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Psychiatric Bulletin (2001), **25**, 187–189

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Service innovation in drug misuse services

This review looks at the need for partnerships in delivering services for drug misusers, to provide a broad base service. It reviews a number of specific partnerships set up between statutory and non statutory agencies based upon identified need and demonstrates the improvement in outcomes that can be achieved through partnerships interventions. In conclusion it reviews some of the basic lessons learnt in the process of setting up successful partnerships particularly the need for joint training between agencies.

Introduction

Partnerships are very much part of the current Government policy in providing services for patients who substance misuse and is one of the key messages in the Department of Health guidelines (Department of Health *et al.*, 1999) and the Home Office guidelines on tackling drugs together (Department of Health, 1995).

This paper will discuss the positive experience that a community drugs team in Cornwall has had in developing partnerships with other agencies, and the lessons that can be learnt.

Background

Cornwall Community Drug Team serves a predominantly semi-rural population of half a million people and was set up in 1989. There are 13 full-time equivalent staff including two full-time equivalent doctors. The service in Cornwall is entirely community-based, with no residential facilities or access to hospital beds. The team treats both opiate and amphetamine misusers and prescribes for 90% of the patients in Cornwall on substitute prescriptions. The service is delivered from outreach clinics across the county and crisis clinics at base on a daily basis. There are no waiting-lists and interval dispensing, and a network of community pharmacists provides supervised consumption. The service receives approximately 500 new referrals per annum and currently has 450 patients on active treatment.

Treatment strategy

The treatment is a combination of substitute prescribing, harm minimisation and psychotherapy/counselling to address the issues that have predisposed the patient to drug misuse.

A study by Griffiths (available from the author upon request) looked at 111 patients, 81 males and 30 females, in terms of their childhood experiences (see Table 1).

The conclusion from this work and similar studies is that many patients who are addicted to drugs have had severe early life trauma.

It is in this context that the team does a full psychological assessment on the patients and provides therapeutic intervention from trained therapists within the team.

Case for developing partnerships

It became apparent from this work that within the limited provision provided by the community drugs team, many of the issues our patients presented with could not be addressed within our resources and this led us to set up a number of partnerships to provide a more comprehensive service.

Obstetric liaison

This was the first partnership, which was set up in 1996 when it was realised that pregnant women who misuse drugs were often not engaged in proper antenatal care, posing a risk to both parent and child.

Table 1 Childhood abuse experiences of patients

	Males *n* (%)	Females *n* (%)	Total *n* (%)
Any abuse	37 (46%)	22 (73%)	59 (53%)
Sexual abuse	15 (18.5%)	13 (43%)	28 (25%)
Physical abuse	24 (30%)	9 (30%)	33 (30%)
Emotional abuse	21 (26%)	15 (50%)	36 (32%)
Multiple abuse	17 (21%)	10 (34%)	31 (24%)

https://doi.org/10.1192/pb.25.5.187 Published online by Cambridge University Press

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The result of this partnership has been that no patients in Cornwall have presented over the past 2 years at time of delivery without being engaged in antenatal care by the specialist liaison midwife, who works jointly with the drugs team and the obstetric team. Only 10% were still using any 'street' drugs at delivery.

Pregnancy is a very important time in the life history of women who misuse drugs to make a therapeutic intervention because it is often in pregnancy that the parents own early life trauma is first recognised and this partnership has enabled us to engage well with this patient group.

Partnership with the NSPCC

This partnership was one that was set up with the National Society for the Prevention of Cruelty to Children (NSPCC), looking at the needs of the children whose parents have drug misuse problems. It deals with issues concerning parenting and looks to break the cycle of the parents' drug misuse and the intergenerational cycle of drug misuse and early life trauma.

The NSPCC and the drugs team work closely in liaison with those families who are identified by the drugs team. The families are offered a joint package of support, with the drug team stabilising their street drug habit and the NSPCC address the issues of parenting and child safety. Close liaison between the teams has been vital in this work and both teams attend joint supervision at a weekly case conference.

This service is now accepted on the 'street' and families are beginning to self-refer to it for help, via their keyworkers.

In this field in particular, the drugs team has learnt to become far more child-centred in its work and has also begun to recognise the importance of working with the family system.

Thus, a partnership between the NSPCC and the drugs team has enabled us to address both the issues of parenting and the issues of drug misuse in parallel, to try and prevent the intergenerational cycle of drug misuse.

Young persons drug worker

In parallel with this, a partnership with the children's services and youth offending team set up a young persons drug worker who works with young people who drug misuse and those who are identified within families who misuse drugs or who are identified by the youth offending teams.

Pilot treatment and testing order – drug stabilisation project

This partnership was set up with probation and the police with the aim of targeting persistent offenders who were not engaged with the drug services. As there is no waiting-list in the county this service particularly targeted those difficult to engage patients who were offending in order to pay for their habit and who elected not to look for treatment. The pilot scheme was set up in 1997, initially for 6 months but has been extended.

The condition of treatment is clearly spelt out to the patient at time of interview, in that the drugs team agrees to inform probation if the patient fails to keep their appointments and if their 'street' drug use remains chaotic.

A high degree of trust developed between these agencies and all decisions taken with respect to treatability were unanimous.

