BREAKING BOUNDARIES:

PROFILE OF

WEST GLAMORGAN COUNCIL

ON ALCOHOL AND DRUG ABUSE

(WGCADA)

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SUMMARY

West Glamorgan Council on Alcohol and Drug Abuse (WGCADA) was established in Swansea by Alan Douglas in 1979 as the "Alcohol Advice Centre." Initially, WGCADA worked only with an abstinence-orientated approach based on Alcoholics Anonymous (AA) and the Minnesota Model. As the agency expanded over the years, it has developed a range of different approaches to helping people with drug and alcohol use problems.

The agency now uses abstinence based and harm reduction approaches to clients in offices in Swansea, Neath, Port Talbot and Bridgend. It operates outreach clinics in various communities and works in four Welsh prisons. The agency has over 100 staff and last year its operating budget was just under £2 million pounds. It collaborates with a variety of organisations in the community, including community drug and alcohol teams (CDATs), social services, local health groups, GPs, mental health teams, police, probation, and many others.

The problems arising from substance misuse, not just illicit drugs such as heroin but also legal substances such as alcohol and prescription drugs, are substantial. Drugs and alcohol impact on individuals, families and communities. The cost of substance misuse to the UK is at least £40 billion per annum. There are substantial challenges facing society in dealing with substance use problems and their contributory factors (e.g. economic and social deprivation, social exclusion). Treatment of substance use problems represents a difficult challenge, particularly given the diverse range of clients who present for help. Many need help with issues other than their substance use.

This publication sets out to profile a diverse range of activities conducted by staff at WGCADA. We first outline the main principles of the 12-step Minnesota model, as well as various harm reduction approaches. We then briefly describe the clients who attend WGCADA, considering mainly the nature of their substance use problem and their referral source. We provide a number of client "personal stories" and "case studies" throughout the profile.

We look at core services provided by WGCADA, in part by using transcripts of interviews with staff members. These core elements include assessment, Pre-treatment, Primary treatment, Harm reduction (needle exchange, outreach, substitute prescribing), detoxification, and the family programme. DOMINO, a programme of activities and workshops designed to develop and promote greater awareness of life without substances, is also described. The importance of the administration and support services at WGCADA, as well as data collection and IT support, is emphasised.

We then describe the activities of a range of specialist workers – community support, tenancy support, arrest referral, youth opportunities, young persons, women and families, domestic violence, and elderly and disabled. The views of WGCADA of clients, a commissioner, a student on work experience, a volunteer, WGCADA staff, and members of the community are described.

Finally, we provide our own views of WGCADA, in part linked to known principles of effective treatment. We also make some suggestions concerning the way forward for the agency.

ACKNOWLEDGEMENTS

We are grateful to all clients, staff, family members and others who provided their valuable time, experiences and views for this profile.

NB. This profile does not describe all the activities carried out by WGCADA. This would involve a much larger piece of work, larger than what we were commissioned to do with resources available. It is also important to emphasise that this piece of work is not an evaluation of the services provided, although we do present some opinions.

1. Background

1.1. Substance misuse

The misuse of drugs and alcohol affects individuals, families and communities. The financial cost of substance misuse to the UK is at least £40 billion per annum, due mainly to expenditure on health and social care, absence from work, criminal activity, and costs to the criminal justice system. The social cost is immeasurable.

In the past twenty years, there has been a large increase in the recreational use of illicit drugs and an increased incidence of drug-related problems in the UK. Alcohol misuse continues to be a major problem and the number of people dying from alcohol-related problems is higher than for all illicit drugs combined. Prescription drugs, such as the benzodiazepines, as well as solvents and other substances that are inhaled, also produce problems in a significant proportion of the population.

Most people who try illicit drugs or drink alcohol do not go on to experience problems. However, a significant minority do experience problems that eventually impact negatively on their physical and mental health and their social circumstances. This harm can arise from the direct negative effects of drugs (e.g. long-term alcohol causes liver damage), indirect effects arising from repeated withdrawal symptoms (e.g. depression from long-term cocaine use), and the negative effects arising from the lifestyle associated with illegal street drugs (e.g. contaminants in street heroin, hepatitis C from sharing needles).

Long-term drug or alcohol use can lead to dependence or addiction. In simple terms, dependence can be seen as an impairment of a person's ability or power to choose. The drug becomes more important than other aspects of their life, which the majority of people would consider as essential. Dependence drives forward heavy and persistent drug use, ultimately increasing the incidence of self-harm.

> "In one word, trapped. I knew I had the ball and chain from that day onwards … I could see no light at the end of the tunnel whatsoever. It had got me. I was being sucked down every day further and further."

Self-control is impaired and the user persists in using the substance even when they know the dangers and when their rational self tells them to stop. An individual's drug and alcohol problems also often impact on their family. Communities are also affected as a result of anti-social behaviour, family breakdown, and higher levels of crime.

Drug and alcohol dependence, or addiction, is a complex condition involving biological, psychological and sociological components that represents a major challenge to treatment practitioners. Unfortunately, there are no magic bullets or simple interventions that are all embracing in the treatment of addiction.

1.2. Treatment

Drug and alcohol treatment services exist primarily to help and support those people who develop problems from their use of drugs and/or alcohol. A range of services and agencies have evolved to meet the needs of people with a substance use problem which aim to:

- reduce the harm which individuals cause to themselves, and others, including family and society
- stabilise and reduce the consumption of drugs and/or alcohol with the aim of, where appropriate and possible, achieving abstinence
- rehabilitate the misuser (back) into society.

Treatment may involve clients abstaining from drugs or alcohol completely, or may involve a form of harm minimisation, such as encouraging clients to use clean needles to inject in order to minimise the risk of infections, such as HIV or hepatitis.

People present for treatment, advice and support at various stages of their drug and alcohol-taking career. Therefore, treatment agencies need to be able to respond to a variety of different situations. Some people who use drugs recreationally may only require information and advice from a treatment agency. Others can be helped by a brief intervention. For example, a brief intervention may involve the assessment of alcohol intake and alcohol-related problems, followed by information about how to cut down on drinking and use of a drink diary.

Some people present for treatment with severe drug and/or alcohol problems. A significant proportion of these people will present with a variety of other intimately related problems. Thus, they may be homeless, jobless and experiencing problems with personal relationships, have a history of criminal activity, and have a physical and/or psychiatric illness. People with severe drug and/or alcohol problems often require an extensive package of treatment and aftercare, sometimes involving medical, psychological and social interventions. The importance of aftercare should not be under-estimated. It is much easier to stop, than to stay stopped.

It is widely accepted that the best approach to treating a person with a serious substance misuse problem is to treat the individual as a whole (holistically), rather than simply focusing on trying to reduce his or her drug intake. Thus, in trying to help people overcome their substance use problem, treatment services may need to help clients access other forms of support, such as housing services, social services, mental health services, education and vocational training.

Practitioners must also be aware that an addiction to drugs and/or alcohol is a relapsing condition in some clients. Some people remain abstinent for many months or years before initiating drug (or alcohol) use again, whilst others continue to periodically pop in and out of treatment agencies over long periods of time. Other people who visit a treatment agency permanently abstain from drugs and alcohol and go on to lead full and healthy lives.

Treatment of substance misuse represents one of the most difficult challenges in the health field. Service users, their families, commissioners of treatment, and society itself expects more from treatment than just a reduction in, or elimination of, drug and alcohol use. Clearly, trying to reduce substance use, improve personal health and social function, and reduce public health and safety risks, is a daunting task for practitioners, particularly given that clients often present with severe and chronic problems at the start of treatment.

Despite the challenges, research shows that "treatment can help improve the client's mental and physical health, reduce offending, improve employability and enhance social functioning generally, whilst also reducing the demands made on health and social services and bringing significant benefits to families and loved ones. Overall, substance dependency treatment appears as successful as medical treatments for a range of chronic conditions, such as diabetes, hypertension and asthma, and the costs of treatment are more than outweighed by the financial savings it brings." (EATA website)

At the same time, whilst research has shown that treatment of substance use problems is effective, it has also demonstrated large variations in the effectiveness of treatment provided by different treatment agencies, with some agencies, despite best intentions,

The challenges facing WGCADA

WGCADA, and other voluntary sector agencies, face a variety of challenges in tackling substance use problems. Most importantly, many of the clients they work with have problems beyond their misuse of drugs and alcohol. Just consider the following.

Many people start to use drugs and alcohol, and develop a problem with these substances, because they have problems in their lives. They may come from poor backgrounds in areas of social and economic deprivation – their fathers and grandfathers may not have worked. Drugs and alcohol, at least for a time, represent a way of escaping the reality of life. Of course, if these people later stop misusing drugs and alcohol, this does not mean that their other problems disappear.

Many people with a substance use problem come from broken homes – others have been victims of sexual abuse, some from early childhood. Others have mental health problems, which may have preceded the substance misuse problem or may have been caused by the substance misuse (e.g. amphetamine psychosis, depression arising from problem drinking). Some people have spent time in and out of prison – and some people have all of this!

The age at which people start misusing drugs is becoming lower all the time. Youngsters developing a heroin problem in the early teens are losing a critical time of their lives – they are not growing up properly. Once they stop using heroin, they have a childhood to live – one they missed. They have social, emotional and practical skills to learn if they are to "survive" in society. And they have to learn these skills, and develop as a drug-free person, often in their mid- to late-20s or early 30s. At the same time, as trying to stay off drugs.

If people are to stay away from drugs and alcohol, then they must have alternative pleasurable activities that take the place of the activities associated with substance use. The latter may include, sometimes on a daily basis, shoplifting, selling of the stolen goods, visiting a dealer to obtain the drug, and the actual ingestion of the drug and experiencing of the effects (a full-time job!). If a person does not find pleasurable alternative activities when they are abstaining, then they are quite likely to become bored, which can lead them to return to misusing substances.

Class A drug users often lose contact with family and non-drug using friends; their only associates are often other Class A users. Once they stop taking drugs, clients need to dissociate from former drug-taking friends. However, this is difficult due to basic practicalities (e.g. finding a house in a new location) and the fact that they have no alternative non-drug taking friends with whom they can associate. In other cases, heavy drinkers develop agoraphobia and rarely leave their home. Once they stop drinking, they must be encouraged to get out more and become more engaged. Treatment agencies need to be able to develop communities of support for former users/heavy drinkers or others who are wishing to reduce drug and alcohol intake.

Treatment agencies must facilitate personal development of clients and their engagement or re-engagement [back] into society. They must help facilitate access to education, vocational training and employment. In some cases, clients will not have worked previously and may have left school at an early age. In some cases, clients cannot read and write.

The UK drug strategy, based on a partnership approach, has greatly facilitated the work of treatment agencies by encouraging all the key agencies and services that are required to support people with a substance use problem – health, GPs, social, police, probation, education, etc - to work together. At the same time, however, it has presented new challenges to treatment agencies such as WGCADA. There are obviously difficulties in getting such a large-scale multi-agency approach to work – we all know what damage one unhelpful individual can do. Moreover, there have been questions about "centralist, bureaucratic, 'inter-agency' delivery systems" and their key conduits (Dates, Smuts). Local delivery of grand projects is often far harder than Whitehall and the National Assembly for Wales understands or accepts.

producing poor outcomes. Clearly, it is essential to identify the multitude of factors that contribute to providing successful treatment of substance use problems.

Research studies have revealed key principles that facilitate the provision of successful treatment. In Appendix A, we detail the major points raised by the European Association of Treatment Agencies (EATA) in their document "Rehab - what works? 20 things you should know about rehabilitative treatment for substance dependency". We will make reference to these points when we provide our thoughts on the provision of treatment and support provided by WGCADA for people with substance use problems (cf. Section 7)

Before this, we will look at the way that WGCADA delivers treatment and support, in part via a series of "articles" based on interviews with staff, clients, commissioners and family members. We will also look at the principles underling some of the approaches adopted by WGCADA.

2. WGCADA and the provision of treatment

2.1. The early years of WGCADA

WGCADA was initially founded and established in 1979 as the "Alcohol Advice Centre", staffed by the director Alan Douglas and part-time secretary Margaret Morris. It was financed by the Welsh Office and by Health Authority funds. However, a great deal of work took place during the four years prior to this date in order to stimulate the interest and involvement of various groups.

In February 1975, a meeting was convened with Mr Derrick Rutherford, Director of the National Council on Alcoholism (NCA). He provided some basic information and emphasised the necessity of involving both Social Services and the local Health Authority in the establishment of a service.

This was followed by a meeting in June 1975 with the South Wales Council on Alcoholism in conjunction with, as it was then called, the West Glamorgan Council on Alcoholism. This first public meeting was called to establish the Council formally, and a constitution of about seventy people attended. This was a very encouraging turnout.

The Health Authority showed interest and assigned Dr Littlepage to serve in an advisory capacity on a newly established committee. By the end of 1975, this committee consisted of representatives from most statutory services, and Dr Riordan was elected as President.

For the next few years, there was a good deal of pressure to raise funds on the Director Mr Alan Douglas. In September 1978, a seminar was held to discuss development of the service, in which Mr Derrick Rutherford (NCA) and Dr Littlepage (Health Authority) played important roles. This was followed by a meeting in February 1979 in which an application was made to the area Medical Officer, Dr Phillips-Miles, for funding. Premises for a possible project were discussed. Mr Derrick Rutherford formally expressed his disappointment that no funds were forthcoming from Social Services.

Another meeting was convened in April 1979. The NCA and local Health Authority both had representatives at this meeting, whilst no representatives from either Social Services or the County Council were present. There was discussion at this meeting about a possible grant from the Health Authority for the year 1978/79. The Welsh Office made it clear that it would make no long-term commitment, but would offer up to £7,500 in matching grants, and would require the Health Authority to continue the grant the following year.

In 1979-80, unsuccessful funding applications were again made to the West Glamorgan County Council and Social Services. Pressure was mounting to attract enough money to claim the Welsh Office matching grant.

Further discussion at a later meeting focused on the type of service, which would be most useful. It was confirmed that as hostels were available in other areas in South Wales, that it would be more constructive to have a counselling service in West Glamorgan.

In the AGM of May 1980, the president, Dr Riordan, stressed the necessity to forge two-way links with both the Health Service and the Social Services so that those with drinking problems should be encouraged to seek early treatment. Dr Rutherford stated that he had arranged matching grants from the Welsh Office, since Dr Littlepage and the area Medical Officer had negotiated a grant from the local Health Authority. It was also stated that suitable premises had been found. A significant statement concerning the role of the Alcohol Advice Centre as a catalyst in inspiring a multi-disciplinary approach to the alcohol problem was made by Dr Alan Hawkins.

The Welsh Office offered a diminishing grant over a set period: 1979, 50%; 1980, 40%; 1981, 40%; 1982, 30%; 1983, Nil. Whilst the local Health Authority increased it's funding annually, unfortunately the Alcohol Advice Centre never actually received a full grant from this body (and therefore the full Welsh Office matching grant). The Centre was therefore always under-funded in its early years. It was felt that Social Service should have taken some responsibility.

Whilst the Health Authority stated that alcohol misuse should not be their sole responsibility, and despite fairly continuous petitioning of Social Services, the latter refused to contribute to joint funding with the Health Authority in these early years. The practical implications of these political manoeuvres meant that the Service was placed in an insecure position. Funding allowed only for one full-time worker (the Director) and one part-time secretary.

Norman Preddy, current CEO of WGCADA, had been doing voluntary work for about one year with the Centre by this time (1983). With such a small staff team, it had become apparent that the Alcohol Advice Centre could not continue purely on Health Authority funding, since the number of clients had increased and the administrative load was too great for a part-time worker.

In May 1984, Alan Douglas applied for finance under the MSC community programme. This application was approved, providing funding for one year (starting October 1984) for one full-time supervisor/counsellor, two part-time counsellors and one part-time secretary. Norman Preddy was employed as the supervisor/counsellor.

All of the personnel were trained and working effectively by January 1985. As might have been expected, the numbers of clients increased dramatically during this time. The Director (Alan Douglas) was therefore concerned that when funding ended in October 1985 there would be far too great a caseload for the original small "team". With the support of the Health Authority, he therefore applied to the Welsh Office for further funding.

This application was approved, resulting in a grant in perpetuity for £20,000 to finance the present staff team. At that time, the Director had attempted to select and train volunteers, but out of fifty applicants he had found only two who were suitable following the training course. Moreover, both of these people left the area soon after completing the training

course. Alan stated that although there was a fair amount of enthusiasm, the trainee volunteers were inconsistent and unreliable on the whole.

Alan felt that the job required certain personal qualities and expertise and it was difficult to find people with both. There were additional external constrains on volunteers which tended to make their commitment erratic, e.g. family, employment, etc. So, for these reasons the Alcohol Advice Centre did not use volunteers for individual counselling. However, relatives and clients themselves helped out occasionally by manning the phone during the day for short periods and making coffees, etc. Volunteers also worked occasionally with the Women's Group. Despite problems encountered selecting and training volunteers, the Centre had two regular volunteer workers who acted as group facilitators - Mary Edwards (two days per week) and Sheila Roberts (one day per week).

By 1986, a timetable of staff activities had been developed - much of staff time was taken up with group work, group work activities and individual counselling sessions. The team comprised Alan Douglas, Joan Anderson, Norman Preddy, Cliff Guard and Rosemary Owen (the latter two were the part-time counsellors), as well as the two volunteers.

At this time, there were 30 counselling sessions per week, for 22 regular clients and a space for eight new clients. This gives some indication of the formally structured programme, but support and help was offered to clients on an informal basis to supplement formal appointments. The main office often functioned as an informal "drop-in" centre for aftercare support and extra help and support for those still in treatment. The secretary, Joan Anderson, took a large part of the responsibility for that aspect of the work. Many clients felt that the friendly informal support consistently available in the main office was an integral part of their recovery programme. Staff not working with clients would spend any free time in the office and an atmosphere of friendly interest and genuine concern encouraged clients who dropped in to discuss problems and support each other.

The role of the secretary in maintaining an atmosphere conducive to this kind of constructive interaction was crucial. She needed to listen, understand and give reassurance as appropriate. It was essential both for telephone work and the office management that she was a mature, level-headed person who could deal with a variety of situations, sometime stressful, as they arose. The present office management throughout WGCADA continue to fulfil these roles admirably.

WGCADA has expanded considerably over the past 25 years, as we will shortly see. However, before considering the current situation, we will describe some of the core approaches adopted by the agency in providing treatment and support in the community. We will first look at the abstinence service that is based on the principles of AA and the Minnesota Model, and then consider the Harm Reduction services that WGCADA also operate.

2.2. AA, 12-step, Minnesota model

In its early days, WGCADA worked only with an abstinence-orientated approach based on Alcoholics Anonymous (AA) and the Minnesota Model. As the Centre expanded over the years, it developed a range of different approaches to helping people with drug and alcohol problems. However, whilst WGCADA today offers a range of treatment options and forms of support, it still has at its core an abstinence-based philosophy based on the 12-step Minnesota Model.

2.2.1. Alcoholics Anonymous

The 12-Step movement developed from AA, a self-help organisation founded in 1935 by two alcoholics Bill Wilson and Bob Smith. They formulated the 12 steps and principles of AA from their own experiences of maintaining sobriety through sharing with others, when they had not managed to do this alone. The book describing this, "Alcoholics Anonymous", published in 1939 is the core text of the AA, affectionately known by members as 'the Big Book.'

The AA based approach has broadened to incorporate other forms of chemical dependency with Narcotics Anonymous (NA). It later developed further to cover behavioural addictions such as gambling and eating disorders. Family support groups have evolved in parallel with the treatment groups: Al-Anon for families of problem drinkers and Families Anonymous for families of drug misusers.

2.2.2. The Minnesota Model

In the 1940s and 1950s, three centres in Minnesota were established that incorporated the AA philosophy: Pioneer House, Hazelden Foundation, and the Wilmer State Hospital. These centres developed an integrated treatment programme that was an adaptation of the 12-step programme. The Wilmer State Hospital programme was particularly influential due to the pioneering work of Dr Nelson Bradley and Dr Daniel Anderson.

A highly structured programme was developed, set in the context of a patient-centred social learning environment, combining medical treatment, multidisciplinary teamwork, individual counselling, group work and a therapeutic community environment. Medical staff and psychologists worked alongside clergy and lay counsellors, who were themselves, recovering alcoholics.

Developed and implemented over a period of three years, mostly from 1952 to 1955, the programme became known first as the Willmar Model. The Model spread to the Hazelden Foundation in the 1960s where it became known as the Hazelden Model. This Foundation was founded in 1949, located in Centre City, Minnesota and directed by a not-for profit Board of Trustees led by Patrick Butler, who was himself a recovering alcoholic. Finally in the 1970s, as it gained wider acceptance, it became known as the Minnesota Model.

The key elements of the Minnesota model are as follows:

- The integration of professional staff with trained recovering alcoholics
- The focus on the disease concept and link to the 12-step fellowships
- The dedication to family involvement
- The insistence on abstinence from the use of all addicting drugs
- The emphasis on patient and family education
- An individualised treatment plan
- A continuum of care integrating sustained aftercare into all treatment plans.

The Minnesota model was first applied in this country with the founding of a residential treatment centre at Broadway Lodge in Weston-Super-Mare in the early 1970s.

2.2.3. Key assumptions

AA, NA and the 12-step Minnesota model are based on the assumption that alcoholism and drug addiction are chronic, progressive illnesses (or diseases) of unknown aetiology that affect the body, mind and spirit. They are characterised by:

- an inability to reliably control the use of alcohol and/or drugs

- denial, or resistance to accepting the reality of loss of control over drinking or drug taking.

The 12-step approach is not based on any notion of a *cure* for alcoholism and drug addiction, but on the idea that one's addiction can be arrested through the help of one's fellow addicts. The 12 steps are a suggested pathway for ongoing *recovery*. The essence of this recovery pathway is a changed lifestyle (habits and attitudes) and a gradual spiritual renewal. The only effective remedy for alcoholism and drug addiction is abstinence from the use of all mood-altering substances.

AA, NA and 12-step programmes have two major common themes: spirituality and pragmatism.

There is a commitment to faith in a "Higher Power" as a key to recovery. Individuals are encouraged to conceptualise this Higher Power in any way they choose, as long as it represents a power greater than their own willpower, which is regarded as insufficient to conquer addiction. Twelve step programmes present recovery from alcoholism and addiction as a process of spiritual renewal, part of which involves a "surrender" to this Higher Power. The Higher Power represents faith and hope for recovery.

Although they promote spirituality, AA and NA are not religious organisations; rather, they are fellowships or societies of peers who are connected by their common addiction and guided by common traditions, not be religious credos.

AA/NA and 12-step treatment programmes are also are marked by a striking pragmatism. There is a strong belief in doing "whatever works" for the individual, meaning doing whatever it takes in order to avoid taking the first drink or dose of drug that will trigger loss of control. Individuals are also told to take recovery "one day at a time".

One important tradition within 12-step programmes and AA/NA is that alcoholics and addicts share in meetings their personal stories of decline through addiction. The purpose of their "speaking" at meetings is for everyone to be reminded of their own experience of decline, so that complacency and forgetfulness do not have a chance to set in. The stories help old timers remember the way that life was for them before their own recovery, whilst newcomers learn that others have experienced what they have been through, learn that recovery is possible, and identify with AA/NA and 12-step programmes.

WGCADA operates an outpatient (or community based) Minnesota Model programme, which works through the first five steps of the 12-step programme. There are two primary goals, which help form the basis for early recovery from alcoholism and addiction: acceptance and surrender.

Acceptance takes several forms in 12-step programmes:

- Acceptance by the client that (s)he suffers from a chronic and progressive illness characterised by compulsive use of alcohol or drugs.
- Acceptance by the client that his/her life is (or is becoming) unmanageable as a result of alcohol or drugs.
- Acceptance by the client that (s)he has lost the ability to effectively control his/her drinking or using through willpower alone
- Acceptance by the client that since there is no effective way to reliably control his/her use; the only viable alternative is complete abstinence from the use of alcohol or drugs.

Surrender includes acknowledgement by the client that:

- There is hope for recovery – sustained sobriety – only through admitting the reality of his/her loss of control.
- Recovery requires having faith that some Higher Power can help him/her when willpower has been defeated by alcoholism or addiction.
- Fellowships of fellow addicts, such as AA and NA, have helped millions of alcoholics and addicts to sustain their sobriety
- His/her best chances for success are to live the twelve steps and become actively involved in a twelve-step fellowship.

2.3. Harm reduction (or harm minimisation)

Some people may not want to, or feel able to give up drugs completely. They might just want to reduce the harm that drugs can cause, e.g. they might change from injecting heroin to smoking it. Harm reduction (or harm minimisation) is a model of working that has been associated with drug use since the mid-1980s. It was a response to the need to try to minimise the harm caused by injecting drug use at the beginning of the HIV epidemic.

The harm reduction model recognises that people will continue to use drugs despite the risks and prohibition, and works on the principle that some of the risks of drug use can be reduced and minimised. Prevention measures and education are important, but if they are unsuccessful we must work with the consequences of drug use. Drugs can be harmful because of the effects of the drug itself, contaminants mixed with the drug, the methods of delivery (e.g. injecting) and the effects on others.

Harm reduction is about educating drug users about the risks of drug-taking and helping them to take responsibility for themselves. With this information, people are able to make choices about the level of risk to which they will expose themselves. Harm reduction is a process and not a treatment. It needs to be integrated with other forms of intervention.

Another important harm reduction intervention is the development of needle and syringe exchanges. These provide drug users with free sterile needles, syringes, in some cases sterile water and other paraphernalia, and condoms. Exchanges also provide a means of safer disposal of used equipment.

Needle exchange users are far less likely to share other people's equipment. Attendance at a needle exchange also gives the person an opportunity to ask for advice on injecting and health issues, and to obtain referral to treatment services if requested.

The provision of substitute prescribing is another important harm reduction intervention. An option for helping people who feel unable, or are unwilling, to undergo abstinence-orientated treatment abstain from drugs, is to prescribe a substitute drug in either reducing or non-reducing doses. This substitute may be the actual drug to which dependence has been developed, although it is more common for a drug to be used that is considered a better and safer alternative. Maintenance treatment with a substitute drug eliminates withdrawal symptoms and allows the individual to address a variety of concurrent issues in their lives, e.g. the chaotic lifestyle often associated with the procuring of money to purchase the drug and the drug itself. Moreover, it helps them avoid the contaminants that are present in street drugs, thereby providing a way by which the person's health may improve (or not further deteriorate).

Methadone is a synthetic opiate, which has been used as a substitute treatment for over thirty years. It has several properties that make it an excellent substitute for heroin and

other opiates, including a long duration of action, being available in liquid form, which deters injecting, and having little euphoriant effect, thus eliminating withdrawal symptoms without reinforcing continued use. It is often written that methadone is prescribed on a maintenance programme - where a stable dose is used, sometimes for prolonged periods of time, even many years - or on a reduction programme, where the aim is abstinence following gradual reductions in dose. However, the best form of prescribing regime is one in which practitioner and client work together to decide changes (or no changes) in dose level and this may vary over time. This approach does not fit easily into a rigid maintenance vs. reduction distinction.

Most methadone programmes require that the client attends daily (often to a pharmacy) to consume their methadone. There is a great deal of variation in the rehabilitation and psycho-social services that are offered in addition to methadone, and also in the dosage levels employed. The most successful methadone programmes have been characterised by high methadone doses (60mg and above), more intensive counselling and the availability of more medical services.

Research has concluded that the main benefits of methadone treatment are reduced opiate misuse, reduced crime and imprisonment, reduced HIV risk behaviours, improved quality of life, improved physical and psychological health, reduced non-opiate use, and reduced death rate. Methadone is also considered important because it helps attract and retain clients in treatment.

Methadone is not an innocuous treatment, and inappropriate methadone prescribing can increase a client's total drug consumption (some clients will use on top of the methadone) and even result in overdose (although the incidence is far less than for heroin). Some people consider methadone to have a higher addictive liability than heroin, and to produce more severe and long-lasting withdrawal.

An alternative substitute drug to methadone is subutex (buprenorphine), which is a partial agonist at a sub-population of opiate receptors in the brain. Subutex has been proposed to be more effective than methadone, whilst causing less adverse effects to the user. It was licensed for use in the UK in 2001, and is suitable for both detoxification and maintenance programs. Subutex exerts sufficient opiate effects to prevent or alleviate opioid withdrawal symptoms, but produces a milder, less euphoric and less sedating effect than high doses of heroin or methadone.

2.4. WGCADA today

Today, WGCADA has just over 100 staff and nearly 20 trained volunteers operating out of premises in Swansea (three), Neath (two), Port Talbot, Bridgend and HMP Swansea. In addition, it operates outreach clinics in a number of communities and has CARAT workers in four Welsh prisons. A new office will shortly open in Swansea. The operating budget for 2004-2005 was over £1.9 million. A total of 2,868 referrals were made and of which 1,594 received an assessment.

WGCADA is a charity and limited company run by a Board of Directors/Trustees (chaired by Dr. Haydyn Rees) who meets every six weeks. The Trustees have delegated to the Chief Executive Officer (CEO) [Norman Preddy] the day-to-day management of the Company.

Please see next page for a full summary of the WGCADA management structure.

WEST GLAMORGAN COUNCIL ON ALCOHOL AND DRUG ABUSE LTD – STAFF LIST JUNE 2005

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Area Manager
WGCADA Swansea?

Area Manager
WGCADA Neath Port Talbot?

Area Manager
WGCADA Bridgend?

Area Manager
WGCADA Criminal Justice?

40 St James Crescent
Uplands
Swansea
Registered Office

(Abstinence)

15 Victoria Gardens Neath
37 Commercial Road
Taibach
(Harm Reduction)

30 Victoria Gardens
Neath
(Abstinence)

4 Gaylard Buildings Court Road, Bridgend

(Abstinence & Harm Reduction)

DRR 3 Walters Road Swansea
Arrest Referral
SPARC, HMP Swansea
Carat Teams at
HMP's Swansea Parc
Cardiff Usk & Prescoed
DtoC, DIP & Cardiff
Probation

2.4.1. Swansea

The Swansea office at 40 St. James Crescent offers primarily a 12-step abstinence based service. Clients have the opportunity to enter a two phase Pre-treatment programme, which enables the client to start leading an alcohol and drug-free existence. Primary Treatment is based on the 12-step Minnesota Model, in combination with Reality Therapy. It consists of a full-day's programme one day a week and on average takes seven to eight months to complete. Active participation throughout treatment is expected in self-help groups such as AA and NA.

The Swansea office also offers harm reduction services (e.g. substitute prescribing) in collaboration with the statutory sector Community Drug and Alcohol Team (CDAT). The DOMINO (Development of Motivation In New Outlooks) project involves a range of activities that clients can engage in, e.g. allotments, cookery classes, walks, IT classes, music lessons, and camping. DOMINO, designed to develop and promote greater awareness of life without chemical dependency, involves any client who has been assessed. Thus, it is possible for a chaotic daily drinker to manage to stop drinking for a few hours during DOMINO and communicate with a client in Primary Treatment who has achieved sobriety over many months.

The Swansea office also offers a service for family members of people with a substance use problem, as well as a range of other specialist workers (e.g. Community Support, Arrest Referral, Home Detox).

A new office was purchased at 10 St. James Crescent and the CEO, Swansea Manager, and other staff - training, personnel, finance and administration - has recently moved to this location. WGCADA has recently been awarded the contract for the Drug Rehabilitation and Resettlement Order (DRRO) – formerly the Drug Treatment and Testing Order (DTTO) – and have purchased a building on Walter Road from which they will operate this programme.

2.4.2. Neath Port Talbot

WGCADA operates two offices in Neath, one which is abstinence based (No. 30 Victoria Gardens) and the other a harm reduction service (No. 15 Victoria Gardens), as well as a harm reduction service in Port Talbot. These three agencies work well together, showing that staff can embrace different philosophies and ensure that clients get a good choice of service, and one that that best suits their needs and provides quality.

In No. 30, clients have access to a Pre-treatment programme and Primary Treatment. The two harm reduction agencies provide a wide range of services, including one-to-one sessions, needle syringe exchange, substitute prescribing and outreach work. There is an arrest referral scheme, and a range of specialist workers in Neath Port Talbot (e.g. Young Person's worker, Tenancy Support worker, Women & Family worker, Domestic Violence worker, Older/Disabled Person's worker).

A number of activities and programmes operate in the area including: six week parenting group, relapse prevention group, and various DOMINO activities such as cookery classes, IT skills, keep fit, walks and trips.

WGCADA collaborates with the CDAT in Neath to operate a triage assessment scheme known as SMART [Substance Misuse Assessment and Referral Team].

2.4.3. Bridgend

WGCADA in Bridgend operates both an abstinence-based and a harm reduction service out of the same building (the only WGCADA branch that does this). In addition, it operates outreach services in four communities around Bridgend.

WGCADA and the local CDAT operate a collaborative triage assessment scheme known as RAP [Rapid Access Point]. A range of harm reduction services are provided including one-to-one sessions, needle syringe exchange, substitute prescribing and outreach work. There is an arrest referral worker, YOT project worker, and a young person's worker. The DOMINO scheme in Bridgend ceased due to a lack of continued funding support.

2.4.4. Criminal Justice

WGCADA provides a range of services in the criminal justice system - Arrest Referral, Care Assessment Referral Advice and Throughcare (CARAT), Swansea Prison Addition Rehabilitation Centre (SPARC), Drug Rehabilitation Requirements (DRRs), Domestic Violence and Youth Offending Team (YOT) workers – employing over 20 workers. Drug Interventions Programme (DIP) funding has just been awarded to WGCADA to operate in Bridgend, Neath and Port Talbot.

The **Arrest Referral** initiative gives an opportunity for individuals to access treatment within the criminal justice system after the initial point of arrest. It is a working partnership between the Police and WGCADA, which currently employs five workers based in the three geographical areas of operation.

Care Assessment Referral Advice and Throughcare (CARAT) is a programme, which is provided by the prison service. WGCADA are the CARAT providers in four HM prisons, namely Swansea, Parc (Bridgend), Cardiff and Prescoed.

The **Drug Rehabilitation Requirements (DRR),** formerly the Drug Treatment Testing Orders (DTTO), is one of the highest community based penalties for individuals with substance misuse problems. WGCADA have successfully bid for and won the contract for the Swansea and Neath Port Talbot area (58 orders). This probation order consists of a high intervention treatment programme within the community, involving a range of activities for service users. The DRR can place an individual on either a 15-hour or 8-hour a week intervention with the treatment provider and probation.

WGCADA has specialist drugs workers in **Youth Offending Teams (YOTs)** in the areas of Bridgend, Neath and Port Talbot.

Within the Neath Port Talbot area, WGCADA has an additional service that is available for individuals who have been subject to **domestic violence**. This service is provided by a specialist worker.

The **Swansea Prison Addition Rehabilitation Centre (SPARC)** is a partnership between WGCADA and HMP Swansea. The accredited programme provided in HMP Swansea is delivered over approximately 28 weeks. It comprises: a 4-weeks Pre-treatment phase; a 12- weeks Core Treatment phase which is the 12-step programme; a 12-week Aftercare Phase, which develops support systems for individuals after the initial treatment phase. The two WGCADA staff members within HMP Swansea are supported by prison employees and probation staff.

3. The central programme

3.1. Nature of client and their problem

A total of 2,866 people were referred to WGCADA (all centres) during the period April 1st 2004 – March 30th 2005. These referrals comprised 66.3% males and 33.7% females. There was a wide range of ages, with 2.6% being under 16 years old and 12.7% being 50 years and older.

The people who were referred to WGCADA generally had a problem with alcohol, illicit drugs, prescription drugs or solvents. A small proportion (7.0%) did not have a substance misuse problem; they were family members of people with a substance use problem.

Of the 1841 referrals for which the **main substance of misuse** was known, alcohol was the main problem in 61.8% of instances and illicit drugs in 38.2% of cases. It is important to note these relative percentages, since the vast majority of Government funding is provided for treatment of people with a drug problem compared to those with an alcohol problem.

For illicit drugs, the **main problem drugs** for referrals were heroin (43.5% of illicit drug users), amphetamine (20.2%), cannabis (19.2%), diazepam (3.4%), cocaine (2.4%), crack cocaine (2.4%), subutex (2.1%), methadone (1.8%) and ecstasy (1.3%). If one considered the number of people whose main problem was heroin, these represented 15.5% of all referrals to the agency. For people with heroin as their main problem drug, 52.3% smoked the drug, 36.3% were intravenous users, and 11.4% used the drug orally.

For referrals aged under 20, 35.1% had alcohol as their main problem substance, 25.1% cannabis and 22.3% heroin. These proportions changed to 44.8%, 10.4% and 27.5%, respectively, for people aged 20-29 years.

Of people who were referred into WGCADA, 60.3% had not previously been referred to the agency, 23.4% had been referred once, 8.7% twice and 7.6% three or more times.

Of the 2,866 people who were referred to WGCADA, 1594 (59.3%) attended an assessment (66% males, 34% females).

3.2. Referral pathways

People with a substance misuse problem enter into treatment in a variety of ways. They may refer themselves, realising they have a problem for which they need help, or they may be convinced or "pressurised" into visiting an agency by family and friends. They may be referred by their GP or by other health services, or by social services or a housing organisation. They may be referred by some component of the criminal justice system; in some cases this may be a "forced choice" (coercion), with imprisonment being the alternative to attending treatment.

It is essential that treatment agencies establish good relationships with potential referral sources, and also look at every opportunity for bringing people into the service. The latter is particularly important for drawing in the so-called "hard-to-reach", those people who have substance use problems but are not in contact with mainstream services in the community. Of course, it is also essential that treatment agencies provide a high quality service and the right sort of environment for clients. The positive experiences of clients are communicated to referral agencies and to potential clients.

WGCADA have been extremely good at developing strong, mutually trusting collaborative partnerships with other agencies in the community, greatly facilitating the referral process. We hope not only to illustrate this in forthcoming sections of the profile, but also demonstrate how a high quality service attracts more and more clients.

The main referral sources to WGACDA contribute in the following way: health system (31.1%): self-referrals (30.3%); criminal justice system (20.4%); other agencies (6.5%); family or friend (5.3%); social services (3.6%); inter-agency [across WGCADA] (2.8%).

The main referral points within the heath service (total 781 referrals) were Bridgend RAP (230), Neath Port Talbot SMART (186), CDATs (123, of which 94 were from Swansea), GPs (110), psychiatric hospitals/services (58), general hospitals (47) and community mental health teams (13). Criminal Justice System referrals (total 514) comprised those from Probation (266), Arrest Referral schemes (166), CARAT programmes (57) and YOTs (25).

The main referrals coming from other sources were housing/housing associations (35), other voluntary organisations (28), fellowships [AA, NA, etc] (18), Swansea Drug Project (17), Tenancy Support Unit (17), job centre (10) and schools (10).

3.3. Assessment

3.3.1. Background

When clients first attend a treatment agency, they are assessed to determine the nature and extent of their problem in order to help the practitioner plan treatment goals and strategies with the client. A variety of different forms of information are collected, only some of which relate to past drug use or drinking, since the client's problem must be treated holistically. This information can include:

- current and past use of different drugs (including form of intake, e.g. injecting) and drinking levels; dependence symptoms, withdrawal symptoms.
- periods of abstinence; past treatment, nature of services provided, what happened?
- lifestyle and social stability (e.g. accommodation, vocational and financial background, interests and hobbies, sexual problems or sexual abuse).
- family background and social support (e.g. where living, family history of substance use problems, do significant others drink or use drugs?, dependent children, marital distress, domestic violence).
- physical health problems (may require details from medical check up), ranging from liver function, blood pressure, cholesterol levels, nutrition status, viral infections such as hepatitis B and C, HIV, damage to veins, etc.
- psychiatric and mood disturbances (e.g. symptoms of psychosis, depression, anxiety, panic disorder), with decision to be made whether the problems are the result of the substance use problem or were present earlier.

On the basis of information collected during assessment, decisions must be made on the most appropriate help to offer, in what order and who should be responsible for providing it (either within and outside the agency). These decisions should depend on negotiations with the client and other agencies.

The assessment of clients serves a number of important purposes other than providing information for the development of a treatment plan:

- It provides the chance for practitioners and clients to build a rapport. As the client observes the practitioner's empathy and courtesy, he will be less likely to take a defensive view about his drug use or drinking.
- It enables the practitioner to give feedback that will help the client to develop an alternative view of his situation.
- It allows the practitioner the opportunity to describe the approaches that can be used to help the client, and outline the philosophy or rationale underlying these approaches.

Assessment should not normally be a one-off event, but should be ongoing during the course of treatment so that practitioner and client can monitor progress towards treatment goals.

Assessment also includes a risk assessment. Risks are assessed for the client, the client's family (particularly dependent children), the practitioner and other professionals, and the wider public. Once risks have been assessed, action needs to be taken to reduce the likelihood of harm occurring.

> "Taking a history should not be a matter only of obtaining facts to be written down in case-notes. It is an interaction between two people and ought to be as meaningful as possible for the person who answers the questions as for the questioner. The patient should be invited to use the occasion as a personal opportunity to review his or her past and present, and to make sense of what may previously have been a chaotic array of happenings. There is research evidence which demonstrates the potential power of the initial clinical encounter to change the drinker's attitudes, enhance commitment and clarify goals."
>
> "The Treatment of Drinking Problems" by Edwards, Marshall and Cook (1997)

All clients receive an assessment when they are first referred to WGCADA. In many cases, clients are assessed within the agency, by an abstinence-based, harm reduction, or specialist (e.g. young persons, domestic violence, arrest referral) worker. As will be seen from various sections in this report, whilst the specific approach may vary a little depending on the client seen, the basic principles remain the same. We first describe the assessment process as carried out by a 12-step based counsellor.

Recently, WGCADA has been part of a regional collaborative effort amongst agencies and commissioners to set in place initial assessment processes that allow determination of the service (e.g. abstinence, harm reduction, DOMINO, CDAT) to which clients should first be referred. We describe one of these processes, SMART (Substance Misuse Assessment and Referral Team), that operates in Neath and Port Talbot. This latter approach has been designed to help better match clients to the available treatment options.

3.3.2. Assessment by a 12-step based counsellor

The primary basis for a person's entry into a 12-step programme is clinical evidence of dependence – the loss of the person's ability to effectively control their use of one or more mood altering substances. In particular, three symptoms in relation to such substances need to be evaluated:

- **Tolerance:** refers to the condition in which the mood altering effects of a substance are reduced with continued use. As a result, person must consume more of a

substance, or a more potent form of the substance, or a different substance, in order to achieve the same mood swing.

- **Loss of control:** The alcoholic or addict cannot reliably predict how much of a substance they will use, will not be able to reliably stop once they have started drinking or using, and/or will tend to substitute or combine substances in order to stay drunk or high.

- **Continued use despite negative consequences:** Chronic substance misuse leads inevitably to progressively severe negative consequences in a variety of critical areas, including the alcoholic or addicts' physical, emotional, social, vocational, and spiritual well-being.

We talked about the process of assessment with Fred Tuohy, Senior Counsellor in Swansea WGCADA. He pointed out that assessments play a number of key roles, including helping the client assess their level of drug and/or alcohol involvement, introducing the client to the agency's view of alcoholism and addiction, and engaging the client's willingness to participate actively in the programmes offered by WGCADA.

Fred emphasised that although the initial assessment involves obtaining as much information about the client's drug use and/or drinking and numerous other aspects of their lives, it is also important in that, for the client, it will form their views of the agency and the staff, which may remain with them for a long time. A critical aspect of successful recovery is engaging the client and providing them with the means to put trust and faith in the services available to them.

> "The assessment interview is not just about getting all the information down It's the most important, as it's the first interview that someone has with any of us here. If the client has it in their head that this guy knows what he's talking about then it will help."

Bridgend Senior Counsellor Steve Lewis also emphasised the importance of the assessment for engaging the client.

> "It is absolutely essential that the assessment is done to the best of your ability at that time. You might lose the person at that point – it has taken tremendous courage for someone to approach the service."

The initial aims of an assessment are for the client and staff member to become acquainted, to obtain an initial impression of how the client is feeling, to explain an outline of the agenda, and to explain confidentiality. Fred emphasised the importance of clarifying confidentiality, as this leaves the client more at ease in disclosing the nature of their drug use.

> "The first thing that I talk about in an assessment is confidentiality. I don't leave it until half way through, I do it straight away. And I always invite the client to ask any questions they want."

Fred pointed out that during the initial assessment, the staff member must determine any previous treatment that the client has encountered, as well as their drug and alcohol history. Assessments of tolerance and of loss of control are also vital aspects of assessment, which aid the staff member in their diagnosis and development of treatment plans. One tool that is commonly used at WGCADA is the Jellinek chart. Fred believes that the chart can be

"crucial in engaging clients and helping them to realise that they have a problem" as it brings to light the negative consequences of alcohol/drug use.

Fred emphasised the importance of instilling belief in the client that they can work through their addiction. Many of the clients who present at WGCADA have lost faith in their ability to successfully achieve their goals and, thus, it is important that the staff build up the client's self-esteem as rapidly as possible.

> "It's thoroughly important to put across a robust approach, and to let them know that we do have a way out if they have a problem. And that we are used to getting people into recovery. Those who are working here have to make sure that it is seen that recovery is an enjoyable thing, it's not white-knuckling it."

For staff conducting assessments, one of their main goals is determining to where the client should be referred. If the staff member is satisfied that the client has crossed the line into addiction, the normal course of events would be to refer the client to Pre-treatment, from which the client may eventually move into Primary Treatment. If the assessment is completed accurately, then the staff member should be able to detect where the client lies on the spectrum of drug use. Fred believes that "this is where the skill comes into it".

Fred emphasised the point that clients must be offered choices and that they shouldn't be coerced into treatment. If the client wants to continue using alcohol/drugs, then staff are able to suggest different routes for them to take, such as reducing their drug intake and accessing harm reduction services. However, the staff can also emphasise that addiction is progressive and that the services for them to recover from their addiction are available to them.

Among the options discussed during assessment are AA and NA (see Section 3.8.). The client must realise that there are a number of things that they can do for themselves between their assessment and their entry into treatment. Clients are encouraged to go to as many AA/NA meetings as they can after assessment. Fred proposed that there is an important social element in attending meetings which can help to build a support network that can help throughout the recovery process.

> "When people stop using or drinking then there is a huge void, so I always encourage clients to go to as many meetings as possible."

Fred emphasised that assessments continue throughout the whole time that the client is in treatment, so that their progress towards their treatment goals can be monitored, and any new problems that may have arisen can be addressed and incorporated into the aims of the program. Assessments are also necessary in determining whether a client is ready to move to the next phase of treatment.

