

Re the effectiveness strategy:

Although I applaud the NTA for trying to tackle quality, I feel they have again missed the target. As an aim, bringing down waiting lists was helpful and was successful in some areas. But it had negative effects in many others, where treatment was reduced to enforced detoxes to keep waiting lists down and removed choice from many.

Increasing capacity was also helpful, as an aim – but not if this capacity was achieved by poor care, burnt out workers and underdosing. Aiming to increase retention is useful, but is this possible in a system that has retention rates varying between 21-98 per cent? Oh, you say – who has retention figures of 98 per cent? That for me is another problem of the strategy – it does not mention the role of primary care. We are different – we tend to retain people wherever they are ‘on their journey’ in treatment. Many people are still registered from birth to death, sometimes (even in London) with the same GP; if not, usually with a small number, whether they are drug users or diabetics.

Our retention figures for the whole of the year (not 12 weeks which seems to me to be an extremely short time) for drug users was 98 per cent and none of these were just ‘sitting on a methadone script’. Some were on maintenance but changing over areas of their lives, some were undergoing or had completed detox and others were in day programmes; BUT all still remained registered with us wherever they were on their ‘journey’.

We have close and valuable links with housing, open access services, the local care and assessment teams and back to work schemes, all of whom we could not do without, BUT we remain the key agency for that person. Is their commitment to helping people on their journey through treatment other words for throughput, enforced abstinence (I totally support abstinence by choice with help – but enforced, no) and a return to thinking of the 1980s?

Another anxiety about the strategy being launched at the same time as Blunkett announcing that drug users need to go into rehab or their benefits will be stopped, and a continued push on the criminal justice agenda, is: are we also moving towards the US model of drug treatment? My role as a doctor is, by involving the patient in all decisions and at every point, to help

people improve their health and well-being, whether they have asthma, heart disease or a drug problem – not to punish. People who use drugs are like other people and cannot be wrapped into nice little parcels and shunted around from one place to another.

I worry there appears to be an implicit drive against long-term treatment. I am struck by how the strategy is couched, with the phrase ‘abandoned on maintenance’ at the forefront. Good methadone maintenance treatment is anything BUT an abandonment. Is the concern really – and perhaps legitimately – about the financial cost of potentially long-term treatment for hundreds of thousands of people? I am worried about how assertive patient management (towards reduction, towards abstinence, towards work, towards whatever) could destabilise patients, if that is what is being proposed.

Dr Chris Ford

Wanted: advice from other service user groups

Recently you have run a few articles on service user groups.

Myself and a few others are in the process of attempting to form an SUG (we’re ex-service users of ARC in Manchester). At present we are trying to establish our aims and objectives and a constitution for our group.

At present we have no name, a few keen members and the will to succeed in this venture.

I would be very interested to hear from other SUGs as we would like to learn from the experience of others.

We would benefit from a little guidance for our fledgling group and would like to be added to the subscription list for other groups’ magazines. We need to maintain our group’s enthusiasm, and have a basic desire to establish connections with others.

We realise from your articles that in time we can acquire funding, training and influence, but at present I/we would appreciate any advice on group cohesion, direction and longevity so we may soon find a voice and one day may be heard.

David Jones, Manchester

If you are involved with a service user group and can give David any advice, please contact him at david.jones1@amservice.com or write to him c/o DDN at the address in the front of the magazine.

Comment

Clinical supervision is much-needed and overdue, says Sue Fletcher

Clinical supervision is a formal process of professional support and learning which enables practitioners to develop and enhance their future practice, knowledge and competence assuming responsibility for their own practice (Vision for the Future, DoH 1993)

Preparation and training for clinical support is seen as essential, the ability to provide and participate is not an innate skill and it does have to be learnt (Good Practice Guide 1998)

As a substance misuse practitioner working with young women in a custodial establishment, my work colleagues and I often requested clinical supervision. It was not available then and for countless workers remains unavailable now.

Yet put a group of workers together and invariably the subject is often under discussion, ask staff whether they would like clinical supervision – undoubtedly the answer is yes. Ask how many actually receive it, and the answer is ‘very few’.

Substance misuse workers – whether they are working in the community, in custodial settings or in rehabs – are usually working within a turbulent environment. As we are all aware, sessions with clients may contain disclosures on physical abuse, sexual abuse, child protection issues, self-harm, destructive behaviours, mental health, dual diagnosis, homelessness, domestic violence, indeed there are a myriad of issues, which may be raised. There may also be times when the worker feels compromised or could be subjected to grooming. We encounter complex issues on a daily basis working with vulnerable clients, whose drug and alcohol use is controlling not only their lives but also their families, often resulting in hidden harm. The content of our work and the impact on our workers must surely determine the need for quality supervision with a qualified supervisor.

I believe that substance misuse workers should be given the recognition that as professionals, who working alongside their health and counselling colleagues within the care profession, they are entitled to, and should be offered clinical supervision.

There seems to be a clear division of opinion around clinical supervision, what it means and what it offers. I am now employed as a manager and I want to ensure we have the means for staff to

access this service, whether we call it clinical supervision or clinical support.

I do not mean line management, which again leads to misinterpretation – many believe that staff are receiving sufficient supervision. I believe both should be available, and without doubt the clinical supervisor’s role should be independent of the line management role.

We tend to work in multi-disciplinary settings and I myself am aware of a team employed by different agencies. Within that team some staff receive clinical supervision and others do not, determined by who employed them. Is this the way to achieve truly effective multi disciplinary team working?

I would say this highlights precisely why we need to raise the issue and ensure that no matter who you work for, clinical supervision is included in your contract of employment.

Certainly there are cost and time implications, but ultimately if it results in employees feeling valued and supported and helps prevent staff burn out, it will only be beneficial.

Supervision provides a protected time where staff can reflect on their practice enabling them to develop their knowledge. By this means, they can maintain and improve the quality of care for clients in a confidential environment. I feel this echoes our ethos for our clients – protected time during which we can explore and discuss their wellbeing within a confidential setting.

It is now time for a national supervision strategy, offering clear guidance to ensure a standardised approach across both statutory and non-statutory agencies.

Sue Fletcher is substance misuse manager, Juvenile Group, at Bullwood Hall, Cookham Wood and Downview