The outcome from this treatment programme was that approximately 40% of these patients remained on the programme and did not re-offend over a 2-year period. Over 50% of the patients referred to this programme were amphetamine misusers and not opiate misusers, which has major implications for the treatment and testing order.

Partnership to address hepatitis C virus infection

Hepatitis C virus is a major issue facing drug misuse services and 80% of patients who injected prior to 1988 are antibody positive. In our studies approximately 60% are polymerase chain reaction (PCR) positive as patients are now beginning to present consistently to the service with symptoms of chronic active hepatitis. The difficulty in treating this patient group is that they engage very poorly with the specialist gastroenterology services and often fail to keep appointments and, therefore, fail to receive appropriate treatment. A partnership was set up with the local gastroenterology service in Cornwall to overcome this and the basis of the partnership is that one clinical assistant within the drugs service dedicates his clinics to screening for and identifying patients with hepatitis C virus infection.

If patients are PCR positive they are then referred to the gastroenterology department. However, the doctor who works for the drugs team also works for the gastroenterology department and so takes his patients with him, but changes consultant. Thus, the patients get treated by the same clinical assistant throughout their diagnosis and treatment career, and this has resulted in a huge increase in compliance and attendance for assessment, including liver biopsy and treatment.

Prior to this programme only 20% of referrals engaged with the gastroenterology department, but after the programme was instigated it increased up to 70%.

Partnership with charities

It was clear from an early stage in the treatment programme in Cornwall that statutory services, particularly with no social services input, were going to be unable to meet a number of the needs of this patient group, in particular the area of relapse prevention and reintegration into society. As a result of this, a charity was set up on the initiative of the police and the drugs team with the remit to address these problems, which now takes referrals from the Cornwall Community Drug Team for this category of patients.

https://doi.org/10.1192/pb.25.5.187 Published online by Cambridge University Press

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Lessons to be learnt from partnership

As a drugs team working initially with a harm minimisation strategy, we rapidly identified a wide range of issues in our patients' presentation, particularly issues concerning early life trauma and social exclusion, as well as the relationship between their drug misuse, offending behaviour and physical illness, particularly hepatitis C virus infection.

As can be seen, we have set up a number of partnerships that have begun to address some of these needs. This enabled the Cornwall Community Drug Team to concentrate on its task of harm minimisation and remedial psychotherapy, while at the same time sharing the care of its patients and their families with other agencies.

One of the main lessons we have had to learn from partnerships is that one has to share power with one's partners and be prepared to be flexible when working with other agencies. Thus, decisions concerning patients' treatment packages are now very much influenced by input from the relevant partners.

In achieving this, the most vital ingredient is trust and it is only by having a relationship of trust and respect between partners that a joint project can work. Much of the work we have had to do to set up our partnerships has involved building up this trust. One of the key mechanisms of building trust we have found is joint training, where agencies will work together for a day, both providing training for the other agency in their own speciality.

Acknowledgements

In preparing this paper, I would like to take the opportunity to thank all the agencies involved: The Cornwall & Devon Constabulary; Cornwall Probation Services; youth justice team; child and family services; The Acute Trust; gastroenterology & obstetric services; and the staff of the Charity Recovery. I would also like to thank Vanessa Griffiths, clinical psychologist and Lorraine Rule, secretary.

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Psychiatric Bulletin (2001), **25**, 189–190

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Memoirs of a press officer

My first encounter with the media was about 17 years ago when Marjorie Wallace turned up at a College meeting. As the conference organiser, I was told by the then secretary of the College, Natalie Cobbing, to ensure that Marjorie was not admitted, as our meetings were closed to the press. In fact, the fear of God was instilled in the staff at that time about the press – no staff were to talk to the media. Disobedience could be seen as a sackable offence. Ironically, Marjorie Wallace is now an Honorary Fellow of the College in recognition of the work she has done in mental health, both as a journalist and campaigner.

Since 1971 the Council of the College had discussed the possibility of appointing a public relations adviser, but it was not until 1985 that it agreed to establish a Public Education Committee. I remember the discussions well because at the time it was a toss-up between introducing a College credit card or appointing a public relations (PR) company to promote psychiatry. Public education won by one vote and the College appointed a PR agency in 1986.

The College's first experience with the world of PR was an interesting one, in that following the highly successful launch of the book *Alcohol Our Favourite Drug* (Royal College of Psychiatrists, 1986), the appointed PR company were informed by their main client, a major brewery company, that they had to choose between representing the College or them. You can guess what their decision was. On the very small budget that we had at the time, and still do have, an external PR consultant was appointed, Jill Phillipson, who has remained with us since then, as a stalwart and astute technical adviser. The role of public education in the College took a real turn for the better when the then director, Professor Brice Pitt, had the brilliant idea of producing our first *Help is at Hand* leaflet for the general public. The Committee, which consisted of six members of the College and staff, used to meet in a huddle in the bowels of the College. Much of our time was spent reading the leaflets out loud to each other to make sure that the language and contents were simple and user-friendly. This method proved very successful and two of the College's leaflets were awarded crystal marks by the Plain English Campaign. The Public Education Committee has now evolved into a Standing Committee of Council, with a membership of more than 25 people representing the different faculties and

https://doi.org/10.1192/pb.25.5.187 Published online by Cambridge University Press