3.3.3. SMART Assessment

Meurig Davies is the co-ordinator of the SMART (Substance Misuse Assessment and Referral Team) team that operates in WGCADA. He works alongside Paul Raymond (SMART worker) and Helen Lewis (SMART Administrator), who are both funded by WGCADA. Meurig believes,

> "WGCADA's strongest point is its acceptance of people, and the fact that it has build up such a strong network in the communities."

SMART was developed two years ago as a result of a funding allocation from the Health Inequalities, a branch of the Local Health Board. The partnership in Neath and Port Talbot was set up between the Local Health Board, WGCADA, local CDAT, GPs and PSALT (Primary Care Substance Abuse Liaison Team), and is loosely defined as a process of triage into treatment.

It was initiated to provide local agencies offering drug and alcohol services with an independent assessment and referral service. SMART aims to ensure that individuals are best matched with the most appropriate form of service or treatment for their specific problems. In so doing, it also aims to try and unblock the clogging of treatment services in certain localities, which can be exacerbated by inappropriate referrals. Such referrals may also be seen as 'setting the client up to fail' and can ultimately endanger individual's engagement in treatment. Lastly, SMART also seeks to reduce the number of 'wasted treatment spaces' through the mis-matching of clients to treatment options.

Each client referred to WGCADA (Neath and Port Talbot) should therefore, receive a SMART assessment conducted by Meurig. From this initial assessment, Meurig seeks to match the individual to the best treatment service for their needs - either within WGCADA (e.g. abstinence, harm reduction, DOMINO) or to other services in the local area if this best suits the client.

Meurig concedes that the system is not flawless, and that in reality he does not assess every single client. On the whole, however, he has found that the service has fitted well into the daily running of WGCADA Neath and often facilitates the best placement of clients. This is highlighted by attitudinal changes towards SMART in some staff. Meurig explains that there was initial suspicion from some staff regarding the need for and potential effectiveness of SMART, which over time has diminished as staff have witnessed the value of such a process.

Although WGCADA also maintains its own assessment tools, mutual questions have been identified which can in turn be omitted from the standard WGCADA tool. This information sharing helps to reduce the time staff spend on assessment, as there is no point 'reinventing the wheel'. It has also become clear that the SMART assessment provides additional information, which can be fed into treatment plans.

Meurig sees his role as providing information and signposting, based upon the needs and wants expressed by the client. This process also helps clients to feel that they have a level of involvement over their own treatment options; it immediately involves them in the decision-making process. Meurig described how this involvement in the treatment plan has been well received by clients, and that he has been surprised by the number of referrals he has sent to the abstinence programme in Neath. He believes that WGCADA is actively offering clients real choice and a range of treatment philosophies and practices to best help them.

Although the SMART process is in its relatively early stages, Meurig is happy with its initial development and its value to WGCADA. However, SMART can only operate within the services that are available and he has found that there is a real lack of in-patient detoxes available in the locality. He emphasises the need for there to be places available for the SMART team to refer clients.

> "I think that SMART does work. The problem (occurs) when you have an assessment service, but there is nowhere to refer people to. This could be because the services are so saturated already."

Meurig also described how there is a need for more consistency in the allocation of funds. His post is not permanent, and he finds that the uncertainty of the post can hinder its successful development. Confusion and disruption can be caused, which will disturb any long-term benefits that could be achieved.

> "… Nothing is guaranteed long-term, and it makes the job very difficult and frustrating."

3.3.4. Final comments

In summary, assessment is a necessary tool for obtaining vital information about the client's substance use and resulting problems, their lifestyle, and future aims. The client is informed about the services they can access to help them with their problems. It is important that the client leaves their first assessment feeling confident about the service and staff. In some cases, the client may leave with a greater belief in themselves and in their ability to be able to change their substance-using behaviour. In other cases, they may have realised for the first time that help can be provided – and someone is willing to help them overcome their problems. The initial assessment plays an imperative role in engaging the client, thus increasing the likelihood that they will initiate and remain in treatment.

3.4. Pre-treatment

The Pre-treatment programme, started in 1997, was introduced in order to reduce the waiting list for Primary Treatment, as well as to facilitate the transition between using/drinking and abstinence. Staff at WGCADA recognised that many clients who dropped out early on in Primary Treatment might be helped if there was some form of programme prior to the person having to meet the demands of treatment, i.e. the needs for abstinence, avoidance of places where alcohol is available (wet places), and the attendance of a large number of AA/NA meetings.

A Monday group was formed between 09.30 and 11.00 where clients could watch a film and listen to a talk by one of the counsellors. This gave clients a gentle introduction to recovery, as well as a form of focus. Clients who joined in this programme stayed in Primary Treatment longer on average than clients had done previously, and WGCADA therefore made the decision to structure the programme in a more formal manner.

Lawrence Mylan was a client in the first Monday Pre-treatment group. He went through Primary Treatment and then acted as a volunteer. When funding was obtained by WGCADA, he became the first Pre-treatment Worker, working alongside Shirley Jones who acted as the Pre-treatment Counsellor. Shirley later left to head the first WGCADA office in Neath, and Lawrence took over running the Swansea Pre-treatment programme himself. In 2000, the Pre-treatment programme was broken up into two phases. Clients can still use drugs or drink during Phase 1, but have to be abstinent in Phase 2.

> "I'm very fortunate to get a job in a field that I believe in. It's a way of life… it's not a job; it's a way of life. I've worked the 12-step programme, now I can teach the 12-step programme."

3.4.1. Phase 1 Pre-treatment

Phase 1 Pre-treatment lasts from 09.30 – 11.30 on a Monday morning. During the first half-hour, the register is taken and clients can network with each other. The programme lasts 11 weeks and involves lectures, films and group discussion.

The once weekly 20-minute long lectures cover a wide variety of aspects about drug and alcohol misuse (see Table below).

Pre-Treatment Phase 1 Programme	
Week One	An introduction to the agency
Week Two	Alcohol use and abuse
Week Three	Drugs awareness
Week Four	The disease concept
Week Five	The progression of the illness
Week Six	The physical effects of alcohol addiction
Week Seven	The physical effects of marijuana addiction
Week Eight	Blocks to recovery
Week Nine	Health awareness
Week Ten	The effects on the family
Week Eleven	Step one

Lawrence believes the education programme is important as it helps people understand about drugs and alcohol, as well as the processes involved in treatment.

> "You get a lot of people who, for whatever reason, are scared to stop … they need to stop, they want to stop, but they are just scared. We gently introduce them to the idea [of abstinence or harm reduction], 'You can do this, and it isn't going to be as painful as you think it is.'"

The first lecture introduces clients to the agency, explaining what goes on and who does what. Most clients have little idea what treatment is and the diverse range of activities that go on at WGCADA. Lawrence might explain, for example, that one of the workers can help clients with their debt problems. There is an emphasis on the importance of telling clients that they have choices, and showing them the various choices or options.

> "The other reason it is called the education programme is that we are educating clients that they have got choices."

Clients learn about the disease model of addiction, and the need for abstinence. If a person does not want to stop, or feels unable to stop drinking or using, the lectures provide them with information about the harm that drugs and alcohol cause and encourages them and shows them how to minimise this harm. The lectures are therefore a form of harm reduction.

Some of the lectures also contain interactive elements. For example, clients write down their 'blocks to recovery' and these are discussed – Lawrence illustrates to them how many different words can be used to describe the same block. The interactive elements of the Pre-treatment programme are essential – if clients are not participating, then nothing is happening for them that will facilitate behavioural change

The number of clients attending Pre-treatment varies between 14 and 18 – the Swansea agency cannot cater for larger numbers. Given the demand for treatment and the success WGCADA has in getting people referred to the agency, this means that there is always a waiting list for Pre-treatment. At present, the waiting list is about ten weeks long.

If clients have not made their mind up about whether they want to proceed down the abstinence path, they are advised they need to go away and think about it. They are encouraged to engage in DOMINO, if they are not already attending. They are reminded

about AA and NA, and that they must be abstinent from substances if they wish to proceed to Phase 2 of Pre-treatment.

Some clients make the transition to Phase 2, a proportion of whom do this after being referred on to the detox programme (Section 3.10.). Other clients leave the agency at this stage, although some return at a later stage of their drug using or drinking careers, whilst others are referred to other agencies as appropriate. Some clients have to attend Phase 1 Pre-treatment as part of a probation order or court order.

3.4.2. Phase 2 Pre-treatment

Phase 2 Pre-treatment, which lasts eight weeks, is the clients' first introduction into an abstinence programme. Clients can enter this programme if they have stopped using or drinking, and if a space is available. They do not have to have attended Phase 1, as long as they are deemed to be ready for Phase 2. The group comprises up to eight clients.

Pre-Treatment Phase 2 first looks at Step One of the 12-Step Minnesota model.

> "We admitted we are powerless over alcohol – that our lives have become unmanageable."

It primarily encourages clients to look at their substance misuse and examine how it has affected all areas of their lives. Clients are asked to attend group therapy sessions (lasting 90 minutes) and one-to-one sessions (lasting 30-45 minutes), both on a weekly basis. Clients are expected to attend a minimum of two AA or NA meetings a week.

Clients are also required to provide written work on Step One, which is used in both group sessions and one-to-one counselling sessions. Help is given to any client with literacy problems. Clients take turns at presenting their written work in group sessions. This written work is also discussed in the one-to-one sessions, and then retained in a personal file of all the client's work.

Pre-Treatment Phase 2 Programme	
Week One	Understanding powerlessness
Week Two	A look at how our bodies react to chemicals. Physical powerlessness.
Week Three	A look at how we think about chemicals. Physical powerlessness.
Week Four	Addiction and recovery. A look at the Jellinek chart.
Week Five	Barriers to powerlessness.
Week Six	Acceptance and moving forward.
Week Seven	Social unmanageability
Week Eight	Personal unmanageability

During Phase 2, clients are encouraged to promote positive change within their lives and for many, this is the stepping stone into Primary Treatment. This stage may help to reduce the time that clients spend in Primary Treatment, as they have, through Phase 2, developed an understanding of Step One.

Clients have to sign a contract prior to joining Phase 2, which states that they will remain abstinent, avoid wet places (e.g. pubs, licensed restaurants, the homes of drug users), and attend at least two AA/NA meetings a week.

If they are found out to have been drinking alcohol or taking drugs, clients are given a therapeutic discharge. This is not a punishment as such, but rather a time (usually six weeks) that a client can use to reflect. WGCADA, like other treatment agencies, has long

waiting lists, and if clients are not ready for abstinence then others should be given a chance. Clients are told they must remain abstinent and abide by the rules and regulations of the programme during the therapeutic discharge.

After the discharge is completed, clients return to complete the programme. However, if they drink or use again, or disobey the regulations, they may receive a 90 day therapeutic discharge and wit further flouting of rules they are generally discharged indefinitely.

Phase 2 prepares clients for Primary Treatment in several ways. It gets them used to:

- a group environment
- discussing personal problems within a group structure
- preparing pieces of written work and reading this material out
- working in a one-to-one environment
- confidentiality.

As in Phase 1, Lawrence helps to build up client's self esteem. He emphasises to clients that they have shown a good deal of courage just coming to WGCADA. He also believes that one of his main jobs is to motivate people.

> "I'm always trying to motivate clients to believe that they can live a life without alcohol and drugs. A good life and a healthier life, medically, physically, mentally…"

Lawrence also considers it essential that he gets clients to understand that their drug and/or alcohol use problem is their own responsibility – they often will not admit that. He tries to stop them from running away from themselves, and accept that they must bring about the necessary change.

> "Only they can change – they can't change their wives, they're powerless. They can't change their kids - they're powerless over them too. But they're not powerless over themselves."

Lawrence's therapeutic strategy is eclectic in that he uses a variety of therapeutic approaches, as needed. But at the end of the day, change must come from within the client.

Lawrence believes that everyone has got a gift. He helps the client tap into this gift and nurture it. He tells clients that they have a gift.

> "They are special people – they are special the moment they walk through that door. I see a person full of desperation, disillusioned, '… but you've got courage. And if you've got courage we can work on that – we can work on your self-worth. I can help you to help yourself. I cannot do it for you, but I certainly can help you help yourself.'"

Lawrence finished,

> "I'm very privileged in a way. I am the first counsellor that many of these people have come into contact with. … But there is a lot of responsibility on my shoulders though… if I gave a bad impression to these clients, they are not going to come back."

3.5. Primary Treatment

The Primary Treatment programme at WGCADA is an abstinence-based model of treating chemical dependency, using key principles of AA and the 12-step Minnesota model (see Section 2.2.) The treatment is also based on the disease concept and on the belief that the illness is physical, mental and spiritual. The goal of treatment is recovery of the whole person from addiction, and it involves an holistic approach. Clients undergo considerable self-examination during the treatment process.

> "The Minnesota Model is the most rigorous form of self examination in the world, and this plays a major role in its success in addiction treatment."
>
> Fred Tuohy

Primary Treatment takes the client through the first five steps of AA by means of a structured group programme with group therapy sessions (one day per week), one-to-one counselling (one hour session per week), and written assignments. Clients must be abstaining from alcohol and illicit drugs prior to entering the programme. Treatment takes anywhere between six and twelve months, with seven to eight months being the average. A Primary Treatment group comprises a maximum of eight clients, who are expected to stick together and provide support for one another. Clients are expected to attend three AA or NA sessions per week during Primary Treatment.

Once a client is thought to be ready to enter Primary Treatment they have a one-to-one assessment with a counsellor. During this assessment, the phases of treatment, relapse prevention methods and treatment tools which prepare clients for group work are described.

The client is then given a document outlining what occurs in Primary Treatment and any other practical issues are addressed. Fred believes that rather than trying to shape the clients' opinions prior to their entering Primary Treatment, it is best to encourage them to "go with the flow" and make their own judgements.

During a typical group therapy day, clients have a lecture or a presentation at 09.30, followed by a break during which they are expected to talk to, and challenge, one another. They then have a group session, which does not last any longer than an hour and a half – due to the intensity of the sessions. After lunch, clients have another group session followed by a chill-out period when they can relax. The day ends with the clients completing forms about what has happened to them over the day, and how it has affected them. These responses can help staff monitor the progress that a client is making, as well as to observe any new developments that may arise in the client's case.

The Primary Treatment programme comprises five phases of treatment, corresponding to the five steps of AA. Phase 1 deals with denial – the difficulty in facing and accepting the loss of one's control over using or drinking, as well as the necessity of giving it up for good.

Clients do a good deal of written work exploring powerlessness, the damage to others caused by their using and/or drinking, and their poor ability to handle feelings. In addition, clients write a detailed life story which is read out to their peers in group and evaluated by them. This is followed by an in-depth Life Story Analysis.

After this and before embarking on Phase 2, clients complete additional assignments - which may focus on emotional immaturity, self-esteem, communication, anger, controlling behaviour, etc - depending on their individual needs as assessed by their counsellor.

FIRST FIVE STEPS

1) We admitted we are powerless over alcohol – that our lives had become unmanageable.
2) Came to believe that a Power greater than ourselves could restore us to sanity.
3) Made a decision to turn our will and our lives over to the care of God as we understood him.
4) Made a searching and fearless moral inventory of ourselves.
5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Whilst the treatment programme has a structured framework, each client has arranged for him/her an individual treatment plan. The model of treatment is flexible and innovative, and any special needs of the client are catered for as much as possible. The whole process of treatment educates the client to self-evaluate his/her actions so as to be "happy, joyous and free".

> "I have noticed that happy people are constantly evaluating themselves and unhappy people are constantly evaluating others."
>
> Dr William Glasser, psychiatrist and founder of Reality Therapy

On completion of Primary Treatment, clients are expected to enter WGCADA's Aftercare Programme which consists of monthly group sessions, together with monthly one-to-one counselling sessions. Clients work through Steps 6 - 12 of AA and early recovery issues which may arise, e.g. family and work issues, spiritual matters, intensity of feelings or inability to handle feelings, childhood issues, other "dependencies" (e.g. eating disorders), etc. Clients are expected to continue with self-help groups such as AA and NA for the remainder of their lives.

The WGCADA philosophy is that the client has to be prepared to undergo a profound change in personality in order to stay clean and sober. Right from the very beginning of Primary Treatment, the focus is on change. A number of the counsellors in WGCADA believe that group therapy is where "the real changes take place". The idea of group therapy is to encourage clients to voice their thoughts and experiences, and to receive constructive judgements and views from other clients and the facilitator.

> "I believe that group is the biggest creator of change in the whole recovery process. It works because they [the clients] are not looking at the world through their own pair of glasses, but are being asked to put on someone else's pair of glasses and look through theirs"

> "Group therapy is a vehicle of change. It produces the most dynamic changes. It's no good just stopping drinking/using. There has to be a massive psychic upheaval. You have to change. That is the key. You have to change."
>
> Fred

It is also important that clients attend AA meetings, as this provides them with further group interaction, even though it is not as in-depth and intensive as the group therapy

"The Twelve-Step Facilitation Handbook" by Joseph Nowinski and Stuart Baker describes a series of specific objectives for 12-treatment programmes which are useful to consider in relation to the approach adopted by WGCADA. These objectives concern cognitive, emotional, relationships, behavioural, social and spiritual domains.

Cognitive:

- Clients need to understand some of the ways in which their thinking has been affected by alcoholism and addiction. For example, drinking and using often lead to rationalising and lying, to ones self as much as to others.
- Clients need to understand how their thinking may reflect denial (or "stinking thinking") and how their own rationalisations can contribute to continued drinking or using despite negative consequences.
- Clients need to see the connection between their substance abuse and the negative consequences that result from it. These consequences may be physical, social, legal, psychological, financial and spiritual. Many alcoholics and addicts are inclined to resist making causal attributions concerning their drinking or using.

Emotional:

- Clients need to understand the AA/NA view of emotions and how certain emotional states (like anger, resentment, loneliness and shame) can lead to drinking and using.
- Clients need to be informed about some of the practical ways that AA and NA suggest for dealing with emotions so as to minimise the risks of drinking and using.

Relationships:

- Clients need to understand that alcoholism and addiction constitute "relationships" with mood-altering substances that eventually take precedence over relationships with people, such as friendships, family ties and intimacies.

- Clients need to see that they systematically encourage the significant others in their lives to "enable" their own alcohol or drug use by helping them obtain alcohol or drugs, and/or by helping them avoid or minimise the negative consequences of their drinking or using.

Behavioural:

- Clients need to understand how their powerful and cunning illness has affected their whole lives, and how many of their existing or old habits support their continued drinking or using.

- Clients need to turn to the fellowship of NA/AA and make use of the resources of those fellowships in order to change their addictive habits.
- Clients need to get active in AA/NA as a means of sustaining their sobriety.

Social:

- Clients need to attend and participate regularly in AA/NA meetings of various kinds, as well as in AA/NA sponsored social activities.
- Clients need to obtain and develop a relationship with an AA sponsor.
- Clients need to access AA/NA whenever they experience the urge to drink or use, or have had a slip (relapse), no matter how minor.
- Clients need to re-evaluate their relationships with their "enablers" and wit fellow alcoholics and addicts.

Spiritual:

- Clients need to experience hope that they can arrest their alcoholism or addiction.
- Clients need to develop a belief and trust in a power greater than their own willpower.
- Clients need to acknowledge their own character defects, including specific immoral or unethical acts they have committed, and to recognise that they have done harm to others as a result of their alcoholism or addiction.

Clients need to begin to heal their shame and guilt through sharing their moral inventory with another trusted person.

sessions managed by WGCADA. AA also provides the clients with a support network that will aid them through each step of the recovery process.

Steve Lewis and Swansea Senior Counsellor Sheila Roberts emphasised that one of the components of the 12-step programme that makes it so successful is the spirituality aspect. Clients are encouraged to conceptualise a Higher Power in any way they choose, as long as it represents a power greater than their own willpower, which is regarded as insufficient to conquer addiction. Clients may place their hope and faith in this Higher Power for their ability to stay sober.

> "This treatment wouldn't work without the spirituality side of it. You just can't get away from that. That is the thing that really works for people."
>
> Sheila

Clients who enter Primary Treatment at WGCADA tend to have a wide variety of problems and come "from all walks of life". Although the average man in the street may view an addict very stereotypically, staff at WCGADA recognise, and accommodate for, the fact that each client has their own personal set of wants and needs. In many cases, the client does not just have a problem with one substance, but with a variety of substances. Sometimes, a problem substance is not identified until the client is in treatment. It is also common for clients to present at the agency with eating and gambling disorders as well as a substance use problem, which must be taken into consideration when treating the individual.

Various techniques and models of counselling and facilitating groups are employed. Both Fred and Steve described an eclectic therapeutic approach, with the particular approach being adopted depending on the specific client or group. In many cases, a number of theories will be integrated to produce the most effective results.

The most commonly used mode of counselling in WGCADA is Reality Therapy, which is a form of cognitive behavioural therapy that focuses on the 'here and now'. Reality therapy is a very questioning form of therapy, which can be used in group therapy or in one-to-one counselling sessions. The basis of the therapy is to get the client to evaluate their behaviour for themselves, so that they can learn that they can change for themselves. Most clients initially have the solid belief that they cannot change, so the therapy focuses on moving them on from that mindset to thinking that they can change.

Reality therapy also focuses on helping the client to overcome their denial by challenging their belief systems and their justifications. It seeks to break through the delusion of denial and re-acquaint the client with reality and the need for positive behaviour changes in order to establish a responsible life-style, which is necessary for a good recovery. In this process, rigorous self-honesty is actively encouraged and promoted. This entails looking in depth at character defects (e.g. anger, pride, complacency, self-pity) and members in group therapy are expected to challenge and confront each other and to "level" and self-disclose. Staff at WGCADA have found that Reality Therapy is "highly effective to get people to change."

WGCADA counsellors believe that key to a client's process of change is their honesty, open-mindedness and willingness.

> "Honesty is one of the big things that we look at. Honesty about what they have done and what they are doing, and also self-honesty about how they really feel about things and themselves. One of the main goals of treatment is honesty and open-mindedness"
>
> Fred

Motivational interviewing is also used by counsellors in Primary Treatment. This approach is a directive, client centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. Motivational interviewing can be used by staff to help clients to achieve the desired honesty and open-mindedness.

The WCGADA counsellors also find that using self disclosure can aid them in encouraging the client to open up about their alcohol/drug use, as well as putting faith into the client that the staff member has extensive, and often personal, knowledge of the area.

> "I use quite a bit of self disclosure from time to time which can be a powerful tool. If the client has it in their head that this guy knows what he's talking about, then it will help".
>
> Steve

Steve described personal experiences of meeting clients who had previously been part of his substance-using life when they themselves present for treatment. He believes that when the clients realise that some of the staff members are recovering addicts themselves, then they start to think, "If he can do it, I can do it too". Fred also endorses the importance of clients believing that staff are fully competent in aiding them through recovery.

> "If the client is genuinely seeking help then the first question that he is going to ask himself is does this guy know what he's talking about and secondly can I trust him."
>
> Fred

The Primary Treatment counsellors we spoke to believe that approximately two-thirds of clients entering Primary Treatment in WGCADA complete each stage of treatment and remain clean for five years after. These impressive statistics are a testament to the staff at WCGADA, and their success in implementing their treatment programs.

The counsellors also pointed out that we need to question what we mean by success. Although some clients don't make it all the way through primary treatment, if they have a better quality of life from their truncated treatment, then that should also be classed as success.

The counsellors at WGCADA emphasised the need for more staff to be working in Primary Treatment. Funding shortages have limited the number of Primary Treatment counsellors to two full-time workers in Swansea, one full-time and one-part time worker in Bridgend, and one full-time and four part-time workers in Neath.

A Client's Story

I am writing about an amazing two years in my life. It has truly been a life changing time. Not only have I stopped drinking (and that in itself I would never have believed possible!), but I have really begun to live more fully and have been able to put my life back together again in a very positive way. Throughout this time, I have had great support and help from WGCADA. I can't speak highly enough about the organisation and the staff I have been in contact with…..so please read on……

Starting at the beginning, I came to WGCADA in despair. I had developed a serious drink problem. I never drank alcohol in my youth and only drank socially small amounts until my

early 30's. By the time I was 40 it had become an important part of my life. But it was fast becoming a bigger part of my life than I could deal with. Initially the amounts of alcohol were not great, but it was the regular daily drinking and reliance on the alcohol that should have alerted me to the problem to come. Instead, I just drank more and more, and wine and cider became a way of chilling out, relaxing after a hard day, cheering me up, slowing me down and just about any other excuse going.

Over time, I became well and truly addicted, physically and mentally and I was very frightened. But I would rarely admit to the intense fear. It normally sent me straight to the bottle again and after a calming drink the future always looked easier and the plan to cut down on my drinking seemed much more achievable.

I tried on many occasions to reduce my drinking through my own self discipline and through a structured programme. These plans were short lived and failed and overall the quantities I drank were steadily increasing. My life was a mess, I was off work ill, long term, from a fairly responsible job. As my condition was getting worse, there was not much hope of going back to work. My family relationships were disintegrating and I had also lost all sense of personal value and meaning in life. The future was very bleak.

I knew my only chance was to stop drinking. I had tried many times to quit and know I couldn't do it alone. I was able to organise inpatient detox. After I came out I felt so clean but I knew there was no way I could be capable of staying that way. My lifestyle and all my impulses were too mixed up in alcohol to stay sober for long. I had been to WGCADA while still drinking and desperate for a way forward. Now I was sober was this a resource I could turn too?

And what an amazing resource! Early on in discussions I had to make a fairly fundamental decision. Was my personal programme of recovery going to be about controlled drinking or about abstinence? I knew I really needed to stay clear of alcohol. Knowing myself, I was sure moderate drinking and I were not compatible! That first week as I heard the counsellor speak to me about abstinence, I remember clearly thinking "how can this counsellor and anything he can say ever have the power to stop me drinking again?" I was as determined as I have ever been about anything, but just couldn't imagine a Programme which could change me that much.

We started to look at the 12 Steps of Alcoholics Anonymous which were new to me and to work in more detail with the Minnesota Programme. I found the structure this gave me was so important. Even so there were weeks when I came to see my counsellor and cried my way through the session in despair. Like many people in early sobriety, life is very hard. Not only is there coping without drink, but there is facing up to the chaos your drinking has caused you and others around you. The help WGCADA gave me to feel my despair and to channel it in positive ways was immense. The atmosphere was so supportive and I felt so accepted for being me, a recovering alcoholic.

I began to gradually work through the Programme. I had already discovered that I was not alone. Many staff at WGCADA understood where I was at, they had been there in their own experiences in the past. The staff were wanting for me what I willed for myself, that positive sobriety. There was always someone to speak to if I phoned, on the occasions when life threw me one challenge too much and I needed to hear some sane strong words. And there was always that access to weekly help and advice in my counselling session. This was not soft, easy advice, and there were many times I didn't want to hear those tough words and reminders of what was best for me!

It is easier to learn in an environment of acceptance. I recognised the unmanageability of my life and my need for sanity. I knew I never wanted to be in that despair and hopeless place again. I also knew I had the beginnings of a new life which was exciting, full of self discovery.

Working through Step 3 was a wonderful experience for me. I had a faith and had questioned it and doubted in my dark drinking days. I found that faith in such a new and real way and could fully understand and accept Step 3, which says, "Made a decision to turn our will and lives over to the care of God as we understood Him".

I completed Step 4 and 5 when I had made my moral inventory and had the opportunity to share it. I was then very moved by a Presentation that was made to me in front of the client group and staff. It was in the form of a letter from my counsellor and a medallion. I will always treasure this to remind me of the hard work WGCADA staff and I put in to the early days of my recovery. I now have the opportunity to continue the counselling on a monthly basis as the initial treatment period is over.

As I write this, I am almost 2 years into sobriety and can honestly say that life is so rich and rewarding and this is the result of being able to digest and apply the lessons of the 12 Steps of Alcoholics Anonymous and its application using the Minnesota Programme. I would not be here without the staff of WGCADA and the amazing programme they helped me to understand and apply.

I continue to follow the Programme. I am on a course, which I know I need to maintain and continually progress along, but I am so blessed to have such a strong foundation.

3.6. Harm reduction (or harm minimisation)

In this year's WGCADA Annual Report, the Neath Port Talbot Area Manager Ifor Glyn wrote:

> "It has now been several years since WGCADA started offering Harm Reduction interventions and focus in its agencies. It was a major step, a step some people felt was going to lead to a weakness in its 12-Step based foundation. However, the expansion of treatment options has strengthened the agency, ensuring it appeals and offers more and more choices to people affected by substance misuse.
>
> As an agency, we still strongly believe that abstinence from substances is far healthier and safer to individuals, families and friends, and the wider communities in which we work. However we also recognise that not everybody is at the same stage in his or her drug-taking career and ready for full abstinence. For that reason alone, it is essential that we can offer some intervention, which reduces the harm, associated with substance misuse, stops the spread of blood borne viruses, reduced overdoses- and generally keeps people alive."

3.6.1. Key principles

In the same report, Ifor Glyn described the principles of harm reduction as laid out by the Canadian Centre for Substance Abuse (cf. their web site) – these principles drive service delivery within WGCADA.

- **Is Pragmatic:** and accepts that the use of drugs is a common and enduring feature of human experience. It acknowledges that, while carrying risks, drug use provides the user with benefits that must be taken into account if responses to drug use are to be effective. Harm Reduction recognises that containment and reduction of drug related harm is often a more feasible option than efforts to eliminate drug use entirely.

- **Priorities goals:** Harm reduction responses to drug use incorporate the notion of a hierarchy of goals; with the immediate focus on pro-actively engaging individuals, targeting groups and communities to address their most compelling needs through the provision of accessible and user friendly services. Achieving the most immediate realistic goals is viewed as an essential first step toward risk–free-use or, if appropriate, abstinence.

- **Humanist values:** the drug user's decision to use drugs is accepted as fact. No moral judgement is made either to condemn or support use of drugs. The dignity and rights of drug users are respected, and services endeavour to be user friendly.

- **Focuses on risks and harms:** on the basis that by providing responses that reduce risk, harms can be reduced or avoided. Harm reduction recognises that people's ability to change behaviours is also influenced by the norms held in common drug users, the attitudes and views of the wider community. Harm Reduction interventions may therefore target individuals, communities and wider society.

- **Does not focus on abstinence:** although Harm Reduction supports those who seek to moderate, reduce or cease their misuse of substances: it neither excludes nor presumes a treatment goal of abstinence. The client's goals are supported and encouraged.

- Seeks to maximise the range of intervention options that are available.

3.6.2 Needle exchange (Neath)

Michelle Hermolle is a voluntary needle exchange worker based in Neath No. 15. She explained how she was previously a paid needle exchange worker in WGCADA and has, therefore, seen its development over the last three years. She feels that the fact that she has returned to work voluntarily demonstrates her strong belief in the organisation and the services that are being provided.

Michelle noted how WGCADA has developed bigger and faster than anyone initially imagined, and she has been surprised by what a strong component the harm reduction services have become in WGCADA's overall service provision. She feels that WGCADA deserves a big 'pat on the back' for how well such a different philosophy has been incorporated into the 12-step abstinence core of the organisation, and how well it has been managed.

> "I think that a lot of people have been surprised by how well harm reduction has fitted into WGCADA which was initially an abstinence-based centre."

Michelle described the harm reduction services that are on offer in Neath and how these have been incorporated into WGCADA as a whole.

> "The harm reduction side of WGCADA provides assessments, care planning, referral pathway, interventions, monitoring, medicating, and obviously the one-to-one key working with the people on substitute prescriptions. We also

> work very closely with all agencies involved with the clients. We also deal with relapse prevention and outreach groups."

WGCADA works closely alongside other organisations that a client may be involved with, to create a team-working approach to best benefit the individual. These may include local CDATs (e.g. for prescribing services), social services, probation, mental health teams and housing organisations.

Michelle emphasised the importance of needle exchange services. It is often the first thing that an individual is looking for when they enter the doors.

> "In one sense, all other services stem from needle exchange because it is one of the first things that the clients looking for harm reduction enter into. A lot of people walk through the door to get their needles and they see the other pathways that are available to them. The door opens to other things and they realise that there is help at their level."

Michelle explained that the provision of such a service has a two-fold action. Not only does it have a direct impact on the level of health risk that individuals may be exposing themselves to and, therefore, the risk of the spread of blood-borne viruses (e.g. HIV, Hepatitis) to the individual, local and wider community, but it is also effective in simply engaging drug users into treatment services.

> "It's about keeping people safe. To stop blood-borne viruses. I know originally HIV was the big disease, but it's hepatitis now… For a lot of clients, they would not have ventured into other areas of treatment if they had not first encountered needle exchange."

The individuals who initially access these services are often not looking for other types of support, but accessing the service and coming into contact with WGCADA workers opens up avenues into education and awareness of drug issues and treatment options. It is therefore a good referral point for those who feel that they now want to try and address their using. Michelle sums up the service as being about giving users help on 'their level' and keeping people safe. She demonstrated the effectiveness of the intervention by the high return rates of needles that WGCADA is currently receiving.

Michelle pointed out that some people are unable to commit to the 12-step philosophy, but offering needle exchange under the WGCADA umbrella provides the opportunity for clients to move into this programme when they feel ready. Some people give up using drugs without the support of the Fellowship.

> "Not everyone is capable of committing to abstinence, but people can become abstinent through harm reduction alone. Other clients may start off with harm reduction and then change over to the abstinence programme when they feel ready."

When an individual engages in the service, a client-led care plan is devised through the assessment process. These care plans are regularly discussed in the WGCADA team meetings, and adaptations are made in conjunction with the client. The goals that are made are realistic and appropriate to the position or state of mind that the individual is in at the time. Michelle emphasised that some clients are only capable of small goals, such as a change in their using behaviour (e.g. reducing risky injecting practices, moving from injecting to smoking heroin), or small reductions in the amount of usage. Others will be

ready to make more drastic changes and may, for example, engage in the needle exchange to try and be referred to be scripted, or access a treatment programme.

Although the needle exchange is a highly effective intervention and is working well to date, there are ways in which Michelle feels it could be improved. Perhaps the main problem is that the exchange is simply too busy. The funding only allows for the provision of one worker to cover both Neath and Port Talbot. This, in turn, results in the overstretching of the service available and, therefore, the worker cannot perform as effectively as possible with either agency. The allocation of more funds to allow for a worker in each site could greatly enhance the effectiveness of the service and benefit the clients.

Lastly, Michelle reiterated the feelings of other workers about the need for a dedicated valleys outreach worker. Many valley towns are isolated and lacking in the provision of services, which WGCADA could help to address.

> "We need outreach. We do a certain amount of clinics in the valleys but there are not enough needle exchange programmes. There are a number of people who could benefit from needle exchange if it was available to them. We need more outreach workers."

3.6.3. Outreach and needle exchange services (Bridgend)

John Lowes is a needle exchange outreach worker and Dean Minett a Class A outreach worker based in Bridgend. John is relatively new to WGCADA and has been greatly impressed by the overall enthusiasm and commitment to change people's lives in the agency.

John points out that whilst he is using a harm reduction approach, helping clients to inject properly and reduce the chances of cross infection, he is also working towards abstinence in some cases.

> "Some clients are just happy to continue using but want the support that they are doing everything they need to do to keep it as safe as possible. The goal for me is also to get someone off using drugs if that is what they want…"

One of John's clients has gone all the way – a long-term heroin user now abstinent six months. He is working with his father as an apprentice builder. He continues his one-to-one sessions, proudly informing John as to how well he is doing and receiving the appropriate compliments.

Dean starting setting up the Bridgend outreach clinics in March 2004, providing the opportunity for clients to access the agency on their doorstep rather than have to travel in to Bridgend. There are now four clinics that operate between 15.00-17.00, one day a week, providing a needle exchange scheme, information, advice and counselling. The clinics are attended by at least two members of staff – there are sometimes four.

Dean points out that it took a couple of months for local people to become properly aware of the outreach service. A good deal of promotion was required, but attendance rates are now high. The service in Wildmill initially operated between 10.30 and 13.00 but attendance was low – most clients get up late! Attendance increased greatly once the opening hours were shifted to the afternoon.

Whilst the outreach needle exchange scheme operates on a drop-in basis, clients can book one-to-one sessions with staff. These sessions are always client-led; an individual approach

is taken as everyone has a different problem. Both Dean and John emphasised the need to look at the whole picture of the client's life before deciding the best way forward – the key underlying issues contributing to the substance use problem must be identified.
Dean and John encourage clients to take personal responsibility for their drug-taking methods, to use safe injecting techniques so they don't loose limbs, get gangrene, or become infected. They talk about health issues with the client. During their sessions, they build up a relationship of trust with the clients. They also get glimpses of a client's motivation to change, and act upon this. They use their chances to facilitate behavioural change as they can.

Dean emphasised that he always uses motivational interviewing, since he believes that it is the best way of getting the information he needs, particularly during the first couple of sessions. Once he gets a rapport with the client, the sessions become easy and conversation just flows. Clients often can't wait to tell him, "my problem this week".

> "It could be that they want to stop, but the area that they are in they are not able to stop because every friend they know is using drugs. So it is difficult for them to get away …. The temptation is always going to be there."

Dean and John provide ongoing reassurance to clients, as well as help them gain an understanding of their addictive behaviour. They also provide information about substitute prescribing, relapse prevention techniques and various other matters. In relation to relapse prevention, Dean says to his clients,

> "If you're going out with a bunch of friends and you know that they are users, you don't perceive them as friends. You have to perceive them as a risk area and then you try and work your way around this ..."

John points out that in clients who are significantly reducing or stopping drug intake, he tries to keep them on an even keel, helping them deal with their emotions and psychological problems. He tells them what to expect when they go on to a script. He emphasises that he always gives the clients the options. He does not promote abstinence over harm reduction, or vice versa. He just tells the client what each is all about. At the same time, he is looking for opportunities to help the client "move long" the path to becoming drug-free.

Dean has a caseload of about 40, of which half are on scripts (70% are on subutex). He prefers subutex as a heroin substitute, believing that some clients on methadone want this drug as a safety option. They believe that they can use on top with methadone if they decide they don't want to stop using heroin. This is not the case with subutex – the partial agonist blocks the effects of heroin.

Dean pointed out that most Class A users in Bridgend know each other.

> "One of the difficulties I've had is when you pick up a client who really has had enough, he really wants to change, but he doesn't really get a chance to because of peer pressure…
>
> If there is a gang of six boys and one wants to come off it, the others don't like it. They put on pressure. I've heard this from many places. Sooner or later someone is going to put on pressure, and more often than not it works. It's me [as a drugs worker] versus the rest of people he knows related to drugs.

> "He's facing a new life of isolation – more often than not they don't know anyone who doesn't use drugs. They don't attach themselves to anyone who doesn't use drugs – they group together, because drugs may be cheap or there may be a bit of free gear."

Dean sees these as major challenges, not just in Bridgend but also worldwide. He believes it is a very difficult situation to deal with and that few people break away from heroin-using networks.

Dean emphasises the need to try and convince and show clients that life without drugs is better. It obviously helps clients if they can move away, but how many can afford to do that? Clients need to be helped back into work, providing a new environment away from drugs, as well as a means of increasing their self-esteem. There also need to be more service user and ex-user groups around the country which can provide additional support.

The issue of stigma and prejudice towards heroin users is a big one according to Dean and John. They believe that there needs to be more understanding of heroin use in society. At the end of the day, it is a problem that affects many individuals, families and communities. There needs to be more promotional work telling people what heroin use is about – how it starts, where it leads, its impact, etc. This information also needs to be reaching young people to try and help reduce the number of people who try the drug. When asked what was special about WGCADA, John said,

> "The whole team really, the way the team interact, delegate to each other, friendliness, accessibility, warmth, genuine people. Been here eight weeks, feels as if I have been eight years – in a good way, that is."

He has been struck by clients' willingness to talk and their honesty. He doesn't know whether this is because they are being treated as people rather than being treated as drug users. He believes that they are nice people – "the core of them is really good."

One of the most positive aspects to the job has been the positive feedback he has received from clients about what he is trying to do for them.

3.6.4. Substitute prescribing: a summary

Substitute prescribing of methadone and subutex to heroin users is carried out in collaboration with local CDATs, GPs and pharmacists.

The CDATs in each area provide a Tier 3 prescribing service for clients with complex needs, including pregnant users, chaotic users, and those users with mental health issues. Low threshold prescribing is carried out by GPs operating within a shared care scheme developed through RAP in Bridgend, as well as a partnership between the CDATs and WGCADA in Neath Port Talbot and Swansea. There are some GPs who prescribe substitutes for heroin users independent of WGCADA and its collaborators.

Clients receive their prescriptions via a daily (except weekends) supervised consumption scheme operated from local pharmacists. The prescribing schemes follow clinical governance, and safety of the clients is paramount. Monitoring of clients is carried out by both WGCADA and CDAT workers.

More details about one prescribing scheme are provided in the section below focusing on the Rapid Access Point (RAP) in Bridgend.

3.6.5. Interactions with a CDAT

Kelvin Barlow is the service manager for the CDAT, covering the areas of Bridgend, Neath and Port Talbot. His role involves the management of the nursing, social services and administrative workers, and he also has a co-ordinating role with the medical staff and psychology post in the service. The role essentially incorporates liaising with, and coordinating, staff to ensure that they are all 'singing off the same hymn sheet'. This facilitates the smooth and directed running of the CDAT and, therefore, their effective collaborations with WGCADA.

Kelvin is employed, managed, and therefore accountable, to the National Health Service, and the Mental Health Directorate in particular. As his post is a partnership post, he is also part-funded by the Local Authorities and Local Health Board in the area. Due to the nature of these funding streams, Kelvin's remit not only involves the co-ordination of the CDAT service, but the development of partnerships with other local services, and in particular WGCADA. He is also involved in local strategic development and acts as Chair for the local subgroups of the SMAT (Substance Misuse Action Team), who are involved in planning the co-ordinated development of local treatment provision as a whole.

The CDAT has historically been a purely medical and prescribing service, offering clients the opportunity to access help, advice and prescribing options to deal with their dependencies (predominantly opiate and alcohol), and the associated physical and psychological consequences on their health. During the last five years, the service has developed further and now comprises psychiatric mental health nurses, doctors, key-workers and a full-time psychology post. The allocation of funds for a range of posts has resulted in the CDAT being able to offer a more comprehensive service to a range of clients.

> "Our bread and butter is a tier three prescribing service, and being able to deal with the more complex needs they may have, so say, mental health problems, or pregnant mothers, or physical health problems."

There are also three social workers in Bridgend.

> "… allowing us to provide a more comprehensive service for people with more complex needs, such as the need for residential rehab or child protection issues."

Kelvin described how he has witnessed the development and expansion of WGCADA services into Neath, Port Talbot and Bridgend, as they coincided with the setup and development of the CDAT. He feels that WGCADA has worked hard to deliver the core abstinence services, whilst embracing the value and need for harm reduction options. These developments have facilitated the initiation of joint working between the two agencies.

Kelvin explains that the CDAT has been working informally with WGCADA for some time, both due to necessity, (in order to effectively utilise the available services in the area to provide clients with the best possible treatment options), and also as a result of the goodwill of individual members of staff. This collaboration essentially involved the sharing of clients between front-line staff in each agency and the informal allocation of room space for the CDAT in the WGCADA offices, particularly in Neath.

Although these informal relationships had worked well, Kelvin described how more recent changes in the Welsh strategy in relation to substance misuse have resulted in a directed drive to develop more formal partnership arrangements.

> "… our thinking has gone down the lines of developing integrated services, particularly between the CDAT, WGCADA, Social Services and whoever else is involved in providing local services."

> "Getting people to collaborate on local planning. It's developing!"

Such strategic developments have led to direct funding for the development of partnership posts between WGCADA and the CDAT. This funding has come from the Local Health Board, SMAT and Home Office. These funds have translated into the two full-time WGCADA workers being based in and managed by the CDAT, CDAT staff working out of WGCADA offices in Neath/Port Talbot offering prescribing services, the development of a Community Rehab Co-ordinator post, and the assessment service 'RAP' (Rapid Access Point).

RAP is a Home Office funded initiative from the Recovered Assets Fund – the latter was developed from the assets of crime associated with substance misuse, essentially from drug dealing. RAP was funded for two years to support set-up and salary costs.

> "The badge that came with the funding was essentially for class A drug users, but what we have developed with it is a rapid assessment service providing a comprehensive triage service to be delivered to clients within a short space of time. It is performed by a combination of both CDAT and WGCADA workers and therefore covers both aspects, both the medical and the social. That's the model we work too and there is some health screening in there and onward referral too."

The RAP worker, like in the SMART assessment process in Neath and Port Talbot, aims to assess clients within three to five working days of referral. This initial assessment aims to delineate the needs of each client in relation to their using, general circumstances, and what they want to gain from treatment.

> "Assessment takes an hour and is a fairly basic screening process. Out of that, a care plan that the client is happy with is devised. This may just involve advice, or be a more comprehensive package that may involve being referred to CDAT and/or WGCADA at the same time, and sometimes an emergency detox."

> "It may involve an ad hoc or formal shared care plan, and therefore, joint referrals."

> "Following referral to one or both of the agencies, a more comprehensive assessment takes place."

Kelvin described how the system has been beneficial, facilitating quicker and more appropriate assessment, and allowing a better determination of the initial best course of action for clients.

> "It's worked extremely well in the sense that since September 2003 when it was set up, it's assessed people within three to three and a half working days. That's the average time to assessment from referral… and I think that the

impact we've seen in CDAT services and WGCADA services in Bridgend is that there are lower DNA (Do Not Attend) rates. People are more likely to attend when they are referred in to our services."

"As well as grabbing people quickly, we are getting them to the right place, whereas before that people would be passed around services a lot more, or they would be in the wrong services and not really be getting what they needed."

The information gleaned from the initial assessment and care plan is then discussed at the next joint weekly team meeting, where the client is assigned a keyworker and the next stages of the care plan are put into place. The client then sees a doctor who assesses both physical and mental health and, if need be, by a mental health nurse.

Although there is a wait (maximum two-months) before clients receive a more comprehensive assessment and treatment, they are encouraged to immediately access other WGCADA services, such as the DOMINO projects. Although this wait is far from ideal, it is short in comparison with many other parts of the country. There is also a degree of flexibility, which allows the CDAT to address the needs of clients who are deemed at higher risk, e.g. pregnant mothers, clients with severe physical and mental health problems. The CDAT aims to see these clients within one week.

The main assessment looks into the client's using, lifestyle and needs in more depth. From the CDAT's side of the partnership, this essentially means determining if the client would benefit from a detox or a substitute-prescribing regime. This is also an opportunity to address other exacerbating or resultant issues such as mental and physical health issues, and the need for social service interventions.

Following this assessment, the client meets the pharmacy co-ordinator, doctor and key-worker, who develop a treatment programme and regime. The client is an integral part of this process, since he or she often has an initial idea of what type of treatment they want - particularly in relation to opiate substitute prescribing, i.e. subutex or methadone - based upon their previous experiences and 'word on the street'. The dose is calculated and titrated over weeks or months to find an appropriate level for the client, which is an amalgamation of client feedback and clinical judgement. Kelvin indicated that there are relatively equal numbers of clients receiving either methadone or subutex.

