvement from an individual to a strategic level, and looks at how agencies can recruit service user representatives who then link into DAT structures.

Cranstoun's Croydon Community Drug Agency was one of the services involved in the project from the outset. Service manager Dean Parsons says though user involvement was already on the project's agenda, the DAT's initiative has helped boost the level of activity

CDA now has three service user representatives involved in different areas of work in the project itself. One delivers an induction to new clients, another co-facilitates the peer support group which meets weekly, and a third is looking at issues around the accessibility of the service to lesbian, gay, bisexual and transgender clients. All reps are assigned a staff mentor for support.

The agency also has a clear structure for receiving and responding to client feedback, as once a month the peer support group becomes a feedback meeting attended only by service users. Matters raised are written up and given to staff to discuss. A response is then posted on a noticeboard. "We can't always make the changes people want but we always explain why we can or can't do something," says Parsons. "It means service users understand where we're at."

The service user reps are then well placed to discuss issues at borough level.



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## User Involvement

### So what's it all about then ?

User involvement is all about involving service users in treatment. It comes in many guises from suggestion boxes and feedback forms at one end of the spectrum to user-run services at the other and operates at both an individual (being consulted about your careplan), collective (local user group) and strategic level (representing service users on a joint commissioning group). But whatever the project, the broader agenda is to give service users a substantive input into their treatment and into how treatment services are run.

### Sounds a bit confusing ?

It is. The fact that user involvement means different things to different people has caused confusion and makes it more difficult to promote. And this is before the discussion moves on to "bottom-up" and "top-down" models for implementation, and the exact definition of a "service user". Does it apply only to people in treatment or should it include former service users long since left treatment? And what about users not accessing services? But proponents say everything becomes clearer once the principle is conceded - service users should have an input into all matters relating to their treatment.

### Why the current high profile ?

User involvement is a fundamental plank of the Government's vision for a modern health system and strong civic society, and it is promoting the agenda right across the health and social care fields. All health agencies now have a duty to consult and involve service users under the Health and Social Care Act 2001. This is considered both every service users right and a crucial component of improved service delivery. It is also seen as an effective way of engaging some very marginalised groups in what the Government sees as a rapidly fragmenting society. Hence all the talk of "expert patients" and "active citizens". The current push to promote user involvement in the sector, most obviously by the NTA, should be seen against this wider backdrop.

### Historical influences ?

Foremost among them is probably the consumer movement and its emphasis on consumer rights, complaints procedures and the need to subject services to scrutiny. Another was the dismantling of the old "nanny" welfare state which it was felt encouraged dependence, and its replacement with a system that expects service users to be more self-reliant. This process was begun under Margaret Thatcher but has been taken much further by the current Government. The civil rights movement too played a role by providing the model and inspiration for socially excluded groups to combat discrimination. Mental health patients and disability groups have both been influenced by its legacy. In addition, since the 1980s there has been increased recognition of the benefits of mutual support.



**BRIEFING**

by **Roseanne Sweeney**  
Communications  
Manager

### Treatment benefits ?

According to proponents there are lots, including improved service provision and better outcomes because clients are more engaged in treatment and providers and commissioners have more feedback about what works or not and why; better understanding of and links with users and their lifestyles so more capacity to reach users not accessing services; and users with more purpose and direction and improved self esteem which again will have a beneficial knock-on effect. Not all providers though are convinced.

### Providers main concerns ?

Reservations range from the top-down way it is being implemented in the drugs sector without adequate consultation, guidance and resources; concern about its impact on boundaries and staff/client relationships, in an area of work that many feel has to remain very boundaryed; and anxiety about putting clients recovery at

risk. There are also concerns about the practicalities of user groups and forums, especially in services providing short term treatment. The cumulative effect is that many providers find it hard to see user involvement as a priority when they are struggling to cope with existing workloads, and changes in the sector.

### How do its champions respond?

Champions of user involvement admit doing it right takes considerable time and commitment but contend the results are worth it. They say staff resistance can be based on a reluctance to accept a shift in the power balance with clients - one that health workers in other areas are having difficulties digesting as well - and to take on board criticism of the way services are run. They contend staff can be guilty of buying into wider discriminatory attitudes towards substance misusers and that this informs the attitude that service users are not interested or too chaotic to get involved. They say staff attitudes and low expectations of service users are the real barrier to user involvement.

### Prospects for success ?

Some elements of user involvement are very achievable. Clients knowing about, and having an input into their careplan is one. But substantive user involvement at higher decision-making and strategic levels will not be easy to implement as it will require a change in attitudes and working practices right across the sector. It will also require considered and sustained effort from the Government, something that cannot be guaranteed (though observers do point to the commitment of senior figures in the NTA as cause for optimism). Service users by definition have more problems than most to cope with, such as poor health and isolation, and lack of resources, education and information. Drug and alcohol users have a few more - stigmatisation and criminalisation. These will have to be overcome however, along with their political differences, if a strong user movement is to finally emerge in the sector. Without this, it is unlikely user involvement will prove sustainable - and the sceptics wrong.

