

Lifting

barriers to treatment

Realising that many drug users felt barred from health and social services, North East Lincolnshire built an outreach team dedicated to making access to mainstream services much easier for users and their families. Annie Darby explains how she instigated the transformation.

Drug users can find it hard to access mainstream health and social services, and often see their own health and social needs as low priority. They might feel that their needs are not being met by mainstream providers because they are drug users, and believe that workers see their problems as self-induced. Consequently they become even more isolated from mainstream services and will only present when there is a crisis.

In North East Lincolnshire DAAT/PCT we decided on a new approach to get people into services – and keep them there until they had had the help they needed. Our region covers 192 square kilometres and comprises three main towns – Grimsby, Cleethorpes and Immingham, along with several villages. The population is approximately 164,000; unemployment remains above average in the area, and around 14,500 children are dependent on means-tested benefit. Lack of housing and escalating crime are major problems, and it is

estimated that between 65 and 70 per cent of acquisitive crime is related to funding drug use.

I began working with North East Lincolnshire DAAT as specialist health visitor (SHV) in October 2002, initially for two and a half days a week. My first task was to begin networking with other agencies to find out what they perceived the problems to be, in relation to drug using families. I also wanted to hear families' views, so I conducted a small-scale survey by sending questionnaires to 22 drug-using families, which could be returned anonymously. The response was excellent; many respondents also attached comments, such as 'it's about time you listened to us'.

My sample ranged from parents expecting their first baby, to those with children in their late teens. Some had statutory involvement, with children on the Child Protection Register or being looked after; others had no agency involvement. A control group of similar

families with no known drug or alcohol use gave me comparison of the take-up of mainstream interventions, such as childhood immunisations.

The research confirmed that drug using families found it difficult to access mainstream services, because of actual or perceived barriers. One respondent explained: 'I did used to go to the baby clinic but one time I could see two of the other women pointing at me. It could have been anything, but I just thought they know I use drugs and they are going to sprag me up. I never went back. A few weeks later I had my health visitor on the phone wanting to know why I had stopped going, but I didn't feel I could tell her.'

Appointments were often difficult for families – particularly as drug-using parents can have a large number of agencies involved with them, all making demands on their time. One parent said: 'I know I miss a lot of appointments for me and the kids, but I have to get my methadone. If I don't

get that, I'm stuffed.'

Drug using parents often recognised that their habit was difficult for their children. 'I wish he had somewhere to go, to get away from the pressure I put on him, so he can chill out,' commented one.

The reluctance of some drug users to access mainstream health services meant that general health problems were not being assessed or treated, resulting in further exacerbation of pre-existing conditions. 'I did go and see my doctor, because I was having breathing problems, but he just kept on about my drug use,' was another response.

The networking and research gave enough information to start identifying interventions and services that would improve outcomes for clients, and gave a foundation for the team that is in place now.

Among the proposed services were:

- a support service for children who live with drug using parents, that could enhance resilience, self-

esteem and give them some essential 'time out';

- a child-focused worker to undertake intensive work with drug using parents in their homes to promote child safety, parenting skills and promote social inclusion;
- a general health nurse to meet the needs of drug users and their families.

It was becoming clear that a team approach could be effective – but that this needed to be an outreach service that would also assist families to integrate into mainstream services and the community.

As the service is designed to meet a wide range of needs, most of the team are general health and social care professionals, who have excellent core skills – especially in areas like communication, advocacy and empowerment. They have all had drug and alcohol training, but the team does not work with the addiction itself; their role is to support drug users in engaging in and maintaining treatment.

Team members have to be flexible, recognising that drug and alcohol use is a relapsing condition. Both users and families will have periods when they are stable and need little support, and times of relapse when it will need to be more intensive.

Having strong and proactive links with all agencies across the area helps to minimise the 'domino effect', where frequent house moves lead to changes of professionals, and scant knowledge is retained about families. Children of drug users are highly susceptible to becoming 'invisible', but by avoiding the usual restrictions of being GP/ PHCT attached, the team can stay involved with the client and provide some consistency.

Working on the ground alongside drug and alcohol users and their families has given our professionals a more accurate picture of parents' experience. It is easy to assume that they have a level of knowledge that in many cases is just not there – often because they have had fragmented childhoods themselves.