"We are lucky in the sense that we are not bound by the financial factors that others in different areas are. Subutex is so much more expensive than methadone."

The client then receives their script, which is typically managed through a daily (except weekend) supervised consumption regime. Kelvin described how the CDAT offers training and support to participating pharmacies to enhance the smooth running of the service, and improve understanding of pharmacy staff towards clients.

If the client requires a detox, the team determines whether they are best suited to an in-patient or community-based detox programme. The CDAT have access to two in-patient beds in the locality, which are used for clients needing a detox, or those with severe physical problems. The in-patient detox is usually favoured when the client expresses a clear desire for this, or has more complex needs, e.g. pregnant mothers, and clients with mental health problems. Kelvin has witnessed an increased demand for the home detox

service in recent years, which has been facilitated by the enhanced support offered through the partnerships with WGCADA.

The client's progress and ongoing needs are continually monitored by their designated keyworker. This may involve implementing psychological therapies, such as motivational interviewing and cognitive behavioural therapy to promote change and recovery. The client may also benefit from accessing further WGCADA services, such as DOMINO, Pre-treatment, or other forms of group-work. Clients have the opportunity of being referred into Primary Treatment, although they will need to have terminated their substitution prescription before entering this programme.

The services offered by this partnership are also supported by the Community Rehab Co-ordinator, who offers relapse prevention and support in the community, to both WGCADA, CDAT and shared clients.

In light of the services that WGCADA offers and the partnerships developed, Kelvin notes how WGCADA is integral to service provision in the area.

> "WGCADA can offer a greater level of support, particularly for those coming to the end of their detox or who are stable on a script, and obviously for those who are aiming for abstinence."

> "WGCADA are crucial to the CDAT as they have the open door policy, whereas CDAT workers have to run by an appointment system."

As with any new partnerships, Kelvin feels that both organisations can learn from the positive and negative experiences to date. There is obviously room for improvement. He feels that further development of staff relationships between the services would likely be facilitated by joint training days and social events, which in turn would create stronger links for the partnership.

Whilst the partnership has been working well to date, there are some areas that are weaker than others.

> "I'm happier with some parts than others, and I guess my role is to balance it up to get a constant service across the area. To develop partnership working to fill the parts that are a bit weaker… We also need to be working with commissioners to get the funds."

Kelvin also feels that more attention needs to be paid to the logistics of the partnership posts – they need to learn from the challenges they have already faced.

> "It's very easy when you are coming up with new projects to think about all the good things you're going to do, and not all the nasty things you have to deal with as a manager. We need to learn from where partnership posts have gone wrong, or where we have struggled. I think it's just part of the evolution of the arrangements… "

> "I think we need to be moving towards formalising those arrangements, so for instance, to be very clear from the outset that if we have partnership posts or projects, who is responsible for what? And what do we do when things do go wrong… How we deal with grievances, how we deal with disciplining, how we deal with complaints…"

Kelvin would also like to see further developments at a strategic level, with particular attention to specific issues and protocols.

> "… hidden harm and child protection - these are things we need to be working very hard on."

> "(We) need to refine procedures for say, child protection. The NHS has a procedure and we need to refine this for the substance misuse field and share it with the voluntary sector."

3.7. Domino

> "The important thing about DOMINO is that it's before, during, and after, and it's the family as well."

The DOMINO project (**D**evelopment **O**f **M**otivation **I**n **N**ew **O**utlooks) was established at WCGADA in 1997. It offers a variety of workshops and activities (e.g. cookery classes, gardening, IT classes, music lessons, basic skills training, walks, trips, etc) in order to address some of the needs of people whose lives have been adversely affected by substance use. These activities are designed to develop and promote greater awareness of life without chemical dependency. DOMINO is an integral part of the wider treatment program offered by WGCADA, and is available for any client who has undergone an assessment.

DOMINO was initially set up at WGCADA, Swansea. Keith Morgan, who started with the Swansea DOMINO project in 2000, played an integral role in establishing a Neath Port Talbot DOMINO project, which developed into a full-time post (Bradley Fellows). The DOMINO staff are clearly dedicated to their work, which is evident in the success of the program.

> "It's more than a job to me, it's a vocation. Something I really enjoy doing."
>
> Bradley

Whether the client is working harm reduction, or trying to remain abstinent from their drug(s) of choice, the project allows them to become part of a friendly, caring group, irrespective of their circumstances. The clients can begin to feel valued and worthwhile members of society, despite the effects that their substance misuse may be having, or have had, on their lives. Keith believes that the socialising aspect of all of the DOMINO projects plays a major role in aiding the clients through treatment.

> "Once the addiction starts taking over, it's a natural progression for the drug to take over and become your only friend…and the thought of getting back into society is absolutely terrifying…if I can get anyone to mix with anyone at all then, you know, it's a start."
>
> Keith

The DOMINO activities provide clients in some way with the opportunity to (re) learn relevant skills to aid them in their recovery. Another of the most important aspects of DOMINO, both to clients and staff, is that they are fun, easy-going and everyone is made to feel comfortable and welcome. The opportunity to meet others and socialise without the use of drugs or alcohol is a crucial part of what DOMINO offers. This can be a lifeline for clients who are at risk from relapse, perhaps through boredom and loneliness.

> "We went to Oakwood park which was a cracking day out…We warned all the clients that if they used on this trip then we would probably not get another trip, so please don't use on it. You know this is our chance to have a laugh, totally drug-free. Most clients couldn't even imagine having a laugh drug-free. And you know, we had an absolute ball. We are pretty good at spotting people who have been using and I believe, I absolutely believe, that no one used on that day. And I have never seen so many people laughing. Half the reason that they were laughing is because they had just realized that they could have fun in sobriety."

Bradley and Keith feel that the caring and supportive atmosphere on the DOMINO projects provides clients with more support and encouragement for recovery, through learning from others in different stages of recovery. Clients are often uncomfortable and feel out of their depth during the early treatment phases, particularly if there is some ambivalence over embarking on a life free of drugs and alcohol. DOMINO therefore provides them with a safe environment to 'find themselves', building self-esteem, and a sense of self-worth which are vital for recovery.

The first DOMINO activity to be established was gardening at the allotments in Mumbles (which is on the outskirts of Swansea). The initial reservations of allotment owners in Mumbles have been replaced by a healthy respect and admiration (and pride) of what WGCADA clients and staff have achieved on their allotments. The allotments at Fairyland Neath are now a twice-weekly event and clients "gather to work off excess energy or simply learn or re-learn how to socialise with people with similar problems to themselves."

Due to the popularity of DOMINO, a variety of other activities were introduced. The walks are considered one of the most basic, yet effective, methods of engaging clients in the service. It is extremely important to encourage clients to socialise in a safe environment, as one of the most powerful factors associated with an addictive lifestyle is the sense of isolation experienced by both the user and family members.

> "The disease of alcoholism is a lonely disease."
>
> Steve Lewis

> "It's more talking than walking, talking positively about their experiences. Mixing with people who have been clean for two or three years, some of them 15 years. We have a volunteer now who comes here and just encourages people, enthusing them, you know, saying it's all there if you want it. You just have to want it. That's what the walks are all about."
>
> Keith

> "The walks are less intimidating than some of the other activities, you don't feel like you have to join a class as the newcomer, almost anyone can just join in and walk and talk."
>
> Client

The clients of Swansea DOMINO produced a fantastic booklet on some of the more popular walks. One of the clients has been asked by the National Trust to help them with their booklets!

The 'Nature Walks', which were attended by a handful (or car full) of clients a couple of years ago, have been greatly developed since the full-time post and the provision of a 17-seater minibus, and is now one of the most popular activities within the Neath Port Talbot Domino Scheme.

> "I don't think we could have had the same level of success had it not been for the transport."
>
> Bradley

Sadly, Swansea Domino lost the loan of their mini-bus during the past year, which has put limitations on the rambles that can be undertaken. However, clients remain undeterred in enjoying the walks and continue to hope that access to a mini-bus will be provided in the near future.

The Swansea group has organised a camping trip at Port Eynon on the Gower for the past four years. There are normally 20 - 25 campers and the barbeque has had up to 150 people. DOMINO staff insist that everyone who attends has been sober for at least a week so that no one experiences withdrawals during the trip.

Another camping is planned for early September at Whitford Sands on the Gower, during which time the group will be liaising with the National Trust. A trip to St Fagans near Cardiff is also organised once or twice a year.

Staff believe that the cookery classes – winner of the 'Afel' Cookery Award this year - provide key information for clients who have become undernourished as a direct result of their preoccupation with their drug(s) of choice. Healthy and nutritious food is not only important for the individual, but for significant family members (particularly children). Maggie Dix, who runs the 30-week course, shows clients how to budget so that they eat nutritious meals and ensures at least one good meal a week.

> "Cookery classes are important because many of the clients neglect food when using. I know when I was using, food wasn't even an option."
>
> Keith

The Swansea DOMINO also one an award from Swansea Police, the Safer Swansea Award, presented by the Chief Superintendent Mel Jayo.

For a number of the activities offered by the DOMINO project (e.g. IT classes, gardening, cookery and anger management), clients can obtain accreditation on completion of the course. These certifications are an invaluable tool of empowerment, and may aid the client in progressing into further adult learning or employment.

A scheme in Neath Port Talbot DOMINO that was extremely popular with the clients was an computer course which enabled them to learn how to build a computer. Clients were supplied with new computer parts and taught to build a computer in the first week. In the second week, clients used their computers to write their own CVs and practise interview techniques, the goal being to motivate them into a possible future in IT. The computers were given to clients to keep at the end of the course – they were thrilled. Clients on both Domino schemes attend IT classes, where they can learn different software packages.

A 'Multi Gym and Fitness Course' on the Neath Port Talbot DOMINO project incorporated many different modules, including circuit training, nutritional advice and mathematics. There was again a focus on writing a personal CV and interview techniques, hoping to motivate clients into a possible future in the leisure industry. As an added incentive, clients were given £250 worth of sports' clothing free.

Bradley stressed that at no pressure was put on the clients to seek employment at anytime. He added that the transformation in some clients was incredible. He also noted:

> "You can see those in the earlier stages of recovery 'light up'. They see that a life without drugs and alcohol can be fun and good and humorous."
>
> Bradley

The 'Music Class' is thriving and half way through producing another CD – tracks from the previous CD can be found on the WGCADA web site. Keith's ability to bring out the best in people's (clients and staff) voices is renowned.

The new songs will undoubtedly be aired at the Christmas reunion, where Domino members will also show off their creative writing and poetry again.

> "If you could see the smile on clients' faces when they have actually picked up a guitar."
>
> Keith

The 'Art and Craft Class', run voluntarily for the last two years by two ex-students from Swansea University, is both extremely encouraging and brilliant. The clients have made many interesting pieces of work and are currently planning a mural and a mosaic to add the finishing touches to WGCADA's newly developed garden. Domino clients developed most of this garden, including laying the foundations for, and much of the building of two superb new sheds.

As WGCADA offers both abstinence and harm reduction services, it is common for clients in different stages of recovery, with different goals in sight, to interact a great deal. Although encouraging socialisation between abstinent and harm reduction clients does carry some risks, the staff believe that the positive effects greatly outweigh the potential negative outcomes.

> "The mix of clients in recovery and those who are still using does work, but I do keep an eye out for who is mixing with who. Particularly if someone is vulnerable, for example, struggling with abstinence… but it is like one big self help group, they all look out for one another."
>
> Bradley

> "The chances are that the newcomers will be inspired and encouraged. I believe that recovery is infectious."
>
> Keith

Although both Keith and Bradley have been through the 12-steps program themselves, and are advocates of the abstinence philosophy, they recognise the need, and value, of offering harm reduction services. They also believe that, in many cases, harm reduction clients receive the encouragement and incentives to move through the process to abstinence-based treatment.

> "There is a need for both and I have no problem with harm reduction. People should be coming through the system. If everybody is liasing well they should reach us [abstinence] at some point, when they are ready. They may be in harm reduction for five years, ten years or forever, but some of them will have enough and pass through to us."
>
> Bradley

The DOMINO projects also offer those who are stable in their recovery to give some of their time as volunteers. Many people in recovery feel that they would like to 'give something

back' and to help others who are going through the same experiences as they have gone through. Bradley currently has two volunteers and another person is soon to join after completing the WGCADA volunteer scheme.

As the DOMINO programme, as a whole, has developed so rapidly, Bradley feels that rather than trying to expand it further it would be more beneficial to maintain some stability and 'keep things ticking over'. This gives the opportunity to build strong foundations in all the new developments, and leaves time for reacting to any new wants and needs of clients as they become apparent. The only thing he is looking for at the moment is more clients – "the more the merrier!"

On the other hand, Keith hopes to be able to expand the DOMINO projects in the near future. One of his many ideas involves collaborating with a number of treatment agencies from around Britain to organise group activities and trips to the Gower Peninsula. In addition, he is working with WIRED to help client groups around the country communicate with each other via an internet-based network.

The DOMINO projects are resourced via the National Assembly of Wales, along with a number of local services such as Life Long Learning and the League of Friends. It is vital that the project can maintain their funding so that the clients can continue to receive the much needed services that the DOMINO projects provide. Keith stated the importance of maintaining a stable environment for the clients throughout the recovery process.

> "The thing you can't do with clients is let them down. It takes a hell of a lot for the client to walk through the door…I get quite protective over my clients if people muck them around"
>
> Keith

One sad piece of news related to the DOMINO programme was the Bridgend project's lack of success in obtaining renewed funding. The part-time Project Worker was bitterly disappointed with the funders for their decision, particularly given the initial hard work that had been done in setting up the scheme. He had watched client attendance rise from two people up to a regular 12 clients in a few short months.

The Bridgend Domino Project had operated out of Coed Hills twice a week between October 2004 and April 2005, with 47 clients attending. One of the activities had involved clients regularly meeting up with a of group of 13 'Artists' whose love of nature and living off the land in 'Yurts' had inspired them enough to build their own little self-contained community far removed from the hustle and bustle of the sometimes stressful 'modern world'. The community took time to reveal their knowledge of the neighbouring wildlife, trees, flowers and surroundings, and time to reveal '*their*' way of life, including how the 'Yurts' were made, how they grew organic vegetables for food, purified water for washing, and how they utilised the wind and solar power into their simple systematic lifestyles.

Clients were encouraged to participate in a number of activities, including 'Bodgerring' - 'Pole Lathes' were used to produce various objects made of wood including candlestick holders, spoons and lamp holders. 'Wood Sculpture' and 'Arts & Crafts were available, where clients made among other things drums and dream catchers.

In summary, as the waiting lists for other treatments such as Pre-treatment, Primary Treatment and one-to-one counselling often have long waiting lists, the DOMINO projects are vital in engaging the clients immediately and promoting instant harm reduction practices. The projects available can effectively enhance clients' independence, self-esteem

and self-efficacy, which aid them through every step of the processes of behavioural change and recovery.

3.8. Fellowships (AA/NA)

Alcoholics Anonymous (AA) was first founded in the USA in 1935 by two alcoholics and first began to establish itself in the UK in the late 1940s. There are more than 3,000 groups in the UK and over 88,000 groups in 134 countries worldwide. The estimated world membership is over two million.

> "It [AA] has helped countless individuals (often when professional intervention has failed), is a repository of astonishing experience and subtle and often humorous wisdom, and has had a profound influence in humanising attitudes towards people with drinking problems."
>
> Griffith Edwards in "The Treatment of Drinking Problems: A Guide for the Helping Professions"

Clients of WGCADA in the Pre-Treatment and Primary Treatment Programmes are expected to use AA or NA. The AA (or NA) meeting is of central importance to the functioning of AA/NA. There are two types of meeting, one which is open to all-comers, as opposed to closed meetings which are restricted to AA members. Meetings are attended by people who have been coming for many years, whilst others may be attending their first meeting.

These meetings involve speakers presenting their personal life story. They generally describe their personal background, the development of their drinking problem (or drug addiction), the sufferings they endured and inflicted on others, and then some turning point or 'rock bottom' experience. They then describe their introduction to AA, their recovery through the fellowship, and their evolving understanding of the meaning of AA as a way of life.

These stories are followed by comments and personal statements from the floor. Themes may be discussed by the listeners. At the end of the formal proceedings, the meeting say together the Serenity Prayer.

> "God grant me the serenity
> Serenity to accept the things I cannot change
> Courage to change the things I can
> And the wisdom to know the difference."

Members then chat and exchange news over tea and coffee. After some weeks, new members are offered a 'sponsor', someone who will offer personal advice and will offer a special degree of availability and support. The sponsors often act as a role model. The AA/NA group can offer more – it can be used as a support network and provide a new community of friends.

AA is often misunderstood as being a treatment method. It is in fact a fellowship of peers, connected by their common addiction, guided by its 12-Steps and traditions outlining the principles of AA. The primary therapeutic intervention of AA can be viewed as relapse prevention.

3.9. Family programme

3.9.1. Background

Recent figures suggest that in the UK there are about 250,000 to 300,000 people with a serious drug problem and over 1.8 million adults using alcohol at a harmful level. Using Copello and colleagues' (2000) conservative assumption that every substance misuser negatively affects at least two close family members, there may be at least 4.2 million people in the UK living with the negative consequences of someone else's drug or alcohol misuse.

However, there are a number of reasons to assume that the number of family members affected is much greater than this. Firstly, since the level of substance use set as 'harmful' is quite high, it is probable that in reality problems for families may be caused at a much lower level. Secondly, it is likely that far more than two family members or close friends are negatively affected by the dangerous levels of somebody else's substance abuse.

> "… I was frightened we were going to have a phone call to say he was dead or he was in hospital with an overdose… we were just waiting for a… knock on the door to say they'd found him in the gutter or something like that…"
>
> "… My life totally revolved around this boy… my every waking thought was this boy… I became totally obsessed… My life stopped with him, I mean I wasn't going anywhere, I wasn't doing anything, I wasn't going out with my friends…"
>
> *from research conducted with family members at WGCADA and Drug and Alcohol Family Support (DAFS) by Gemma Salter and David Clark*

Research has shown a set of universal or core experiences for those living with someone with a drug or alcohol problem. This includes finding the user difficult to live with; financial difficulties for the family; concern for the health of the user and his/her future and safety; concern for the harmful affects on the family as a whole; experiencing personal anxiety; feeling helpless; and feeling low or depressed (Orford et al, 1998; Salter and Clark, 2005). It can be especially difficult and disruptive to live with a user, since the user often adopts many problematic behaviours, such as violence, unpredictability and stealing. The substance misuse problem can also cause a restriction on relatives' social life and a negative impact on family relationships.

One major consequence of substance misuse problems is in terms of the stress it causes families, which is often severe and long-lasting. This stress can often result in higher physical and psychological morbidity of relatives and can lead to increased rates of primary care consultations.

3.9.2. Swansea Family Worker

Jo-Anna Russon is the family worker at WGCADA in Swansea, having joined the organisation in November 2004.

When Jo-Anna first meets a new family client presenting to the agency and conducts an assessment, she tries to get an understanding of the situation that they are in and a feeling for how well they are coping with it.

She then tries to introduce the ethos of and teachings of Al-Anon and Families Anonymous to her client. She believes that these are 'fantastic' teachings and an excellent resource for family members learning to cope with an addict in the family. However, what each individual is able to take and apply from this information varies greatly, being related in large part to their personal circumstances and specific needs. Jo-Anna sees herself integrating the theoretical with real life, working out what principles the client is ready for and where they can start from in order to detach or change their behaviour in other appropriate ways.

> "I have to take the time to see where each family member is standing, and then from there say OK, where can you start on the whole concept … which bit do you think that you can change… As brilliant as all the principles are, and as much as I believe in them, not everyone is ready for them."

Jo-Anna's days are almost always full. She generally sees five clients a day in one-to-one sessions and has a caseload of 30 - 40 clients. Appointments are made approximately once every two weeks, although some clients are seen on a weekly basis.

Most family members who visit the agency expect Jo-Anna to help the family member who has the substance use problem. They do not come because they need help themselves. Jo-Anna has to turn the focus onto the family member's life. They often do not really have a life - it has been absorbed by the addict – and they have not been taking care of themselves physically and emotionally.

Jo-Anna uses a specific assessment form for her family members. She goes through the questions in a non-threatening way so that the family member can see how they have lost control over their lives and realise that they need to sort out their own lives, not just the life of the addict. The assessment process is in fact a brief intervention – it aims to shift focus away from the user to oneself.

After the assessment, Jo-Anna explains the purpose of continuing to use the service offered by WGCADA. She points out that it serves two purposes, counselling to help the family member get better and practical advice to deal with situation.

> "… more in the counselling context, talk about you, to put the focus on you. To look at how you are coping with all of this. It gives you the opportunity to talk and offload. And the other side of it, is a lot more practical. Looking practically at your family situation, your behaviour and the positive of that and the negative of that and looking at what can be changed."

She helps clients set goals and later looks with the client at whether these have been achieved and if not, looks at the factor that influenced the situation.

Most of Jo-Anna's clients are mothers. In a small number of instances, both husband and wife attend. She encourages all clients to attend Al-Anon meetings, although only a few do initially. Some clients refuse to go to group meetings (such as Al-Anon), although Jo-Anna brings the issue up in later sessions with the client. She believes that the ideal intervention is a combination of one-to-one and group therapy. Clients are also told that they can access DOMINO and/or the Tenancy Support worker.

Jo-Anna points out that the family service is not promoted publicly, but she has a steady supply of clients. If the service was promoted properly, there is no doubt she would be overloaded. Jo-Anna believes that there are lots of family members who seek medication

from their GPs because of the problems caused by a substance misuser in their family who would benefit more from family counselling and support.

This is the first time that Jo-Anna has worked with families, having previously worked in a residential rehabilitation centre. She finds that work conducted with family members has to be conducted at a slower rate. She found it difficult at first in her present position, having at hand a fantastic set of principles from Al-Anon and Families Anonymous, but soon realising they not everyone was ready to and wanted to use them.

> "… he's (the user) nearly forced us to split our marriage up, because they're so devious… that he's putting a wedge. I could see it, but he (the husband) couldn't see it… I was sort of fighting him (the husband) and the boy (the user)…"
>
> "… you could tell by the tone in her voice that she was pointing the finger… how do you fetch your children up in a round about way… it makes you feel that you haven't done things right for your family, where have you gone wrong is what you say to yourself…"
>
> *Salter and Clark, 2005*

Jo-Anna emphasised the importance of using an empathic approach with her clients. Many family members had not experienced this empathic approach before.

A significant number of family members made their first visit to WGCADA after the person with the substance use problem had started having treatment, as it was the first time that their lives had not been completely consumed by the addict.

> "A lot of clients come into family counselling once the addict has started treatment, because their whole life has been so taken over that it is only once the addict has been taken off, and starts getting themselves better, that the reality stares them in the face that they do not have a life any more, and that they have not had a life for years and that they have totally neglected themselves. And all they are is a mental and emotional wreck and sometimes a physical wreck as well. It's at that point often that they say, 'Wow I need some help'."

Family members often feel guilty because the addict is off getting help and they are not feeling ecstatic for them because they have come to realise what a mess they are in personally – a bitter irony!

3.9.3. Julie, a family member

Julie described how she first came to WGCADA around two years ago as she was struggling to cope with the effects of her son's alcohol addiction. She recalled how she became so desperate with her situation that she didn't know where to turn, so she visited her doctor and asked for help. He referred her to a local Al-Anon meeting. Although she tried it out, she felt that this process wasn't the right help for her at the time, so she was referred to WGCADA to access one-to-one counselling. This was a turning point in her life.
Julie described how the pressure and isolation of living with her son's drinking took its toll on her.

"I was really, really down. I was totally crushed."

Julie recognises how her life became completely focused on her sonr and his addiction from the point where she discovered his drinking and it began impacting upon her. As a continuation of this state of unbalance, Julie concedes that when she first started accessing help, her idea of what 'help' was, was naive.

> "[When I] went to the first meetings [Al-Anon], to be honest it did nothing for me because I went in thinking that they were going to stop my son from drinking. That was my idea at the time."

Julie described that when she first entered WGCADA, although she was nervous and unaware of what to expect, she was put at ease immediately by the warm and friendly reception from all the staff – and the offer of an informal cup of tea! She was assessed, allocated a counsellor, and started receiving one-to-one counselling shortly thereafter. During this initial process, she was introduced to the 12-steps and given literature to read.

> "When I first read the 12-step programme I thought it wasn't [for] me, [but then] as I hit rock bottom, the total desperation pushed me into starting them."

After engaging in the activities that WGCADA offers, and starting to work through the 12-steps, Julie soon recognised that she was not accessing the centre to try and help her son, but that she needed help for herself.

> "Listening to other people's stories, I realised they were there to help me and not my son."

She then described a long process of change, which has completely transformed her life. Looking back, Julie sees that in order for her to move forward and to start recovering, she had to go through a period of dark days where she faced up to her past and feelings.

> "When I first came here I got very, very depressed because everything was coming to the surface. I would go home and think I'm not going back there, but then I always came back. Something was bringing me back."

Julie found that the process of working through the steps helped her to have more insight into the situation she was in – and in particular her own behaviour in relation to it. She found that the step themselves enabled her to 'let go' of some of the responsibility and obsession over her son and recognise that she was in need of help herself.

> 'We admitted we were powerless over drugs and other people's lives – that <u>our</u> lives had become unmanageable.'

As she began to learn more about addiction and the effects that it is has on both the individual and those around them she began to understand that she too, was suffering from the addiction, in a similar way to her son. Julie came to see many parallels between her behaviour and that of her son. Her son was under the direct control of the alcohol whilst Julie was under the direct control of her son's drinking.

> "I am an alcoholic but without that specific disease."

As a result Julie's efforts to cope with her situation, with no real understanding of the processes involved had led to negative coping mechanisms. She found that although she had been trying to help her son she had ultimately been acting in ways that could actually exacerbate the problem. One example was her controlling behaviour. Julie had lost sight of the fact that her son was responsible for himself and ultimately, was the only person who could change his behaviour. As a result Julie had taken to trying to control him, in whatever way she could.

"I know I am a controller and I am sick. My behaviour was sick."

This acceptance and the support offered to her through WGCADA has freed her to have a greater insight into her situation, and to make appropriate changes.

> "I've learnt a lot about myself, and through changing my behaviour towards my son we have a better relationship. It's made me see my faults, and my strengths and to become a better person. I am more relaxed when he [her son] comes to me. I am able to be comfortable because I've developed boundaries. I'm able to say 'no' to him, whereas I never could before. I now know I can only control myself."
>
> "[It's given me] insight into life in general. I was locked away in myself before."
>
> "I can talk now. I couldn't get anything out before."

Julie has recently completed the fifth Step.

> "… which is wonderful. I feel great, I can see myself now."

She feels that in addition to the actual steps, WGCADA as an organisation has been just as influential in her recovery.

> "I walk through those doors and I feel safe… I can feel that people aren't judging me. It's a feeling of belonging and I can be myself and there's no pressure. It's like one big happy family really! It's like the family I've been missing all my life."
>
> "I've had an excellent counsellor. Maybe she happened to be the one for me, but I have really responded to her."

Julie has also engaged in a number of additional activities that WGCADA offers, such as attending the women's group and going to the gym. These activities have helped her to meet and socialise with new people, which has really helped to build her confidence and self-esteem.

> "There's always something going on and they get in touch with me and ask if I want to go. I meet other people, whether they are suffering from the disease or family members, we're all mixed in here."

This friendly and supportive atmosphere and the treatment offered have translated into Julie feeling that she is now in the best point of her life so far.

"If you could see me two years ago you wouldn't believe the difference!"

"I think now (that) I've been coming here for two years and I'm never going back now."

Julie feels extremely lucky to have had the chance to start the programme, and blessed that she has responded well to the help that was on offer to her.

"It's a wonderful programme, I can't praise it enough."

"I can't tell you how thankful I am for this programme."

As a result, she attends Al-Anon meetings and any other family events to try and use her experiences to help others. She described how there are a great number of individuals who are suffering as a result of a loved one's substance misuse, and that this is hugely evident in her local area.

"Where I live there are lots and lots of families who are suffering the same as I am. Some of them know that I come here (WGCADA) and they come up to me and question me and ask me to tell them a bit more about it. It shows that there are people out there."

For this reason, Julie is further thankful for the opportunities and help that is on offer in WGCADA and would like to see it expand further to accommodate the needs of others who are in the same position as she was.

"I just hope that it [the family programme in WGCADA] will keep going and it will strengthen… that more families will be as lucky as I have been."

3.9.4. Mandy, a family member

Mandy first came to WGCADA as a 'nervous wreck' approximately a year ago. She described how she has had many destructive relationships, often with people suffering from alcohol addiction, which over many years have had a hugely detrimental effect on all areas of her life.

"I was, well at the edge of a nervous breakdown. I was long-term off work sick… I was on medications from the doctor and having panic attacks."

"I existed… I got up in the morning and looked after my daughter. I fed her, washed her and clothed her, but I wasn't there for her emotionally, which I realise now. She would go to school and I would go to bed and then get up half hour before she came home. I was utterly miserable. I was so depressed it was unbelievable."

"I had no life before. Every day was just miserable and horrible, and I had this great sense of doom all the time."

Her partner at the time of her referral to WGCADA was also an alcoholic who had entered treatment in the agency 18 months previously. His counsellor referred her to the agency to access support. She conceded that she initially agreed to attend to help him.

"… my partner of 13 years was an alcoholic and initially I came here because he had been through treatment… Initially I thought there was nothing wrong with me, I thought it was all him."

However, when she was assessed and began to talk about her life she soon realised that she was desperately in need of help for herself, independently of him.

> "I was just desperate to sort my life out, because I thought I can't carry on living my life like this."

This realisation allowed her to be open-minded when she was introduced to the programme and she was keen to start the steps because of the impact it had had on her partner's life.

> "My partner had been through WGCADA 18 months previously and I'd seen how well he had done doing the steps here. He hasn't been drunk for 18 months. And I thought if it can work for him then maybe it can work for me, so I came in here with an open mind."

Mandy described how she was at 'rock bottom' at this point and was ready to try anything to regain some form of a life. She was, therefore, quite positive about WGCADA and what they could offer.

> "I think I was so strung out I don't think I was nervous. I guess I didn't know what to expect, but I knew that whatever I was going to do here couldn't be worse than what I had gone through for the last thirty years, so I was looking at it quite positively."

She found that the atmosphere in the centre and the qualities of the staff facilitated this process and meant that she felt safe to be honest and open to the treatment offered. In particular, the fact that many of the staff have experienced addiction, either as an addict or a family member, helped her to feel at ease.

> "The majority of staff have had addiction problems or are family members, so even though everyone's problems are different, you feel that they can advise, that they have been there and experienced the problems themselves. You don't feel that you have to hide anything, you can be completely honest."

> "They're really friendly, you feel like you know them. It's like a shared experience. I can see how easily it could have been me with a drug problem, because we (affected family members) share so many characteristics as an addict. Everyone has been through a shared experience."

Mandy described her first day at WGCADA.

> "I went in and was made a cup of coffee. I was then introduced to the person who was going to do the assessment and she took me through what goes on in the centre and talked about co-dependency and what can happen to family members… (She) showed me the shared characteristics between the alcoholic and the person who live with the alcoholic."

She found that from this point on, WGCADA as a whole, and in particular working through the steps, has enriched and enlightened her life. She discovered new insights into her life.

> "I never felt I was good enough, clever enough, pretty enough, just not good enough. Then I got into a very violent relationship (related to) alcohol and I felt that I was trapped there because I had no self-confidence. Now I know that unless I love myself, how can anyone else, and what other people think doesn't

make any difference. I can't be perfect for everybody and that's what was trying to do and I was making myself iller and iller. I wore myself out."

"From being here now and looking at my life I've been in a lot of destructive relationships with other alcoholics… I was coming here blaming him [her ex-partner] and now I realise I was just as sick as he was."

Mandy relives the journey that she has been on during the last year and recalls how she has had to accept things about herself and her behaviour which she has found difficult.

"It's a big thing to take on your shoulders, that you have played a part in it and enabled them. You think at the time that you are doing things for the best, but you are actually prolonging it and you have the guilt that goes along with that."

However, she tells of how the impact of such realisations, and the opportunity to learn how to live a healthier life through working the steps and receiving support, has resulted in huge changes, both intrinsically and related to her lifestyle.

"I accept that things are going to happen to me and it's learning to cope with it, learning that you can't control everything that happens."

"I feel totally more confident. I've got a social life, I'm back in work, I'm off medication, my relationship with my daughter is not just going through the motions, but I love spending time with her, and I've started training again… It's just given me my life back, definitely without a shadow of a doubt."

Mandy feels that there is a general lack of awareness about the effects of addiction on family members, both in general society, and in individual family members themselves.

"People don't really understand what addiction does to the family members. I was definitely as sick, if not sicker, than my ex-partner. They say that for every one person who is addicted there are seven who are affected, so it's actually a bigger problem."

"It needs to be more widely publicised. Many people know about AA and NA, but not many people know about Al-Anon, especially because when you start treatment you think it's the addicts problem not your problem. So you think, Why do I want to go to a support group?'"

Considering this, and when thinking about the impact that WGCADA has had on her life, Mandy describes how there is an urgent need for others who are experiencing difficulties associated with a loved one's addiction to have the opportunity to receive treatment and support as she has. She feels that there needs to be more support and publicity about the problems that people are living with, and where to access help.

"With AA and NA there are loads of groups, but (for family members) there's only two Al-Anon meetings in Swansea. I think it would be great to have family meetings as they do for addicts. It's the strength you get from the sharing with others because you go through this thinking you are the only one and then you start going to meetings and you realise you're not. (Also) because there are only two groups you get the same people there week in, week out and it can get a little stale. I think you need the injection of new people in."

Further expansion of existing services is also greatly needed, for example,

> "Somewhere for the family members who don't go to Al-Anon, for whatever reason to meet."

> "(For people who are) working and (for those who) childcare can be a problem, it would be good to have them (meetings) in the evenings."

Mandy would like to encourage others who are experiencing similar difficulties as she was to access the help that is available:

> "I wish that people who are skeptical for whatever reasons would give it a try, just for six weeks and be open-minded and see the changes. And be around others who have been through it."

> "I wish I could bottle the steps and give them to others."

3.10. Detoxification (detox)

3.10.1. Background

Detoxification is the controlled withdrawal from a substance such as heroin or alcohol that has resulted in physiological and/or psychological dependence. It is a procedure that aims to alleviate withdrawal signs and subjective discomfort, and prevent the risks inherent to suddenly stopping use of a substance that has resulted in dependence.

Detoxification is a carefully planned procedure that follows a thorough assessment of the client. However, it is not a distinct form of treatment for addiction in its own right. Detoxification, or detox as we will now call it, is one step of an ongoing process – it needs to be supported by a period of aftercare (involving relapse prevention) for the client to produce long-lasting changes in behaviour.

3.10.2. Swansea home detox team

Gavin Thompson is one of the team members of the home detox team that operates in Swansea. This service was developed through the collaboration between WGCADA, the CDAT and Swansea Drugs Project to fill the gap in provision of detoxes available in the community. The collaboration is an example of efforts made in Swansea to develop partnerships between treatment providers and to encourage the cohesion of different treatment philosophies in the local community.

Gavin works at the CDAT in Cwmbrula. This is a statutory service which uses a harm reduction philosophy – it was keen to 'join forces' with WGCADA to provide cost- and outcome- effective services to drug and/or alcohol misusers in the area. The CDAT were able to provide prescribing and advice services to individuals who were willing and able to detox from their substance(s) of choice, but recognised the near ineffectiveness of providing detox in isolation from other forms of treatment and support.

> "… detox without treatment is pretty valueless, really. It just provides a little break. What is really needed is therapies alongside a detox to make the treatment effective. I don't think that any purely medical treatments are effective on their own because other changes are needed."

The CDAT also recognised that the majority of clients they were encountering were actively seeking abstinence and, therefore, they were often referring clients to WGCADA. The latter recognised the need for detox for individuals who were trying to address their using or drinking behaviour and had the skills, expertise and facilities to provide support, relapse prevention, and aftercare. WGCADA also recognised that the opportunity to engage with potential clients at an early stage could encourage their progression into the treatment, which the agency offers.

The detox team is funded by the local Community Safety Partnership (CSP) for an initial three year period. The team receives referrals from a variety of services, including primary health care, drug and alcohol agencies, housing services, social services, social support schemes, psychiatric wards, community mental health teams, as well as self-referrals to the CDAT in general.

Gavin explained that when an individual is referred for a detox they receive a response letter, typically within one week, allocating them a date for assessment by the CDAT. The initial assessment determines whether the client is best-suited to an in-patient or home detox programme. For those whom an in-patient detox is preferable, the CDAT contacts the detox ward in Cefn Coed hospital for referral.

The home detox is designed to accommodate the needs of individuals with an alcohol or opiate dependency, and the inclusion criteria require that they are: motivated for change, have a suitable home environment, and have a carer or family member (who do not have an addiction) willing to support them during the detox.

There are many reasons why a home detox is a better option for a client than an inpatient detox. These include being a single mother, having employment commitments, or a preference to detox in familiar surroundings. Clients may prefer to detox at home for reasons of familiarity, and/or because they feel a need to 'face up' to their environment rather than 'escaping' into hospital.

> "It's more comfortable at home. You can get used to life without the (physical) addiction straight away and you get regular visits from the home detox team."
>
> Client

A second, more in-depth, assessment that looks at the individual holistically follows the initial assessment. This assessment involves looking at all areas of the client's life, including their circumstances and the issues with which they may be dealing.

This session is followed by a home assessment, where the physical surroundings and level of support from a carer or family member is determined to be appropriate or not. This assessment is essential to ensure the safety of the client and to place them in an environment that is supportive of the changes they are trying to make.

A full medical assessment is then carried out to determine the medication needed during the detox, and best practice for the individual. During this process, the client is required to contact Andi Plastaris, the team member from WGCADA, to arrange an assessment and to determine the level of support that she can offer. Andi is responsible for running relapse prevention groups and access to other WGCADA services. The team then devises a care plan with the client and their carer to ensure that everyone is aware of how the detox will be managed and the options available to them.

Once the medical detox is initiated, it is closely monitored by the CDAT team. This involves daily home visits from a team member, and liaisons with the client and carer. Andi offers support during this process and takes the time to build a supportive relationship with them both. The medical detox is supported by the implementation of motivational enhancement techniques. Each client is also offered, and is expected to complete, relapse prevention sessions.

> "Clients are asked to contact Andi and start the relapse prevention work. It work(s) very well and we find that introducing the client to their relapse prevention worker prior to their detox reduces their levels of anxiety and helps to keep them engaged during the physical detox and throughout the whole process."

Gavin strongly believes these sessions play an essential role in the effectiveness of the home detox. This effectiveness is demonstrated by the high levels of engagement from clients. The statistics to date indicate that around 90% of clients engage and complete such sessions.

> "The majority of clients do engage… I was quite surprised by the rates of clients completing relapse prevention and clients still remaining free of their drug of choice."

These relapse prevention sessions encourage the clients' continued engagement with WGCADA and the services they offer such as DOMINO, Pre-treatment, and progression into the 12-step programme following this initial detox.

> "Their DOMINO project has been a major step forward especially in engaging people. It's open to a much broader client base rather then just focusing on 12-step."

Each client also receives aftercare in the form of follow-up sessions with the CDAT liaison nurse three months post-detox. Outcomes are monitored by staff using the Maudsley and Christo inventories. Referrals to additional services, such as other drug and alcohol services, social services, and GPs, can be made if appropriate.

Gavin describes how this comprehensive package of detox, engagement in WGCADA and follow-up, is a 'step beyond' standard detoxes and translates into higher numbers of clients moving beyond the initial detox stage towards sustained changes in their using, lifestyle and progression towards abstinence.

However, despite the effective partnership, and encouraging statistics to date, Gavin believes that there is still room for improvement. For example, the team is keen to initiate group sessions of relapse prevention, which would not only be more cost-effective but also encourage clients to meet and support others in the same position as themselves.

Gavin also recognises that to offer help to a wider population of clients, more resources need to be directed to relapse prevention training for individuals who are unable, or not willing, to go through the 12-step treatment philosophy.

> "The 12-step philosophy does help and work for a lot of people. But I think to help a wider group of people, more resources to do relapse from a different perspective such as motivational learning could be beneficial."

As with many services and posts within the substance misuse field, this scheme has only received funding for three years. Gavin would like to be part of discussions between the Trust and the local SMAT to discuss how it will be continued. Gavin hopes that further funding can be obtained to allow for more prescribing services to be set up, waiting lists to be shortened (currently around three months), and further development of the service to be achieved. He would like to see detox pre-treatment groups and a service user self-help group to be available to clients completing a detox and during aftercare.

3.11. Admin and support (Swansea)

Angie Welch and Esther Mead describe WGCADA as unique. They work on the front desk in the main Swansea office and describe their jobs as 'the best job they have ever had in the world!' Their roles incorporate a variety of responsibilities, including interacting and encouraging clients to access the service, both by manning the desk and answering the phone.

Both have worked for WGCADA for a number of years (Esther for ten years and Angie four years) and they have witnessed WGCADA's recent development and growth. They believe that as there is such a variety of care pathways now offered, WGCADA have the ability to adapt to the needs of individual clients in a special way.

> "Everyone can fit in somewhere as the help and support is so wide."

Angie and Esther are acutely aware of the importance of a client's first experiences with, and impression of, WGCADA.

> "… it's a huge step for that client, whether to pick up the phone or walk over the threshold… their initial experiences help determine whether they come again."

They make great efforts to ensure that each client receives a warm welcome and are made to feel wanted and cared for from day one. In this sense, the influence that they can have on clients' views and beliefs in WGCADA is the first part of the therapeutic process that the agency offers. A major part of this is instilling hope and reassurance that the client has come to the right place – that WGCADA can help them and they are no longer facing their problems alone.

Angie and Esther explained that they spend a lot of time interacting with clients, giving them an opportunity to offload and share, both before and after engagement in treatment. In relation to the latter, they offer a continuation of contact that supports the work that other staff do in the therapeutic process.

> "More and more people are calling in and you build a rapport with those people, and that is a form of treatment and support."

As the admin staff are always on the 'front line', Angie and Esther find that they can also make observations and grow to understand clients in a way that supports the treatment workers. They find that the team meetings offer an opportunity to feed important information back to staff and, therefore, the WGCADA community as a whole can feed into the service that each client is offered.

This rapport and the relationships developed with clients often translate into Angie and Esther becoming advocates for clients, particularly those who are struggling or desperate to enter treatment.

> "As we are on the front desk we see clients coming in day in, day out, desperate to start treatment, in a way that other staff wouldn't see. We really root for them."

They find that in order to offer the clients the most effective service, a certain amount of flexibility and instinct is needed.

> "We often work on instinct… you can tell when someone is very sick and in desperate need, and we try to pull out all the stops for them."

> "You can tell the difference between when someone wants something – and when they really need it."

As WGCADA operates on the motto that the client always comes first, Angie and Esther also enjoy being part of the service as a whole. They are willing to be adaptable whatever demands are made of them. This can occasionally involve picking clients up if there are no available staff, going along to DOMINO projects, and driving clients to appointments. They are also involved in putting together the Christmas hampers and attending Gower camping trips.

A 49 Year Old Alcoholic

In May 2004 I found myself having to introduce myself as an alcoholic. Yes, there was a stigma attached in my mind and yes, I did feel a mixture of fear and relief.

My drinking career started when I was 19. It was excessive and invariably I would end up drunk causing various degrees of chaos. I could be verbally abusive acting in a very superior way. My first drink, I thought, gave me confidence. So, from the start, and without realising it, I used alcohol as a drug which enabled me to feel different. It is a mood altering drug.

At university, my mind was becoming increasingly fixed on the need to be in pubs or bars. I muddled through and qualified and got an increasingly responsible job in the construction industry. However I lacked peace, inadequacy and restlessness haunted all areas of my life. The atmosphere of drinking dens became more desirable. By the 1980's, frequently drunk, I managed to wreck a relationship, lose property and end up in financial difficulties. Various attempts at cutting down my drinking failed. I changed work places and drinking places and type of drink. But none of those seemed to work. I still had the puzzling need to be in places where you could drink, and found myself getting drunk and in trouble even when I didn't want to. The whole process baffled me.

I changed career in the late 1980's, finding myself in a very public role and having to curtail my drinking. For a while I seemed to manage, although binges continued and the recovery progress was longer. After complaints to my employer concerning conduct and behaviour, I confined my drinking to drinking at home, calculating my opportunities to do so. Despite not drinking in the mornings, I became increasingly unwell mentally and physically, taking time off work. Irrational feelings, fears and negativity were typical. Eventually, I was arrested for drinking and driving, and the resulting publicity and events combined made me face the truth.

When I came to WGCADA on the recommendation of a colleague, I would describe myself as being 'spiritually dead' and at my lowest ebb. I didn't know what I felt, who I was, wanting to resign my job and finding any excuse to be in pubs or bars.

By the time arrived for my assessment, I was prepared to do anything to regain my grip on life. Through the treatment process, WGCADA enabled me to explore why I had started and continued to drink as I had. Like peeling off the layers of an onion, and with the support and confrontation of counsellors and group members, I began to see myself clearly for the first time. Both good points and bad. I started to explore why I felt as I did, and how that connected to this illness. And it has been well worth it. Painful, yes. Liberating, yes.

I now know that I drank as I did because of the two-fold nature of alcoholism - a mental obsession and a physical craving. I understand that the only way forward for me was to remain abstinent and work the Twelve Step Programme. A Spiritual Awakening is the key. I would have been unable to deal with this in such depth through A.A. alone. At WGCADA, there is no escape, HONESTY is the foundation. I desperately wanted my life back.

I completed Primary Treatment about two months ago. Life improves each day. I have to be careful, asking for support when needed. Through the care and competence of the staff at WGCADA, I believe I have been given the 'tools' on which to build. The Centre is a wonderful place which literally brings people back from the 'dead'. Alcoholism seems to be a spectrum. But wherever you are, it seems important to have help from people who have been there. And it seems important to have a treatment programme which empowers people to deal with reality. For thirty years, I lived a very unrealistic life which was spiralling out of control.

Today I am in touch with reality and, as far as it is possible, in charge of my decisions. And it's great. Thank you.

In addition to their direct input with clients, Angie and Esther are essentially responsible for the day-to-day running of the agency. This can involve a variety of roles – some more pleasant than others!

> "Our roles include a huge variety of things! Everything from admin to housekeeping, emergencies, etc"

The running of WGCADA involves a lot of 'behind the scenes' work to ensure the smooth running of the agency and to support the treatment staff in their roles.

> "It really is as varied as the service offered."