## MARCH

**1:** 2012 and Beyond: Designing Crack and Stimulant Services for the Future Community Drug Project conference supported by LDAN. Kensington and Chelsea Townhall, Hornton Street, London W8. For more info email [conference@communitydrugproject.org.uk](mailto:conference@communitydrugproject.org.uk)/tel: 020 7840 0092

**9-10:** The National Drug Treatment Conference The 5 major themes addressed will be marginalised groups; key clinical issues; prison healthcare; commissioning; pharmacy services. Radisson Hotel, Glasgow. Organised by Exchange supplies in partnership with the NTA. Call 01305 262244/ [info@exchangesupplies.org](mailto:info@exchangesupplies.org)

**13-15:** "Drugs, Alcohol and Criminal Justice: Addressing the Balance". This conference will examine principles underlying the approach to tackling drugs issues, discuss the relationship between harm reduction and abstinence based approaches and look at examples of good practice. Warwick University. For more info go to [www.conferenceconsortium.org](http://www.conferenceconsortium.org)

**16:** Drugs and Crime Forum, Mitre House, Borough High street (opposite Borough tube) 2-430pm. Contact [Shona.Flannigan@ldan.org.uk](mailto:Shona.Flannigan@ldan.org.uk)/020 7704 0004

**17:** LDAN/NTA Service Providers Forum, NTA regional office, 930-1230

**22:** Young Peoples Forum, St Giles in the Field, behind Centrepoint 2-430pm  
Contact: [Shona.Flannigan@ldan.org.uk](mailto:Shona.Flannigan@ldan.org.uk)/020 7704 0004

**24:** Engaging Young People as Community Leaders Against Crime. St Albans centre, Holborn. Organised by CSAS, see [www.csas.org.uk](http://www.csas.org.uk) /tel 020 7793 3965

**29-30:** Restorative Justice in Action. Organised by the Winchester Restorative Justice Group, this will examine the successful use of restorative justice when managing those who have caused harm. Speakers include Attorney General Peter Goldsmith, Christine Knott, NOMS and Rod Morgan Youth Justice Board. Contact Debbie Young on 020 7324 4364 Email [debbie.young@neilstewartassociates.co.uk](mailto:debbie.young@neilstewartassociates.co.uk)

## APRIL

**4:** Quiz Night organised by the Friends of One North East. Tickets £5, proceeds to the project. Venue: One North East, 1 Beulah Road, Walthamstow. Doors open 7pm.  
**5:** Drugs and Alcohol Today This one day event brings a host of representatives from the drugs and alcohol sectors under one roof. Organised by Pavilion. Tickets £20. Go to [www.pavpub.com/08708901080](http://www.pavpub.com/08708901080).

**26:** Service User Involvement: What does it mean for service providers? LDAN Network meeting, Hamilton House, Mabledon Place. 2-430 Contact Shona Flannigan on 0207 704 0004/email: [Shona.Flannigan@ldan.org.uk](mailto:Shona.Flannigan@ldan.org.uk) (See box for more details)

**27:** Changing the Landscape: Delivering Drug and Crime Services. Collaboration between the Centre for Public Innovation & Futurebuilders. ORT House Conference Centre. Organised by Pavilion Publishing. Contact 0870 8901080, [www.pavpub.com](http://www.pavpub.com)  
**27:** Make the links make Progress. Overcoming the barriers to work for former drug users. Guildhall, London. This event is designed to bring together practitioners and those responsible for organising services to help former drug users into employment. Organised by London Drug Policy Forum. Book online at [www.cesi.org.uk](http://www.cesi.org.uk)

**27-28:** 11th National Conference: Management of Drug Users in Primary Care This event is the largest in the UK for GPs, shared care workers, drug users, nurses and others interested in the management of drug users in primary care. Manchester For more information email [katie@healthcare-events.co.uk](mailto:katie@healthcare-events.co.uk)

**28:** Drugs: Guidance for Police Working With Schools. Regional dissemination event for police officers with responsibility for school or community liaison. For more information email: [acpo@drugscope.org.uk](mailto:acpo@drugscope.org.uk)

Hello! So as not to break from the subject matter of the newsletter, we have a special network meeting on service user involvement coming up on 26 April so mark the date in your diary. This will look at what's happening with user involvement in the drug and alcohol sectors as well as



## HIGHLIGHTS

by Shona Flannigan  
Membership Coordinator

highlighting the areas of most relevance to service providers. It will also provide staff with the opportunity to discuss some of the difficulties around implementing user involvement on the ground. The speaker line up so far includes Allan Johnstone, NTA User and Carer Manager and Don Shenkar, Director of Policy and Services at Alcohol Concern and former chief executive of Addiction Support and Care Agency.

## INTERESTED IN JOINING LDAN?

Contact Shona Flannigan for details of membership rates and benefits on 020 7704 0004 or [Shona.Flannigan@ldan.org.uk](mailto:Shona.Flannigan@ldan.org.uk)