This was demonstrated by a case where the parent was generally providing good care. There was plenty of emotional attachment, but she found it difficult to get up in the morning because of her methadone dose, and consequently the children were late for school. The client said she did not

really know what her routine should be, as she had been in care for much of her childhood; so one of the team went in three evenings one week to show her how to prepare as much as possible the night before, while arming her with several alarm clocks. The methadone timing was also adjusted – which all helped to get the child's school attendance back on track.

Half of the team's referrals come from social services, but other agencies include our local user group, The Roundabout; drug and alcohol services; probation; housing; pharmacies; health; police; and maternity. Self-referrals have increased by 5 per cent this year.

When a client is introduced to our service, we ask their consent to share information. We then assess their needs and compile a care plan. Our aim is to address the presenting problem and empower the client to access appropriate services. The work is usually short term, but as this is a relapsing condition, we use a revolving door approach, with most clients returning to the team at variable intervals. Service agreements are in place for structured work, which clients are asked to sign.

The service is evaluated in two ways – with the team member and through a form for the client (which is still being developed further), asking about their levels of confidence in accessing mainstream services. The point of this exercise is to compare where the client was at the point of referral with where they are at point of closure. An example might be drug treatment: if they were not involved before, are they now – and how is their compliance?

Our evaluations have shown that for more than 60 per cent of clients, the service is helping them to engage – particularly in drug treatment services and mainstream health and social care. It has helped them to address their health needs: contraception uptake was particularly high, and clients are now immunised against Hepatitis B and C.

The work of the child and family support worker is particularly encouraging. On the last evaluation it was shown that of the ten families audited, six of them had had the amount of statutory involvement reduced from Child Protection Registration to Child in Need. Two families no longer needed any social service involvement. Social isolation had been reduced in 58 per cent of clients who are now engaging in

Who's who - the magnificent seven

Specialist health visitor/ service manager

Funded by the DAAT, I manage the team and develop services. I'm also involved in regional and national projects, training and development. My work with clients is around assessing the needs of drug-using families that have been referred by social workers and drug workers, and identifying what interventions can be introduced. I look for inequalities in provision, particularly in geographically isolated areas of the PCT, and develop specific services for women. I use my bereavement skills to work with the police, coroner and ambulance service to support those affected by a drug-related death.

Nurse practitioner

A post joint-funded by the DAAT and the Drug Intervention Programme to access clients in their homes, hostels and drug treatment services. Key tasks include treating general health needs (vaccinations, wound care, contraception), chronic disease management, and assessing and treating minor illnesses and injuries.

Child and family support worker

Funded by two local children's centres, this experienced nursery nurse with drug and alcohol training provides a non-judgmental service for drug using parents. She promotes home safety, empowers families to access mainstream services, and improves lifestyle by working with families on routines, child growth and development, and preparation for parenthood.

General support worker

Funded by the PCT, this role has been crucial in delivering advocacy and integration work. A former health care assistant with training in drug and alcohol work, counselling, diversity and advocacy, she works very much on the ground with clients, accompanying them to health appointments, supporting them through treatment, and putting them in touch with job training.

Carer development worker

Funded by the DAAT, the only member of the team with a drug and alcohol worker's background supports all carers especially those caring for children, many of whom are grandparents. He also facilitates the carer support group and manages volunteers.

Children and young person's worker

Now a full-time post funded by the DAAT, this role is based and managed in the young person's service but links in with the team. Coming from a social service and childcare background, the post-holder provides one-to-one support and facilitates group work. The role grew from a project supported by the Children's Fund, which involved children in talking about their needs as part of a steering group and helped to shape the service.

Accommodation / substance misuse link worker

The most recent member of the team tackles housing problems to reduce the 'domino effect' on children. He comes from a housing and social care background and is managed by a local housing support agency.

diversionary activities like job training and support groups.

Despite our successes, a significant number of individuals and families will become disrupted and may break down. The advantage of our outreach team is that individuals and families can still receive a service, even if they see a different team member. If the children are removed to

grandparents, for example, they need not lose touch. The child and family support worker may hand over to the carer development worker – but they will still keep the client in their sights.

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