Perhaps one of the most important tasks is keeping the diary up-to-date and full, to ensure that clients are seen and treated as soon as possible. This involves being diligent in filling spaces, fitting people in, and supporting staff in maintaining their caseloads. Manning the phone is also highly important, as this is an integral point of contact and access, not just for clients and family members, but also collaborators and other services.

Esther and Angie dedicate a lot of time to the administration of the service.

> "People often don't understand admin. It's so important for the running of the agency."

Their jobs involve filing, photocopying, entering data, keeping track of assessments, appointments, dealing with the paperwork, responding to requests from other agencies, dealing with the switchboard, and so on. Angie and Esther also make great efforts to be there to respond to requests from staff, to support them in their direct work with clients, including typing letters, photocopying, posting and packaging, and making phone calls.

"We feel that we are willing to accommodate any request and would hope that the staff feel this too."

There are also a variety of 'mundane jobs' that need to be done to keep the building and the service 'ticking over'.

"Just generally keeping the place going involves so much work… maintaining the coffee machines, the water machines, ordering stock, watering the plants, making sure the toilets are OK, keeping the place clean and tidy…"

To keep up with all of these demands and be there for clients on an ad hoc basis often involves a juggling act.

"In addition to this, you have clients dropping in and you give each one time. Even if you only give five minutes to each one, which doesn't feel like a lot when you are doing it, it can take up a lot of your day."

"You need to be adaptable and be able to multi-task and not get phased by things."

Angie and Esther both feel that the demands of maintaining all of these roles and responsibilities make the job more rewarding.

"The job is not mundane! Even though it is an admin job, I don't feel bored."
"I love the variety of the work and the hustle and bustle."

They view their contact with clients and the opportunity to witness clients receiving help and overcoming their problems as an amazing privilege.

"Seeing people getting well and each one is a miracle."

"Lovely seeing people go into recovery and then getting back into normal living, e.g. getting a job, custody of children and so on."

"It enthuses you… and people ask you what you do and think it must be so depressing, but it's not! I feel so privileged."

They feel that the good team spirit within WGCADA, and the individual staff that work there not only facilitates the treatment process for clients, but also creates a good working environment for staff.

"I have real friends here who I trust and have a lot of fun with."

"I love working with Esther. We have a really good, healthy relationship which can work as an outlet for frustrations, troubles and someone to share with."

As previously mentioned, Angie and Esther have witnessed the recent development and expansion of the agency. They feel that many of these developments are hugely beneficial to both the agency and staff, particularly the ability to offer a diverse service to accommodate the needs of different types of clients.

The developments have occurred rapidly which has translated into huge changes and challenges to WGCADA as a whole and to individual staff. They feel that staff and management alike need to be aware of such challenges and address them in due course to

maintain the qualities of WGCADA which make it such a special and effective agency. These include the cohesive team spirit, the warm and friendly atmosphere, and the flexibility needed to accommodate the diversity in needs of clients.

Both Angie and Esther feel that WGCADA has both the ability and motivation to rise to the challenge of expansion, whilst maintaining the core elements which personify the agency.

> "… Hope that through all the transition that is going on at the moment WGCADA will find a healthy level and maintain its excellent reputation."

And they are keen to express how WGCADA is a…

> "Really is a great place to work!"

3.12. Statistics, IT and Reports

Robert Salmon, the Administration Statistical/Reports Officer, described WGCADA's journey into the age of computers and IT in the last Annual Report. We briefly take a look at this journey, and also see how the agency has been developing a system for storing client information, and for compiling and reporting performance and outcome measures.

Robert first started working for WGCADA as a volunteer administration worker in January 1999. He decided to play around with the computers in the Swansea office – all two of them! He found they were operating Windows 95 and some ancient version of Office.

A Database system, lovingly known as "Miriam", had been installed on one of the computers, but had not yet been implemented. Robert was asked to utilise his knowledge of databases and explore the system with a view to using it. He was soon inputting client data, and WGCADA started the journey into a different level of technological use.

Robert was employed at Neath No. 30 when it was opened in 2000. A budget to spend on IT was used to purchase five computers and a server, and these were networked. Port Talbot and Swansea were soon "upgraded" in a similar fashion. Staff started to use the computers, some more readily and confidently than others. There are now over 40 computers, including five servers, across the WGCADA offices.

WGCADA have recently changed to the more modern and efficient "BOMIC" database system, which is used independently in each office. They are now looking to merge the four current databases into one large database, with all agencies connected into it via a VPN link.

BOMIC allows the inputting of a wide variety of variables about the client, treatment intervention, agency office, staff member, referral in and out, etc (just take a look at the Annual report)! It is important to be able to collect a wide variety of information, and be able to break it down in a multitude of ways, because particular funders can ask for specific information not requested by others. It is also essential that the database can easily be transferred to WORD and Excel, which is the case with BOMIC. Of course, the information collected is not only of value to funders (who require regular reports) and government bodies (National Assembly for Wales, Home Office), but also to the agency as a whole and to individual staff members.

Roberts believes that this database allows WGCADA to work more efficiently than their original system, in that he and others can:

- store more relevant client information

- access statistical information far quicker for both reports and funders queries
- access outcome measures
- cut down on paperwork
- save workers' precious time.

Using BOMIC, staff can track clients from their first assessment, through their period of waiting for entry into treatment, during their various treatment stages or forms of treatment intervention, and then look at outcomes. Each client can have a number of care plans open in their database, so the impact (or success) of each can be determined. Robert pointed out,

> "Success can occur in different ways. If someone is sent here purely to do the DOMINO project and they stick to the project, then that's a success. If someone is sent here on a court order to do Pre-treatment phase one, which is purely educational - and they don't have to be clean and sober – and they stick to that for the 11 weeks, then that's a successful treatment."

Robert raises an important point here – the meaning of success, or a positive outcome. Success is not always about a client becoming abstinent, or reducing their drug and alcohol use. In some cases, it is about achieving what was required by the programme or funders – which may just be attendance of a programme.

Robert pointed out that WGCADA is now piloting the use of the Christo assessment tool to provide a measure of client outcomes. This tool, which is quick and simple to use, provides help in determining whether the client is experiencing improvements in various aspects of their lives, e.g. reduction in drug and/or alcohol use, improved health, improved social circumstances.

> "Treatment isn't just about getting someone off drink and drugs, it's about the knowledge of staying off drugs and improving the lifestyle."

All WGCADA staff have recently been given enhanced training on BOMIC because of the new features that Robert has added (e.g. pre-formatted letters, the ability to print workers' weekly work sheets, etc).

Staff at Bridgend were the first to fully appreciate the advantages of typing all their notes about clients on BOMIC.

> "One of the keyworkers in Bridgend actually said to me, 'Do you know what? You have actually freed up enough time for me to take on one extra client every week on a one-to-one. That's one more client that has got into treatment due to a computer program!"

Robert is impressed with the speed at which WGCADA as an organisation has embraced the technological age. Some staff find it difficult to imagine that the agency can go any further – but as Robert said in the Annual Report, "WATCH THIS SPACE!" He has a number of definite plans:

- A BOMIC database merged across agencies – this is happening.
- Computers on every workers' desk.
- Touch Screen Monitors in use.
- Speech recognition on some computers, to assist with data inputting and for those people with dyslexia.

- All agencies linked via a Wide Area Network (WAN), replacing the current Local Area Network (LAN). This will hopefully allow for a more efficient system and easier access to information regarding clients in all agencies. Workers will be able to talk to each other over the WAN, instead of using telephones.
- Web Cams on all computers, allowing for video conferencing. Meetings will be held at short notice and staff will not have to leave their own office.

With regards to "Reports and Stats", Robert would like to foster greater dialogue between Funders/Government and WGCADA, so that the latter can provide the information that is required in the best way, and to continue current funding as well as possible funding for other projects. Also, he would like to think that commissioners and government would consult with WGCADA and other treatment agencies before setting KPI's (Key Performance Indicators) that they will have to provide.

> "Challenges that are facing WGCADA are the demands that are being asked, and they are growing all the time. It's not just meeting those demands, but persuading the funders and commissioners to provide us with the money to take on the workers so that we can keep up with the demands."

4. Specialist workers

4.1. Community Support Worker

> "The man is just unbelievable. The amount of dedication, the hours he puts in, but not even that, it's the way that he is with clients. They all feel that he's their friend."

Dave Watkins, the Community Support Worker in Swansea, has an extremely multifaceted job. He is a true "Jack of all trades". Among the roles that he occupies are recruiting clients into treatment, helping the clients with any housing, legal or benefit problems, resolving any problems surrounding the children of the clients, and painting flats!! Dave immerses himself in the clients' lives, and becomes involved in improving all aspects of their lifestyles.

Dave has formed an extensive network of contacts in many agencies throughout the Swansea area. This greatly aids his work and results in him being able to help in countless areas of the clients' lives. Dave focuses on all of the consequences of a client's substance use problem. Whilst the main aim of WGCADA is to help clients abstain or reduce their drug and/or alcohol use, staff realise that it is extremely difficult to do so when the clients lives are so chaotic and disordered. That is where Dave's role becomes so important, as he is able to reduce the stress imposed on the client by their turbulent lifestyles, so that they can focus on, and put all of their energy into, treatment.

> "If someone is sleeping on a pavement then they need that bottle of cider at night because it's so cold. First of all, you need to put a structure into place. We can bring them in and find out what they want us to do."

Dave works very closely with the courts, the police, probation, social services, solicitors, the CDT, housing services and GPs. Together with these services, he is able to make great changes to the social lives of the client, thus aiding their process of behavioural change and recovery. Dave believes that it is vital that WGCADA "works with them [other services] rather than against them". This means that goals can be achieved more readily, and any problem areas in the clients' lives can be resolved as soon as is possible.

Before Dave began working at WCGADA – he was an engineer - he used to be "the kind of guy who thought in terms of black and white. If there was a problem then sort it. There were no grey areas". However, since encountering substance misuse in his family, he has realised that not everything has a simple answer. He will now persevere through thick and thin with clients, in many cases over a number of years, to help them receive the treatment that they need, when they feel that they are ready for it.

Dave has helped one of his clients through countless attempts at treatment, However, he will not give up hope in him, and still believes that the client will soon be ready to change his drug-taking behaviour permanently.

> "We don't give up on anybody. He still wants it. He's not far from it. I honestly believe it."

Dave believes that if WCGADA can help just one individual who has a reputation in areas of Swansea with large scale social and substance use problems, then it will encourage others in their area to come forward for treatment. This is one of the reasons why Dave will go to such extreme lengths to help clients work their way through treatment. He especially hopes that younger alcohol/drug users will see people that they know successfully go through treatment, and will thus be tempted to follow that route. Dave's 'stubbornness' is also reflected in this quote from one of his colleagues at WGCADA.

Spending a Day with Dave by Annalie Clark
(Appeared in the 17th edition of Drink and Drug News)

9 o'clock on a Thursday morning and Dave is already hard to pin down. Rushing around dealing with telephone calls, clients and staff, he is unnaturally energetic for the early hour, and in my bleary eyed state I start regretting volunteering to follow him around for a day. At this rate, I'm bound to lose him and get left somewhere, undoubtedly with some unsavoury drug dealers or the like.

My fears are compounded by the ominous warnings I receive from people around the agency, along with advice not to enter his office in case I get lost amongst the clutter (despite the clutter management course!). This is a man whose reputation as a "superman" precedes him, and I, a naïve medical student from a sheltered background, am going to have to do my best to help and not hinder him in his duties. Yikes!

Yes, I am undoubtedly extremely naïve to the world Dave works in. I may live in Scotland, the home of "Trainspotting" and legal street drinking, but I've never actually seen or met (at least knowingly) anyone with an active addiction. What I will learn today however is that I probably *have* seen people suffering from a drug or alcohol addiction. I just haven't realised it because they mostly look like normal people and don't fit into my stereotypical view of what an addict looks like.

Sitting in on an interview where Dave describes his role, I start to get a real understanding of what Dave does: absolutely everything and anything. From arranging housing, to dealing with debts, to working on the agency's allotments. He talks of the importance of his

network of contacts, which I am to see in person later – he seems to know everyone, from receptionists to magistrates!

What starts to sink in is the fact that Dave hardly ever, ever, refers to the person's drug

habit. Not what I would have expected from a drug worker. It dawns on me that whilst his colleagues at the agency deal with the addiction, Dave's role is to provide the resources an individual needs to support them in beating the addiction and preventing them from being pushed back into it. It's no wonder that someone living on the streets needs a bottle of cider before going to sleep – they need *something* to warm them up! And there's no point in helping them to recover from their addiction if they are going to face the same circumstances tempting them to drink when they get out of rehab. Armed with this realisation of the importance of Dave's role, I start the day.

The first person we see is a homeless man who is a recovering alcoholic. He had experienced a relapse a few days previously and was feeling hopelessly guilty about it. Moreover, he was desperate to find a flat, because living with his brother was putting a lot of pressure on him. Dave goes to get his big book of contacts, and I face my first challenge of the day: talking to my first client. Until this point, I had been following Dave around like a lost soul, feeling hopelessly awkward and unnecessary. And as the seconds tick by, and we sit in silence, that awkwardness increases and increases.

I have no idea *what* to talk about: whether he feels comfortable talking about his addiction, whether he *wants* to talk about his addiction or whether I should just make desperate small talk until Dave's welcome return. Finally summoning up the courage to talk, I find that we are united in our mutual love of our mobile phones and Playstations. What strikes me is his complete normality – he is nowhere near what I had imagined an alcoholic to be like – and his unprompted openness about his addiction, even to a stranger.

Our next stop is Singleton hospital, to visit an alcoholic suffering from pancreatitis. When we arrive, the Sister informs us that he is ready to leave, and that he can't stay the weekend because they need the bed. Approaching the bed however, I get a different impression. The man is sobbing and sobbing, due to the pain he is experiencing. Apparently he is not allowed any pain relief because he is a drug user as well. He tells us that he is depressed and cannot even hold water down. I immediately feel immensely sorry for him, blaming the hospital staff for being uncaring and insensitive.

Dave, on the other hand, knows the client far better than me. He has seen this behaviour again and again and seen the client turn down numerous rehab places, just to return to drinking on the streets. He says he finds this incredibly frustrating, but nonetheless, he makes a number of phone calls, eventually finding a place in a rehab in Weston Super Mare. I am hugely impressed by this dedication – Dave makes the effort to give the man another chance, despite the fact that it has been thrown back in his face again and again.

Back at the centre a gorgeous, smiling woman asks for Dave's help. I am shocked to hear that only seven years earlier Dave had literally picked her out of the gutter, helping her to overcome her addiction to amphetamines. Her husband has been convicted of aggravated bodily harm, under hugely unfair circumstances, and she came to the centre hoping someone could help. There is clearly little Dave can do however, but this seems to me to be a prime example of people's faith in the centre, and what they can do to help them – even to the extent of influencing Crown Court proceedings!

It is now that I get to experience the first of many of Dave's magic tricks. He had talked about his "magic trick meeting" earlier in the day but in my naïvety, I thought it must be a key word for some sort of rehab or detox. But no, he actually meant *real* magic tricks! And very impressive ones too! Dave explains to me the importance of gaining the trust and

confidence of clients, by engaging them, or their children, by performing a magic trick. And from what I see, it really does the trick! Another one of Dave's talents, which I am discovering by the minute!

Running late, because Dave's scheduling encompasses all the problems he encounters regardless of how insignificant, we arrive at Cefn Coed – Swansea's psychiatric hospital. I am immediately intimidated by the red brick building, which is like something out of a film, and this feeling is far from alleviated when Dave explains that half of the front door is boarded up because someone drove a car through it the previous day. Great!

Inside, the hospital is dark and dreary – some wards are locked all the time and doors are boarded up where people have forced entrance. Despite obvious efforts to improve the atmosphere of the hospital, I feel overwhelmingly uneasy in it – it really doesn't inspire the most positive mental attitude! On the secure detox ward, Dave chats about a number of patients who are in, or have been in, the ward. His detailed knowledge of a client's history regarding their addiction and treatment is amazing, especially considering the sheer number of people with which he deals. We meet a client who has obviously been self-harming – Dave addresses the subject in a direct yet positive manner, emphasising that it wasn't as bad as last time. Dave's unfailing ability to say the right things in the right manner and tone is so remarkable – he knows exactly how to pitch advice for each individual client, whatever their state of mind, and never, ever seems to put his foot in it!

The next woman we see at the hospital is undoubtedly the most striking case I see all day. She is an alcoholic. If she is let out, she will be on the streets, drink again, be picked up by the police and bought straight back. So she has been sectioned for an indefinite length of time because, Dave says, "no one wants her." She hasn't got any friends with whom she can live. Her family don't want to know her. And so she will probably be in the hospital, in a secure ward, for who knows how long. The fact that even Dave says that nothing can be done for her emphasises to me the gravity of her situation – Dave, the "superman," who does everything and anything he can to help people, even if they don't want that help. Nonetheless, even though he can't do anything to help her situation, Dave continues to visit her. Amazing really.

Next, a quick call to check-up on a client whose friends are worrying about her. We get no answer on the intercom, so proceed up to the flat. At the door, still showing the signs of the last time Dave had to break in, we bang and shout through the letter box to no avail. She is either out, drunk or dead. Reassured by a neighbour that she wasn't drunk earlier we leave, although I remain worried.

Our final call of the day and we're visiting an alcoholic with an eating disorder. She is so painfully thin she looks like she could be broken at the touch of a finger. She moves slowly, as if in a dream, and her speech is confused. From my lack of experience, I assume this is the normal effect of chronic alcohol abuse, but Dave later tells me he suspects she is taking another type of drug. This perceptiveness amazes me – it hadn't even crossed my mind! As we sit down, she brings out piles and piles of unopened letters, mostly all from creditors.

This is another aspect of the job that I had no comprehension of, but I can know see how quickly financial situations can spiral out of control – a number of deadlines had been missed because she had been burying her head in the sand and not opening her mail.
Despite the daunting size of the task, Dave gets to work, reading, sorting and making phone calls – a hugely complicated job, but another one of Dave's talents! Within an hour the mail has been sorted, Dave has been in contact with her solicitor and has arranged a medical appointment to ensure that she doesn't lose her benefits. Another job well done!

So I reach the end of my day with Dave, and to my surprise I've survived! My brain is only slightly frazzled and all my previous misconceptions about drug and alcohol addicts have been pretty much thrown out the window.

Despite having heard numerous stories and news reports about drug and alcohol addiction, I was completely unable to comprehend the reality of the situation, because I couldn't relate it to *actual* people. But meeting clients today has enabled me to relate real experiences with real people, people who are just as normal as you or me.

And as for Dave, what can I say?! He really is a superman!

We thank Claire Brown and Ian Ralph of Drink and Drug News for their kind permission to use this article.

> "It doesn't matter what you tell Dave [Watkins], we can't do this because of this, his answer will be yes we can, we can do it."

Dave's job is not a 9-to-5 job. Much of Dave's work is conducted after hours, as he will not turn down a client when they need his help or support. This may be one of the reasons why he is so popular with his clients, as he is always there for them when they call for him. Dave certainly plays a significant role in the success that WCGADA has in getting their clients through treatment, and he is an invaluable member of the team.

Dave is well-known for taking out students, members of the WIRED team and others for a day whilst he runs around dealing with his clients' problems. We have included two pieces written by Dave's "followers", one by first year medical student Annalie Clark and the other by Cheryl Hancock (see Appendix C).

Cheryl's daughter Becky had been coming home every night after working with WIRED and telling her mother about all her interesting experiences. Cheryl eventually got so sick and tired of this – and intrigued – she eventually decided she had better take a look. WIRED offered her a commission to write about "a week in the life of Dave Watkins" and Cheryl took up the challenge. She later ended up working for WGCADA!

4.2. Tenancy support worker

Lesley Thomas works closely with the Tenancy Support Unit (TSU) of the City and County of Swansea Council. The TSU is an umbrella for a number of organisations, including the Red Cross, Age Concern, and Cyreenians.

The TSU assesses people who have been brought to their attention through a variety of ways: rent arrears, neighbourhood watch, marriage breakdown, violence and theft. They assess the person to determine their needs, and refer the client on to have these needs addressed. If the TSU think that drugs and/or alcohol are a core issue, then they contact Lesley and provide her with the name and address of the client.

Lesley assesses the client, looking at their drug/alcohol use and resulting problems, as well as various other aspects of their life. She determines their needs through this assessment and the information provided by the TSU.

She then helps the client with their problems and the issues that they have, at the same time as informing them about the agency and in some cases encouraging them into treatment. Lesley sometimes has to hint to the person that he or she has a substance misuse problem, rather than confront the issue directly, and she talks about her own past

alcohol problems and recovery. She tries to draw them in to treatment if she believes they need this help. She will arrange a detox, help introduce them into Pre-treatment, or encourage them to access the DOMINO project.

Lesley deals with a variety of client issues. She helps clients with their rent arrears and other housing problems, their debts, and their benefit and disability claims. She takes them to the doctors, solicitors, courts and even shopping if they have no transport. The people she works with have often lost basic skills and levels of understanding about the workings of certain aspects of society after long periods of alcohol and drug misuse.

> "All the years under influence, where do you start?"

This sort of general help often needs to be provided after the person has stopped using drugs and alcohol. Other problems – like debt – don't necessarily disappear if a person stops drinking. Lesley emphasised that some people need help when they return to their homes after a period in residential rehabilitation.

> "Their homes when they're using, they're in quite a bit of mess. When they sober up and come home from rehab – I know I did it myself – take one look at the place, it is enough to drive you back there. It's so dirty … "

There are other problems that arise for people leaving residential rehabilitation to return to the same home they had left earlier.

> "People who have spent five or six months trying to get clean and sober and you them straight back into an environment where their next door neighbour are going to know at the door and say, 'Nice to see you, have a drink'."

When asked what things get in the way of her job, Lesley said "awkward partners." She described one partner who is causing considerable problems for one of her clients.

> "He's a control freak … a controlling partner. He hasn't got an alcohol problem as such, but he supplies her with alcohol. As soon as she gets up in the morning there is a cup beside her. He likes to keep her under the influence. He knows that if she sobers up he is going to lose her. She's going to be out of there."

Lesley has to visit their residence with the partner's Support worker (for his mental health problems) as he can get aggressive. This support worker takes him out while Lesley befriends her client. Unfortunately, she cannot get her out often as she is so ill, and if she takes her into hospital, they cannot medicate her because she is raely sober. She gets fed up being in hospital, starts to crave alcohol, gets angry and walks out, knowing her partner will take her to the pub. Situations such as these can greatly complicate Lesley's work.

Lesley is officially supposed to have nine clients on her books at any time – at present she has six. The clients are supposed to receive six hours a week intensive support from the agency, provided by herself and other team members. Lesley encourages clients to attend DOMINO, which some do periodically.

Whilst some clients engage well with the agency, in reality you cannot ensure that each and every one receives the full six hours support each week, since they may only want help in certain matters. Some clients have been with WGCADA long-term, whilst others come in and get sorted out and then say, 'That's enough, thank you'. One client appeared to want

help with his drug/alcohol problem, but left as soon as Lesley sorted all his debts and entitlements, such as his Disability Living Allowance. In one sense he was a success – he went away happy.

Lesley worked with one young lady for five months and it just didn't go anywhere. It was,

> "Just a one way system, just not going anywhere. She's not ready, but hopefully I've planted the seed."

Lesley said that she could have been working with someone who had wanted help, rather than with this person. Sometimes you have to give up on someone who is not ready for change, but it is difficult to know when to make that decision.

She described one client, aged 29, who had come to Swansea to escape an abusive, addictive relationship. She was homeless and was flagged up by the TSU (via Housing Options) when she was in a B&B. She was assessed by the TSU and referred both to WGCADA and a psychiatrist (for her obsessive compulsive disorder).

After assessment by Lesley, the client was sent to Broadway Lodge where she spent six months residential. Sadly, this client relapsed in the week of our interview with Lesley, after being clean and sober for eight months. Lesley is hoping that the drinking at the weekend was only a lapse: at least she had helped the client stay away from drink for eight months. She had never managed even eight days since her descent into problem drinking.

Lesley emphasised the importance of her position – and this referral pathway – as her clients are the sort of people who would not access the agency in other ways (the so-called hard-to-reach). A lot of her clients are not even aware that they have a drinking or drug problem. They see their drinking as a natural response to financial problems or abusive partners. Even if they do realise they have a problem, clients have no idea that help is available.

A lot of her clients are agarophobic – they have been drinking excessive in their house and now cannot get out. Lesley takes these clients down to the allotments (or other DOMINO activities), even if it is only for an hour.

Some of Lesley's clients feel very alone. She tells them her story, so at least they can see that there can be life at the end of the tunnel. Some clients may never have received help before. They may have had appointments with solicitors and doctors in the past, but had not been able to get there. Other clients cannot read and write – they receive letters which need to be dealt with, but they don't respond because of their difficulties.

4.3. Arrest Referral workers

4.3.1. WGCADA Neath worker

Maria Davies is one of the Arrest Referral workers based in Neath - she works out of the No. 15 base. The Arrest Referral posts were developed as a result of the allocation of funds for drug and alcohol treatment through the criminal justice system.

Maria describes her role as a point of contact for individuals who find themselves in the criminal justice system - in the police custody suites or in the courts - and as an opportunity to promote WGCADA as a free advice, assessment and referral point for access to help with drug and alcohol problems. She also offers clients help to deal with the court process. She

aims to use the opportunity to meet individuals to engage them in WGCADA, or to refer them to other services that may benefit them.

> "We are like a mediator. We are just normal people offering help, support and advice for people who generally do not know where to turn. They are distraught, distressed and we can just offer them free help when they feel that they have nowhere else to turn. We can then refer then to what they need."

The opportunity to meet with Maria (or Vanessa, the other Arrest Referral worker in Neath) is offered to everyone who is arrested. She believes that that working independently of the police to some extent is imperative, to gain the trust of potential clients and engage them in the services that WGCADA can offer.

> "We work independently of the police, so obviously the clients don't have to worry that whatever they say to me will be passed onto the police. That first meeting is very important, because we are building trust and we can engage the client.'"

Maria describes how WGCADA's Arrest Referral workers have built good working relationships with the South Wales police. The service offered is generally viewed as a useful resource in trying to deal with the impact of drug and alcohol misuse on society, and the effect that this has on crime. She concedes that whilst there may have been some tensions or reservations from the police when the posts were first introduced, this was to be expected. Importantly, the two organisations have risen to the challenge remarkably well, and made efforts to accommodate each other respectfully.

> "There may have been discrimination [from the police] in the past, but now individual custody sergeants and custody staff are given training in arrest referral and the role of an Arrest Referral worker."

Maria describes how she takes care to work within police rules, is never pushy, and does not get in the way of the duties of police officers. She has found that this simple approach, alongside the impact of the services offered on some of the clients she has engaged, has led the police to realise the benefit and need for WGCADA's involvement.

Maria works particularly closely with Inspector Mark Walters and DS Dick Johnson, and regularly attends meetings with them to discuss the workings of the collaborations and to work on future developments. The impact of these relationships inevitably results in the good promotion of the Arrest Referral scheme to individuals who are arrested and police encouragement of individuals' engagement.

Maria visits the police station and courts once a day to meet potential clients, and finds that officers will also call her up if people are arrested in the interim. Her remit includes anyone who is over 18 and expresses a desire to meet with her (individuals under 18 are referred to the Youth Offending Team).

She described how she encounters an extensive range of individuals from a variety of backgrounds, including homeless people, individuals engaged in other services (e.g. social services, mental health services), and professionals. These individuals are arrested for a variety of reasons, such as incidents involving domestic violence, automobile crime, breach of the peace, violence, assault and threatening behaviour. Many of these crimes involve, or are exacerbated by, alcohol or drug use. Other offences are often termed 'trigger offences',

and are related to either the use of alcohol and/or drugs, or the acquisition of drugs. These trigger offences include possession, dealing, intent to supply, and acquisitive crimes (e.g. shoplifting and burglary) to fund a drug habit.

Maria pointed out that many individuals are often relieved to be met by someone who is not in uniform and is non-intimidating. They are often surprised by her alternative attitude to the police, as she is concerned with the person and not with the offence. This alternative viewpoint is often a welcome change for individuals who have found themselves trapped in the cycle of drug/alcohol addiction, e.g. the need to have a drink/drug to be able to function normally, the need to fund their habit, and finding themselves on the 'wrong side of the law' through possession.

> 'Clients are normally relieved to see me, especially if they have been locked in a cell, and especially because I don't wear a uniform. We dress very casual and low-key. And perhaps we go in there with a different attitude. We are not looking at the offence, but at the person.'

Maria's understanding of the effects that alcohol and drug misuse can have on an individual's lifestyle, their behaviours and their 'sense of self', can often help them to look objectively at the impact that it is having on them, and the options that are available to them. Although some people are not ready or willing to address their alcohol and/or drug use and, therefore, do not engage with Maria past their first meeting, she recognises that she is able to 'plant the seeds' of recognition of the effect it may be having on their lives, and increase their awareness of services available to them. They may choose to engage at a later date.

When Maria first meets a client, she takes care to present herself as a mediator and advocate for the person. The meeting is very informal and she simply introduces herself as 'Maria' rather than as an 'Arrest Referral worker'. This is to encourage potential clients to see her as a 'normal person' who is there to offer support and advice.

> "When I see a client, it's really about just introducing me. It's not about introducing WGCADA, it's about letting them get to know me. We don't want to scare them off. You have to bring things down to their level, whatever that may be."

Maria is friendly and easy-going, which encourages the development of a trusting relationship. She immediately makes it clear that anything discussed is confidential and will not be used against them to help the police build a case for the crimes they may have committed. She works within the confidentiality regulations of WGCADA, and explains to the client that confidentiality will only be broken under the following circumstances: a real or significant risk of harm to yourself or others; risk of harm or neglect to a child or children; and a subpoena by a court of law. This allows the individual to be reassured and comfortable in talking honestly and openly to Maria – and in some cases, to be aware of what is acceptable to disclose or not.

Maria described how, for some individuals, she is offering something that they may never have known existed before. Her role, therefore, is a form of outreach into the community, as the people she encounters may not be aware of treatment centres, and the help that is available to them. Her role is to take clients through the range of options that WGCADA offers, whilst taking care not to overload them with too much information.

There is an initial standard assessment where Maria gathers information to build up a picture of the client, including their using, lifestyle and any issues which they may be facing. She reiterated to us that it is not simply the drug and/or alcohol misuse which she aims to address, but the individual as a whole. This includes the underlying issues surrounding the substance misuse and can involve housing issues, lifestyle problems, psychological problems and so on.

> "A client may come in initially with an alcohol or a drug problem, but there will be other things underlying, and they are the things that need to be addressed at a later stage."

In response to the information that this assessment provides, and the needs and wants that the individual expresses, Maria will take them through the various types of assistance that she can offer them. This includes: preparing reports for the courts, writing supporting letters, offering free legal advice, contacting solicitors, introducing the notions of harm reduction and abstinence services, making appointments with WGCADA, liasing with the council, and helping with housing or safety issues. Maria is also able to refer clients to other agencies or services which can help them to address other issues or problems they may be facing, e.g. violence and anger management, counselling, eating disorders, or mental health issues.

In collaboration with the client, Maria devises a flexible action plan to work towards meeting their needs. She explains how the approach is very client-led and may change over time. An individual's engagement typically involves their regular attendance to meetings with Maria, and possibly other services that WGCADA offers such as DOMINO, harm reduction services or referral to the abstinence base in Neath No. 30. Maria reinforces the fact that the client will have to put in a lot of effort if they remain at WGCADA.

> "It's not an easy option because the still have to put in all the hard work. We expect to see them at least once a week and hopefully more. We provide a lot of activities to engage the client, and we expect a great deal of involvement."

Maria emphasised how much she enjoys her job and the opportunity it gives her to help others. She is proud of the strong relationships that WGCADA has built with the local police and the way in which the service has developed over time.

She told us how she hoped that there would be provision of a weekend service, where workers who are able will cover the weekends to enable individuals who are arrested over the weekend to be offered the same level of support as those during the week. At present, people who are arrested on a Friday night or during the weekend (which is commonly known to be a 'hotspot' of crimes associated with alcohol) have to wait until Monday morning to have the opportunity to meet with an Arrest Referral worker. Maria recognises that many of these people may have been released or bailed by this point. This lack of provision may therefore, be resulting in potential clients 'slipping through the net'.

> "It would be great to have Arrest Referral workers available on the weekend because how it is at the moment, if they get arrested on a Friday night then all they do is fill in a form. And then when we try to contact them, they haven't got a clue who were are."

Maria also suggested some developments which she feels would greatly expand the scope and effectiveness of the service. The fact that her post is only secured on a one-year basis

translates into a feeling of being unsettled, and can sometimes be a barrier to looking forward to possible future developments or expansion of the service.

> "WGCADA faces funding problems. I work on a one yearly contract basis, so I have no long-term job security."

She also feels that the allocation of a specific worker who would be based in the custody suite of the police station would be beneficial to clients, WGCADA, and the police. This would facilitate the swift meeting of potential clients, and could encourage more people to meet with an Arrest Referral worker. This would also reduce the amount of time each worker spends travelling back and forth, which could help maximise the efficiency of each worker.

> "I would also love to see one member of staff custody-based, with their own desk or office at the police station so that they are always on hand. That would be ideal."

Maria loves the fact that working for WGCADA feels like working within a family atmosphere. She believes that this is due to the good team cohesion within each site, and that the group social events (e.g. Christmas parties, nights out, the AGM) help to bond WGCADA as a whole.

4.3.2. Bridgend Arrest Referral: developing the scheme

Becky Hancock is the Arrest Referral worker in Bridgend. The Arrest Referral scheme was introduced to the area in July 2003 and is provided by WGCADA, in partnership with the police, probation service, social services and the local health authority.

Planning and designing the scheme

When Becky first came into post, she recognised that it would be beneficial to spend time with other Arrest Referral Workers and therefore, spent a week shadowing WGCADA's Swansea Arrest Referral Worker and a day shadowing a TEDS's Arrest Referral Worker.

She then spent time determining treatment and support services in the Bridgend area. These included treatment services such as NHS specialist services (residential, rehabilitation, detoxification), services in the community, social care and voluntary sector providers. Furthermore, given the range of problems likely to be identified for an individual, the role of training providers, employment service, benefits agency, housing department and debt counselling services were also taken into account.

For the scheme to run efficiently it was important that the partner agencies clarified the aims and objectives of the scheme. At a practical level, the setting up and running of the Arrest Referral Scheme requires collaboration and co-operation between a number of agencies; the most important being the police. It was important to emphasise that the Arrest Referral is separate from the criminal justice process. There is no formal link to the due process of law. Substance misuse may help to explain someone's criminal behaviour, but it does not absolve them from criminal responsibility.

In August 2003 Becky discussed and agreed with Bridgend Police Station's Sector Inspector Eifion Evans access to custody suite and cells, interview space, privacy and security. Initially, she was accessing the custody suite at nine o'clock each weekday morning. However, this did not prove to be successful as she was often missing (some) arrestees as Reliance (a private security firm) took them to court earlier. With police agreement, she now visits the custody suite at eight o'clock every week day.

Due to the nature of the clients that Becky assesses, it was important to notify (e.g. letters and leaflets) the Solicitors in the area about the scheme.

Monitoring and evaluating the effectiveness of the Arrest Referral Scheme is paramount. Therefore, she spent time devising a system of data collection (i.e. a Microsoft Excel spreadsheet) and reporting to the Drug Prevention and Policy Unit (based at Port Talbot Police Station) on a monthly basis.

How does the scheme run in Bridgend?
Currently the 'cell sweep' approach is being used in Bridgend Police Station. The client allegedly commits an offence. Whilst they are in the Custody Suite at the Police Station, regardless of whether the alleged offence was committed under the influence of alcohol/drugs, they are offered help by the Arrest Referral worker or via the arrest referral forms. At this point, the independence from the police and confidential nature of the scheme is stressed to the arrestee.

The role of the Police officers in terms of the success of the scheme should not be underestimated. They facilitate contact, and provide time and space. In recognition of their key role, time was spent ensuring that the officers were well informed about the scheme and the services available to the arrestees. Furthermore, when Becky is not in the custody suite, the custody staff have the job of promoting the scheme to all those who have been arrested. An on-call service has been set-up within the working day i.e. if somebody is brought into custody and accepts the Arrest Referral scheme, the custody staff have Becky's mobile number and, if she is available she will go to the police station.

The role of the 'jailers' has been civilianised. From April 1st 2004 Securicor employees replaced the Police 'jailers'. Again time was spent ensuring that all custody staff are aware of the Arrest Referral scheme.

Developing the scheme further
Other Arrest Referral schemes have found visits to the court cells before the court is beneficial. It allows contact with offenders who have been taken to court before they have been seen in custody cells and with those who have been remanded in prison. In an effort to introduce the scheme to the Magistrates' court, Becky met with Darren Sheppard, the CPN attached to the Court Mental Health Assessment Service, in October 2003. They decided that it may prove more efficient for Darren to refer appropriate people to the Arrest Referral scheme due to the space (and time) limitations at Bridgend Magistrates' Court.

Becky also contacted Mr Tony Secular, the Clerk to the Justices, regarding accessing the courts. She wrote a short document about the Arrest Referral Scheme for the December 2004 Court newsletter. The Clerk to the Justices has supported Becky's request to be available in the reception area of the Magistrates' court for a few hours a week, allowing the scheme to be introduced to potential clients due to appear at court. It also provides an opportunity to access existing or previous clients to offer further support. Posters briefly outlining what the scheme is about and WGCADA's contact details are now on display in the Magistrates' Court. Becky also attended the Court User's group in June 2004 to present a short summary of the scheme to the relevant people, and is also a member of the court user group.

Currently there are posters advertising the scheme in Bridgend Police Station's custody suite. However, it is hoped that in the near future the walls in the custody cells will be stencilled with details of the Arrest Referral Scheme as arrestees often sit in the cells for a

long time and this can be a chance for them to reflect. D.S. Dick Jackson (Drug Prevention and Policy Unit) has recently secured a free phone 0800 number for arrest referral clients.

In February 2004 DC Colin Whitehouse was appointed at the Drug Liaison Officer for the Bridgend division. He expressed his support for the scheme and has become more involved with its promotion. Furthermore, an Arrest Referral steering group was set up which meets on a quarterly basis consisting of WGCADA's arrest referral workers, WGCADA's Criminal Justice Manager, DS Dick Jackson (Drug Prevention and Policy Unit), Inspector Mark Walters (who overseas the Custody Sergeants in South Wales) and the respective Drug Liaison Officers.

A Bridgend Client's Story

My first encounter with WCGADA was via the Arrest Referral Worker, who visited me whilst I was detained overnight for shoplifting. I failed to keep the appointment offered. I had been recently diagnosed with a Bi-Polar Disorder, and failed to even attend psychiatric appointments.

Following a second offence of shoplifting, for which I was convicted, this and my drug use seriously impacted on my life and sent me into a mixture of manic and depressive episodes. I received a one year Probation Order, and my Probation Officer, seeing that I wanted and needed help, referred me to the Arrest Referral Worker at WCGADA, who I had met previously.

WGCADA was the lifeline that I'd needed. I didn't have to stay in this rut - there was hope, but I just hadn't realised it. I started to slowly feel some sort of self-worth. The first few meetings were about me learning to open up and discuss my life, and see the results of two years serious addiction. Initially, it was hard to relive those years and be completely truthful. But the more I got to know my key worker, I realised that WCGADA weren't sitting in judgement and they were genuinely there to help with no prejudice.

We went through each drug including solvents, one by one, with all the relevant information: How much? When? How often? I was still using for the first few months of our appointments, although I had started to make lifestyle changes and cut down my heroin use. Each week, I felt I could unburden everything that had been worrying me that week. I feel that helped to keep me going, knowing I could get good advice on even the most mundane issues.

Fairly soon, I was referred to the Community Drug and Alcohol Team via the Rapid Access Point. The feeble excuses I'd always made, " It'll take too long to get seen!" and "I don't feel well enough, unless I've scored first", were very quickly buried as I had an appointment within a week of her referring me.

We discussed various options, residential rehab, in-patient and home Detox, rather than a maintenance script. I feared relapse from detox, and believed a reducing maintenance script was the answer along with changing my lifestyle.

Due to my desperation to move, I grabbed the only hand out there, which happened to be from a newly found friend who was a fellow drug- and alcohol-dependent. He had been sober and clean for one year and offered me a "safe" refuge away from the estate. I thought it was the best thing to do. My key worker advised caution but I went ahead.

It turned sour and became a dangerous situation to be in, as he was determined to prolong my dependency for his own agenda. This was a very difficult time for me, but my key-worker could see the situation clearly and made it her job to help find me somewhere to live. She took me to the local Council offices, to see Shelter (Homeless Charity), and made numerous phone calls to Hostels and Refuges. All this, while I was having numerous meetings with the CDAT to assess my suitability for a maintenance script, multiple probation appointments and a difficult home life.

My Subutex prescription eventually started in April 2004. It was the best news I'd had in years. I was to collect my script on a daily basis and take it on the premises, which was great. My heroin use ceased immediately. Then came the news that I'd got a place in a Women's Aid Refuge. My life was turning round! I continued my appointments at WGCADA, and continued to stay out of trouble attending all my probation appointments. It was during this time that I met my current partner, Paul

Slowly but surely, the friendship developed into a relationship. This was something I would never have recommended to anyone newly sober or clean, but it has worked for me. It so happened that we met each other when we were both in a fragile state, only I was affected by drugs, and he'd recently ended his failed marriage and left two children behind that he was struggling to get access to. This brought us together and we both supported each other enormously. Together, we found myself, with a view to both of us in the future, a lovely home away from my old haunts and faces. Both our family and friends helped enormously.

Very soon, we got the news we had been waiting for - Paul was given temporary custody of the children, due to their mother's illness. However, it wasn't long before we had a setback. Due to my past drug problems, Social Services questioned me seeing the children, and for a brief moment I felt like my world had just fallen apart. But then I thought, 'No, that's not what WCGADA have taught me. They've taught me to be strong and if at first you don't succeed, try, try, again.'

So I picked myself up and told myself this won't be for long. I set about proving the person I am today, my suitability, and also the beneficial effect I knew I could have on the children's lives. As well as this, I contacted my key-worker and went to see her. She did all she could in the way of speaking to the relevant people, and writing the relevant reports, to prove that I'd come as far as I had.

The children have been with us for about eight months now and are thriving. As well as other prospects, I am attending a Welsh refresher course to help both children with their schooling, particularly the little one who has speech difficulties. Paul has recently got custody and we are building a life as a family together now.

I still have regular contact with WGCADA and I am attending a Relapse Prevention course. This has certainly opened my eyes to all aspects of drug and alcohol dependence. This, along with other projects my key-worker's involved me in, has left me with a strong desire to get involved in this field myself professionally and help others who are in the situation I was in.

4.4. Youth Opportunities worker (Port Talbot)

The Youth Opportunities worker post was developed to be part of a team addressing the needs of young people in the community who are misusing drugs and alcohol. There has been high profile media coverage of the increasing levels of substance misuse in young

people in recent years, typified by reports of children as young as ten experimenting with heroin and crack cocaine.

Chey Jenkins, the Youth Opportunities worker in Port Talbot, sees such increases first hand, and advocates the importance of addressing other factors in the young person's life in addition to their drug and alcohol use. He therefore takes a child-centred approach to look at the young person holistically, and is acutely aware that the substance misuse is often a symptom of other issues or factors.

> "The important factor is to look at all aspects of their lives. Drug use is symptomatic of what's going on in someone's life. You can't treat the drug use in isolation."

Chey takes care to build a trusting, friendly relationship with his young clients, and provides a safe environment in which they can explore the causes and roots of their using behaviour. He recognises that some young people may start and continue to use drugs and alcohol because they enjoy the feelings they produce, and/or because they are a normal part of life within their peer and social circles. In these cases, Chey notes the importance of education and advice about drugs, drug use and addiction, to minimise the harm they may be causing themselves and the potential for dependency in the future.

The initial assessment can often be a very scary prospect for young people. Chey uses the opportunity to make them feel comfortable and ensures that they move at their own pace.

> "You have to assess at a pace that keeps the young person happy. Sometimes, they have been through such horrific circumstances, and they are so used to assessment they don't put any emotion into it."

Meeting young people 'where they are at' can influence their initial view of WGCADA, and can be integral in engaging them in the services that are on offer. Chey estacblishes by whom and why the client has been referred to the centre, and the issue of confidentiality is immediately addressed. The referral routes include, among many, social services, parents, young people's organisations, schools and doctors. Chey makes it clear to his clients that the service is not there to get them into trouble, but rather to 'back their corner'. He feels that it is vital to gain the client's trust early on.

> "If that young person doesn't feel that they can have trust in me, then its going to be totally ineffective."

The client's substances of choice, and level of usage, are explored in a non-judgemental atmosphere, establishing Chey as the young person's advocate. This role helps the young person to recognise that the service is there for their benefit, if they choose to take it. It is not something they have to engage in, but rather an option for them. This helps to build trust and avoid a 'teacher-pupil, adult-child' attitude and the barriers this can sometimes create.

The approach takes into account the many influences that are likely to be affecting the young person, including school, peers, family, and past experiences. This often involves recognising that, although every client is extremely vulnerable, each one is individual and needs to be treated accordingly. To facilitate this, Chey takes care to take into account past discrimination that they may have encountered, and tries to be creative in his approach. This is particularly important as some of the young people he works with display a lack of

emotion and sometimes use drugs to enable them to cope with other aspects of their life, for example, family issues.

Chey notes the importance of combining these factors with a theoretical approach and use of guidelines for best practice, including the Health Advisory Service Report, to develop his skills and the services he offers. He finds that utilising the training he has received is an important factor in the quality of the service provided at WGCADA, and helps to engage the young people.

When Chey starts working with a young person, a typical course of action is to initially spend time building a strong and trusting relationship. This respectful base helps him to work with the young person to delineate and face the issues they are experiencing in all areas of their life. They will then discuss these issues, where they are stemming from, the effect they are having on the young person, and the consequences of trying to deal with them in the ways they have been to date. From here, Chey and the client can decide upon the steps that can be taken to stabilise their lives, emotions and drug/alcohol use.
WGCADA and the Young Persons' team have built good working relationships with other organisations in the local areas, both statutory and independent, including social services, youth offending teams, schools, and out-of-school groups. Chey explained how WGCADA is committed to formulating creative ways of working with other agencies so as to educate the staff members as well as the young people.

> "My job is to educate other agencies that drug use is symptomatic of what's going on in their [young peoples'] lives. If we can all work together and provide a bit of stability, then it should reflect on their drug use."

Chey feels that Wales is 'behind' in many ways in terms of developing a strategic approach to address the needs and different ways of working with young people. WGCADA is keen to develop such an approach with the organisations with which they are working, so as to improve the quality and integration of services available to its client base. This is also facilitated by the regular meetings between WGCADA's young people's workers to evaluate the service they are providing, both in individual sites and in the agency as a whole. These meetings are an opportunity to take stock, assess the needs of the clients, and develop and improve the quality of service.

Chey also explained how he tries to include and work with the young person's parents and carers (with the client's consent). He pointed out how this aspect of a care plan is different to that with most adult clients as, with the latter, the responsibility for their treatment goals, and the implementation of change, ultimately lies solely with them. Although young people have control over their own actions and decisions in relation to both their drug use and potential changes, it is also important to recognise that young people, particularly under the age of 16, are still children and therefore, their ability to take care of themselves independently and their level of maturity need to be taken into account.

The maturity levels of the young people entering the service is an important indicator of the most effective and nurturing way that Chey can work with them. He recognises the importance of assessing maturity appropriately, as it is not always directly related to age, but rather the client's circumstances, experiences and individual differences. This judgement can be particularly important when, for example, introducing the notion of prescribing services.

> "The needs of young people are different to that of adults, and we work with them in a different way to adults. The main differences are that it needs to be

> a child-centred approach, you have to be more flexible, and you have to be creative with your way of thinking, and the tools that you use."

Chey has witnessed the expansion of the Young Persons' service and feels that the increasing client base, respectful relationships with other workers/services, and the impact of engagement on the young people' lives demonstrates the demand and effectiveness of the service to date. However, as with any service, he sees opportunity for improvement and is keen to see these changes put into place in the coming years.

Perhaps the most obvious avenue for expansion is the need to implement a more 'community based' service – to actively go into the community where the young people are spending their time to provide options for education, advice and treatment. He would like to see the development of such outreach services to encompass partnerships working with existing services in the isolated valley towns around Neath and Port Talbot.

> "There's a need to work more effectively with the valley communities which are very isolated. They need to develop outreach services, or work more closely with services that already exist in the valley communities."

Ideally, Chey would also like to work on the development of a dedicated young persons' multi-agency centre. This would facilitate the provision of a comprehensive service incorporating youth offending services, young persons' mental health workers, social services and drug agencies. This could help prevent young people from being pushed from 'pillar to post', and to reduce the numbers who are 'slipping through the net'. Due to the nature of young people, and the chaotic lifestyles that many of them have, it can be difficult to ensure that they will attend appointments with many different agencies despite the value that each one can offer. The delivery of the whole service under one roof can therefore help to engage the client, and offers a fixed location where they know they can go for help with many different issues. Such a service would also maximise the reach and cost-effectiveness of the existing services through the pooling of resources and ease of partnership working.

In recent years, a change in Governmental strategy has led to the increased distribution of funds for drug and alcohol services through the criminal justice system. Chey feels that some of the money could be put to better use 'on the ground', in helping drug/alcohol users before they enter the criminal justice system. He suggests that drug users have been unfairly labelled regarding the amount of crime they commit to fund their habits.

> "Drug users need more understanding and effective treatment rather than being put into prison and given a label."

Chey believes that drug treatment agencies should be consulted when money is being allocated to the field, as the workers are aware of where improvements need to be made.

4.5. Young Persons' Worker (Neath Port Talbot)

Colin Lloyd, the Young Persons' worker for Neath and Port Talbot (based in Neath No. 15), has been in post for four years. He immediately spoke of his passion for the job.

> "It's a great place to work and I love my job. Also, WGCADA has the benefit of having someone in this post who really enjoys this job."

It is this passion, which contributes to the thriving and successful young peoples' team at WGCADA.

Colin described how he works with a variety of young people from age 12 to 25, and offers a brief intervention that lasts six weeks. The service that he offers is determined by the type and stage of drug and/or alcohol use that the young person is engaging in. He finds that, broadly, the young people he sees who are under 16 are usually in the experimental stage of substance use and, therefore, benefit from prevention and education work.

> "We look at various diseases, including sexually transmitted diseases, as well as Hepatitis and HIV, and we hope to reduce the spread of these through the services that we offer here."

Most young people over 16 are using in a more problematic fashion. In addition to education about drugs, drug use and addiction, they may also receive support or treatment such as prescribing services, needle exchange or referral to the abstinence programme that WGCADA offers. These young people have often left school, and he helps them to work through the decisions they are facing as they enter the world of young adulthood.

> "Young people have to be worked with very, very differently."

Since the service was set up (March 2004), Colin has had a constant flow of referrals from a variety of places including social services, youth offending teams, youth access, other youth services, the Prince's Trust, local schools, hospitals, parents and some self-referrals. He has 36 young people on his books at present, and is currently working with ten clients under 18 years old.

When Colin first meets a young person, particularly minors who are still in school, he finds it essential to take time to build a trusting relationship. For many of his clients, confidentiality is a major issue, particularly as many of them have issues surrounding their home life, including parental problems, domestic violence, and rape.

> "I wouldn't say that you have to meet them at their level, but you have to build more of a relationship with them. The young person has to trust me, and I have to trust them. Confidentiality comes into it big time."

This relationship, and the need to take into account their personal experiences, and the issues that an individual may be facing, means that Colin takes a very client-centred approach when offering any intervention. He does, however, aim to incorporate prevention and education to everyone. He uses this opportunity to try to educate them on all types of drugs and drug use, and to take them through the concept of harm. In addition to this, he tries to engage young people in fun things to do which do not involve the use of drugs or alcohol, including use of computers, videos and attending The Pad in Port Talbot [see below].

Although six weeks is a relatively short space of time for an intervention, Colin feels that if immediate and direct change is going to be made, signs will be seen within this period. He believes that if it is possible to make an impact during this time, prolonging the intervention will not add to its power. However, each young person is made aware that WGCADA is always there if they need any additional help, or feel ready to re-engage at a later date. It is widely known that for anyone to make changes in their drug/alcohol use, or lives in general, they must be ready and willing to do so. Colin's 'open-door' policy is, therefore, very important in maintaining a link with young people who perhaps are not ready to make changes at their time of engagement, but may do so later.

> "I will spend six weeks with them and we will do lots of fun stuff… However, I make sure they know that if they don't do something that I have asked them to do, then it doesn't matter. They are still welcome to come back."

Parents and carers are able to engage with Colin throughout the six weeks intervention (with the permission of the young person), and are also invited to attend a meeting at the end to discuss the activities, discoveries and possible changes that have been made. Colin is available to give them advice and support, whilst always maintaining trust and respect with the young person.

WGCADA also runs 'The Pad', a free and confidential drop in for young people, every Thursday afternoon. The Pad aims to reduce the risk and harm caused by drug and alcohol misuse. WGCADA staff are not there to preach to young people, only to provide advice and information to enable young people to make informed choices.

WGCADA also recognises the need to have organisations and places to refer the young people to, in order to support any potential changes in both their drug/alcohol use and any other related behaviours. They have, therefore, created links within the community, including with schools, The Prince's Trust and the Duke of Edinburgh Award Scheme. These links help Colin offer clients' alternative activities to get involved in which they can learn new skills, and be in an environment which can support the building of self-esteem and confidence. WGCADA also works with the Forrest School, which aims to provide 'underachievers' with a ten-week programme where they can learn new skills, such as how to make and use tools, make shelters, the premise of healthy eating, and good teamwork.

Colin, alongside others from the WGCADA Young People's team, also does a lot of prevention and education work in local schools. He described how they get a very positive response to this education, in particular from the young people they meet.

> 'They think it's absolutely fantastic – they really love it. Their evaluations are always positive.'

This is also an opportunity to build good outreach networks with the schools in the area, and facilitate potential referral pathways. Colin uses this as an example of how they have been 'knocking down doors' since the service was created to establish networks with the local community to facilitate access to young people who could benefit from WGCADA's services. In addition to the specific young persons' services, they have also gone out of their way to promote WGACDA generally as a service by, for example, inviting people to the AGM, team talks and conferences.

As a result of this increased involvement with other agencies and organisations, Colin has seen first-hand the need for increased awareness and training amongst professionals in other areas of life. For example, he sometimes finds that when he is giving talks in schools some teachers may be a little 'twitchy' when he starts touching upon areas of their own lives (e.g. drinking behaviours). He has also recognised that some youth workers have very little, or no, awareness of drugs and drug education. As drug and alcohol use is so prevalent in society of late, particularly in young people, he finds that this exemplifies the needs for existing youth drug/alcohol workers to be educating such individuals. This is something that Colin would like to see developed in the near future.

As Chey Jenkins also expressed (see above), Colin would like to see the development of a dedicated young persons' centre where the multi-dimensional needs of young people can be

addressed. As WGCADA already runs the Pad, perhaps this could offer the opportunity to invest and expand upon this existing service, and the client base that attend.

The reach of the Young Persons' service could also be enhanced by the provision of more manpower, particularly outreach workers. Colin recognises that most of the young people who are using drugs/alcohol, and who are at risk of problematic use, are still 'out there' and unaware of the services that WGCADA offers. He feels that there is a great need to actively go where the young people are to try and engage them. Colin also expressed the urgent need to have a valleys outreach worker to offer options to the young people in the isolated Welsh valleys.

As Colin explained, the drug scene does not seem to be improving in any way, as demonstrated by WGCADA's ever increasing workload. There is an urgent need to invest in funds to open new sites, develop more comprehensive services, and increase staff numbers so as to deal with the present and potential demand. The allocations of young peoples' workers is an integral part of this, as (some of) those who are experimenting with, or those with problematic drug/alcohol use, are likely to grow into adults who do the same.

4.6. Working with young people in Bridgend

Natalie Webster is the Youth Offending Team (YOT) worker and Daniel (Dan) Jenkins the Young Person's worker at Bridgend WGCADA. Nathalie described her role as conducting harm reduction and preventative education work with young people (aged 10 – 17) who have committed criminal offences, using both one-to-one and group sessions. Daniel's role is very similar except that he does not work with young people currently in the criminal justice system (although they may be on the "fringes" or have passed through it), and the upper age limit of his remit is aged 25. This means that Natalie and Dan generally know each other's clients, so are able to offer support and advice to each other where necessary. Both also work with other members of the family of their young clients. We talked to them together.

A large percentage of the clients that Dan and Natalie encounter are poly-drug users. They have found that for many young people, drug use is,

> "… about getting into as worse a state as possible, as quickly as possible. It doesn't matter what they use."

Whilst only a small percentage of their clients have severe addiction issues - most are recreational drug users - Natalie and Dan can see the pattern of problematic drug use emerging in a significant proportion of cases. It is their aim to stop young people from taking their drug use any further.

A significant proportion of Nathalie and Dan's clients say that they use drugs to escape troubles in their lives. In fact, Dan emphasised that the major issue is not the drug use per se, but rather the issues that drive the drug use.

> "It doesn't seem to be that it is the drug use that is the issue. It is the issues that drive the drug use. And it is whether you can help them resolve that. That is the million dollar question."

Some clients cannot see the issues that are driving their behaviour, which makes the work of the WGCADA team more difficult.
Natalie and Dan work with schools, youth clubs and the Pupil Referral Unit. They pointed out that their clients are very impressionable due to their age, so they try to focus on educating

them about the facts of substance misuse, whilst trying to dispel the myths. In many cases, their jobs are made harder by the parental role models that the young people have. If the client has been brought up in an environment where substance misuse is seen as a normal, every day activity, then it is extremely difficult for Natalie and Dan to change the views and beliefs of the young person.

In one instance, Natalie tried to talk to a sixteen year old who appeared to have an alcohol problem about his drinking first thing in the morning. At their next meeting, the client said,

> "Don't worry, I've got it all sorted. I don't have a problem so I don't need to see you any more. I was chatting to my dad and he said it was silly to have a beer first thing. It's daft. You've got to wait and have it with your breakfast. Then it is fine."

When Natalie and Dan are presented with situations such as this, they are placed in an extremely difficult situation as they are faced with having to disagree with a parent's view and try to alter the client's attitudes. A number of the clients come from dysfunctional families, and/or they have dysfunctional myths. The WGCADA workers try to dispel these myths by telling young people the truth, and by providing evidence to support the truth. But ultimately, how do you argue against a parent?

In doing their work, Natalie and Dan recognise they are treading a fine line between engaging a young person and alienating that person from the service. They emphasise the necessity of coming across honestly and in a down-to-earth manner. They build up trust with young people and indicate that they have no agenda. Another way in which client engagement is achieved, is by letting young people know that they have options as to whether they want to return to the service. By giving the clients the responsibility and choice of deciding what actions to take, the staff have found that the majority of clients do return to the service.

> "We take them face value, we have no airs and graces. I accept you, I hope that you accept me, and we just go from there. Young people can spot a fake just like that."

Natalie and Dan have organised an 8-week programme of outdoor activities for young people. The programme runs one day per week and encompasses a drug awareness session in the morning (a different drug topic each week) and team building outward bound activities in the afternoon. They are currently starting a RAP project (a National scheme which is being rolled out in YOT's throughout the country) which will enable the young clients to write lyrics about their lives and what it means to be living in the area, which is currently awaiting funding. This programme of activities is currently in the process of being accredited.

Natalie and Dan pointed out that a lot of their clients use alcohol and drugs because,

> "They find it to be a really quick and easy way to deal with stuff such as boredom, upset, depression, and anger. Whatever it is, it's an easy quick fix."

Therefore, by providing activities for the young people to participate in, the team are able to reduce the boredom commonly experienced by adolescents in the local area, and therefore reduce the likelihood of drug use. Partaking in these activities can also enhance social skills and boost self-confidence which helps the client change their dug-using behaviour.

There is a strong educational component built into some of the organised activities. One such activity involves young people producing posters promoting cocaine use, or posters trying to stop people from taking cocaine. Activities such as these lead to debates which help the adolescents consider the wider picture and issues surrounding drug use. Natalie and Dan strongly believe that the young people gain a great deal from educational activities such as these, and they believe that much more education should be available.

> "If it's good enough to teach drug workers about stuff like that, why aren't you teaching young people? If they are listening, then they are picking up facts that they might take away with them"

Some months ago, Natalie approached management about developing a new educational programme for young people, since she felt that the current Pre-treatment course was not as appealing and interesting as it could be for this group. She developed a new 12-week Substance Misuse Programme for young people which covers all aspects of drug and alcohol misuse and its consequences. This educational programme has now been accredited and it very popular with clients.

Natalie and Dan have found that the young people who they encounter have, in many cases, missed out on a lot of their childhood due to the situations that they have encountered whilst growing up, and the circumstances in which they have been brought up. Whilst these adolescents tend to act in a way which is beyond their years, at the same time however, they are in many ways also very child-like. Natalie and Dan have to be careful about finding a balance between these two identities, and ensure that they treat the client with respect, whilst also catering for the needs of a young person.

> "You get this, 'I'm such a man', hardened young kids, but then you get this child-like person as well – we have to balance between these identities."

They have found that a simple gesture, such as receiving a certificate for an activity, can greatly enhance the young persons self-esteem and self-efficacy as, in many instances, the client have never received a certificate before. This can lead to further client engagement, and thus increase the likelihood of the client remaining with the service.

During some of the educational activities, young people are asked to discuss and debate about drugs and the laws surrounding drug use. They are asked to take over an identity and act out being a drug czar, policeman or old lady. Natalie and Dan find that the arguments that the clients develop are very mature and often are in contrast to their previous, or current, drug use. An example of this is one discussion where clients proposed that cannabis should be illegal until you are 25 years of age as, "you're growing up and it affects the way that you are thinking. So you need to grow up first."

Although education about drugs is a vital aspect of the success experienced by the WGCADA team, Natalie and Dan also emphasised that the clients must be encouraged to "just be children"

> "They are kids. We get them dirty. We get them out, get them filthy dirty, doing all sorts of stupid things. Just being children. Forget about what is happening at home, about the YOT. Teenagers have forgotten to be teenagers, silly teenagers, in today's society."

Dan pointed out to us that he often thinks back to when he was the clients' age and imagines who he would have listened to. He finds that the key to success is gaining the

clients' respect and identifying with them. He believes that a young person's antisocial behaviour can diminish if they have even one positive connection with an adult. The one connection can outweigh all of the other negative role models in the young person's life. This is why it is key that he and Nathalie form strong relationships with their clients, ones that are based on trust, respect and understanding.

Natalie and Dan learn from the young people important information regarding drug trends in the area. Young people know what is available on the street and how much it costs. They also can pass on information to other young people, providing a way of increasing awareness about drugs and alcohol. Natalie emphasised that clients are proud to be part of something like this. She also provided an example of how their clients have helped reduce drug-related harm in the local area. She and Dan were aware that PMA, an amphetamine-like drug which is a derivative of MDMA, was causing a large number of hospitalisations in Brighton, Liverpool (cities in which Natalie had good contacts) and other parts of the country. Natalie and Dan informed their clients about this problem, and asked them to spread the word that this drug was dangerous. It was very encouraging to find that whereas PMA became freely available in the Bridgend area for a period, only two young people were hospitalised, suggesting that it was not widely used.
Dan pointed out that the drug supply available in the area is often pretty poor in terms of purity.

> "Bridgend is pretty far down the food chain, so whatever kinds of drugs are going to get to Bridgend, the purity is going to be dramatically affected, and the adulterants are going to be unbelievable."

This makes it especially important that young people receive education about drug use and the numerous effects that it can have, both physically and mentally. Given that Bridgend is not near a port or major access point, it is easier to predict what the forthcoming drug trends are going to be, which is useful information to be passed on to other practitioners. These efforts of monitoring the drug scene, and using the information to reduce drug-related harm on the streets, are supported by WGCADA. Natalie and Dan feel that many other agencies would not support this type of activity.

> "WGCADA listen to us and trust us to do the right thing, whereas some organisations treat you like a child."

Many of the clients that the YOT encounter have stereotypical expectancies of what drug workers are like. There is a common perception that they are liberalised, middle class people with no experience of real life. Natalie and Dan believe that it is important they break down these attitudes, so that they are able to relate to their clients and are thus more likely to be successful in their work.

Before starting work at WGCADA, Natalie had worked in various voluntary sector agencies around the country. However, she has never before felt that she has received "so much support from management and colleagues. If you have an idea then they will run with it". Natalie has found that her viewpoint and ways of working have fitted perfectly with the WGCADA views of treatment,

> "It was not until I came to WGCADA that I found an organisation that agreed with me".

One aspect of the job that Natalie had not previously encountered is the organisation of parenting classes. This has aided her in dealing with, and helping her young clients, and has added to the success of her work.

Both Natalie and Dan have found that the way that WGCADA is run is extremely effective and successful. They believe that WGCADA listens to the staff, and trusts them to do the right thing, whereas other organisations can treat staff members like children. Nathalie and Dan believe that part of WCGADA's success is that they are willing to adopt new strategies and ideas.

> "Some organisations are very, very controlling. Things are just filtered down from the top, and it's too regimented. There are too many restraints. The young person's world is forever moving, forever changing… you've got to be flexible with your plans, your ideas."

4.7. Women and Families worker

Carole Atkins is the dedicated Women and Families' worker based in Neath No. 15. The post was created and funded in 2003 by Children In Need for an initial period of three years. It was designed to support children of substance misusing parents, aiming to reduce the risk of harm and generally improve their lives.
This involves providing appropriate and effective help to women who have a family or are pregnant, and are dealing with a substance use problem, to reduce the harm caused both to themselves and their children. Although Carole's role is dedicated to the provision of support and skills training to women, other family members (e.g. fathers, etc) are also offered the opportunity to engage in WGCADA for treatment, support and advice.

When women access the service, they often have social services involved with them and are struggling to maintain responsibility for their children.

> "A large number of the women I work with have social services involvement and it's often a case of seeing if they are suitable parents really and working with the mum to help them get their children back or stop them going into care."

Carole recognises that the strength and impact of their addiction can render mothers helpless in their ability to look after their children and, historically, research shows that women do not use drug and alcohol treatment services as much as men. However, this does not necessarily translate that being an addict equals being a bad parent.

Carole runs practical sessions to equip her clients with a better understanding and skills base to provide for the needs of their children. This not only involves addressing the drug or alcohol use - perhaps encouraging them to enter treatment if they are ready or to reduce their intake, implement safer practices, etc - but also educating them about parenting skills, child development and basic life skills.

The development of a women's group in Neath has been a major development in engaging women and provides a safe environment to discuss their situation and emotions. WGCADA also run parenting groups in conjunction with NCH (National Childrens Home), which have been highly successful.

The women who access these groups are often vulnerable and may be suffering from depression. Carole recognises they often feel extreme guilt over their using and its effect on their children, which can often exacerbate depression, low self-esteem and can sometimes

lead to self-harming. It is, therefore, imperative that Carole is diligent in providing the women with informed choices about their using, other related behaviours, and treatment options. This can help clients to see that there is hope and a way out of the desperate position in which they often find themselves.

Carole also offers women a specialist antenatal service, which involves extra screening in the local hospital and access to a specialist midwife. This is particularly important for pregnant users, as they often find it difficult to keep to appointments due to their chaotic lifestyle or homelessness, and they and their babies are generally more at risk due to their drug use or excessive drinking.

An important part of the work Carole does is engaging her clients in activities that in addition to helping them to learn new skills, assists them in building a drug-free or drug-controlled life, and provides a safe and nurturing environment to build self-esteem, confidence and make new relationships. These activities include cookery classes, summer daytrips with their children, and the opportunity to engage in training to prepare them for eventually getting into the workplace. In addition, Bodyshop came in to do a make-up demonstration and "make-over" for some of the clients.

These activities are particularly helpful as the women Carole sees are often isolated due to their drug use, may have lost contact with their family, and need to learn how to mix with other women. They can further support the women both in their recovery and in learning to better look after their children. These activities also help clients to learn and practice new routines that to others would be considered a normal part of life, e.g. building routines around taking the children to school, keeping appointments on time, going shopping, and practical skills around the home.

> "Trying to get them back to normality, really."

Carole's clients also have many other issues that need to be addressed to support their recovery and new behaviour patterns. These include issues surrounding domestic violence, being a single mother, financial problems, health issues, and housing. Carole supports women through taking control of these situations and may refer them on to specialist services if needed.

Her continued support also helps clients to maintain changes that they make. For instance, many women will make big changes in their using and other behaviours when they are pregnant, but can often fall back into their old lifestyle when they have given birth. It is therefore hugely beneficial that clients know that Carole is there to help them for the long haul if need be. Due to the specific and varied needs of her clients, Carole's work takes a very client-centred approach.

> "Being really understanding to the client and offering them the chance to see what they want, rather than putting them on a definite programme … the client has an input on where their treatment goes."

Carole has built good relationships with other services in the area and often receives referrals from voluntary services, social services, probation, and community midwifes. She finds that this can greatly assist the client, as a team approach can be taken when they are accessing different services.

As previously mentioned, many of her clients are often also involved with social services. Carole finds that clients often display great negativity towards social services and are fearful

of their involvement and having their children taken into care. She has worked within social services and finds that this helps her in trying to educate clients that their involvement does not necessarily mean they cannot parent. She tries to make them see that social services will not automatically take their children from them and that their involvement can often benefit their situation. She finds that changing this negativity is one of the greatest challenges in working with her clients.

When women first access the service, they are often very worried about confidentiality. One of the first things that Carole does is to explain the confidentiality contract and assure them that they only breach it if their parenting is compromised and the child is at risk. She has only had to take this route twice.

> "I have only done it twice, and I have always done it with the client's consent. I do not use it as a threat, and always try to present the involvement of social services in any scenario as a positive experience."

> "There are some people who utilise the services who are misusing drugs and really their parenting is compromised, but in a lot of cases it is about trying to keep the children and the family together."

Carole therefore likes to work with social services to try and treat the clients in the most beneficial way possible – for them, their children, and the family as a whole. There have been joint training sessions between WGCADA and social services to enhance awareness, and facilitate the team approach to their shared clients, including fathers.

Carole would like to expand the women's group work further and to incorporate crèche facilities into the service that WGCADA offers women. This will assist women in accessing the service and, in turn, further support the children involved.

> "One of the biggest things that women need is to be part of the community and to do that they need childcare facilities. Unfortunately, we cannot offer that in WGCADA."

She feels that the changes would greatly improve the service as a whole, but recognises the lack of availability of allocated funds.

> "Finance is always a big problem… there is never enough money to do everything you could!"

4.8. Domestic Violence worker

The Domestic Violence post was developed in response to local needs and a general knowledge concerning the role of alcohol and drugs in cases of domestic violence. It has been reported that substance misuse plays a role in 50% of cases of domestic violence, and that one in four women are actually killed by an abusive partner.

Caroline Hamilton, the dedicated worker who operates out of WGCADA Neath No. 15, reiterates the importance of an availability of services to help the victims of such crimes, to deal with both the violence and additional problems the victims may have.

> "My clients are at risk of being killed, because one in four women who die are killed by an abusive partner, so they are living in a life-threatening situation."

Caroline works very closely with other women's services in the local area to create a team effort toward providing help and support to domestic violence victims. These services include Womens' Aid, Victim support, local hostels, and the domestic violence team in the local police force. She also sits on the Domestic Violence Forum (a multi-agency forum to discuss and establish effective working practices to tackle domestic abuse), representing Neath and Port Talbot WGCADA. This role helps her to publicise the service available in WGCADA, to build relationships with other services, and to create referral pathways.

Caroline's clients enter the centre from a variety of referral pathways. These include social services (particularly if there are children involved), hospitals, womens' refuges and Womens' Aid. She has found that as people have become aware of the services that WGCADA offers, self-referrals have increased. This latter referral process is facilitated by word of mouth, as Neath is a close knit community.

> "You tend to find that word goes round that people can get help, so I get a lot of people just dropping in. Sometimes it's just a brief intervention, they just want some advice on where to go for a solicitor, what their rights are, where the nearest refuge is, and I liase to find that space for them."

She finds that many clients who enter WGCADA, regardless of their referral pathways, report current or previous experience of domestic violence. They benefit from addressing the issues surrounding this violence, which can further aid their recovery from their substance use problems, in addition to providing them with tools to deal with the negative effects they may be experiencing.

> "Most of our clients report some level of domestic violence, physical abuse and quite often it is unreported but they are living within that situation."

Caroline explained that the clients she works with are highly vulnerable, confused and powerless, both over the substance(s) they are addicted to, and the abuse they are experiencing. At the time of interview, approximately two thirds of her clients were women and one third men. Some of these clients will be directly experiencing violence, whereas others have experienced it earlier in life, often as children. A particularly shocking finding is that approximately 75% of Caroline's clients were sexually abused as children.

> "They've often come from a destructive background to start with. There's been domestic violence, alcohol and drugs present…substances take people away from that, it's a way of coping with things."

The ways in which domestic violence interacts with substance misuse and addiction are varied and complex.

> "The substance has a catalytic effect on behaviour, but I'm not saying that is the cause necessarily of the domestic violence, because it's about power and control, full stop"

Many of Caroline's clients have had disrupted backgrounds, including the threat of, or actual, violence and use of drugs and alcohol to try and hide from, or relieve, the trauma they feel as a result. Some initiate their drug or alcohol use to relieve the pain of beatings, or the depression and fear that invariably results from living under the control of an abusive person.

> "A lot of women use alcohol to cope with the pain and it gives them courage to be able to cope with things."

They may also use drugs to try and keep up with the demands of their persecutor, for example, use amphetamine or other stimulants to provide energy to carry out all of their 'duties' appropriately. Many of Caroline's clients have also been abusing substances since childhood, which can place them in situations where they are open to abuse (e.g. from dealers or partners who feed their habit) or exacerbate low self-esteem and depression which can make them 'easier targets'.

> "I work with a lot of women who will live with abusive men because that person is their dealer. They may then pass round a circle of dealers… it's just a very abusive lifestyle."

To respond to the huge variations in experiences and needs within her client base, Caroline takes a very client-centred approach when offering help and support. She aims to offer clients an intervention to equip them with the tools they need to do something about their situation, both their substance misuse and experience of violence. The empowerment of women is an integral part of the work Carline does; in terms of their attitude towards themselves, belief in their ability to change their situations, and choice over their own actions and treatment.

> "People are often doubly victimised. They are addicted to a substance, that's one problem and they are living with an abusive dealer, that's the other problem. My role is to somehow tease that out, so that we can work with the substance misuse to give that woman a choice in what she is doing, and to empower her to make the break from the person."

> "I want to see empowering groups for women. The anger management for women for me is not how to not be angry its how to accept and admit you're angry and getting it out there and using it constructively and assertively, rather than hiding it and not saying anything. I think you must empower the women, and help them to find the skills they need to move on. It's no good just taking the drug away, because they will just be lost."

As part of this approach, Caroline makes sure that she actually asks the client what they want – rather than basing the course of action purely on her perception of what is needed. This is particularly important, as due to their chronically low self-esteem and inexperience of change, there is a danger that as Caroline is the 'professional' they may accept her suggestions, even if they are uncomfortable with it. This will further hinder them in terms of addressing their abuser and their recovery from addiction.

> "I usually see people initially on a one-to-one basis because they are very frightened of disclosure… I always ask a client what they want when they come in… I might perceive something as being the perfect option for someone and they might feel obligated to follow that course… what I would prefer to do is talk it through and not be too concrete in making decisions about the treatment plan. If something doesn't work, that's fine… they don't need me dominating them because that's what they've always had"

In essence, Caroline's work is geared towards breaking a client's dependency on drugs and/or alcohol, offering hope, and helping them to look at their options. The prescribing and supervised consumption services that operate out of Neath No. 15 or the referral pathway

to the 12-step programme in No. 30 facilitate this process. Clients may continue to access ongoing one-to-one counselling support from Caroline's if they are receiving a substitute prescription or join the abstinence-based service.

The additional services that Caroline provides include womens' groups, exploring assertiveness, one-to-one work, days out and engagement in DOMINO if appropriate.

Caroline also helps clients with security in their home, for example, if their partner is soon to be released from prison, through liaison with the police domestic violence unit. She also tries to work closely with GPs in the local area, as many of her clients are severely anorexic and benefit from a multi-disciplinary approach. Domestic violence clients often have very limited, if any, support networks. They have often become isolated both due to their addiction and because of their abuser. The opportunity to access the centre and meet new people is therefore highly desirable.

Caroline finds that much of the support she offers is simply 'being there'. Although she aims to try and engage her clients in some form of treatment and ultimately to leave the abusive relationship, her clients can often feel trapped under the control of their addiction and abuser. They may, therefore, need some time to come to terms with making changes.
Due to the nature of their chaotic lifestyle and the unpredictability of living under the control of an abusive man, her clients often access the centre during crisis points. One of the challenges Caroline (and WGCADA) face is providing a service that is flexible enough to deal with clients as and when they need help. For example, if a client arrives at WGCADA beaten or needing to go to a safe house, Caroline needs to be able to drop everything, focus her attention on their needs and make quick decisions.

This has been made possible by the flexibility within the organisation to support the role. There is a real feeling of a team approach to Caroline's post, which allows it to cater for the needs of a highly vulnerable group of people. It is important to remember that her clients are living in a life-threatening situation, which makes it hard to access services. Abusers will often time any journeys the client makes, socially isolate them, and emotionally hinder them. For some women, the only way they are able to speak to Caroline is if they can drop into the centre during another journey. It is again imperative that Caroline can see them immediately, as they may not have another chance for a sustained period of time.

Caroline finds that there is always a member of staff who will take over from her if she is called away to deal with a client - this process is facilitated by the volunteer system, as it always helps to have more hands on deck.

> "It's a constant juggling act. Most clients are very willing to adapt and adjust though if there is a crisis…having a volunteer base is very useful and crucial"

Caroline is acutely aware of missing appointments with clients or leaving them during a crisis, so the availability of someone to take over, make new appointments, and generally reassure the client that Caroline would not leave unless it was a highly urgent matter, helps to prevent jeopardising existing relations with clients. This support also allows the provision of occasional home visits. Due to the threat of violence, Caroline cannot go to a visit on her own, which is obviously resource-consuming as another member of staff needs to go with her.

These demands are also supported by the development of a duty roster system, whereby each worker has a half-day per week where they operate the needle exchange and cover in emergencies, and do not book in clients.

> "It means you're there if something happens, if someone calls in off the street, so there is always a floating member of staff on duty. That system has proved very useful for me."

Caroline is also working alongside probation, developing a perpetrator's programme, which started in October 2005. This programme focuses on power and control.

> "One of my problems is the high level of referrals of perpetrators being referred for anger management. I have laid down the law that anger management is not an appropriate referral pathway for perpetrators, because all you are doing is teaching them to mask their arousal, which is taking away the warning sign from the victim."

Caroline would like to see the service develop further – of course, funding permitted. She would like to encourage the development of sustained peer support, and to couple this with empowering group work. She finds that the group-setting is a safe environment to work through issues and to meet other people. She would therefore like to develop more group work in general, including fitness and self-defence. These activities would help women to rebuild their lives and get used to doing both new and routine activities, again in a safe environment.

Caroline would also like to take women out of their situation, even if it is only for a short time, for example, by arranging daytrips for them and their families. There may be an opportunity to combine this with the daytrips that run through Carole Atkins, the Women and Families worker.

> "Taking people out of the environment, taking them somewhere pleasurable and they are together as a peer group and can support each other… I want to encourage peer group support, because I think it's very important for all women to be able to talk freely and share their experiences and gain support from each other."

Despite the great benefit that this post brings to the local community, and the governmental push on meeting the needs of those who experience domestic violence, Caroline's post is only funded on a yearly basis. No wonder she is frustrated. This sort of short-term contract can cause insecurity and puts extra pressure on WGCADA and Caroline, which can hinder potential developments. Caroline feels that there is a need for this specialist service in all of the WGCADA sites.

> "Every year we walk around with a begging bowl trying to get my post funded and I think it is appalling… it's a continual quest… I do my own reports, I do my own stats, and I'm constantly presenting, saying, 'Look, this is how busy it is, this is how hard we work'… I think it would be good if we had other workers like myself in Swansea and Bridgend. I split between Neath and Port Talbot. I think it's a key area where they don't seem to be willing to put money… I get spread too thinly."

In addition to needing funds to continue and expand the availability of domestic violence worker posts Caroline is highly interested in developing a refuge service specifically designed for women with substance misuse problems. She explains that

> "Often their chaotic behaviour means that they are not accepted by a refuge or are evicted due to substance misuse. A partnership between Women's Aid and WGCADA to provide refuge with treatment for substance misusers would be a major contribution to services."

4.9. Elderly and disabled worker

Anne Craven is the dedicated elderly and disabled worker in Neath No. 30, and works with clients from 55 years of age onwards. The post is part-time. Anne described how this client base usually have different 'types' of drug and alcohol problems in comparison to the younger people who access WGCADA, and also have an additional set of problems relating directly to their time of life.

> "Their needs are generally more complex. It [support] may… involve addressing their housing, welfare, hygiene needs, even if it's just nutritional needs, because obviously when they are drinking they become very neglected, not just personally but in their home surroundings."

Anne initially works with the client to try and address such issues. This may involve getting social services involved if the client is willing. Such help can often take pressure off them to enable them to take a look at their drinking.

Anne's clients present primarily with problems relating to alcohol.

> "Their drinking is really quite different from any other person's drinking. They usually fall into two categories: one is the person who has always had alcohol in their lives, you know, finish work, go to the pub… and then you have the drinker who, through retirement or the loss of a partner, has turned to it for some sort of relief from pain or for comfort and is often, therefore, directly related to their time of life."

Older clients are also affected medically by alcohol in different ways to younger clients and Anne's nursing background can often help her to discuss and support her clients through this. Their organs deteriorate much more rapidly through alcohol abuse and this adds to the natural deterioration of the organs with age. Any natural memory loss is exacerbated by the memory loss often experienced due to the alcohol - this can often be mistaken for dementia. Some clients, therefore, can be overlooked in terms of their alcohol misuse, as early warning signs can be mistaken for old age.

Anne also finds that as she starts to work closely with her clients 'an element of a drug problem', usually involving prescribed drugs, sometimes emerges. She feels that this type of using or dependency is slightly different from some younger clients and is often exacerbated by the clients' lack of awareness that they are 'using' these prescribed drugs. There is sometimes a perceived lack of danger or 'problem' with these drugs as they are received from a trusted professional and not 'off the street'. Although this is true across age groups, Anne feels that this attitude can be more prevalent amongst the elderly – perhaps due to a general lack of awareness about the nature of substance misuse.

This lack of awareness can also extend to the very reason why they present at WGCADA – their drinking. Although clients always engage in the centre of their own free will, Anne finds that many do so following advice or pressure from concerned others, primarily family members. As a result, she has quite a few self-referrals, and others from family members and neighbours.

Anne also has good relationships with other organisations working with the same client group in the local area and receives referrals from a wide range of pathways including GPs, social services, Community Psychiatric Nurses, SMART, Neath/Port Talbot hospital (elderly and psychiatric unit) and the Meals on Wheels service. This referral process has been facilitated by such services becoming more aware of WGCADA and the services it offers.

Anne maintains that ultimately the decision to attend the centre, or access the services that she can provide, lies with the individual in question. She recognises the value of, and implements, motivational enhancement, but maintains that the choice and responsibility for their own well-being must remain with the individual. It is well-known that in order for someone to make changes in their drinking or drug use, they must actually want to address the problem. This approach also communicates a level of respect between WGCADA and the client, and can help to prevent hostility toward Anne.

Anne has a few clients who are disabled and of a younger age. The needs of this group can often be incorporated into the normal WGCADA treatment programme, but if Ann considers that an individual would benefit from a home visit, she becomes involved in their treatment plan. As she pointed out, when someone is suffering from addition, "time is of the essence."

The post was created to ensure that WGCADA could effectively respond to the needs of the 'older' population who are trying to deal with their substance use problems. The development of the service has been shaped to the nature of the clients presenting at the agency. Whilst Anne's background as an abstinence counsellor meant that initially she was more abstinence-minded in her work, she sometimes found that the clients were not looking for, or were not ready for, abstinence. She therefore began to ask them exactly what they wanted and work towards.

Perhaps the most obvious need for an elderly and disabled worker is related to the difficulty that this client group often experience in getting to and from the centre. Anne's home visits are, therefore, hugely beneficial in initially engaging the client into the service, building relationships, looking at their drinking and in trying to draw them into some type of structured treatment plan.

Although her clients are not treated differently on assessment and are offered the same services as other clients, Anne finds that their wants are often different. She described how her clients often feel more comfortable around others of a similar age and, therefore, can be reluctant to access mainstream treatment. This feeling is also exacerbated by older clients' common underestimation of the problematic nature of their drinking, and the gentle and considered approach sometimes needed to get them to take it seriously. Older clients can often 'keep up appearances' of normality, particularly as they may be drinking quietly at home, not causing trouble or seemingly not hurting themselves. Anne therefore has to recognise that her client group can often be much slower to address their problem than other clients.

Anne, therefore, often finds herself taking on a more supportive role, rather than providing structured counselling or 'treatment'. She takes a slower approach to encourage them to take small steps towards changing their drinking.

> "I would say that I'm more of a support, than say the roles of my other colleagues, even though I am a qualified counsellor and a qualified nurse… but that fits in nicely with the background of the elderly."

Anne often encourages her clients to look at their drinking, and she helps them become aware of the negative effects and dangers. From this, they will start to discuss the types of changes they might be comfortable with.

> "I take more of a harm reduction approach and then possibly work towards abstinence… The pace is much slower, less confrontational, and again it's just done with care."

Anne finds that this gentle and less abrupt approach is more beneficial to her clients, particularly as they are often very ashamed about their drinking and try to keep it hidden. She finds that her clients can also quickly become withdrawn and lose some of the will to live, particularly as they are acutely more aware of their own mortality. There is often an attitude of 'just leave me be'.

This attitude is sometimes mirrored by other services who come into contact with elderly people experiencing alcohol or drug problems, and Anne recognises that there is a general uncertainty about where to refer the older client to. In turn, such clients may be left to 'get on with it' (sometimes seemingly out of kindness), whereas younger clients may be more encouraged or coerced to access some help. This highlights the need for more extensive partnership working and training for services in the locality.

Anne spends as much time as is needed to get to know her clients and encourages them to perhaps reduce their alcohol consumption, change their drinking habits (e.g. not drink until the evening), and to try and get them involved in other activities, e.g. DOMINO or attending AA meetings.

> "We look at what's out there, because they can become quite isolated, [through] loss of a partner, they are no longer working, they've lost their comrades be it through death, or they are just isolated through the drinking, and others move away from them…"

Anne has some clients who have benefited from the Pre-treatment educational package, in addition to her one-to-one support, and have implemented some changes in their drinking. If this is all that the client feels they want at this point, Anne will not try and coerce them into abstinence, but will take a step back making sure that the client knows "the door is always open". Due to the nature of addiction, clients may attempt 'controlled drinking' many times before feeling ready to try abstinence.

For those clients who do want to try and abstain completely, Anne finds that the methods and processes involved are again, often different from younger clients. Anne describes that when her clients are working towards abstinence, they often do not go through the normal treatment process. This is often due to the slower pace of change and a lack of commonalities felt between them and younger clients. She does, however, find that the AA fellowship is often more compatible with their wants and needs. They find that there is an older element to the AA fellowships where they can strike up friendships and fit into the 'structure' of AA.

Anne described how the approach that is needed to meet the needs of the elderly is slow, gentle and respectful. Although they may not be working towards abstinence straight away, she finds that the client-centred approach that is possible through WGCADA means that she sees increasingly more clients finding the solution that is right for them. She currently has around 50 clients that she is working with at varying stages in recovery. Around 10 of these people are now sober and engage only to keep in touch and to access relapse prevention.

> "At the beginning, I see them quite frequently but I have had some clients for two or three years and now I see them every six months to find they are sober, going away on holidays and have got a new lease of life. As a result there is also less of a drain on the health service as well."

Due to the sheer numbers of clients that she has on her books, Anne finds it a juggling act to provide for all of their needs within the remit of her part-time post. In light of this, WGCADA have been trying to obtain funding to increase this to a full-time post and on the day of the interview Anne learned that it had been granted. Good news!

One of the biggest challenges that Anne faces in working with the elderly client group is dealing with clients who see no point in addressing their drinking.

> "… Whereas the older client would say, 'What am I getting sober for?' Some just want to be left [alone] and say 'just forget about me' …"

Anne always respects the decision of the person involved, but finds that because she has built up a rapport with them they do not mind if she continues to call and stay in touch. This keeps the channels of communication and engagement open.

She also finds that this group are often more considerate of her feelings than they should be! For instance, they will sometimes not want to fill out a drink diary because they feel that their drinking has let her down, or because they feel ashamed. Again, this is a situation where a gentle and slow approach can help her clients to overcome these tendencies and to use the service for what it is there for – to make people well again.

> "Possibly by the end of a few sessions, they grasp the importance of being open and honest, and that even if they relapse we'll deal with it and move on. It's just they do tend to feel that they are letting everybody down."

Anne sometimes feels that the lower limit of her remit to work with individuals of 55 years onwards is perhaps a little too young. She finds that clients of this age often fit into the mainstream treatment plan well, and are not experiencing the same issues as some of the other more elderly clients. She recognises, however, that these are the guidelines that were set out for the post, and as the support she offers is so client-led she is able to adapt to fit the needs of everyone.

Anne clearly feels that her post is both highly relevant and valuable, which is apparent from the amount of clients on her books. Since the post was created in (????) the numbers of people accessing the service has steadily increased and she feels that this would be true of any town or city. She would, therefore, like to see an elderly and disabled service available in all WGCADA sites.

> "Particularly as people are becoming more aware that this service is available in Neath, they are just coming out of the woodwork…"

Due to the specific needs of the older client, both in terms of an understanding of their time of life and the specific treatment issues previously discussed, Anne is hoping to encourage the development of an 'older client' group. This would offer a safe environment to provide support, perhaps work through treatment stages, the opportunity to meet others in similar situations, and a group forum to think about ways of developing the service further.

Although WGCADA tries at all times to accommodate the practical needs of her clients, e.g. making downstairs rooms available, giving rear access to the building to avoid steps, Anne also recognises that to further encourage them to access the centre it would be helpful to be able to provide all the relevant facilities e.g. a stair-lift and wheelchair ramp.

Anne also thinks that the elderly, their families, workers and the general public would benefit from more information regarding alcohol/drug abuse and old age being available on the Internet. She feels that it would be a good resource in times of need, and would also increase awareness of the needs of the elderly.

> "There is a very real and great need out there. We all need to be aware of it… They are forgotten."

There is a general lack of understanding of how to deal with substance misuse in the elderly, and a common attitude is to "Leave them to get on with it, they haven't got that much time left, let them enjoy it." Anne feels that this attitude needs to be challenged as help should be available to individuals who are willing to address their drink or drug use.
She feels that this attitude is exacerbated by services' lack of understanding and ability in offering such help. Anne feels that this will take some careful planning and encouragement, as response has been slow in the past. For example, when the service was set up, WGCADA flooded all the surgeries in the area offering training and an open day to discuss the situation. They were disappointed to receive only two replies. Anne is aware that the only way to develop the network of support to the elderly is to develop effective partnership working with local existing services.

> "… social services are hungry for information about this category… they are the ones who are more on the front line."

Although it will take time, she feels that if there were increased awareness of the prevalence and effects of substance misuse in the elderly, this would encourage a 'team effort' with local services to tackle the situation.

5. Views and experiences

5.1. Clients

We interviewed seven clients from Swansea WGCADA to determine their views about the services offered by the agency in helping them overcome their problems with excessive alcohol and drug use. The primary problem with the majority of these clients was alcohol.

5.1.1. James

James is 23 years old and originally presented at WGCADA with an amphetamine addiction. His drug use led to amphetamine psychosis, and prior to attending WCGADA, James was given an ominous prognosis by his GP. However, at the time of the interview, James had been clean for eighteen months and two days.

> "When I came to this centre I was totally gone. I was told by my doctor that if I carried on I would be dead within six months, so coming to this centre was a life saver for me really."

Before attending WGCADA, James felt that he was not ready for treatment, and he thought of WCGADA as a last resort. He now knows that the help is there if you want it, and he feels that the staff at WCGADA have provided him with what he needed to overcome his

addiction. James believes that WCGADA had something that he wanted, and to this day it still does.

> "I don't know what it was that kept me coming back here. It's just that they have something that I want. And to this day, I still don't know what it is that they have – it's just that it's something I want."

When James first came to WCGADA, he did not know what he wanted to gain from treatment. He had previously seen a psychiatrist on a number of occasions, but had not been honest as he was scared that he would be sectioned. However, at WCGADA he has felt able to be honest with the staff, which has been vital in his recovery. James feels that WGCADA has taken the necessary step of taking control of his treatment, as he feels that if he had had more control then he "would not have gotten very far".

At his assessment, James looked at the chart of dependence which was a turning point for him, as he was able to see the answers to where his addiction had taken him. After his assessment, James joined the DOMINO project which gave him hope for the future. He feels that WGCADA has offered him the help that he wanted and needed.

> "DOMINO was really good. I loved the gardening and the cooking. I remember the first time I went gardening I was really scared and paranoid, 'cos I was coming in to this new big wide world that I had never known. And I was being told that there is another way of life and it does get better."

James found his first meeting to be quite overwhelming. However, he soon made friends and settled into the ways of WGCADA. He has found the 12-step philosophy to be fascinating and, for him, successful. James feels that the support he received from his sponsor and from the centre were vital in his recovery.

Although James dreaded group meetings at first, as he was forced to listen to things that he did not want to hear, he now acknowledges that they are vitally important in the recovery process. In group sessions, James has had to confront the issues in his life, and although this has been very tough for him, he appreciates that it is necessary.

> "Group therapy is the best thing that I could have done. Group therapy is basically a group of people telling you the things that you don't want to hear, but you get to be good friends with them. We learn to get the habit knocked out of us."

James believes that the main reason why WGCADA is so successful is due to the "understanding and supportive staff". Staff make the effort to take time out to talk to the clients and tell them honestly about their own experiences. He believes that the staff do genuinely care about the clients, and rather than taking on authorative roles, they treat the clients like friends. James very much appreciates that staff have bent over backwards for him, and have provided support for all aspects of his life, including helping to arrange for him to keep in touch with his daughter.

> "I got access in the courts to my daughter last week, and the staff were there for me every step of the way, providing me support when I was angry and frustrated… And writing letters to the courts, letting them know that I've been doing this and doing that."

James believes that one of WGCADA's main strengths is the holistic approach that they adopt. Since attending WGCADA, James has received help with his housing, benefits, giro, debts and solicitors, which has taken the pressure off of him so that he could concentrate on dealing with his addiction. James believes that WGCADA has helped to "build a bridge to get well and get back to normal living". He refers to WGCADA as the fourth emergency service, and strongly believes that the staff and the centre have saved his life.

> "I love the understanding and support. The way that the staff care about their clients. It's almost unconditional love. They will go to any lengths for you. All they ask of you is to be honest."

James is currently making plans for his future that include going to college and getting a job. However, he still plans to attend aftercare for the foreseeable future, and feels that this is a vital part of the recovery process.

> "After I've finished treatment I want to go to college and find myself a small job. And just start to build a life for myself. I've always wanted to go to college and do something useful. And I want to build a relationship with my daughter. And then next year I'll make more goals."

5.1.2. Jess

Jess is 41 years old and has had valium and alcohol addictions for eight years. Four months ago, she reached her rock bottom and went to the doctor as she was ready and wanting to change her drug-taking behaviour.

> "When I came here, I had hit rock bottom and I was a complete wreck. I really needed help and now I have been clean for eight months."

Her doctor referred her to WCGADA. Jess believes that her addictions stemmed from a traumatic childhood, as her mother died when she was only 13 years old.

Jess did not know what to expect from WGCADA, and initially she was very nervous. She had previously wanted to receive help with her drinking and dealing with her childhood. However, she never remained in treatment for long. At WGCADA, Jess feels that she has found a treatment that is suited to her, and she feels that the agency has changed her life.

> '"I'd tried so many times to do it by myself, and the longest I could do was two weeks. And I was promising people that I would come off it, but I knew that I wouldn't. I needed the help to do it. Without it [WGCADA], I couldn't do it."

During Jess's assessment she looked at the dependency chart and was told that she was an alcoholic. Since then, she has joined the DOMINO project and started in Pre-treatment. She finds group therapy very helpful, as she is able to talk about her feelings and discuss any problems in her life, as well as getting to know the other clients and staff members. During group therapy, she now feels able to talk without any embarrassment. During her time at WCGADA, Jess has received plenty of information about the nature of addiction, and now feels that she has a wider understanding of it.

> "The activities really helped me a lot. They used to talk to us and there were people here the same as me. And I wasn't embarrassed, it was great, I felt great. It's all about what they tell you and what you read and what it can do to you. I don't want to go back. I'm enjoying myself."

As many of the staff at WGCADA have experienced addiction themselves, it has made Jess feel that she is not alone. She feels that the staff are "lovely, friendly and welcoming", and now "looks forward" to going to WGCADA. Jess refers to the staff as being extremely flexible, and clients only have to pick up the phone to be able to speak to someone and get some help. She thinks that the staff are "fantastic – can't fault them". She also thinks that it is extremely helpful that WGCADA looks at the whole package of the individual, so that all aspects of the client's lifestyle can be improved.

> "They help you with lots of problems in your life which is very helpful. You know that you only have to pick up the phone if you have a problem and they will be there for you."

Jess believes that WGCADA has changed her in general, and she now thinks a lot more, and feels like a different person. She says that she feels ten times better than before attending WGCADA, and that every week that she comes to the centre she feels even better. Jess thinks that opening up and talking about her past has been a major turning point in her recovery, and WGCADA has offered her the chance to do that, and to feel comfortable doing so. Overall, Jess is feeling much more positive about her future, and thinks that "things are looking good now".

> "I'm ten times better than I was when I came in here. Every week I can feel myself getting better and better. Its great…I'm glad that I've opened up to someone, 'cos I was being tortured to death. I feel much better for opening up. Things are looking good at the moment."

5.1.3. Alan

Alan began drinking at 14 years of age and from there began experimenting with cannabis, LSD and amphetamine. Alcohol has been part of his life for as long as he can remember, although he had managed to have a successful career until his retirement in 2002. After his retirement, Alan's drinking started to get out of control, and it was at this point that he believes that he developed an alcohol problem.

> "I retired in January 2002 and that's when my drinking got completely out of control. It had been bad before, but I had had to continue going to work and there was no drinking on the platform [BP oil rigs]. But once I didn't have to go to work, there was nothing holding me back. I would use every excuse, but at the end of the day I have a drink problem."

A year ago, Alan sought help with AA. However, he found that this was not enough for him, as he needed the intensity and the structure of treatment. He feels that although AA kept him sober, it was not doing enough. He knew that he needed help, and he was able to accept that he was an alcoholic. However, he could not accept the help offered by AA. One aspect of AA that he feels was not right for him was that there were no open forums, and there was no feedback until the end.

> "I could go to AA tonight, and I could speak about a problem I'm having but that would be it. I wouldn't have any feedback unless right at the end. Here though, we have feedback and we can relate to others and they can relate to us. There's an added openness and you can realise things that you have never thought about before."

Alan learnt about WGCADA from his brother-in-law who was a recovering alcoholic, and who recommended the services available at the centre. When he presented at WGCADA, Alan

felt apprehensive, nervous and ashamed. However, he soon settled into the "friendly, welcoming and caring" atmosphere.

Alan joined the DOMINO project and found it particularly useful. As he had been a house drinker, the activities got him out of his house, and engaged his mind once again.

> "DOMINO offered me the chance to get out of the house. I was a house drinker and the minute that my wife would go to work, at 7.10am, the bottle would come out and I'd get as drunk as I could, go to sleep, and hopefully sober up by the time that she came home."

He also found it very helpful to socialise with others who had similar experiences, and so could understand where he was coming from, and what he had been through. Alan particularly appreciated that the staff and clients were willing to listen to his experiences without judging him.

> "It also helps that you realise that there are other people out there like you. To be able to talk to other people who are like you and understand you."

During Pre-treatment, Alan found group sessions to be very helpful, as they enabled him to share his life story with people with similar problems, both in relation to their addictions and the associated lifestyle problems. Furthermore, he found the positive feedback enlightening, and he feels that the support that he received from the staff and clients has been essential in his recovery process. In comparison to AA, during the group sessions at WGCADA, Alan felt that he could explore any issues, and that the information would not go any further.

> "I know it's not going to go any further. You can share in AA meetings, but there's things that I would share here that I wouldn't share in AA… You can say anything in AA as long as it is alcohol-related. But here you can talk about anything. And it might not seem to be alcohol-related, but then as I talk about it I realise it is."

Alan believes that the environment at WGCDA, which he describes as "feeling like home", provides the perfect setting to explore the mental and the spiritual aspects of addiction. He feels that he has been accepted for who and what he is at WGCADA, which has enabled him to be open about his addiction.

Alan believes that the staff at WGCADA are great at their jobs, in part, because they are not afraid to tell the clients the home truths that they need to hear. Alan feels that the fact that many of the staff have experienced addiction themselves, combined with their honesty of their experiences, has aided him through treatment. For Alan and his group members, he believes that the WGCADA principles are working for them.

> "The vast majority [of the staff] have been there and done that. I may not like them all the time, but that's because they tell you the home truths… Everyone here has had a member of staff tell them something that they don't agree with. But not once have I known the staff to be wrong."

During his time at WGCADA, Alan feels that he has "learnt a lot about how to be a person". He feels that he has been given life and freedom, and is now more content, and feels lucky to be at WGCADA. In the future, Alan hopes to be "a contented alcoholic who is sober for today".

At the agency, he enjoys hearing about other clients who say, "'That they have been a day sober', as this gives him the strength and faith to remain sober himself. At present, WGCADA is giving Alan peace of mind, and he feels that he "can do anything I want today".

> "WCGADA has given me a life and given me freedom. I've got the feeling today that I can do anything I want to do. And piece of mind. If I had to sum it up into one word it would be freedom."

5.1.4. Andrew

Andrew initially started drinking through peer pressure from his friends; he described himself as "a broken man" by October 2004. At this point, he had been in and out of AA, but could not maintain it. He knew that he needed to get sober, and that his time was running out. Andrew was determined to make it work and he believed that the only way to achieve this was to, "hand myself over to others who know better than I do".

Andrew went to his GP who recommended that he try WGCADA. He went to the centre and was completely honest with them, actually begging them for some help. At this point, he "had a feeling that this was final". He had his last drink two days before his assessment.

> "When I came back in October last year, I was broke, really broke. My alcoholism had gotten to the stage where I think we were looking at a matter of weeks. I had no options left. It was the jumping off point if you like. I either had to do that or I was going to die. Faced with that decision, I came here and sort of begged them, and told them that I was ready."

Being at WGCADA removed Andrew's loneliness and isolation, as those around him had been through addiction too.

> "Alcoholism must be the most lonely illness on the planet. When I came here, I felt so isolated and alone and thought that no one could feel as bad as I do. But then you go into that room and realise that everyone is feeling the same way as you, and you aren't alone. You become part of a group again of like-minded people with the same fear, insecurities and worries."

The staff taught him self-awareness, and Andrew learnt that, "even without alcohol I still had an illness". Andrew feels that counselling enables the client to have a strong recovery, as emotional issues are dealt with. He thinks that although AA is valuable, it does not provide the same level as support as WGCADA, which is why he believes that it was not helpful for him.

> "This place offers the self-awareness of what makes me tick. You know even without the alcohol, the problem is still me. I still have the illness whether I'm drinking or not. There was a lot of baggage and issues that needed to be addressed if I was going to maintain a strong and good recovery."

Andrew believes that one aspect that makes WGCADA so successful is its flexibility. Although he appreciates that the agency must have a set programme, he believes that the staff put the effort in to treat each person as an individual, and that counselling greatly helps to achieve this. Andrew believes that it is important to have a balance with the staff. The clients need to be able to mention their concerns, but still have faith in the staff. This is a factor that he thinks has been achieved at WCGADA. Andrew also appreciates that the staff will often allow the client time to think over what has been discussed, and consider what course of action they want to take.

Andrew refers to the staff at WGCADA as "first class staff who have been there and done it, so they give hope and are brilliant role models for the clients". He believes that staff will go out of their way to help the clients in any way possible, and they are also able to relate and empathise with the clients. Due to this, the clients have a great deal of confidence in, and respect for, the staff at WGCADA. Andrew feels that he was particularly lucky, as he was assigned to a counsellor who was very well-suited to him.

> "The staff are first-class. Really, really wonderful staff. I couldn't pick faults… The fact that they have been there and done that, and some have gone further than where I did. Their information isn't coming out of a text book. They can relate and empathise. They know what they are talking about, and they could see beyond what I was saying.'

Andrew believes that WGCADA has far exceeded what he was hoping for, and he readily admits that he was "hoping for a miracle".

> 'It's far exceeded everything that I hoped for. I don't know what I hoped for. A miracle really. It really was my last chance. I've lost so much to alcoholism, but I have gained so much in the last year. It's like a sixth sense of self-awareness, not just of myself but of others.'

He feels that WGCADA has saved his life. He now has increased self-esteem and self-confidence, and a renewed enthusiasm for life, in comparison to before entering WGCADA when he would have preferred to have died. He now feels confident about the future, as the fear has gone, and "life seems full of promise and is in God's hands". He refers to WGCADA as a "lifeline" which has enabled him to "have choices again".

> 'WGCDADA has increased my self-esteem, my self-confidence, pretty much anything that is self!! Right across the board. It's the renewed enthusiasm. I got to the stage in my drinking when I didn't care if I lived or died. In fact, I'd rather die. Each relapse I would pray that I wouldn't wake up. To go from that to where I am now. With so much promise and all the fear has gone. It's a complete turn around for one extreme to another really.'

5.1.5. Megan

Megan started experimenting with aerosols, glue and alcohol. Her substance misuse slowly progressed until, at 32 years of age, she started to drink due to depression.

> "I would use anything that changed the way I was feeling. It progressed slowly until I was 32 and then I went on a major binge, because I split up with my then partner. By the time I came to the centre, I was very close to death."

Social services became involved as Megan had a young daughter, and they suggested that she try WGCADA. Megan was relieved that social services became involved, as she knew that her drinking had to stop.

Initially, Megan did not know much about WGCADA, or what to expect from them. However, after her initial assessment, she knew that it was suited to her and she wanted to come back. She found the centre very friendly and safe, and she enjoyed socialising with others who were in recovery.

> "Every one is just so friendly here. And it was a big help to know that they were in recovery as well. It's just a safe place."

Megan feels safe and serene whilst at WGCADA, and she feels able to say anything she likes as no one judges her. She has confidence that the information will not go any further. She greatly appreciates the fact that the staff are always there for the clients and that the door is always open, and there is a safe environment where everyone knows everyone is provided.

> "The fact that no body judges you and they all understand. Every time I relapsed and didn't come back for a couple of weeks, whenever I would walk through the door, they would all be so friendly and welcoming. It was great."

Megan feels that "the staff seem the same as me – they know exactly what I think, and they will tell you things straight". She feels that this understanding from the staff greatly contributes to the success of WGCADA.

> "I love the staff to bits. They are fantastic. They are the same as me, they know what I think and they know how I think… they can be tough, but it's all for our own good. They will be straight with you, they wouldn't hide anything from you. They are completely honest."

During phase one of Pre-Treatment, Megan found that not a lot of the information was sinking in. However, gradually it all began to come together. She so desperately did not want to return to her old behaviours that she began "working the program". She now appreciates that it is up to the client to abide by the rules, and that the staff will not force them into doing anything. As part of Megan's treatment, WGCADA have also been there for her children, and all members of her family have been seeing a counsellor.

> "They have not just been there for me, they have been there for everyone, my family, my children because they have been badly affected as well. They can walk in here any time and see a counsellor and they know that it's a safe place for them as well. We all love this place."

Megan feels that WGCADA have exceeded any expectations that she had, and they have "given me my life back". She has now "grown up" and has been given the ability to be responsible for herself. She now feels that she can deal with anything and is thoroughly enjoying life. Megan believes that the services available at WGCADA were perfect for her wants and needs from treatment.

> "To be honest I think that they are doing the ideal package. They gave us the ability to start being responsible for ourselves. If we stayed here forever and ever then we would never want to leave. It's about growing up, and they give us the tools to give us a good start."

Megan feels that without WGCADA she would be dead, whereas now she can be a mother to her children and she can rebuild her life without having to depend on alcohol. In the future, Megan hopes to work with the homeless.

> "My heart is on the street with people who are like me, who are desperate. I would love to be out there with those people… giving them a bit of hope. There's not a lot of hope on the streets."

5.1.6. Laura

Laura managed her drinking for ten years, until three years ago when her drinking escalated and she began drinking every day. Christmas was a turning point for Laura when she realised that she was drinking due to loneliness. At that point, she knew that she wanted to stop drinking, but she did not know how. Through her job, she had referred a number of people to WGCADA, and in January 2005 she decided that she needed help herself.

> "I came to WGCADA early last year, as I felt that my drinking was becoming unmanageable. I wanted to get better, but I didn't know how to do it, so I though that the best thing to do would be to come to the people who knew how to do it."

At the time of the interview, Laura had only been in treatment at WGCADA for four weeks, and although her discomfort was slowly easing, she was still uncomfortable with the fact that she was in treatment. At present, she felt that she no longer knew who she was, and this was one of the main motivating factors for seeking treatment.

> "I've started sharing, which I find quite difficult. Talking about yourself isn't easy, but then talking about things that you would rather not share is much, much harder. But I'm very comfortable with the group and they are providing me with a lot of support.
>
> "At the moment, I feel quite privileged with being part of the group. We've all got something in common. When we start off on this part of treatment, we don't know who we are."

Before attending WGCADA, Laura had spent a month at Roserchan (a residential rehabilitation centre). However, she had relapsed and was given a six week therapeutic discharge. She then did a home detox through WGCADA, and has since been accessing the DOMINO project and attending two or three AA meetings a week. Laura has been attending group counselling for four weeks, and feels that slowly her trust in the centre is being build up. She finds WGCADA very welcoming, and enjoys the fact that she has something in common with other clients.

Laura knows how much she needs the treatment offered by WGCADA, and feels privileged to be receiving it. Due to this, she is making every effort to not jeopardise her place at the centre.

> "I need this treatment very badly and I'm not prepared to jeopardise it in any way. They have told me that the rules are there for a very good reason and that there is method behind their madness, and I believe them. I trust them and have faith in them."

Laura has had to rely on the staff at WGCADA for advice, tools for recovery, education about addiction, and information about AA meetings. She enjoys the family feel of the centre and, at present, is trying her hardest to remain in the right frame of mind to help her through the recovery process. Laura feels safe at WGCADA, and confident in the confidentiality principles adopted by the centre. She believes that WGCADA means "my recovery".

Laura very much appreciates the "unconditional and non-judgemental support" that the clients receive from the staff at WGCADA. She is very impressed with their dedication, such as offering to see the clients in their homes, or collecting the clients to bring them to the centre.

> "They [the staff] are here for you. You always get a welcome. I have rung here during my relapses and they always have time. I have been on the phone to them for over an hour at times. They will offer to come and get me, to bring me to the centre no matter what state I was in. They have offered to come and see me at home. It's just the unconditional support, I think."

Laura feels that the fact that many of the staff are recovering addicts helps to keep her at the centre as she feels no embarrassment. Furthermore, she always feels very welcome at the centre, and the staff are always, "willing to make time for you, with nothing being too much trouble for them."

> "The staff all being in recovery themselves helps me because they have been there, done that and got the t-shirt themselves so they understand… They are proof that treatment works providing that you work it yourself."

5.1.7. Daniel

Daniel started drinking at 18, and continued drinking "socially" until his thirties. However, he can now see that it was becoming a problem over the years.

> "I have made a few attempts to come off alcohol, but my friends, or so called friends, were out drinking… so I was back there drinking again day-in day-out until the days just linked. It didn't matter what time of day it was. As long as I had cash in my pocket it would go on alcohol."

Prior to WGCADA, his treatment experience included a detox at Cefn Coed, and a stay at Hope House, although two days after leaving he relapsed. Daniel now realises the devastating effects that alcohol had on his life.

> "Slowly but surely, it wrecked my life. It took away my friends, job, place that I lived, relationships. My family almost gave up on me, but luckily they stuck by me."

When Daniel started accessing DOMINO, he was still drinking. To stop this, he had to cease all contact with his previous friends, and stop going to places where alcohol was available. He found this very hard to deal with as he suffered from loneliness. However, after many attempts, he was successful at maintaining abstinence.

> 'I was coming to DOMINO with alcohol in my system, and as soon as I left the premises I was plying myself with more. It wasn't any real help to me until I realised, 'Look, I need this help'. It was the realisation that I needed help."

Daniel feels that DOMINO provided him with the opportunity to meet new people and do something with his time, as well as making him feel like he was achieving something. He liked the fact that he was given the choice of what activities to partake in, and he found the other clients and staff full of humour and laughter.

> "The DOMINO project helps a lot. It gives me something to do with my day, and I get the chance to meet other people. We can meet people who are in the same boat as you. They want resumption of their life before alcohol became a problem, just like I do."

Daniel enjoys going to WGCADA, as he is surrounded by people who want the same as he does. He is now experiencing the feeling of being wanted, and WGCADA has offered him the opportunity to make a new circle of friends.

> "The circle of friends that used to be involved in my life are no longer in my life. I'm making new friends through the meetings that I attend, and I'm taking interest in the people who want the same out of life and who make me happy."

Daniel feels that the help available at WGCADA is freely given and the approach is brilliant. WGCADA has shown him that there is more to life than alcohol, and he has learnt that recovery has to come from the desire to recover.

> "WGCADA is showing me that there is a lot more to life. Life is a gift, so treat it as one."

Daniel believes that the staff at WGCADA are 100% committed to their jobs, and this attitude suits him, and makes him feel closer to them. He also appreciates the fact that many of the staff have been through addiction themselves, so they can understand where he is coming from. He is very impressed by how the staff are always there for the clients, and how they will bend over backwards to offer any help that is needed. He also finds the encouragement that they offer extremely helpful.

> "There is so much help available. And the staff's approach to it is brilliant. It is wicked that they have been through all that shit before, and they are now there to help you get through it. The staff are priceless and they always have time for you."

5.2. Criminal Justice Case Studies

5.2.1. Case 1: Bridgend Arrest Referral client, 31-year old male

The client asked for help with his alcohol use while he was in custody at Bridgend police station on an affray charge. It transpired that he was binge drinking, consuming in excess of 60 units on the weekend. During the assessment, the client informed me that a few years ago he was involved in a car accident, which led to him having reconstructive surgery. He displays signs of post-traumatic stress and has previously been admitted to Coity Clinic at the Princess of Wales Hospital, Bridgend, due to anxiety and panic attacks. Furthermore, he has recently experienced two close bereavements. Although the client feels that his parents have been supportive, his relationship with his father is strained, as his father drinks heavily and has been diagnosed with clinical depression.

Due to the client's work commitments, he was unable to attend our groups. Therefore, we agreed he would attend weekly one-to-one sessions at our agency. At the time of the assessment, the client informed me that he had been abstinent from alcohol for a fortnight. Furthermore, he recognised that he is unable to drink alcohol socially, as he is unable to predict how much he will drink. Therefore, he requested a referral to one of WGCADA's abstinence counsellors and has agreed to attend AA meetings.

Update

Since his arrest, the client seems to have developed a more mature and responsible outlook on life. His first priority appears to be providing financial stability for his wife and their child. Recently, he changed employers, taking on a full-time apprenticeship at a higher rate of pay than his previous position. Indeed, the client seemed to have re-evaluated his whole

attitude towards fatherhood, realising the importance of a stable and loving home environment for his son. He is hoping to achieve this by dealing with his unresolved issues.

The client does not have a significant forensic history, having never served any prison or probation sentences. However, due to the severity of the offence he was sentenced to four months imprisonment. I have referred him to the CARAT team and arranged to visit him in prison to ensure that the appropriate support is established before his release.

5.2.2. Case 2: Bridgend Arrest Referral client, 46-year old male

The client asked for help with his alcohol use whilst he was in custody at Bridgend Police Station on a Drunk and Disorderly charge. He has been arrested numerous times for similar offences, and has received a Probation Order. During the assessment, he stated that he was drinking three 2½-litre flagons of cider a day, and had been doing so for the last three years.

From the assessment, it transpired that there has been a long history of Social Services involvement with the client's children, with all the children being on the Child Protection Register for emotional neglect. Currently, the client is separated from his partner and children. He was recently served with an eviction notice due to his antisocial behaviour. We discussed a referral to Wallich Clifford for Tenancy support.
The client requested a detox. Therefore, he was referred to the Rapid Access Point for a triage assessment with the hope that he will be referred to the core Community Drug and Alcohol Team for medical intervention. The client agreed to attend our agency on a weekly basis for one-to-one support around reducing his alcohol consumption.

Update
The client failed to attend his Rapid Access Point triage assessment. He was admitted to the Princess of Wales hospital, Bridgend, as he was found unconscious having fallen down drunk. Unfortunately, he discharged himself from the hospital and has failed to contact our agency.

5.2.3. Case study 3: Swansea Arrest Referral client, female

The client was arrested for being drunk and disorderly and subsequently assessed in Swansea central police station, which identified her alcohol issues. The client accepted that she could do with some help and advice, although was not prepared to give up completely. The client was reassured that this scheme was set up to educate and advise her with regards to her drinking.

The client has been attending one-to-one appointments and was placed in the Pre-treatment group 1. She is currently writing a weekly diary, identifying her alcohol intake and the money spent. The client has attended four one-to-one appointments to date, only missing one.

Update
The client has worked hard to reduce her alcohol intake over the last five weeks, although she still has a drink almost daily. She has started a part-time job locally, and enjoys the extra money that she saves from not spending it on alcohol. The client is also looking forward to starting Pre-treatment group 1. There have been no further arrests to date.

5.2.4. Case study 4: Swansea Arrest Referral client, male

The client was assessed in the police station after having asked to access the Arrest Referral scheme. It was identified that his alcohol use had escalated to the point where he had totally lost control. He had reached the point where he was being arrested on almost a daily

basis, and had incurred an anti-social behaviour order for being drunk in the city centre. The client identified his need for help and became willing to engage with WGCADA.

The client was taken through his options for treatment, taking into account the urgency of his case in relation to the very probable breach of his ASBO in the very near future. It was decided by the client that his best chance for recovery was to remove himself from this chaotic environment, in order to give himself a chance of becoming sober. An initial referral to the CDAT was made for an in-patient detox, and the client continued to engage with the agency but continued his drinking on a maintenance level. A further phone call was made to Hope House rehab to enquire about the possibility of as assessment. In the meantime, the client took it upon himself to attempt to detox and succeeded. The client was taken almost immediately to Hope House for assessment and was given a place in the rehab that day.

Update
The client is still in Hope House after ten weeks and doing extremely well. His decision to detox himself has been vindicated - it would have been something I would have strongly advised him against, bearing in mind the dangers of alcohol detox. The crucial ingredient of this particular case was timing. All of the fundamental interventions were made at key times in the client's road to recovery, thus empowering the client to make his own life- changing decisions.

5.2.5. Case study 5: Neath Arrest Referral client, 53-year old male

The client first presented at this agency due to a pending court case for a drink-driving offence. He has a previous history of alcohol related offences. The client has engaged in the Arrest Referral Scheme, in order to receive free, confidential advise, support and treatment for people facing legal problems associated with alcohol/drugs.

The client firstly attended for an assessment, the result of which showed that he would benefit from on-going one-to-one support surrounding his alcohol misuse. It also became apparent that the client would need help regarding his forthcoming court appearance, in the form of a supporting letter from this agency.

Update
The client is currently engaging well with this agency, and continues to receive one-to-one support from the Arrest Referral Scheme. He has also agreed to a referral to WGCADA no. 30 with a view to abstinence from alcohol. The client is currently still awaiting his court appearance, and is working towards remaining in a positive frame of mind.

5.2.6. Case study 6: Neath Arrest Referral client, 29-year old male

The client came through the Arrest Referral Scheme, following his release from prison. It was agreed that he should be monitored upon his release, in order to provide aftercare and relapse prevention information. However, the client returned to the use of heroin and cannabis when released from prison.

Following several appointments with the client, it was agreed that he should be referred to PSALT for prescribing. The client attended this agency a regular basis since his prescription was started, and has shown a commitment to his treatment programme.

Update
The client is currently stable on a methadone prescription, and has also engaged with WGCADA no. 30 (DOMINO project) in order to rebuild confidence, self-esteem, and to gain identification and support from other substance misusers.

5.3. A Commissioner: Martin Riley

The Community Safety Partnership (CSP) in Neath/Port Talbot commissions drug and alcohol treatment services from WGCADA. The CSP comprises senior members of the police and fire services, as well as local councillors.

However, members of the CSP recognise that they do not possess sufficient expertise about treatment for drug and alcohol problems and so they have asked the local Substance Misuse Action Team (SMAT) to make recommendations concerning commissioning of treatment services on their behalf. The CSP follows these recommendations.

Martin Riley, formerly a youth worker in the voluntary sector, is paid by Social Services to work full-time in the substance misuse field. He has been commissioning services from WGCADA for a number of years and has worked closely with the organisation. Martin believes that commissioners need to understand the treatment agencies they work with.

> "It's a thing of understanding the organisation, understanding the pressures they are under, every day operational things. And how can you assist them in delivering the best service … and what do we get out of it. In Neath and Port Talbot, we get an excellent service…"

The CSP commissions funds each year, which helps support the two offices in Neath, as well as the one in Port Talbot. In addition, the CSP commissions services from the Neath Community Drug Team (CDT), which works closely with WGCADA.

Martin emphasises that he keeps members of the CSP well informed about developments within WGCADA, providing them with 'good news' stories. He believes that this feedback is essential for very busy people who may otherwise have little feeling for, and understanding of, what they are commissioning and the impact of this funding on the organisation. He also encourages the WGCADA CEO to maintain a 'presence' in the community, so he also can keep people up-to-date with what is happening in the agency.

Martin works closely with WGCADA in trying to raise funding for the agency from other sources. He helped work on two successful Lottery bids, one for the Domino project (£90,000) and the other for funding to purchase Neath No. 30 (£320,000).

The opportunity to work full-time in the substance misuse field offers Martin Riley the opportunity to work closely with WGCADA in a way that is difficult for commissioners who only work part-time in the field to do.

However, it is more than this that makes the relationship between Martin (and the SMAT and CSP) and WGCADA special. He is clearly dedicated to improving treatment services for people with a substance use problem - and their families and friends – as well as helping this population improve their lives. He believes passionately in what he does. He also feels that the substance misuse field is the poor relation in society today, not receiving the level of funding and support it clearly merits and requires.

> "We don't even have decent facilities for clients to go for treatment… Police stations are of a standard, they spent millions in Swansea to make sure the cells were good for locking people up, to meet a standard. They haven't done that in substance misuse. I think that the Assembly has an idea about doing it, but I don't think that it's got a vision."

Martin has a good working relationship with the WGCADA CEO, Norman Preddy, and the local WGCADA Area Manager, Ifor Glyn. He believes that he can work together with WGCADA in helping them develop further, and in solving the agency's problems in an honest and open manner.

> "If I saw something that was terrible, I could say it to him [Norman Preddy] and I feel as if he would take note of that and act upon it. It would not be, ooh, we'll defend our position…"
>
> "… Norman has always been honest with me that if they've got a problem, he will share that problem with me, and he would like me to share a solution with him. Or help him with a solution, or he will tell me what solution they will carry through and make me aware. I don't think you can ask for more than that. That's a partnership. A partnership is the good, the bad and the ugly. You don't just share the good."

Martin believes that WGCADA is doing well in the way that it looks at its own performance. The quality of reports is good. He prefers to read case studies and stories, to examining statistics provided by the agency. He believes that the case studies provided in the reports are excellent.

Martin regularly visits the WGCADA offices, often dropping in unexpectedly. He feels that he can get a better picture of what WGCADA is achieving in terms of its outcomes by visiting regularly and talking to staff, clients and management. He always gets a good reception.

Martin is very impressed by the way that staff interact with clients. As research shows, the quality of staff and staff interactions with clients is a major predictor of successful outcomes. He feels that staff are always positive and rarely negative, which is what clients need.

> "And it's the thing that when you see the clients, you must always be positive and not be negative … you must be positive about their achievements, even if its small … and if they do slip, to say you've done it once, so let's try again… that's a good attitude."
>
> "… they [staff] don't need to tell people the negative part of drugs and alcohol, they already know it. They need to encourage the good side of sobriety or using less…"

Even when clients are discharged for using, staff put a positive side to the situation. Clients are told that they cannot come back for six weeks, and during this time they should reflect on what has happened and what could happen if I joined again. Martin Riley believes that clients do reflect about what was good about being involved in that organisation, what was good about not using as much substances. Clients have had the good part reinforced to them.

The way that WGCADA uses positive reinforcement is illustrated by the DOMINO project. Clients are encouraged to attend the allotments for four hours in the morning – for some clients this is a challenge, but hopefully an achievable challenge. And if they stay the four hours and enjoy the stay, they've met the challenge, made small steps forward.

Martin sums up by saying:

"They [WGCADA] have an openness about things that I find healthy. They are a can-do organisation."

5.4. A student on work experience: Rachel-Jane Thomas

My five months student social work experience with WGCADA has had an impact on my personal and professional development, for which I will remain ever grateful to my wonderful practice teacher Shirley Jones and her team at the WGCADA Neath Abstinence Agency.

On my first day, I had the pleasure of meeting WGCADA's Chief Executive Mr. Norman Preddy, who questioned me extensively regarding my reasons for choosing to work for this agency. Following a discussion on the increasing problems of alcohol and drug dependency, I promptly highlighted the promotional efforts of the Bridgend teams' work with my college, and how interesting Julie Williams made her job sound at a college presentation.

My initial working experience within an abstinence treatment group gave me an awareness of the effectiveness of the 'Minnesota' counselling model used at WGCADA. This was echoed within extensive supervision support, and further research that identified the constructive goals of confrontational counseling, and the beneficial effects on chemically-dependent service users to accept the reality of their situation.

Although I have been mainly based with Neath's abstinence team, I have also been fortunate to spend some time with other WGCADA workers. For example, I spent a day with Colin Lloyd, 'Young Persons Worker'. I was particularly impressed with Colin's school 'drugs awareness' talk where he made a class of 15-year-old moody girls sit up and take notice. I was certainly in awe of Colin's professional, slick presentation style, that was nothing short of perfect. I would thoroughly recommend other students (even staff members) to experience.

My workload at WGCADA has been fulfilling as well as challenging. I have become familiar with assessment procedures, crisis intervention, care management, and the roles of one-to-one counsellors and group work facilitators. I have had the benefit of a supportive and knowledgeable team of colleagues who have contributed to my learning development, and to whom I have become quite attached. I have also been fortunate during my time with WGCADA to observe service users progress in their treatment from a phase one Pre-treatment education programme to primary therapy group work, in addition to seeing the healthy, confident people they have become.

I would like to thank all the staff at WGCADA for their time, support and encouragement over the past few months. I have enjoyed working with the Neath Abstinence Team, who have made me laugh, cry and think hard about my future career.

I would especially like to thank my 'amazing' practice teacher for her ongoing nurturing supervision and guidance. I feel her professional commitment and overwhelming enthusiasm makes her an asset to the organisation. She is a unique and compassionate person, whom I admire, respect and aspire to. My time at WGCADA has certainly been a rewarding experience and has given me a solid foundation of substance misuse knowledge to which I can develop further in the future.

5.5. A volunteer: Carolyn

My name is Carolyn and I have been a volunteer with the West Glamorgan Council on Alcohol and Drug Abuse Ltd since November 2004. I have been based in the Port Talbot office. The office itself is located in Taibach and is a converted mid terraced house. I'm sure

it has been said that it used to be a doctor's surgery, and it has that cosy, well-used friendly feeling about it. The receptionist area is to the left of the waiting room, which is the first contact most clients and new people have with WGCADA. So it was for me when I first arrived to have a 'chat 'with the manager to see if it would be possible to volunteer.

My first time in the agency left a lasting impression on me. The reception/admin people were really welcoming and made me immediately feel at home. I met the manager, who was really interested in my reasons for wanting to volunteer, and during that time I think I was introduced to everyone I could be. It felt like the staff really enjoyed the prospect of having new people come into their agency.

From a practical point of view, all volunteers are invited and expected to complete WGCADA's in-house training course that is held one day a week over a number of weeks. This gives everybody an opportunity to learn about what WGCADA does and how they practice. It also serves to give all the volunteers a chance to meet each other. The volunteers are encouraged to meet up together, so that the volunteer voice can be heard within WGCADA. Additionally, many other one day/morning training courses are on offer to all staff. Since last year, I have attended three and I am looking forward to the next training day which is offering comprehensive 'needle exchange' information.

I work one day a week in the Port Talbot agency, although sometimes I end up coming in for an extra afternoon to catch up. As a volunteer you can offer as much or as little time has you have, and WGCADA will do their best to accommodate you. I have started seeing clients and have started to build up a small but steady caseload. The work is interesting and varied, as are the clients, and there is a never-ending amount of knowledge to be gained. This aspect can be very daunting for the new volunteer. However, plenty of help is on hand. Volunteers are shadowed by an experienced worker, who will show and explain to the volunteer what is the best/better way to proceed in their work. Supervision takes place on a monthly basis.

I think what has stood out for me is that the Port Talbot agency is a very friendly place to be and work. The staff seem genuinely pleased to see you, and really appreciate the effort you are making to be there. There is unlimited knowledge and experience to be gained, and thankfully there is always help at hand. The staff are endlessly happy to impart their expertise, and always want you to be able to work with the client to the best of your ability. Therefore, they will do their utmost to help you achieve this in the most supportive and informative way they can.

6. Comments about WGCADA

6.1. WGCADA by WGCADA

"We offer a variety of ways of helping people get better. It's also special because we have a high success rate in helping people get well. It is successful because the majority of staff expect people to get well … we are never negative about that. We are always positive that people can come off and stay off drugs and alcohol and enjoy their lives."

Norman, CEO

"It works – it is simple as that. If you look at the reunions and look at how many people … people who were here ten to fifteen years ago and they are still well and their lives are successful … It is also special because it gives a great deal of satisfaction to the people who work here."

Ann, Finance Manager and Deputy CEO

"Doesn't have any boundaries … it's like the illness has no boundaries and nor does WGCADA. No one gets turned away. Everybody is invited in – no addiction is too small or too big … It's not just the client, it's the family, the extended family, the kids, they're all included.

Lesley, Tenancy Support Worker, Swansea

"The expertise here. It's how they connect with you – they seem to know exactly what you are thinking, what you are feeling."

Lawrence, Pretreatment Worker, Swansea

"The bottom line is we save people's lives. It saved my life."

Fred, Primary Counsellor, Swansea

6.2. Friends of WGCADA

"We accept referrals from WGCADA and we also refer people to them, as we are a Tier 4 and they are a Tier 3 organisation. They are excellent; they have grown and expanded in line with service users' needs in an exemplary way. When Rhoserchan opened, WGCADA were small and very 12-step orientated. They have now expanded and although they are still 12-step based, they respond to the needs of a wider range of clients. I have a lot of respect and

"I think WGCADA is a fabulous organization, full of people who are totally dedicated to helping others. It is a privilege to be involved with people who care so much."

Graham Thomas (chairman of the League of Friends)

"I am the Managing Director of Holistic Services Limited, a management consultancy providing HR support. We supply WGCADA with both strategic and practical advice on Personnel matters. I also provide supervision for the Chief Executive, Norman Preddy, thereby completing the supervision cycle for all staff.

My professional opinion of WGCADA is that they are a large, yet successful organisation, who practice what they preach. In previous days, they were able to work in a more informal manner – these days legislation determines that the organisation adopts a more formal and precise methodology. However, despite this, they seem to have managed to hold on to their friendly and informal ethos, whilst simultaneously maintaining best practice. I have been impressed by this, and I am proud and pleased to be professionally associated with WGCADA.'

Henry Gilbert

"WGCADA offers a very positive service. They deal with a lot of different problems and do so in a way that brings a lot of hope. The fact that they are dependable people also brings stability to the individual, and to the community. I have a lot of personal involvement with WGCADA. I talk to a lot of the clients and I am here if they want to talk. However, I do not interfere with the professional duties of the staff."

Reverend Duncan Walker

"I first became involved with WGCADA in 1986. I had just become a City Councillor and a colleague who was chairman of WGCADA at the time asked me to become a member of the Management Committee. I have been a member off and on since then.

My involvement deepened two years ago when I became a director of the new Limited Company. I have always held WGCADA and its aims in very high regard. They rightly have the symbol of an open door on all their literature, because they are constantly looking for ways to improve their accessibility to the individual, their families and employers, and the wider community. They have Centres in Swansea, Neath, Port Talbot and Bridgend. As well as treatment, they are concerned with prevention and will advise schools, colleges and any organization that needs help.

I admire the hard work and dedication of the Team at WGCADA, many of whom have worked there for years."

Sue Waller (board member)

7. WIRED views of WGCADA

In this piece of work, we have profiled a diverse range of activities carried out by WGCADA to give the reader insights into what is required to tackle substance use problems in society today. Whilst we did not set out to evaluate the success or outcomes of treatment provision in this agency – that would require a large-scale piece of research – we have been able to make some judgements about the quality of treatment provision and the factors that are likely to be important in providing successful treatment.

In this section, we describe our views of the services provided by WGCADA to people with a substance use problems, their families and loved ones, as well as the wider community.

Research has shown a number of key principles that facilitate the provision of successful treatment. We recognise a number of WGCADA's attributes which relate directly to these principles, so we will make appropriate references to major points raised by the European Association of Treatment Agencies (EATA) in their document, "Rehab – what works? 20 things you should know about rehabilitative treatment for substance dependency". In addition, we refer to the National Institute on Drug Abuse (NIDA) document, "Principles of Drug Addiction Treatment: A Research Based Guide."

7.1. Principles of effective treatment

7.1.1. The importance of choice

"No single treatment is appropriate for all individuals" (NIDA)

"Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society."

"Abstinence and controlled use both have their place" (EATA)

"For some people with less severe problems, controlled use can be a viable and appropriate treatment goal. Controlled use is rarely sustainable in the long term, however, for people with severe dependencies."

The key principles above emphasise the need for diversity in treatment options, and an understanding that different people will change their behaviour in different ways in trying to overcome problems associated with substance use.

Whilst part of WGCADA remains firmly rooted in the 12-step philosophy, the organisation recognises the importance and value of different treatment philosophies. In recent years, WGCADA has expanded to incorporate a range of services, which have emerged from the harm reduction treatment philosophy. These include needle exchange services, prescribing options, controlled consumption, and advice about safer injecting.

WGCADA believes in a continuum of care, and recognises that although abstinence may be the ultimate goal, many clients are unable, unwilling, or not ready to accept this when they first enter treatment, or indeed for some, ever. WGCADA is committed to offering clients choice and strongly advocate that a client's engagement in treatment, whatever that treatment may be, is ultimately beneficial. It recognises that a treatment agency should offer a range of services that aim to attract a wide range of clients, with differing needs and wants.

In addition to offering a range of services, WGCADA also provides clients with the information to make choices. Information is provided during the assessment process, pre-treatment, and at various other times the client is interacting with the service.

7.1.2 "Treatment should be based on the individual's needs"

> "The length of treatment, setting, approach, range of issues addressed, use of medication etc. should be tailored to the individual, based on a clear assessment of the individual's needs and expectations. Clients are not a homogenous group and a standard, one-size-fits-all approach is of limited value and may actually make matters worse. People's needs can change during treatment and treatment plans should be continually reviewed and updated where appropriate."

WGCADA's commitment to developing a multi-faceted treatment service enables it to tailor treatment to the individual's needs.

A comprehensive assessment procedure is designed to delineate the client's full needs and wants, to better inform a treatment plan with the best chance of success. The recent developments of SMART (Substance Misuse Assessment and Referral Team) and RAP (Rapid Access Point) aim to facilitate this assessment process, to ensure that clients are matched to the treatment method and staff which best suits their needs.

The development of specialist worker posts is of particular value to clients, ensuring that both their treatment and contributory (see below) needs are addressed. Specialist posts such as elderly and disabled, women and families, young people, and domestic violence, were created as a direct response to the needs identified in treatment populations as a whole, and in the local area. WGCADA recognises the specific needs of discrete treatment populations and the need to develop effective ways of working with them. The availability of such workers may also facilitate the client's initial engagement in treatment.

As WGCADA offers many different treatment components (for example, the core 12-step programme, pre-treatment, harm reduction counselling, detox and so on) clients treatment plans and timings are formulated upon full consideration of what will best suit them. Clients

progress are monitored and the frequency and length of treatment components can be adjusted to accommodate for any changes in client needs.

WGCADA has also developed partnerships with other local service providers (such as CDATs) to widen the options available to clients, and to encourage continuity of care (for example, from detox to pre-treatment).

7.1.3. "Treatment must address associated contributory factors"

> "As well as focusing directly on client's substance use, and medical, psychological, social, vocational, and legal problems which the client may have and which would otherwise increase the probability of relapse should also be addressed."

WGCADA recognises that for many clients, their drug/alcohol use is just one part of a myriad of problems that they may be experiencing. These additional problems can sometimes be attributed as a cause or effect of the substance misuse. It must, however, be noted that most clients have additional problems, that in one way or another can contribute to, or exacerbate, their using behaviour.

WGCADA is committed to addressing the client holistically and this is reflected in the comprehensive assessment procedures. Clients are offered a range of services to help address such factors. Counselling staff aim to provide clients the opportunity to recognise and tackle problem areas and life events which can act as blocks to recovery, for example, clients may use alcohol and drugs as coping mechanisms to deal with unwanted emotions and memories.

Clients are supported with issues such as housing, benefits, and court appearances. This has been facilitated by the good working relationships that have been developed between WGCADA and a variety of other organisations within the community.

The DOMINO projects were also developed in response to known factors that are likely to contribute to continued drug/alcohol use and relapse. These include, too much time on a client's hands, lack of meaningful leisure activities, lack of social interaction, and the need to develop new interests and skills.

7.1.4. "Co-existing psychiatric disorders should be addressed"

> "A full assessment should look for evidence of any psychiatric conditions, and where this is found treatment should focus on both the client's substance use and their mental health problems in an integrated fashion. Services should draw on specialist psychiatric support as required."

WGCADA's assessment procedures assess the client holistically and issues of dual diagnosis are addressed. When clients present with psychiatric conditions, staff work closely with them to address and monitor their conditions. For some clients, problems may be co-existing or a direct result of their substance use. WGCADA have developed good working relationships and partnerships with the local CDATs and Community Mental Health Teams to address such issues, and they also work closely with the local Psychiatric wards.

7.1.5. "Treatment staff are key"

> "Treatment staff are central to the success of treatment. Research shows that staff should be well trained, closely supervised, confident in their work and empathetic

> towards the clients. A high staff: client ratio is important, as is close support and supervision. Whether or not counsellors have themselves had a drug or alcohol problem appears to have little bearing on their professional abilities. However, there is some evidence that a staff team which brings together counsellors who are in recovery with others who have no history of problematic use can be particularly effective."

WGCADA boasts a large, multi-disciplinary team, made up of individuals with and without personal experience of substance use problems. The team offers a range of expertise, enhancing the services and support accessible to clients.

We found that there was, in general, good staff morale amongst ground workers, where staff felt supported and valued by their peers. This facilitates good working relationships and team spirit, which adds to up-beat and positive attitudes towards treatment.

Clients illustrated a number of qualities in both individual staff members and the team as a whole, which they found to be a huge credit to the organisation. They described the staff as warm, empathetic, genuine and committed. They felt that such qualities facilitated their engagement in treatment and enhanced their belief that change was possible. All clients described how the empathetic and non-judgemental approach helped them to feel comfortable in the agency and fully participate in treatment.

The relaxed and friendly atmosphere in the centres can be 'felt' as soon as someone walks through the door. Clients and staff mix together, and build respectful relationships which helps to prevent barriers or, a 'them and us' attitude.

Staff members also feel confident that they can genuinely help clients get better. They create an almost infectious atmosphere, facilitating improvements in self-efficacy, a key predictor of successful outcomes.

> "They practice what they preach – if they are abstinent, they practice that and clients can see that. They believe very much in a work ethic and also to putting some structure into their own lives and other people's lives, and they seem to follow that through themselves. And I think that people can see that. I think that people need role models … the staff are good role models for people to look at."
>
> Martin Riley, Commissioner

A number of people external to the organisation commented that the high quality of staff (and services) had in general been maintained as the organisation has expanded. Whilst many treatment agencies in the field have expressed concern about the quality of applicants they are receiving for new jobs - with the expansion of funding in the field – this is not the case with WGCADA. Their reputation goes before them.

Finally, it is evident that a lot of staff in WGCADA are willing to go the extra mile. The agency has few problems with finding staff who are willing to work late on evenings where such a service is offered to clients. This sends a positive message to clients.

7.1.6. "Treatment should be readily available"

> "The harder it is to access treatment and the greater the hurdles placed in the way of potential treatment applicants, the greater the proportion of people who will fall by the wayside before they get a chance to take up any available treatment opportunities."

The issue of treatment availability is one that burdens the substance misuse field as a whole. It is widely accepted that the swift uptake of clients into treatment can be hugely beneficial in engaging individuals, enhancing motivation and facilitating change. Clients often talk about the need to access treatment at the exact point in which they are motivated to do so. Fulfilling this need, however, is often limited by the availability of funds to develop services and the simple logistics of local demands often outweighing the ability to supply treatment places.

WGCADA, like other treatment agencies, has waiting lists for treatment. Whilst the agency is committed to developing services and mechanisms to keep these to a minimum, they also recognise that it is unrealistic to expect waiting lists to disappear overnight. The development of the DOMINO projects is a huge credit to the organisation. The projects offer the opportunity to engage clients and offer a service of some kind, at the first point of contact. This is often integral in engaging and retaining clients. Clients often comment how the DOMINO projects 'eased' them into treatment, helping to put their apprehensions of accessing the service at rest, and facilitated the developments of support networks to help them cope with the demands of addressing their substance misuse.

It must be noted, however, that the importance of the DOMINO projects to the overall provision of treatment that WGCADA offers is sometimes under-appreciated. All commissioners need to be aware of the value of these projects and to reflect this in the allocation of appropriate funds. This was perhaps exemplified by the disappointing lack of funds to develop the services in the Bridgend area. Enhanced and sustained funds to all the DOMINO sites would greatly benefit clients, and the provision of treatment that WGCADA can offer them.

7.1.7. The importance of outreach work

The outreach work conducted in the community is an invaluable element to the services that WGCADA offers. It offers the opportunity to engage individuals who otherwise may not know of the services available to them or who are reluctant to engage. Outreach work helps to spread the word of what WGCADA can offer to individuals and encourages the development of relationships between the agency and those in the community. For those who are unwilling or unable to attend WGCADA, outreach workers provide a point of contact and an open door for those who may become ready to engage at a later date.

Outreach work is of particular value when considering young people. Young people who are using drugs/alcohol experimentally or recreationally may be unaware of the advice that WGCADA can offer them and preventative work is a core component of the WGCADA young people's workers. It is often noted that there is a great need to 'go where the young people are' and not to expect them to seek out and attend treatment agencies themselves. WGCADA is exemplary in working in this manner. Such outreach can engage young people who may be in need of treatment or again, provide an open-door if they ever should in the future.

The government has emphasised the necessity to attract the so-called hard-to-reach into treatment. WGCADA seems to be doing this very well, in part by their specialist workers and in part by making the community aware of the services that WGCADA has to offer.

7.2. Points to consider

To ensure the continuity and effectiveness of good practice, it is important for service providers to regularly assess and evaluate their organisation. Providing effective treatment is a rolling process, which involves a balance between maintaining existing services that work well, and development to expand the scope and reach of options available to clients. We will now consider a number of issues for consideration.

7.2.1. Knowing when to stop

WGCADA has undergone a period of rapid and large-scale expansion in recent years. In so doing, they have vastly increased the availability and range of treatment options offered to clients – across a number of localities. Such developments have transpired in part as a result of the overall vision of WGCADA, and as a result of new funding avenues (for example, those created by the allocation of funding streams via the criminal justice system).

WGCADA have done well in incorporating new, and developing existing services under the overall WGCADA umbrella, to date. However, there is a feeling amongst staff that such rapid expansion needs to be further managed and a decision needs to be made concerning further expansion. All staff agree that access to treatment is essential and clients are obviously benefiting from increased opportunities. There are some concerns however, regarding the ability to 'keep up' with such developments and maintain high quality delivery. WGCADA need to carefully balance reacting to possible avenues of funding and such concerns expressed by staff.

7.2.2. Autonomy/cohesiveness between localities

WGCADA has been successful in expanding services across the South Wales area and currently operate in Swansea, Neath, Port Talbot, Bridgend and Cardiff. Each service is operating well with good team cohesiveness, and central management appears to have good links with all offices.

The development and expansion of each site has been managed well by local management, in conjunction with central management. However, there are some concerns and/or confusion surrounding the scale of the role of central management in making decisions concerned with each of the individual sites. It appears that a strategic planning needs to be considered regarding the relative autonomy and/or cohesiveness between sites. There are pros and cons associated with both more and less central management, but with careful planning and feedback from workers it should be possible to get the balance. No one wants to lose the main umbrella and ethos of WGCADA, but it also important to get the balance of central vs. local management right.

7.2.3. Consistency across services

As previously discussed, WGCADA boasts a range of specialist services and workers across its sites. The availability of such services is determined in part, by the availability and allocation of funding for the specific posts. It would be beneficial for clients in each area to have access to the same services as those accessing other sites. At the same time, we recognise that services offered are dependent on the level of funding that is available from commissioners.

There appears to be a current lack of harm reduction services (needle exchange, prescribing and harm reduction counselling methods) offered by WGCADA in Swansea. In turn, the

particular benefits associated with access to specialist workers (e.g. elderly and disabled, domestic violence and so on) are limited to certain offices.

This issue should be further discussed with commissioners and funders, and strategic planning amended as management see fit.

7.2.4. Training and professional development

Staff appeared to be highly motivated to continue with their professional development and attend further training. In addition to WGCADA's in-house training, staff felt that they as individuals and the agency as a whole could benefit from attending conferences with other agencies, and receiving training provided by external organisations. There was a general feeling – shared by ourselves - that WGCADA does not offer enough training opportunities for staff. This is a vast, complicated field – in other words, there is a lot to learn and a lot of developments that need to be followed.

WGCADA needs to develop a clear training strategy – the development of this strategy should involve the views of staff on the ground and clients. The agency might also be advised to get the opinion of an external person or organisation about their training strategy. Training is key to producing high quality staff, which, in turn, is key to producing good client outcomes.
It is also essential that WGCADA as an organisation (and individual staff members) links in with the advances in professional development in the field. For example, they need to be looking at DANOS and the accreditation schemes developed by the Federation of Drug and Alcohol Professionals (FDAP) and EATA.

There is a need for further understanding between staff of the different philosophies and services operating within WGCADA. Whilst WGCADA has done well to bring together the abstinence-based and harm reduction philosophies (in particular in Bridgend, where it happens under the same roof), there have been some tensions over time. These have been exacerbated to some extent by the rapid expansion and the lack of a more cohesive training strategy. Many staff felt that there needed to be more understanding of the different philosophies, and of how other sites are operating, by themselves and their colleagues. A number of staff proposed the idea of 'job swaps'.

7.2.5. Data collection, client outcomes and research

WGCADA have done a good job in collecting information about their clients, and their database system is both useful and informative (and is appreciated by staff). The agency also produces high quality reports, which includes informative case studies. WGCADA are operating at a high standard relative to many other treatment agencies.

However, the system needs to be developed further to give a better indication of how many clients are receiving different forms of intervention, and to look at "treatment" outcomes. We felt that whilst the Annual Report was full of interesting and informative numbers, it was difficult to work out, for example, how many clients started and finished Primary treatment, how many were on methadone and subutex programmes, etc. This should not be seen as a criticism of what is being done – rather it should be viewed as the next stage of natural development. There also needs to be more assessment of treatment outcomes – commissioners must be made aware of the added costs of doing this. We would be happy to talk to WGCADA further about these points.

WGCADA has provided WIRED team members, and students from Swansea University, the opportunity to carry out research within their organisation. They have always shown a keen interest in the research being carried out, recognising the value of such work. The people who taken up these opportunities have always been impressed by the organisation – and grateful for what has been offered. WGCADA should be congratulated and thanked for what it is doing to help enhance our understanding of substance misuse treatment and support.

7.2.6. Marketing

WGCADA do an excellent job providing treatment and support for clients with a substance use problem. Whilst at one level they do a good job of telling people about what they do, at another level they do not market themselves well enough. They need to market themselves more and widen the range of individuals (from users, family members, to employers and the wider community), who are aware of what WGCADA can do. Enhanced general awareness of the agency can help facilitate people into treatment and the generation of referrals. WGCADA also need to instil more life into their web site, which started off looking so promising (outstanding compared to other treatment agencies) but has withered over time. A good garden needs tending!

7.2.7. A word to commissioners

Commissioners need to be aware of the range and quality of services being offered by WGCADA. They must realise how difficult it is for an organisation to be working at this level. WGCADA and its staff need all the support and understanding that is possible.

Commissioners must also be very aware of the need to maintain WGCADA's core services at the level that is required. Too often a new funding initiative results in a new "bolt-on" to the core services, putting more strain on the latter. For example, the recently funded Drug Interventions Programme provides WGCADA with money to provide a prescribing service for a three-month period. After that period, WGCADA is expected to maintain a continued service for these clients – but no money was provided. Both commissioners and WGCADA must recognise the need to expand core services in the agency.

7.2.8. The Open Door

WGCADA's logo reflects what the agency is all about. It provides an open door to a diverse variety of people with a substance use problem, their loved ones, practitioners, commissioners, policy makers, researchers, and members of the general public. It is a credit to the community.

8. Appendices

8.1. Appendix A: Natalie's story

Natalie describes a happy early childhood. Her family were well off financially and she remembers having holidays lasting months at a time. Her parents gave her anything she wanted. She was popular at school. But there was a darker side to Natalie's family life.

Her parents had a serious drug habit that became apparent to Natalie when she was eight years old. She realised that her father's frequent trips to London were drug-related. The family home was always busy. Many people were around at all times of the day and night. In spite of her father's absences and her parents' drug habit, and all that it entailed, Natalie reflects on this part of her life as being a happy time.

> "I liked that life because they had a lot of money and I was taken places. I was treated well."

However, when Natalie was nine years old she started to resent her parents' drug habit.

> "…I said to my mother that I didn't like her doing drugs… I just said how would she feel if her mother did it? And then that's when my mother stopped… but my dad carried on."

Natalie's family moved when she was eleven years old. Disaster struck the family a week later.

> "…my dad got arrested and was given a long sentence…"

Her dad's imprisonment was for a drug offence.

> "That was a week after I moved here and I had to start a new school, and our

> house, our names, everything were in the paper, on the news because Margaret Thatcher was prime minister and totally against drugs. It was a terrible thing. It was horrible, a horrible time in my life that I had to go to school and everybody knew. And I just felt really, really embarrassed…"

Life was difficult for a while for Natalie and her family. She also continued to be haunted by her father's case.

> "I got paranoid at school if anybody talked about drugs I thought they'd bring up my dad's case. I felt a lot of shame and I felt really, really bad."

Her father's sentence was reduced by two years after appeal. However, by this time Natalie had grown tired of visiting her father in prison.

> "I stopped visiting him. I didn't want to go to prisons anymore and visit him… then it seemed that our lives just got on, we were skint because all the money and everything was frozen. It was all drug money…"

Natalie started using cannabis and alcohol when she was 14 years old.

> "I started feeling, it was something I knew. It was a really funny feeling, I knew it, …I knew about wraps, I knew… how to make them, how to roll a joint. And it stopped me feeling, that was really good. So I could do things and not have a conscience about it. I didn't feel guilty about anything."

> "I started mixing with different people, the ones that always looked exciting at school, you know, the ones that were smoking."

At this time in her life, Natalie described her mother as being "liberal and open-minded."

> "…like we were allowed to smoke in the house. She'd let all my friends in and we would be up to no good…"

Natalie started dating when she was 14. Her boyfriend, Richard, regularly stole money from his parents.

> "… He used to take a lot of money. Like one hundred pounds a day. So I started 'mitching' off school, we'd meet, go and score first thing in the morning, hash, and then just like, it was great, going round cafes, doing what we wanted, catching buses where ever we wanted. Doing whatever we wanted. And that I suppose reminded me of having money and doing what I wanted when I was young. So that was great. And then we started doing 'trips' on the weekend. And it was all really good fun then."

Natalie hardly attended school at this time. She was arrested for breach of the peace and was also caught shoplifting.

> "We just seemed to do whatever we wanted and I like that feeling. I was free and I could do whatever I wanted. I didn't have any guilt."

Natalie became pregnant by Richard when she was 15 years old. She split up with Richard when she was four months pregnant.

> "It wasn't very good then 'cause I wasn't going to school so I didn't really have any friends, they were all at school or whatever and it was really boring. I used to argue with my mother a lot."

Even though she had not been attending school, Natalie still sat her GCSE exams. She was pregnant at the time. She remembers this as another time in her life when she felt a lot of shame because everyone was talking about her. Natalie abstained from all drugs during her pregnancy.

> "And in that period that I was pregnant, I gave up everything. I didn't see anybody, I gave up cigarettes. I didn't take drugs, didn't do anything. And I thought that was a way out I suppose."

Natalie gave birth to her son when she was 16 years old. Four months after her son's birth, she started smoking cannabis again. She started dating Richard again two months after her son's birth. This time the relationship lasted seven months. In this time, Natalie fell pregnant again but decided not to keep the baby. Natalie then began to date Mark, who she describes as "quite intelligent, had a lot going for him."

Around the age of 17/18, Natalie discovered the rave scene where she took her first ecstasy tablet. She began to take ecstasy every time she went out clubbing. When Natalie's son was two years old, she took speed in front of him for the first time. At this time, Natalie's primary drug of choice was alcohol.

> "I wouldn't have said I was addicted to anything at that point, but probably drink, when I look back 'cause I use to get hammered at the weekends…"

Natalie then began to date John, Mark's friend, for five months. John was dealing speed and hash. Natalie finished with John and returned to Mark.

> "I really didn't like John and, 'cause he was an alcoholic and always use to get in right states."

However, John was not completely out of her life.

> "I really didn't like him and it was great because… I could phone him up and he'd come down and take me out. And he had a lot of speed, that's when I started doing speed."

During this time Natalie had moved out of the family home and in to a flat. She recalls her flat being burgled when word got out that she was stashing three nine bars of cannabis. Natalie returned to the family home. When Mark went abroad as part of his degree course, Natalie's speed and ecstasy use escalated.

> "…that's when I really started to party… I went out. I lost lots of weight. I got store cards and everything. I had lots of nice clothes. And then I was going clubbing every weekend, doing E's…or speed."

When Mark came home from abroad, Natalie realised that "things had changed" between them. Natalie was far more interested in going out than with her relationship with Mark.

> "And then I started meeting lots of guys that would supply me. That's what seemed to be the pattern… So I started to use men for what I wanted. I didn't

sleep with these guys."

Natalie started dating John again after a misunderstanding the day before he was on trial for an offence.

> "I slept with him which was a stupid thing to do. And he went to court the next day and he actually got off! And he came over my house thinking everything was great and we were together. I thought 'Oh God.' I felt I couldn't let him down. I just went a long with it. I suppose low self-esteem whatever. And that's when I started doing more and more speed."

Initially, Natalie felt that her use of speed was controlled.

> "I'd do speed like on a Thursday, I think I controlled it at first. So I'd do speed on Thursday, lose weight for Friday to go out and then I'd do it over the weekend and then on the Monday, Tuesday and Wednesday I wouldn't do it."

Natalie felt confident and happy when she was taking speed. She also explained that she was still "able to be a mother."

> "And I was taking valium and eggs [temazepam] as well at the time to come down off the speed. I wanted to go to sleep."

Natalie's valium and temazepam was supplied illegally. When Natalie was 19 years old, her father came home from prison. He had developed a heroin habit while in prison. Natalie believes that this is when things probably started to go "pear-shaped" for her.

> "He came out, and I didn't realise it at the time, but he was a heroin addict. I didn't know that. While he'd been in prison, he went down because of crack, and when he was in prison his illness must have progressed and he ended up using smack. So when he came out I didn't realise that. And I think he was on methadone and stuff."

By this time, John had also been sent to prison for an offence and whilst there he tried heroin for the first time. When John left prison, Natalie's father started to supply him. Natalie tried heroin for the first time when she was 21 years old.

> "I didn't think anything much to gear, and I thought… 'Oh what's everyone on about? It's not that brilliant.' But at the same time it was like…I felt really chilled. You feel really calm and chilled out. So I think I probably tried it again a week later. Then I just didn't bother, I didn't do it for a while."

When John came out of prison he was jealous and angry about the male friends with whom Natalie had been socialising. Natalie readily admits that there were times when John's temper scared her. It was during this time that Natalie, 22 years old, took an overdose of paracetamol.

> "I just took the overdose to get me away from here."

Around this time Natalie was drinking a lot and going out regularly. Sometimes while Natalie was drinking she would take temazepam (often about ten) as well. As a result:

"I wouldn't remember anything…I would take speed, so I could drink more".

"It was probably around that time that I would end up fighting in town and all that kind of stuff."

Natalie's son spent a lot of time with Natalie's mother and his father. Around this time, Natalie ended up in hospital with a problem she associated with her drinking and the speed she was taking. She also got sacked from her job at a pub when she was caught taking a drink. Natalie recalled times when the pub owners were away when she would put her mouth under the Jack Daniels' optic and take shots. Aged 21/22, Natalie stopped taking ecstasy.

"I stopped doing E's because I couldn't be bothered with the paranoia and I thought, 'Oh well, I can go out and just do speed.' And I was having just as much as a good time just doing speed without the E's…"

John's heroin use was increasing and Natalie's relationship with him was becoming more volatile.

"… we used to argue a lot. I used to try and control him all the time. I seemed to have lost that, you know, he use to do anything I say and now that I was with him it was like he'd got me and it wasn't working anymore but for some reason I kept going back for more and more and more. I liked being taken out."

During this time Natalie got pregnant by John. She did not keep the baby. Natalie recalled the time that she did a 'geographical' and moved out of the country to start afresh.

"… I was only over there six weeks. I took my son out of school. When I was out there I got in a fight with somebody, a guy. He gave me a black eye. Somebody I met on holiday had my son for the night. I was like, more or less stripping in this nightclub. They got me hammered, I don't know who… The DJ kept saying 'Oh someone's buying you a drink over there' and I was drinking them and drinking them. I don't know what they were. Before I knew it my top was off…"

It soon became apparent to Natalie that the situation in the nightclub (i.e. the free alcohol) was a set-up, since she saw pictures of herself advertising the nightclub. Natalie came back home and to John who was still using heroin. She started college. At this time she was using speed everyday and smoking heroin occasionally. She had also tried crack. She grew tired of arguing with John over his heroin use.

"… in a way…I thought 'Oh my God, I might as well join him.' Do you know what I mean? He was such a state. He couldn't talk or anything, he'd be gouching out all the time. So I just thought 'Oh well, I might as well join him. I'm fed up of arguing with him about it'…"

Natalie started using heroin with John in the evenings when her son was in bed. Natalie described how the taking of heroin became 'normal' to her.

"… it started becoming acceptable. I just accepted it – John was doing it, my dad was doing it. I started doing it, dabbling in it. It didn't seem to be a problem. I was thinking 'What's everyone on about you can get addicted

straight away. That's bollocks,' you know, 'I can take it or leave it.' I thought I could take it or leave it but for some reason I still kept doing it."

Her father would give her gear sometimes:

"…his way showing he cared. He didn't want to see me in pain and withdrawing."

Natalie's heroin use began to escalate.

"I couldn't believe how fast this had happened. I never, ever, thought this was going to happen to me."

She began using heroin at three o'clock in the afternoon. The situation got worse until eventually she was using it all day, every day. This went on for two years.

"To be perfectly honest, that two years of my life is really vague."

Those around her were using heroin and it had reached the stage where she was taking it in front of her son.

"All of my friends were on it. My brother started doing it. Everybody was doing it. Unfortunately, my son lived in my room with me so he saw everything."

Natalie described the feeling that heroin gave her.

"You just don't think…It totally numbs any feelings that you've got at all, you know, more so than any other drug I've ever taken…You can't cry if you're using gear, no way…"

"You're just oblivious. Totally on a different planet…"

This period of constant heroin use came 14 to 18 months after Natalie's initiation with the drug. Heroin was not the only substance that Natalie was using at this time. Speed had its function.

"… I was still taking speed to counteract, well I had to be active, you know, I had my son… and I was working."

"I don't know how I worked. I'd have six-hour shifts and I'd be really ill after that. I'd have to get home. I couldn't go out. It was horrible. It was a horrible place to be 'cause I couldn't go anywhere 'cause I needed heroin…"

Natalie remembers the times that she would come home from work and just gouch out in her work clothes. She would then get up next morning and go straight to work in the same clothes; this routine would go on for days at a time. Natalie recalled not bathing for two weeks

"… my hair use to get so greasy, I just use to put talcum powder on it…"

Natalie talked about the times where she would try and do 'normal' things with her son, camping or trips to theme parks such as Alton Towers and Oakwood. But the trips were

never 'normal.' When John and Natalie took her son camping, the bong went with them. When John and Natalie took her son to Oakwood, they were taking ecstasy and smoking heroin. When Natalie took her son to Alton Towers, they spent most of their time in the toilets where Natalie was constantly rolling joints. There came a point when Natalie was no longer able to take her son to school as she could not get out of bed. She would set her alarm for ten past three, so she could get up and get dressed ("so it would look as if I had been dressed all day") before her son came home from school. Her mother started taking responsibility for Natalie's son.

> "I was just house-bound. I had to be in the house smoking gear."

Natalie's relationship with John was not getting any better. John was now dealing heroin and Natalie would frequently steal from him and lie about it.

> "I was totally with John just for his drugs, completely and utterly. I really disliked him. Couldn't stand him…I was with him because I was so addicted to it…[heroin]"

> "John was supplying my dad, and my dad would be supplying John."

Natalie's habit was now costing her £130 a day. Between John and Natalie, they were smoking 3 ½ grams of heroin a day. She needed John to support her habit and John was aware of this.

> "If I wasn't with him I'd just be cold turkey and I couldn't deal with that."
> "He was able to speak to me like shit. Walk out when he wanted…"

> "When he wasn't about, I'd be on the floor looking for the tiniest bits. I'd be smoking all kinds of crap – dog hair, you know, anything. If it looked like heroin and it was all stuck with dust, I'd be smoking it…"

At the peak of her habit, Natalie described herself as "totally lost."

> "… I was lost. I didn't know where I was going, what was happening… I did consciously think 'I'm scared' but I didn't see any way out. I felt completely trapped. I absolutely hated using gear because of what it was doing. I couldn't do anything. John controlled me and the heroin controlled me and that was it."

Her social network consisted solely of drug users. Natalie emphasised the fact that she saw no way out of the situation she was in.

> "It's really strange because you don't see there's any way out. You don't realise that you could just stop. You don't even see that."

> "… eventually it got so bad, I'd have to use heroin to think of how I was going to give it up… I needed it to think… to function, you know, I couldn't do anything…"

Natalie has memories of having to get up in the middle of the night to use heroin.

> "I used it to function basically, just to act normal."

Natalie recalls collapsing twice from using too much heroin. One time she was alone with her son when she collapsed in the bathroom. She came around having no idea what had happened. She was sick most days when using heroin. She remembers that it got to the point where she didn't want to be alone - she would be sick in a carrier bag in front of other people, including her son, rather than be sick on her own in the bathroom. This was a nightmare for Natalie's mum.

> "My mother was nearly having a nervous breakdown. My dad was on it, my brother was on it, I was on it."

Natalie was forced to seek help when her mother threatened to kick her out of the family house.

> "I think it came to a head when she sat me down, me and John, and she said, you know, 'I can't cope with this anymore. You're going to have to go…' And I just thought 'Oh my God…I'd have to go and live with John with William [Natalie's son].' And I couldn't bear that, living like that. So I just said there and then, 'Get me the phone,' you know, 'I'll phone the agency.'
>
> "I phoned the agency. And it was the first time that I said I was a heroin addict to Pauline and I was crying on the phone and she said 'Your appointment is…' and it seemed like ages away. It was, I think it was three or four weeks…"
>
> "I wanted my life back."

Natalie was assessed by one of the drug workers at a local treatment agency who offered her a place on the pre-treatment program.

> "… he kept saying to me 'You'll do this kid.' And I was like 'Oh my God, do you really think so?' and he kept saying 'Yeah.' And I really, honestly didn't. I just didn't think so."

Natalie started attending Narcotics Anonymous. However, she continued to use heroin for a further two months.

> "People kept saying, 'When are you going to give up then?' And I kept thinking 'Well what do you mean when am I going to give up? I can't just give up – I'm addicted!'"

Natalie went to a local psychiatric hospital for an assessment for the inpatient detoxification. She was totally against the idea of going into the hospital, but if she had to do it she would. It was Natalie's father who helped her on her road to recovery. Natalie decided on a reduction regime to wean herself off the heroin. Her father weighed her out a certain amount of heroin each day with each portion progressively decreasing in size.

> "I tried all that before but it didn't work. But this time it was different. I really wanted to do it."

Natalie's father was not the only man in her life that helped her on the road to recovery. Her son was also instrumental in helping her determination to beat heroin:

> "I didn't want this for him."

The day after the hospital assessment, Natalie decided she was going to give up heroin.

> "I just decided that I was going to give up. I phoned everybody up. I phoned all my friends. I phoned John up and said, 'I don't want anybody to come round. Don't phone me or anything for two weeks.'"

Natalie's story – Part 2
Natalie was forced to seek help to overcome her heroin addiction when her mother threatened to kick her out of the family house.

> "I think it came to a head when she sat me down, me and John, and she said, 'I can't cope with this anymore. You're going to have to go…' And I just thought, 'Oh my God…I'd have to go and live with John with William [Natalie's son].' And I couldn't bear that, living like that. So I just said there and then, 'Get me the phone, I'll phone an agency.'

> "I phoned up and I couldn't get through. It took me about a week to get through. I wasn't trying that hard. And then one day, I was just sitting in my room, I was crying, I was withdrawing, I'd had enough and I just got the phone."

Natalie clearly remembers the telephone conversation that she had with the treatment agency's receptionist.

> "She asked me what my problem was and I said, 'Heroin.' It was the first time I'd said to anybody that I was a heroin addict. I was crying on the phone to her and she gave me an appointment and suggested that I went to a self-help group. And the appointment was for about three weeks later."

The agency accessed by Natalie is based on the Minnesota Model of addiction. In this model, addiction is viewed as a medical disease which can be treated with one-to-one counselling, family therapy, group therapy and involvement in 12-Step self help groups such as Alcoholics Anonymous [AA] and Narcotics Anonymous [NA]. During Natalie's first appointment at the agency, she was assessed by one of the drug workers.

> "… and he said, 'You'll do this. You're gonna do it.' And I… really didn't think I would. I thought he was just saying it just to make me feel better. I cried a bit in that session."

Natalie was offered a place on the agency's pre-treatment program, much to her surprise.

> "… he said, 'I'll probably get shot for doing this but come to the pre-treatment group on Monday.'…"

Natalie remembers being very nervous on her first day.

> "On the Monday I was so nervous about going to pre-treatment I got my mother to walk up with me. It was first thing in the morning. It was nine thirty and I thought it was punishment in itself. I thought, 'They're doing this deliberately – half past nine in the morning!'"

Natalie was still using heroin.

"So I went along and I was late, I'd been up since six using."

She was surprised that there was someone in the pre-treatment group who had been through situations similar to her.

> "There was about fifteen of us and there was somebody in there that was an exheroin addict who'd been clean for about sixteen years at the time and she came out and then she talked to me and… she said 'That's the same as me. That's what I did,' and I was just like in awe from that day. I just thought 'God, I can't believe this – that she's done exactly what I've done. It sounds the same.' She… took me under her wing. From that moment, I didn't feel so alone."

Natalie attended pre-treatment every week for two months - during this time, she also started going to NA meetings.

> "The agency suggested I go. I went there and I sat there and listened to the stories… I couldn't actually believe that people who were saying they were clean, were clean. I thought, 'Oh yeah – they're just saying that. They're bound to have a smoke. Oh definitely have a smoke, especially her…'"

However as Natalie's time with the agency and NA progressed she recalls a sense of belonging.

> "It was just fantastic. I felt this is the right place. I belonged somewhere. I felt we all had something in common and that was really shocking for me. I started to understand my addiction and realised that my behaviour was part of my illness."

The agency suggested to Natalie the possibility of a detox at a local psychiatric hospital.

> "… I was absolutely horrified that they mentioned it to me. I thought 'There's no way - me going to detox. That's for down and outs, not for me. No way.' And so after speaking to my family about it, they were like 'Oh no, you don't need that. Surely to God you don't need that.' But I started thinking about it more and more, and I thought 'Yeah I do. I actually need detox.' So the agency were trying to set-up an appointment for me…"

Natalie decided that it was time to start reducing her heroin use.

> "I was working in a pub. And I loved working there. I really did like it. Just from the time I started going to the agency and NA, I started trying to cut down. I was scared to give up completely. I knew it was coming to a head at some point, I didn't know when."

So her father began to weigh out a certain amount of heroin each day for her with each portion progressively decreasing in size. When Natalie initially began the reduction regime, she was using 1½ grams of heroin a day, which at that time was costing her £120. However, just before Natalie stopped using completely, her heroin use was costing her roughly £10 a day. The reduction program was "probably over a period of two months. It wasn't very structured."

> "… Before the appointment [for the detox] came, I'd done that reduction program just doing it myself and I thought on Monday I was going to give up heroin. I then thought 'No, just do it tomorrow.' So I stopped the next day."

Natalie was not confident that she would be able to stay off the heroin long-term so she still went along for the detox appointment, despite being clean for three days. During her assessment at the local psychiatric hospital, she was asked what she expected from the detox.

> "… I said 'I would like is just to be normal and have a happy life.' He looked at me and I said 'Do you think that's too much to expect.' I really thought that was too much to expect and he said, 'No. Not at all'…"

Natalie was added to the waiting list for detox at the local psychiatric hospital. She decided that a change of scenery would do her good so she booked a holiday two weeks later.

> "So I thought if I went away for two weeks when I came back, that would be sort of like a month then I'd been clean. So I did that. But in this time, even though I'd given up heroin, I was drinking and smoking hash."

Four months after the assessment, she received a phone call from the hospital informing her that they had a bed for her. However, she did not need the inpatient detox as she had been clean for just over four months.

> "I said I didn't need it… and they were like 'Oh that's brilliant. Good luck.'"

Natalie described the heroin withdrawal.

> "It wasn't too bad because I was cutting down really slowly. It was over a period of time, so it wasn't too bad."

However, she feels that the alcohol she was consuming may have helped to mask some of the withdrawal. Natalie was drinking three pints of lager ever night. Furthermore, every three to four days, she would binge drink, drinking anything from spirits to lager to wine, to the point where she would drink herself unconscious.

> "… so I was still a bit chaotic even though I'd given up gear… my life didn't automatically change. Withdrawals – you'd think you'd never forget, wouldn't you? But I do. And that's when you've got to be careful… I've got to always remember where I've come from."

Natalie also took physeptone tablets to ease the withdrawal. However, she was afraid that she would become addicted to them. So on the first day, she took four physeptone tablets. On the second day, she took two physeptone tablets and 7mls of liquid methadone. On the third day, she took one physeptone tablet in the morning and one in the night. By the fifth day, Natalie had stopped taking the tablets. She remembers having trouble sleeping.

> "I didn't sleep. I couldn't sleep. That lasted for about two months. Sometimes I'd be awake for hours in the night. Sometimes I couldn't get to sleep and I would do whatever I had to do."

She also recalls feeling disorientated.

> "Shaky, very shaky inside. I didn't know whether I was coming or going or what was happening. It was like being put back in to the world after being locked up for a couple of years."

Natalie described how strange the feeling was when she stopped using heroin and became aware again of simple things, like the taste of food, birds singing and springtime. Natalie found the psychological withdrawal far worse than the physical withdrawal.

> "Mental was worse, physical I could handle… The mental was like you know when you just want to rip something… it's like you're so wired up. What I did, I kept a journal and I've still got it… probably the first ten days I was going out of my head. I'd have to start writing or doing something, it's got in there 'I'm so demented.'
>
> "… as I said my family would support me so they would take me out if I said 'I just can't handle this.' They'd take me out straight away – take me down the beach, take me anywhere. I might not want to go. The mental frustration of just being torn really and scared. You've got so many things going on, you're scared, you've done this so many times, you're gonna mess up again… You've got feelings rushing around but you don't know that they're feelings because you've suppressed them for so long."

Natalie recalls not being able to distinguish between the feelings of hurt and anger. Her counsellor helped her to re-learn what her feelings stood for. The agency provided Natalie with telephone numbers of people who had been through treatment and were willing to be contacted.

> "I was using these phone numbers to phone people up and they'd say 'Just go with it. Do whatever you can to take your mind off using – read, iron, go for a walk, go to meetings'…"

Natalie described how she would try to stop herself from thinking about heroin

> "So it would be things like, it could be two in the morning and I'd think 'Right, I've gotta do the dishes. I have to do anything to stop me thinking about it [heroin].' So I'd start doing the dishes or I would cook something… you know whatever it was, ironing. I read a lot. I read a lot of the literature I was given and kept thinking I want this, I want this, I really want this…"
>
> "… sometimes if I was awake at six in the morning and I couldn't go back to sleep, I would go up and go to the café and just persevere with it and then I'd be knackered all day and then I'd sleep in the day. It was all chaotic, I was sleeping whenever. Tiredness was the main thing. Boredom, very bored. I didn't see anybody. I ate a lot. I wasn't sick. Sneezed a lot. I was irritable and sensitive."

Natalie described the coming off the heroin as:

> "… the easy part, the hard part is carrying it on and sticking at it."
>
> "… because you don't want to face your problems, that's why you've taken drugs. You don't want to face up to things that have happened or the things that you've done. You've got to sort this out raw, you know, no drugs,

> nothing in you. You've got to face them, they're there and you've got to deal with it."

Initially, Natalie found it difficult to break the ties to her social network of drug users.

> "At the beginning it was difficult 'cause people were phoning me and wanting to come back in to my life, my friends and John. And that was hard because it was still raw and I wanted to be with them but at the same time I didn't. And I was jealous that they were still using and still doing it and I wasn't. I was stuck in the house now."

John was particularly persistent and Natalie had talked with her counsellor about taking out an injunction against him.

> "… I remember we talked about that in one of our sessions – me and my counsellor - because he was hassling me and he'd never let me go easily before. But when we sort of like made the decision [to take out an injunction against John], he stopped. I had letters from him through the door and I burnt them, I didn't read them. I did what I was suggested to do – not to be involved, don't read the letters, burn them. I did all that – kept myself safe and that's what they [the agency] kept saying 'Keep yourself safe' so that's what I did."

Natalie recalled a memorable incident from when she was trying to re-establish a 'normal' life. She was so used to gouching out every night in her clothes that she had forgotten the process of going to bed.

> "I really didn't know that you got into bed and I was there one night and I thought 'Well, what do you do? You must put your nighty on.' It'd been so long since I'd done it. And so, I put my nighty on and I got in bed and I thought 'Well what do you do now?' I was in bed and I thought 'Right, people set their alarms don't they?' so I did that and the feeling was so strange, I hadn't done it for years. I thought 'This is what normal people do,' and it usually was about two o'clock in the morning. It wasn't like a normal time, but I thought that was quite normal, two o'clock in the morning."

However, she found it relatively easy to get back in to the routine of day-to-day life.

> "… and more or less straight away I started getting in to the routine of doing the things that I had to do. I started taking my son to school, walking him to school."

Natalie described the withdrawals from heroin as "…they weren't that bad." However, she is not surprised that she did not come off it sooner because as she points out:

> "… you're just scared. You don't know what the future's going to hold…"

> "… you have a fear of it [coming off the heroin]. You think you're going to die through it."

It became apparent to Natalie that if she wanted to access the next stage of treatment, she had to abstain from all substances.

> "… to go in to primary, you have to be completely clean so you have to stop drinking and smoking hash but I never saw that as a problem. I know I did lots of hectic things when I was drinking but it wasn't a problem – I could give up whenever."
>
> "There are times when you think 'Right, okay. I'll never drink, I'm twenty-four now, I'll never drink. Tidy. Can I really do this?' and then you just remember that you've only got today, you could be dead tomorrow… and that's what they teach you 'It's only today you've got. You haven't got the rest of your life to think about it – just today.'… "

It was not only the drugs and alcohol that she would have to give up if she wanted to start primary treatment.

> "… they'd [the agency] said to me that if I wanted to go in to primary group therapy, I wasn't allowed in any wet places, which is pubs and I was working in one. So I had to leave my job…"

Natalie discussed the possibility of giving up her job with her family.

> "… went home, told my family and they were like 'No. It's a perfectly good job. You love it there. They're your friends there.' It was about the only positive thing that I really had in my life apart from the Centre [the agency] and I thought 'No.' After about a week I got used to the idea. And I thought 'Right, okay, yeah I'll leave work…'"

Natalie told her close work friends why she was leaving. They were surprised to learn that she had a heroin problem and was in treatment.

> "… one night when I was at work, I got drunk after I'd given up heroin and I told them at work… I said I wanted to carry on doing the program that the agency had on offer and they were like 'No, you don't need to. We're your friends, stay with us.'…"

However, Natalie knew that she needed the agency if she was going to have any chance at beating her addiction.

> "… I wouldn't have been able to do it without the agency – no way. Because they give you that structure. They taught me, you know I didn't even know how to be a mother… me and my son used to argue like brother and sister… I'd reverted back to a child. I didn't know how to mother him. I mean he was really angry… I'd finished with John and he wanted John back and I couldn't work it out, 'Wasn't he unhappy? Didn't he hate the way it was?' but he'd got used to it. He wanted John there. So he hated me for that."
>
> "I did what they [the agency] suggested really because I was unable to do anything myself. I didn't know how to look after myself so they had to guide me which was fine because I needed it. I needed to be taught how to live again, to eat properly…"

She had forgotten the routine of meals, e.g. breakfast, lunch and dinner. Instead, Natalie would binge eat from three or four o'clock in the afternoon. She recorded her food intake,

enabling her counsellor to help her to devise a balanced diet plan. A further obstacle in Natalie's road to recovery was her father's use of heroin. She was living in the same house. Not surprisingly, people doubted Natalie's willpower to resist the temptation of the ever-present heroin. Natalie wouldn't advise people to give up in circumstances identical to her own.

> "People didn't think I'd do it and I don't blame them for saying it… They said, 'There's no way, not with everyone using. You're not going to do it in the house.' But I did."

Even though her father's heroin use made Natalie "really angry," she remembers times when his using actually assisted her in her quest to overcome her addiction.

> "Well, the thing is, people used to say, 'Oh God, it must be really tough.' But at the same time you're looking at somebody who's doing it and you just think 'No, I don't want that. That's something I don't want. I'm going to do this.' And anytime that I felt like 'I want to use,' I just used to look at him and then think, 'No. If this is what it's all about - no thank-you.'"

Natalie's determination to beat her addiction was spurred on by the stories that she heard from ex-users and by what the agency had to offer.

> "Oh, what everyone else had and what the Centre [the agency] had to offer – I wanted this. And I felt such a failure for everything I'd done, I just, I don't know I just went along with it. It was something here [at the agency] that kept me going, that I wanted this. And the stories that I read, NA, the people that I saw… And I really wanted that. They were happy."

More than anything, Natalie longed for happiness and the feeling of belonging somewhere.

> "I'd been totally unhappy, I wasn't happy at all [when she was using heroin]…"

> "For the first time I felt I belonged somewhere. I felt like I belonged here [at the agency]. There was something about this place. I just loved the people, they weren't judging me… they treated me like a human being, supported me in whatever I wanted to do and treated me as if I was a nice person. Most importantly, they believed in me."

> "I just can't tell you, this place made me feel excited. I was in awe of it. I just loved everything about it. If I could come here early for my counselling session, I'd be here to speak to the staff. They'd sort of like become my friends… There were things going on at home and they gave me the space to air it here like in group therapy I could talk about it."

The nervousness that Natalie had experienced on her first day at the agency resurfaced on her first day of primary treatment.

> "… I was really scared when I first started. But there were a couple of people that I knew from the meetings that were there…"

Natalie described what primary treatment entails, once you make the commitment to access it.

> "You come here one full day a week. You've got a commitment of three NA/AA meetings a week. You have to have one counselling session a week. You have to do written work. And you've got rules to follow: you're not allowed to take holidays; you're not allowed to look for a job unless you're already employed; you're not allowed to go in to a wet place; you're not allowed to have lifts with people that are in group with you, things like that."

Even in primary treatment, Natalie still doubted her ability to overcome her addiction and complete treatment.

> "And I still didn't think I was going to do it… And I use to speak to people and they use to say 'Yeah, you will.' I had all these people believing in me and wanting the best for me, which was something that was totally different to what I'd been use to."

Natalie began to notice little changes in her self.

> "… Things like on my birthday John sent me fifty pound in a card and I'd think, 'Yeah! Yeah this is brilliant!' And then I thought about it and off my own back, I sent it back to him. I was skint. I was on income support and I sent it back to him saying 'How hypocritical it would be of me to take his fifty quid, and it would show how I hadn't changed when I won't speak to you and I'll take your money. It would mean that I hadn't changed. I don't want that and thanks very much' … Things like that, little things were happening and I thought 'Yeah, I'm changing. I'm getting some self-respect here.'"

Natalie began to do vocational courses in college and also helped out at a local school.

> "I started doing little things like vocational courses at college. I did pottery and dressmaking… I was up the school, helping the kids read. I was in treatment while I was doing this…'
>
> "… and I started mixing with other people, people who are not addicts because you become quite isolated in all this. If you're not going out there, mixing with people that are normal. So I thought that was important that I did that and I was supported here [by the agency] to do that…"

She was so determined that she was going to complete treatment.

> "I just wanted to finish it. I wanted to achieve something… there's something magical that keeps making you come back [to the agency], keep on doing it. And there's obviously times when you think, 'Oh God, I miss John' but that's a really tricky place for me to be in because I don't miss John. It's my head telling me I miss the drugs really 'cause John is drugs as far as I'm concerned. And there are times when you do feel lonely…But I never wanted to leave treatment."
>
> "There were times when I was scared like when I was doing my life story [in primary treatment]. I thought, 'Oh God I need a valium to get through this. There's no way I can sit there and read for forty minutes my life story no way' … I thought I was going to go blind and I wouldn't be able to read! And they're the things I don't particularly like – it's when you feel like you need a

> drug to get through something… but then once you do it and you do it sober – you feel good then."

There have been situations in Natalie's past where she has felt that certain people, especially men, have taken advantage of her. However, during treatment, Natalie began to take responsibility for the role she played in her addiction, instead of blaming John for it all. Furthermore, she began to take responsibility for the way she had treated certain people.

> "I started forgiving people for what had happened to me and not blaming them – I did have to take responsibility for my part in all of this."

Natalie found the counselling sessions extremely beneficial.

> "My counsellor was fantastic. I mean the stuff we went through, you know, everything. I can honestly say everything was brought out in to the open one way or another."
> "I did have a lot of issues to deal with as well. I was angry when I was living at home. I was angry; I wished my dad would stop [using heroin]. I didn't want to see my family going through the pain they were going through. I kept thinking 'How selfish of him to carry on' … every morning I would smell it because it's got a distinctive smell. And he would be in contact with all my old friends which was awful, and John."

Her father's involvement with her old drug using friends was made worse because they used to visit the house.

> "… It was horrendous 'cause I felt really… I just felt stupid for giving up. I know I should be proud but at the same time they're all coming round and like you know… 'Given up now have you? You don't go out. You don't do this' and looking down at me and I was twenty four at the time… John would come to the house…"

She desperately wanted to move out of the family home. Her counsellor helped her do this.

> "… and all the time this was going on, they [the agency] were trying to get me out of there, out of the house. I was desperate to move. I was stuck in that room with William. I think at the time William was probably seven or eight, so I'd been in the same room with him all this time. My dad was using and I needed to get out basically."

> "And nothing was coming up and I thought 'I'm not just going to move up to [the poorer parts of the town]'… 'Why would I want to move up there? I don't know anybody up there. I'm not moving William from school.' So I was picky. I thought 'No, I deserve this. If I've been through what I've been through, I deserve to live where I want to live even if I am on income support.' So I only put my name down for … the sort after areas really…"

A flat became available in her chosen area a week after she left primary treatment.

> "… it was what I use to call 'my holiday home' … and it was a cheap flat. There was no damp, there was nothing wrong with it. It was really, really nice. So I accepted the flat. I was really scared… 'cause it was something I was doing on my own."

Although Natalie's family were initially reluctant about her accessing treatment, they came round to the idea when they started noticing changes in her behaviour roughly five months after she started going to the agency.

> "My family, even though my dad was whatever he was, he was still supportive. Even though everybody slagged me off for leaving work and doing this, they started to think 'Okay' because they thought they [the agency] were going to try and control me here, but they started to believe it then. They started thinking 'Oh yeah, she's made some changes.'… The help the agency had given me was immense."

Natalie admits to have reservations herself about the treatment when she first accessed the agency.

> "I did start thinking 'Oh my God, I'm gonna end up not wearing make-up. I'm not gonna wear a bikini in the summer you know, not going there. I'm gonna be like an old woman. What are they going to turn me in to?' and I remember coming here [to the agency] and saying to my counsellor 'Do you know what I mean – it's putting me off wearing short skirts and stuff coming here.' … But it's nothing like that"

However, Natalie admits that during treatment she let the agency lead the way because she "didn't have a clue" about 'normal' day-to-day functioning.

> "You are a bit, I've got to say this, the first year I was sort of like in their hands and they had to just lead me the way… I hadn't really become my own person. That came after I came out of treatment when I was left to defend for myself really. I was out there and there was no counselling and I had to get on with life on my own. They'd given me everything I needed to go out there."

The thought of speaking in group therapy initially terrified Natalie.

> "… my voice would be shaking but after a while you get used to it. I trusted them. It's about trust, I think. And I trusted them all and you get used to it. And when you've had nine months of it, you just feel like telling these people all the time, everything about you, you just get used to it in the end."

> "I did all my meetings, I was very good. I didn't realise how good I was. I was so scared of ending up back using [heroin] that I did everything I was suggested to do. So I did that and it's paid off."

Natalie was in primary treatment for nine months. After completing the primary treatment, she accessed the aftercare programme.

> "So from the day that I had an assessment to the day I left primary was a year and one day exactly. And then you have aftercare which is once a month… it's for an hour and a half and it's just like a big group so like fifteen people… And I was finding when I was going there that I didn't have any problems – I'd always had problems… Nothing major's happened in my life – it's been smooth for the last two years…"

The aftercare programme enhances the gains (e.g. life skills and coping mechanisms) made by the clients, in the form of one-to-one counselling and group therapy and involvement with self-help groups such as AA and NA. Natalie then began doing voluntary work at the agency, which she describes as "little tiny steps that got me where I am now."

> "…I left doing the stuff up the school. I finished those courses and that was another thing… I had never completed a course before, even though it was really small, I hadn't done it before. And I completed treatment which was absolutely amazing."

Natalie applied for and was accepted on a Social Welfare Diploma course. However, a week before she was due to start on the course a job opportunity arose that she simply could not resist.

> "…they [the agency] offered me a job full-time… so I thought, 'Right okay. Can I do that voluntary?' that's what I thought, I didn't think it was going to be paid. And then I said, 'Oh voluntary?' and they said, 'No, paid' and I just said, 'Oh my God! This is like a dream come true. I love this place.' And still now, I still have the feeling that it makes me excited. I love it."

Natalie remembers the surprise she felt when she was offered the job at the agency.

> "… You have these ideas in your head that you'd really like to happen but you never, ever expect it to happen to you. It's not going to happen to you, I thought. I think it's typical of addicts, they think the worst of themselves. So even when I came here to do some voluntary, I thought they wouldn't accept me, there's no way. I'm not good enough, let alone work here. But I knew they were looking for staff and I can honestly say it didn't even enter my head that they'd ask me. I thought because I hadn't got any GCSE's or anything, I wasn't very good on the computer at the time – there's no way and then they did."

This job opportunity was another significant turning point in Natalie's life.

> "… my life completely changed. I'd never worked full-time in my life before. And in all this time as well, I'd got new friends, I started mixing… My sponsor [at NA] became my friend, a very good friend of mine… I had a friend that was in group, we became very close. And another old friendship, that we hadn't spoken for ten years, we became friends again after ten years."

> "… and this was the thing I think I've been destined to do. All the times I wanted to be, when I was using, wanted to be somewhere you know be somewhere I fitted in and people could understand me because I felt I was very misunderstood and this [the agency] is the place."

Natalie has succeeded in re-establishing her self-respect and gaining respect from significant others.

> "… gradually through my treatment I started getting some respect."

> "To walk down the street and be respected and everybody from my past is in awe of what I've done. I mean they go on about it still and that's nice but most of all the respect I've gained for my self. I am a worthwhile person."

Natalie has a clear sense of ownership over her journey to recovery. Looking back over all the things that Natalie has accomplished – the list is plentiful.

> "… and I feel today, I just feel I've done this on my own. I didn't have anybody with me, I'm single, I'm a single parent. I moved out on my own, came through treatment on my own. I know I've got the support of my family and they have been absolutely fantastic. I set up my own flat. I've started new friendships. I work full-time and I'm just really happy."

> "To happen to me and I'm nobody special, I'm nobody different… Anybody can do what I've done…"

Undoubtedly Natalie's experience and strength played an instrumental role in her father overcoming his addiction.

> "… the week that I started doing voluntary work was the week my dad came in to treatment. So I started here and so did he. It was getting really bad for him and he saw what was happening to me and he said he was prepared to take back what he said about the Centre [the agency] in the beginning… he'd seen the results and everything. So… he went in to detox. He came off everything…"

Natalie has been abstinent from illicit drugs and alcohol for two years.

> "I've been clean and sober now for two years, March 23rd."

It's hard to believe that Natalie is the same girl she described as "totally lost" two years ago.

> "I would say I'm quite balanced. I wasn't balanced at all. I didn't have anything positive in my life. I wasn't a balanced person… I'm happy and confident."

Natalie has a new social network. She has rebuilt her relationship with her family and more importantly her relationship with her son.

> "I was re-building my relationship with my son [during treatment], my son still wouldn't trust me or anything. It took him a long time to even cuddle or kiss me. So that was painful because he wouldn't come near me…"

> " I was thinking about this last night. I was in bed with him and I was hugging him, there was a time when he wouldn't, and he'll be eleven this year and he still wants to do it… our relationship is really good now."

Natalie's son actually saw the agencies family counsellor. It took a long time for her to rebuild her relationship with her son.

> "It took a long time. When I moved in to the flat I had awful problems with him. It was just me and him. He'd lock himself up my mothers. He wouldn't come with me. He'd say I'd have to drag him if I wanted to take him… I'm in his room, he's nearly eleven and I'm still sleeping in his room with him and that's due to me leaving him on his own… There were always other family

> members around him because we were living at my mum's but he freaked when he use to wake up and I'd be gone. And he still worries about that."
>
> "… it's just something he's just going to have to deal with. He's going to have to trust me. It's been two years now… He's got to face his fears, it'll just take him a bit longer than what it's taken me."

Natalie's most memorable moment through her whole experience of treatment involved her son.

> "We smashed the bong up together. We bricked it out the back."

Due to a more positive outlook and freedom from drugs, she has embarked on a more rewarding stage of her life.

> "I owe them [the agency] everything. Without this place [the agency], I know I have the fellowship and NA and AA, but it wouldn't be the same, no way."
>
> "… it's [the agency] just absolutely fantastic. I owe them my life really. And I hope I never stop feeling the way I do about this place. And I'm ever so grateful, very grateful and it's just a shame it doesn't work for everybody…"
>
> "They have taught me a new meaning to life. I have peace of mind these days."

Natalie would recommend treatment to anybody who wanted to put an end to their substance misuse as long as they were genuinely ready for the transition.

> "Oh it would be the best thing they do if they want it, it's only if they want it. If they don't want it, it's not going to work. It's only when they're ready and obviously I was ready."

Natalie's story: part 3

We interviewed Natalie two years ago and she became the first "Personal Story" on our web site www.substancemisuse.net. Natalie had been in treatment for her heroin addiction. We recently interviewed Natalie again. We asked her about her life now, how she finds working life, and about the changes she has experienced over the last three years. First, read a synopsis of Natalie's drug-taking experience and her recovery. And after the interview, take a look at her original personal story.

Natalie started smoking cannabis when she was 14. This rapidly got out of hand and she also started taking acid and valium. She became pregnant when she was 15 and kept away from drugs during the time of her pregnancy. She remained drug-free until she was 17 when she started taking ecstasy. At 18, she was drinking a lot and taking speed. Her boyfriend when she was 19 was a dealer of speed and she started taking this drug a lot. It gave her plenty of energy and helped her deal more effectively with being a mother. Her boyfriend went to prison where he developed a heroin habit. Natalie started to use the drug and over the next year was taking it two or three days a week. After about two years she was taking it every day. She stopped taking her son to and from school, stopped going to bed, washing and putting on clean clothes. Her son witnessed everything and Natalie feels he has been affected. Although Natalie had reached a stage where she hated her boyfriend, she could not leave because he was her supplier. She couldn't face a life without heroin.

Aged 24 years, she contacted a 12-step based treatment agency. She knew that she needed help although she was not sure what a treatment agency could do. She went through treatment, which completely changed her life. She started doing voluntary work about six months later. After six months, they offered her a full-time paid job. It will be three years this September since she started work.

Natalie, two years on: The interview

We asked Natalie about the impact that having a job had on her life
She'd never had a 9-to-5 job before and her initial concerns were whether she could cope. She also had a very high opinion of people in the agency and was concerned that she would do things wrong and let them down. She thought about it for a while and then decided that if other people could do it, she should give it a go herself. She was pretty quiet when she first started work, but soon gained her confidence. The counsellors in the agency were supportive and friendly. The opportunities that earning money – that would not be spent on drugs - opened for her were considerable.

> "First, I managed to pay off my debts. I don't have any outstanding debts… I managed to take my driving test, get a car, go on holiday… if William [her son] wanted something I could get it for him, guitar lessons etc… and just being able to pay my own rent, my council tax, being independent, having money to do what I want to do… what I've always wanted to do."

Would you ever have seen yourself here? [the treatment agency]

> "No, no, no. I thought, there's something different about this place, it's safe… and they knew where I was coming from. I saw happy things going on here, people getting on with their lives… it was a dream, it wasn't something I ever thought I could be part of really."

If you look at yourself now, what do you think when you reflect back on where you were, and how far you've come?

> "When I look back I feel a certain amount of distance from my using. I shock myself when I think of the state I was in. I was 24 with no future other than my addiction and I truly believed I would never achieve anything. As a child, my dream of what it was like to be an adult was nothing like how I was living and that was very sad."

> "But now I am so happy and that dream of adulthood is far better than I ever imagined. I feel free and very fortunate. Most people who come here are really shocked when they find out I'm a recovering heroin addict."

> "I do feel quite distant from my past, it just does not feel real… when I go over it you know, I just can't remember… it just doesn't seem important anymore. It is awesome now though, it's good."

How do you feel when you think about the fact that your life went down that path, and that you've managed to recover?

> "I don't think that I'm any different from anyone else, I really don't…"

"I know I didn't think I could do it [recover]… I used to go to these self-help groups and I would look at everybody and I'd think they were a different type of person, because they could do it and I was never going to..."

"I was a different type of addict, I wasn't a together addict, they must have been together in the first place but my life was a wreck… There was no hope for me and I used to think that I would try and probably wouldn't succeed in anything I did."

"I know I'm no different from anybody, definitely not… I think anybody can do it [recover]… People think I've got something that they haven't got and that's not true."

"But you have to be ready to do it and it is tough, its not easy…"

"You're talking about giving up all your friends, all my friends were users…"

"… and if you do come into group therapy it means you don't going to wet places (I left my job, a place where I was really happy) as it was a wet place…"

"… and it caused problems at home, some people didn't agree with the fact that I was abstinent…"

"… there is a lot of changes you know… you have all that to contend with, and also thinking are you going to make it, are you going to be able to do this."

Any regrets?

"I think everything is meant to be… even the bad stuff that happens… something positive can come out of everything. Even the worst stuff that can happen, you can use it to turn your life around."

"I even think my using etc. was meant to be… I wouldn't change that cos if I changed that I wouldn't be where I am now… I wouldn't change nothing."

We then talked more about Natalie's recovery.

What were the most important things that helped you turn everything around?

"My son, definitely my son… all the support… my family were a tremendous support without a shadow of a doubt…"

"… the meetings… the self-help groups… this place…, for me this place had a huge impact, it is where I got my job, etc. I owe this place a lot. I am very lucky"

What is it about this place?

"They carry you… You don't actually know anything, you're going on blind faith… They're telling you all this stuff and you think should I trust them and

believe them and go ahead with it?... I felt I was giving up a lot… I was 24 and stopped going out, stopped drinking..."

"They've got to carry you really and take you through until you believe in yourself… and they do that for you… They give you the love you need to get you through…"

"I mean Dave, he assessed me… and I asked him, do you think I can do this… and he said, 'yeah, course you can', and that was the first time I ever had anything of hope, that someone believed that I could do it."

"It's also having people that believe in you… people telling you as it is… building up the trust so they can say, 'what's going on here?' when you don't seem right'."

"I had a sponsor… and she's my best mate… I used to speak to her every night… when I felt I was going out of my head, and bored."

"[You] need a support network, a sponsor, a counsellor… and somewhere stable, cos you're not used to stability, so… just having a stable home, eating at the right time, you're not used to that… I had to learn all that."

"I mean, I didn't know how to go to bed… I actually didn't know anything, I didn't know how to eat… how to put my pyjamas on. I used to go to bed and lay there and think, well what do you do… and I thought you must set the alarm and lay down…"

"So they've got to teach you all that. I know it sounds insane… learning how to be a mum… but I did have a supportive family too."

What did you do yourself that helped you, for example when you had cravings or were struggling?

"I'd read recovery books, go to a meeting, speak to sponsor, all the things that they tell you to do... they advise you what to do and you just go on blind faith and do it…"

"I found it easy to follow the advice. I know loads of people who didn't… I'm fortunate I never relapsed…. Because I was just in awe, I couldn't believe this place…"

"And things like the cookery course… I started filling up all my time, helping out in the school… I mean me! This person who never used to take their son to school and I started helping the kids learn to read!"

"Time was a big thing. I did have a lot of time on my hands."

What were the key things that you found helped?

"I think it's really hard if you haven't got a treatment agency… how else would you know unless you were learning, for example off a counsellor? I think you need support, definitely."

Would you do anything differently?

'No, no… there's nothing I regret… If my son got damaged through it, he must have, even though he's fine I know it must have affected him…. I wish I hadn't hurt other people'

What would be your message to people who are in the same situation that you were?

"There's hope, anyone can do it… if they want to do it they can do it… Nothing is too immense to sort out, but it's reaching out really and getting the help, doing it…"

"And not to think that you can do it on your own. You don't have to do it on your own, there are people who will help you… and the self-help groups, they are amazing as well."

How would you describe your life now, and in terms of your recovery?

"Life's definitely different in the last two years… the first two years, I was putting the foundations of my life down, all the learning I had to do… getting to know myself… I wasn't in a relationship for 3 years…"

"All the foundations were laid, and now I'm living the way I want to live… and I feel confident speaking to parents at the school… I always had a problem with that as I felt less than them… making friends with the teachers… I've got loads of new friends… different friends…"

'Its stability and being free and having choices"

And finally, what are your projections for the future?

"I have no idea… I don't know… I can't really say because the way I live, I only live for today. That's another thing they teach you… anything can happen.... I don't know… I don't have huge expectations. I haven't got great career plans… so really… I'm just going to plod along for a minute… I'm quite happy where I am."

8.2. Appendix B: Lesley's story

A habit that started with a few glasses of shandy turned into 'drinking to oblivion'. Lesley retraces her steps to tell DDN about her nightmare days of playing hide and seek with social services, as her life spiralled out of control.

For as long as Lesley can remember, alcohol was part of her family life. She recalls camping trips during her childhood where her parents would spend time in the pubs allowing Lesley a glass of shandy. By the time she was 18, Lesley would frequently go to pubs with her friends. She remembers making sure that she had one drink more than everybody else, especially at closing time. Lesley's first long-term personal relationship lasted three years and she was devastated by the break up. She began to drink heavily, two or three bottles of wine a day – 'drinking to oblivion'. She continued to drink this way for a year until she went back to work. When Lesley was 29, she began dating Steve. They were drinking every night, in the pub straight after work until nine or ten o'clock. When Lesley's father fell ill, she gave up work to help her mother look after him. Her mother was an alcoholic. She kept her mother company drinking, sometimes from lunchtime. 'She deserved it, having to look after my father and I was keeping her company – my excuse.'

When her father died, Lesley and her mother hit the drink hard. Within 18 months, her mother also passed away. Again, Lesley's drinking escalated. 'I was completely off my rocker all the time.' She cannot remember exactly how much she was drinking at this time – cans of cider and lager, made up with half a bottle of whiskey a day. Lesley continued drinking chaotically until she was 37 years old when she gave birth to James. This prompted her to look at her drinking. She slowed down, having a couple of cans in the evenings. Her partner continued to drink heavily. When James started nursery, Lesley would meet her friends in the afternoon in the pub. She was drinking with people who drank like she did. She continued to drink in the evenings as well. Her drinking further escalated. Social Services became involved and James, aged seven, was taken into care. Lesley tried detoxing three times in a local psychiatric hospital. She also tried numerous home detoxes. However, she had no intention of staying off the alcohol.

> 'I'd just give my body a break and go back out there… I'd no intention to stay off it… let my liver recover and be nice to Social Services and they'll give me James back.'

She was sober for six months when Social Services gave James back to her. However, although she had cleaned up she had not changed her way of thinking. She attended a harm-reduction agency, where she was encouraged to control her drinking. 'It was giving me licence to drink, wasn't it? You know, as long as I show up on time… it was good.' James was home six months when Steve had a stroke. He was diagnosed with brain cancer and

given five weeks to live. Lesley looks back at this as a wonderful licence to drink. She visited Steve in hospital every day while under the influence of alcohol. Two cans in the morning for breakfast for courage and two cans to drink during the visit hidden in the toilets.

Steve was in hospital for four months before Lesley was allowed to take him home. At this point, she was drinking cider, as lager was no longer giving her a quick enough kick. She then had to take Steve to chemotherapy every day. Social Services took James off Lesley again. Her friends volunteered to foster him and Lesley was allowed supervised contact once a week. Inevitably, Steve had to go into a nursing home. When he died, Lesley weighed just six stone. With Steve gone and James in care, she felt as if her life had collapsed and began to question, 'What have I got to live for?'

Steve's funeral was on a Friday and Lesley went into the local psychiatric hospital on the following Monday to detox. Her detox lasted ten days. Once again she turned to alcohol. She didn't feel guilty, she didn't feel anything. To her, 'a detox was just a detox'. She started to try and control her drinking. She also tried changing her drinks. She tried to rationalise that she couldn't be an alcoholic because she drank whiskey and Martini, not only cheap lagers and ciders. She drank from long glasses, decided to have only one drink before tea – but tea kept getting earlier – and was grateful for the invention of Coca-Cola (you could hide so much in it!). She started to take valium in the morning if she did not have alcohol, in order to avoid withdrawal symptoms.

Lesley was now spending most of her time on her own. She described herself as 'a poor helpless little waif with nothing going for her' at the peak of her drinking.

> 'I didn't care, I couldn't be bothered. I was dirty. I didn't bother washing. Didn't bother eating. I was the person no one wanted to talk to. Even my drinking friends, the majority of them had deserted me. I was an embarrassment. I was very, very lonely. Very lonely.'

Lesley story part two

In our last issue, Lesley revealed how drinking sent her life on a downward spiral. In the second part of her story, she tells how she picked herself up; found a treatment programme to tackle her dependency and found life is worth living.

During the six months after her partner Steve died, Lesley became involved with a local voluntary sector treatment agency. The initial contact was made in the detox ward at the psychiatric hospital. The local agency arranged for Lesley to go to a residential treatment centre away from her home. Even though she was aware that she had an alcohol problem, Lesley looked upon her forthcoming time at the residential centre as a holiday. It would be nice to get away, as she could do with a break. Lesley's drinking continued at the same level while she was waiting to start residential treatment. She had to sell some of her possessions, and sell or swap her prescribed valium to obtain alcohol. By this time, it wasn't taking her much to get drunk – she would drink approximately six cans of lager or cider a day. 'I couldn't take anymore. I was just passing out or blacking out.'

During 21 weeks in the residential centre, Lesley's life changed dramatically. After detoxing, she spent eight weeks in primary care, a treatment programme that aims to help patients face the reality of their addiction, change the behaviours associated with it, and provide the foundations for recovery. The programme is holistic in nature, incorporating one-to-one counselling, group work and medical support, along with audio and video presentations,

lectures, stress management, relaxation sessions and aerobics. During primary care, clients work through the first five steps of Alcoholics Anonymous (AA). Members of the client community are also encouraged to help each other.

Lesley had originally intended to stay only eight weeks, head back home, and try to arrange for her son to come out of foster care. However, after about three or four weeks something changed inside her and she decided she wanted to enter secondary care. This programme, which lasts another 13 weeks in residence, is a stepping-stone between primary care and returning to the wider community. It combines group therapy, one-to-one counselling and personal assignment work. Secondary care is a therapeutic community, which also involves residents taking part in the active running of the houses and household activities – shopping, cooking, budgeting and household management. Residents are also encouraged to become involved with voluntary work within the local community. 'Secondary gives the opportunity to live in the real world while still cocooned. You still have your fallback if anything goes wrong.'

When Lesley left the residential centre, her local treatment agency and social services continued to support her. She attended AA – 90 meetings in 90 days – which she found really scary. She also had some support from a family member. She had intended to receive aftercare from the local treatment agency, but felt more at ease periodically attending the residential centre for this form of support as she had more people there with whom she could identify. However, she engaged in the diversionary activities at the local agency (computer classes, cooking and gardening), which she found very helpful. Three months after Lesley came home from the residential centre, James was visiting more often. As she began to stand on her own two feet more, she cut down on the time she was spending at the local treatment agency and at AA meetings. James eventually came home full-time and has remained there since. He had spent approximately three years (on and off) in care or with foster parents. Looking back, Lesley feels that she needed residential rehabilitation, rather than being treated as an outpatient, despite her strong positive feelings towards the local treatment agency. 'Some of us need to be locked up, for want of a better expression… I didn't feel I had enough going for me… I was home and what the eye couldn't see… I'd be drinking at home and I'd be coming in here [local agency] and lying through my teeth.'

Lesley believes that her main reason for remaining abstinent was for herself and her son. 'I couldn't put my son through what he's been through another time.' She now enjoys a 'brilliant' relationship with James – they are best friends. During her drinking days, Lesley's relationship with her sister deteriorated badly. Now, they have a positive and loving relationship that far exceeds anything they had before. She started to work as a volunteer at the local treatment agency and eventually was appointed as a tenancy support worker. She no longer describes herself as lonely. 'I like to think I'm someone people get on with… no, I know I'm someone people like to get on with and like to be with these days… I feel worthwhile…' Lesley has been sober for over four years. She has not had a compulsion to drink since she left residential treatment. But she knows that she mustn't become complacent because that could be dangerous. Life without drink is 'brilliant', she says. 'You notice everything… Learning to live clean is good because there are lots of things you think you can't do, but you can. And it's brilliant looking out in the morning, the sun is shining, you know? The smile on my son's face.' 'Recovery is about learning to live properly, live as we're meant to live… something clicks and suddenly, "Yes, I am worth living. I am worth a decent life. I am a good person".'

8.3. Appendix C: Cheryl's diary

A Week in the Life of a Drug and Alcohol Community Worker at West Glamorgan Council on Alcohol and Drug Abuse (WGCADA)

> *"It's like being a fisherman. I cast my net with tasty bait and see what I can haul in. Some of my catch is ready to move on, some are not and I have to let them go. But they might be ready next time round."* Dave Watkins

Dave Watkins is the Drug and Alcohol Community Worker based at the treatment agency West Glamorgan Council on Alcohol and Drug Abuse (WGCADA). He covers so many different 'roles' over the course of a week - indeed over the course of just one day - that it is very hard to give him a job description. The above quote is the most concise way Dave could describe how he sees his job. So, to find out what the job entails, it was decided that 'shadowing' the community worker on a daily basis, seeing it all first hand was the best way to proceed. It was decided that someone with no professional background in the field would be used to do the 'shadowing'. The work of the agency would then be observed through 'fresh eyes' and the profile would be written in an easy to read format without all the professional jargon.

For more than 30 years, Dave Watkins worked as a mechanical engineer. He is married, and has two daughters and three grandchildren. Dave took up his present post as a Community Drug and Alcohol Worker at WGACADA five years ago. Initially, the post was for 20 hours, but it soon became a full-time position. An introductory meeting was held with Dave where he outlined his work within the community with examples of the nature of his clients, their problems and some of the ways in which he can help. Dave works with very vulnerable people and went to great pains to stress the need for sensitivity and confidentiality during the 'shadowing'. Dave works from his office base at WGCADA in Swansea but spends most of his time out in the community. One of his most important tools is his diary in which he organises his schedule for the week. The words 'typical' and 'routine' certainly cannot be applied to Dave's day. Colleagues have said that they see no structure to Dave's day, but given the often-chaotic lifestyles that his clients live, it would be impossible for him to follow a rigid appointment system or plan. However, certain days and/or times are set aside for specific tasks. For example, 10.30 – 1.30 on a Tuesday is set aside for the WGCADA allotments, Wednesday morning for visiting the detoxification (detox) unit and wards 4 and 6 at Cefn Coed, a local psychiatric hospital, and Friday morning for the team meeting. Clients can make contact with Dave either by self-referral, friends or family, or through their social worker, probation officer, GP or other medical staff. The first point of contact at WGCADA is through Esther or Angie on administration.

On first meeting the client, Dave will go through an assessment form. This helps him to gauge the level of help or support each client needs. Assessments can be carried out at the centre, in hospital or in the client's home. Once the assessment has been completed, Dave can put wheels into motion by contacting the professionals he feels will best be able to help the client in question. In some cases it will be helping the client to engage with WGCADA, whilst in other instances it will be getting them into a detox programme, whether it be at home or in hospital. With some clients, the priority is finding them somewhere to live. These assessments also help Dave to prioritise the scheduling of the service to fit the client's needs and decide also where they need to be slotted in to his caseload.

One of Dave's responsibilities is the Mumble's allotment that is run as part of the Development Of Motivation In New Outlooks (DOMINO) project. This WGCADA project involves a range of diversionary activities including gardening projects, cookery classes (that are accredited by Swansea College), guitar classes, first aid courses, anger management, Information Technology (IT) and art classes. These courses are designed to develop and promote a greater awareness of life without chemical dependency. Initially, the funding was through a three-year lottery commission's grant (1997-2000). Presently, the DOMINO project is resourced through the Welsh Assembly's Challenge Fund with additional funding from Lloyds TSB.

The DOMINO project very often plays a part in the initial engagement of a client at WGCADA. As well as teaching the client new life skills, the scheme also provides a way to stop the client becoming insular and withdrawn whilst waiting their engagement in detox or a rehabilitation (rehab) programme. The DOMINO project is also accessed by clients who are still in treatment and by those who have completed treatment. This provides a continuum of support for the recovering addicts, not only from the Centres' staff but also from their peers. I spent five days "shadowing" Dave Watkins and it turned out to be an illuminating experience. It is important to note that the client's permission was always sought before I sat in on any interview and/or assessment. All the client names used in this diary are fictitious**.**

Day 1
It is 09.30 and our first call is to check on two brothers, Gareth and Rhys, both who are in their thirties and have a serious alcohol problem. They are hoping to be admitted to Cefn Coed detox ward. Part of the difficulty getting them admitted is that they want to go in together. There are only four beds in the detox ward. Before meeting them, Dave gives some background to prepare me.

He expects them to be in an intoxicated state even this early in the morning. The brothers prove Dave right! He wants to check on how they are doing and to remind them that they have an appointment next day for a psychiatric assessment. Dave is hoping to get them onto the detox programme using the Mental Health Act. Both Dave and the brothers' social worker will be present at the assessment to take place at a health centre in Morriston. Gareth and Rhys seem genuinely pleased to see Dave. In turn, Dave engages them in easy banter whilst putting across his concerns about their behaviour and the importance of their forthcoming assessment interview.

10.00: We are on our way to pick up a young female heroin addict, Caroline, to take her to the allotments. Dave wants to encourage Caroline to access the activities at the Centre, with the hope that she will eventually decide to attend the Pre-Treatment programme. To take part in the Pre–Treatment group at the Centre the client does not necessarily need to be abstinent. The aim of the pre-treatment is to educate the client about substance misuse and addiction. It also helps determine the individual's commitment to the abstinence

programme. The Pre-Treatment programme consists of two phases. Phase one spans eleven weeks and provides education on what substance misuse can do to your health and the effect it has on family and friends. The programme's lessons are preordained:

Week 1: An Introduction to the Agency
Week 2: Alcohol Use and Abuse
Week 3: Drugs Awareness
Week 4: The Disease Concept
Week 5: The Progression of the Illness
Week 6: The Physical Effects of Alcohol Addiction,
Week 7: The Physical Effects of Marijuana Addiction
Week 8: Blocks to Recovery
Week 9: Health Awareness
Week10: The Effects on the Family
Week 11: Step One.

In phase two, the client begins work on Step One of the Minnesota Model. In this first step the client looks at; Recognition of Dependency, Acceptance of Unmanageability of One's Life, and Recognition of Dishonesty With Self and Others. By this time the client must be abstinent. If a client decides to access the abstinence 'Primary' programme they are usually involved in this rehab programme for 8 –12 months, where they work through the first five steps of Alcoholics Anonymous. The treatment is based on the Minnesota Model. They spend one full day (09.15 – 16.15) at the Centre a week for group therapy, lectures and educational activities. It is a full, structured day. The client also has one-to-one counselling once a week. They are encouraged to take part in the DOMINO project and to attend at least three AA or NA meetings a week.

There is no answer at her flat but Caroline's mother, Mrs C, calls us into her flat informing us that she will try to phone her daughter to get a response. There is still no reply. Mrs C becomes very upset, telling us that she is really concerned about her grandchildren being taken into care. She quizzes Dave about her daughter, because Caroline won't tell her anything. Dave calms Mrs. C by saying that her daughter has made a very positive step by contacting us. He says that he will phone her when we get back to the office to give her the name and telephone number of someone from a family support group who will be able to offer her advice and support. We also promise to check the local Post Office to see if Caroline has made her way there to cash her weekly giro. When we leave the flat, Dave explains to me that he has to respect client confidentiality, so he had to be really careful about what was said to Mrs. C. We check the Post Office but with no luck.

11.00: Back at the Centre and getting ready to leave for the allotments. About 15 of the Centre's clients are waiting for the mini-bus to take them, but the driver is ill. We manage to ferry the clients to the allotments by car. I am more than impressed with the allotments. I had been expecting something along the lines of the allotments we see on 'Eastenders', but this was far more impressive. There is a magnificent array of flowering plants, shrubs, fruit and vegetable plants, plus a pond complete with pond wildlife and a very nice sitting area for tea and coffee breaks. What a wonderful place to practice or learn new gardening skills, as well as being a peaceful place to sit and chat. Dave explains that there had been an initial reluctance by the original allotment users to allow WGCADA's clients to use the allotments. The improvement that the clients' hard work had brought to that area of the allotments has now allayed the earlier fears. I am surprised and impressed that most of the clients actually get involved in the gardening and don't just sit around chatting and drinking coffee as I did! Dave takes the opportunity to have quiet informal chats with some clients, individually. He even gives an impromptu topiary lesson. Asked where he had learned such

skills, he says that he had picked it up off a TV program. I am to learn later that Dave has picked up many tips off the TV, but more of that again! At 13.15 we start to clear away, ready for making our way back to the Centre.

13.30 – 14.00: Coffee/lunch breaks back at the Centre. Dave, grabbing coffee on the run, goes off to check on phone messages whilst I have a chance to chat to some of the clients who have come in for the IT lessons that are being held that afternoon. 14.00: Dave takes a client to a probation meeting. I stay at the Centre chatting to a young man who is a heroin addict. He is on a rehab programme at WGCADA. He tells me about the trouble he was in before he started the programme and shows me the exercise he has to do as part of the next step of his treatment. The exercise involves him looking at his strengths and weaknesses and the effect his behaviour has had on him and those around him. He has to write his answers down to discuss them within his counselling group. It is wonderful to see his enthusiasm for what is needed to make him better. I am surprised at how much he shares with me, a stranger ten minutes ago. This was something I was to get more and more used to.

14.30: Mrs. A., a lady in her 40s, arrives at reception asking for Dave. I assume she is a social or probation worker looking to liase with Dave until I notice how nervous and agitated she is. I then realise she is Dave's afternoon assessment appointment. Angie and I are trying to calm her down just as Dave arrives. We take her up to one of the offices to carry out the assessment. Whilst interviewing Mrs. A. in order to complete the assessment forms, it becomes apparent that she is in denial of her excessive use and reliance on alcohol. It is obvious that she has been drinking already that day, but she tells Dave that, "I last had a drink three days ago!" She does not think her drinking is the main problem in her marriage, but blames her husband for not communicating or demonstrating his love.

Dave asks her to attend an Alcoholics Anonymous (AA) meeting later that week, saying that we will take her there and stay with her for support if she feels that she needs it. She agrees. Dave also tells her about the allotments and asks if she would like to join us there next Tuesday. She declines. We give her literature on the centre, and a list of AA meetings and other educational leaflets about alcohol abuse/rehab. 'Bedtime reading' as Dave calls it.

16.00: A call comes into the Centre from a worried couple, Mr. and Mrs. D, concerning their grandson who has been drinking heavily and living rough as a consequence. They had tried to get Brian onto the detox ward at Cefn Coed but had no success. They had then tried to get him into a hostel but couldn't find one willing to take him, as he wasn't in receipt of housing benefit. Nearly all of the hostels/boarding lodges require the applicant to be in receipt of housing benefit as a means of covering their board and lodgings. Mr. And Mrs D had no idea what to do next, so had been put in touch with WGCADA.

16.45: We arrive at Mr. And Mrs. D's house to carry out an assessment. The family see finding Brian somewhere to live as the first priority – they don't want to see him sleeping rough again. Due to their own ill health they are finding it too difficult to cope with Brian and his excessive drinking and Brian's parents will have nothing more to do with him. Although Brian owns his own home he can't live there because he rents it out to bring in enough money to cover the cost of his mortgage and rates. This causes Dave a bit of a 'headache' as most of the hostels require the 'lodger' to be in receipt of housing benefit, to which this client is not entitled. Brian has an appointment at Cefn Coed tomorrow but can't remember what time. Dave makes a phone call to the unit to confirm the date and time. He suggests to the family that they try the Nun's hostel on the Strand, after their appointment at Cefn Coed tomorrow, as they are run as a charity and do not rely on the housing benefit. Dave also suggests that Brian engages with WGCADA for support through the DOMINO

scheme initially, with the aim of moving on to their rehab programme. Brian agrees to come to the allotments next Tuesday and to go to an AA meeting Wednesday evening.

18.30: On our way to do a home visit assessment. The client, Colin, has started a home detox from alcohol and is afraid of suffering 'fitting' episodes during the withdrawal. His GP had given him tablets to help with the symptoms of withdrawal but he didn't recognise them and so was afraid to take them. Dave phones Cefn Coed to ask one of their doctors what the tablets are. It turns out to be a drug similar to Valium and the doctor informs Dave how many should be taken and how often. Dave promises to speak to the client's GP the following morning to advise him of Colin's delay in starting the medication and to get a further prescription written. Dave also promises to bring the client's parents up-to-date with Colin's new regime. Dave has helped this client previously so already has a good relationship with the family.

20.00: We arrive back at the Centre. Dave asks if I'd like a cup of coffee before I make my way home!! I feel so tired I can barely string a sentence together and can only marvel that Dave is still standing. I wish I had half of this man's energy. I make my weary way home whilst Dave goes off to his desk to make his diary entries, check on phone messages and prioritise the tasks for tomorrow.

Day 2.

09.00: Dave places a call to Mrs. C., the mother of the young girl we missed yesterday, to give her the name and contact number for her local Al-non family support worker who will be able to offer advice and support. There is no answer. He then calls Colin's GP to ask for the detox prescription required and to provide an update on this client. Dave phones Colin's parents to tell them that there will be a prescription ready for collection at 15.00 today and he explains the regime that needs to be followed.

He then calls Colin to see how he had coped through the night, reminding him to take it slowly and not to rush getting back to work because it was really important that he makes sure that he is well first. Dave explains that Colin's parents will be picking the prescription up from the surgery after 15.00 and goes back over the regime to be followed. Before saying good-bye, Dave promises to phone again to see how things are going.

10am: We arrive at Cefn Coed Hospital in Swansea. Dave asks if I have ever been to the hospital before. As I have not, Dave tells me a little about the detoxification (detox) ward and the other two wards that he visits and explains what happens to the patients after detox is completed. Detox is the controlled withdrawal from a substance such as heroin or alcohol that has resulted in physiological and/or psychological dependence. It is a procedure that aims to alleviate withdrawal signs and subjective discomfort, and prevent the risks inherent to suddenly stopping use of a substance that has resulted in dependence.

Detoxification can take place in the home or in a hospital. Detox in Cefn Coed normally takes 7 – 14 days, depending on the individual patient. The detox ward is a 'locked' unit (staff require a security code to enter/exit and patients are not allowed to leave without discharging themselves from the programme) that has four beds (a fifth bed will be available shortly). Patients admitted to this ward usually feel that they wouldn't be able to complete a detox programme at home. This may be because they don't have a supportive home environment or because they have a concurrent mental or health problem that may be exacerbated by the withdrawal process, e.g. history of seizures, heart or respiratory problem. They need the help and support of the nursing staff that are on call 24 hours a day. The patients are either referred for detox by their GP or by a social, probation or other drug worker. Detoxification is one step of an ongoing process - it needs to be supported by

a period of aftercare for the client to produce long-lasting changes in behaviour. Once a detox programme has been completed, the patient usually then moves on to a rehab programme which could be based at a treatment agency such as WGCADA.

Some clients find it too hard to detox and go through rehab whilst living in the community; this could be because they do not have a strong family/friend network for support. Dave will contact a residential lodge on behalf of these clients. There are a few residential lodges in Cardiff, but WGCADA places a lot of their clients at either Walsingham House in Bristol or Broadway Lodge in Weston-Super-Mare. WGCADA uses these two places because of the dreadful shortage of beds/funds available for drug and alcohol rehab programmes within our area.

Prior to admission, an assessment is carried out to determine the clients' suitability for treatment. Once that has been accepted the next step is to secure funding for the period of stay. The client could spend up to twelve months in rehab. The first stage of treatment can take 6-8 weeks and up to 10 months for the second stage. Wards 4 and 6 at Cefn Coed are general psychiatric wards but are also used as an over-spill ward if there is an emergency detox admission. Ward 4 is reserved for patients from the Neath/Port Talbot area, whilst Ward 6 is for the Swansea area. Dave explains that some of his clients are also admitted to Wards 4 and 6 for related mental health problems. Generally, there is someone on the detox ward that Dave knows, but he was never certain if any of his clients have been admitted directly on mental health issues to the other wards. He always checks both the detox and Wards 4 and 6 on each visit. Today, we were going to visit the detox ward first. As we cross the car park, we bump into Brian, the client who needs somewhere to live. He had just completed an interview to get his name on to the detox list at the hospital. Dave encourages him to go down to the Strand, where the hostel for the homeless run by Catholic nuns is located, to ask if they would take him in. Dave tells him that if he has no luck, to get back in touch and Dave will do his best to sort something out. Brian is also encouraged to go to an AA meeting.

There are two patients on the detox ward when we arrive. Dan, who is in his 40's, is there for an alcohol detox. Dan is hoping to have a place on rehab at Walsingham House in Bristol. He asks Dave to chase up the paperwork needed to secure the funding to pay for his place. All Dave's paperwork is in, but the client's GP seems to be dragging his feet. Dave promises to make a phone call to the GP to see what the hold-up is. Dan asks if anything can be done to get him re-housed. Dave tells him that it will be looked at later as they have the rehab programme to go through first. Dave goes to speak to the nursing staff to check on whom they are expecting to be admitted over the next 24 hours. While Dave is away, Dan turns to me and says:

> "Dave's such a great bloke. He works so hard, he should be made a saint."

The other patient is a young female in her 20s who is there for a drug detox. She also asks Dave if he can get her on a rehab programme. Dave advises her to speak to her Community Psychiatric Nurse, (CPN).

11.00: Dave checks to see if he has any clients on Ward 6. Today we have just one client to visit, Ruth is a client that Dave has known for some time. Her drugs of choice are 'speed' and 'crack' and she has completed detox and rehab programmes a couple of times. We settle down for a chat and Ruth tells Dave that she had been in for a month now and doesn't expect to be getting out any time soon. Dave asks whether she was still hearing the voices? She replied that she was but not so much. Dave later explains that he has had conflicting views from doctors who have treated Ruth. One doctor felt that Ruth was making

the voices up for attention but another felt that the voices were 'real'. Dave asks Ruth if she is still self-harming. She says she hasn't recently and holds out her arms to prove it. She tells us that her mother and sister are looking after her three children. She wonders how her Mum and sister are coping but says that she knows she couldn't cope. She and Dave reminisce about the antics she got up to when he accompanied her to one of the rehab centres. Ruth was at the top of the staircase as Dave was saying goodbye before leaving. The next thing Dave knew she was falling head first down the stairs. When Dave asked her what had happened she told him that the 'voices' had told her to throw herself down the stairs! Dave has an encyclopaedic memory of all the facts relating to his clients - past and present. He recollects their families, their relationships, their 'highs' (and 'lows'), their achievements, etc.

Ruth asks how some of the staff members at Broadway Lodge are doing, particularly one member of staff that had spent several hours walking the grounds with her during her rehab. They then went on to chat about some of the friends she had made at WGCADA and Dave encourages Ruth to come back to the centre when she is discharged. She asks if he would come back to see her soon and Dave promises that he will.

12.00: Dave suggests a coffee break, sitting in the hospital grounds and enjoying the sunshine. This is one of the rare occasions that Dave has stopped working, even though the conversation is still about clients. We talk about the clients we have seen so far that day. I start to ask Dave questions about self-harming when a hospital worker, Jim, spots him and comes over to say "Hi". Dave introduces us and tells me that this is the man who can give me some answers to my questions as he works with people who self-harm. Jim relates his experience and opinions on self-harming and its progress. In his experience, people who selfharm use it as a way of releasing strong emotion, such as anger. Jim says self-harmers rarely grow out of it, although the 'cutting' may become more superficial over the years. Another of Dave's network of knowledgeable "experts" with whom he has cultivated an excellent working relationship that enables him to call on them for their expert advice and vice versa.

12.30: We start to make our way up to Ward 4 but en-route Dave recognises an old client. He stops to chat so that he can catch up with what is going on in this client's life at the moment. He promises to check up on him the next time he was in the hospital. When we arrive at Ward 4, we are told that there are none of Dave's clients on the ward at the moment. Dave has a chat with the nursing staff before we make our way back to the car.

13.15: Back at the car, Dave gives me some background on the next client. Margaret is an elderly lady with an alcohol problem – a "lace curtain" drinker. Dave is particularly concerned whether she will be comfortable with my presence.

13.30: At Margaret's home, Dave initially speaks to her alone to make sure that it is okay with her for me to be part of the visit. Her husband has suffered four strokes and is confined to bed. Although social services provide some daily help, she is looking after her husband 24 hours a day. Margaret says that she only has a little drink to help her cope, but admits that she has already been drinking sherry that day. Her social worker arrives after ten minutes. Dave and the social worker have been trying to persuade Margaret to go into Cefn Coed to detox but she has refused adamantly. As Dave explains later, it is the stigma attached to a 'mental hospital' that makes this option abhorrent to someone of her generation.

Previously, Dave had enlisted the help of two WGCADA clients, who were well on the road to recovery from alcohol problems, to visit this lady under the pretext of helping maintain her

garden. Whilst there, as prompted by Dave, they told her their "drinking" life story and how they accepted help to recover. She was amazed at the quantity of cider they had consumed but it served to help her recognise her problem with excessive alcohol consumption and the effect it had on her ability to support her invalid husband. As she is so concerned about caring for her husband, Dave attempts to persuade her to enter a centre for detox/rehab that will also take her husband as well. He finally manages to persuade her to visit the place, provided it is "not Cefn Coed", with him to see if her and her husband would like it. Dave also discusses AA meetings as he feels that Margaret will benefit from the company and support from female members of the group. Once Dave is satisfied that she will visit the rehab centre and is seriously considering going to an AA meeting, we start to say our goodbyes. However, we are told in no uncertain terms that we are to stay for a bit longer. Chastised like two naughty children, we sit down again! We chat for another five minutes or so but then Dave tells Margaret that we really must go as we have two clients to take to an important meeting. Reluctantly, she "allows" us to leave after Dave promises to call to see her soon. Once out in the car, Dave tells me that we really have to 'get our skates on' as we were supposed to be at the next clients' home by 14.30 - it is now 14.30!

14.45pm: We arrive at the home of Gareth and Rhys, the brothers from yesterday, to find that the social worker has left a note pinned to the front door. He has taken the brothers for their assessment and asked us to follow on and meet them there.

15.00: We arrive at the Health Centre in Morriston. Dave bumps into a member of staff he knows who takes us to the room where the assessment with the psychiatrist is being carried out. My first shock of the day – the brothers have completely shaved their heads! The psychiatrist asks many questions but seems to be very surprised by some of the answers. He appears to find it unbelievable that the brothers can drink up to 16 pints of cider a day and don't put any money aside to cover bills and buy food. He seems shocked that every penny the brothers spend is on alcohol, although this is behaviour typical of the alcoholic in Dave's experience. As a lay observer, I find the psychiatrist's response frightening as it displays a complete lack of appreciation of the disease. Dave seemed unfazed by the psychiatrist's naivety, having witnessed this type of response many times from professionals in the social and mental health fields when confronted with practical examples of substance abuse. As the assessment comes to an end, the psychiatrist says that he cannot help to get them on to the detox programme at Cefn Coed. Walking back to the car, Dave asks the brothers,

"What am I going to do with you boys?"

"Dunno, Dave. Can you believe that bloke thought we had money put away?"

After a bit of bantering and inspection of their scalps - to check out the nicks from the head shaving - we manage to get them into the back of the car and set off for their home. There follows a disjointed, rambling discussion about local events that I have great difficulty in following but Dave manages to keep up with. He seems to easily tune on to their wavelength!

As we pull up outside their front door, Gareth and Rhys tell us that their gas was cut off that morning. Dave explains that it was done for their and their neighbours' safety. It was felt that, in their regular inebriated state, they might switch the gas on, not light it properly and cause an explosion. Dave asks if they still have electricity for light and heat and they say that they do. Dave promises to check in on them soon and will let them know as soon as he has found a way to get them into detox. As I am saying goodbye, one of the brothers (I

couldn't tell them apart!) tells me that he wishes the council would cut down all of the trees in front of his house. When I asked why, he says that they spoil the view from his window!

16.00: We are on our way to Morriston Hospital to visit two female clients. The first lady, Sheila, was admitted to the hospital about a month ago. Dave and Angie had called at Sheila's home to do an assessment prior to getting her into detox/rehab. When they arrived, they had found her in a really bad way. She was barely conscious and had dragged herself across the floor to open the front door. All that was visible to Dave and his co-worker was a hand covered in excrement coming around the bottom of the door. The flat was in a terrible mess – urine and faeces were all over the floor and the bed, and empty bottles were lying around. Obviously there was no need for an assessment. This lady needed help desperately, there and then. The female worker took the client into the bathroom to get her cleaned up whilst Dave set about cleaning up the flat. Then Dave made the necessary phone calls to arrange for an ambulance to take her into Morriston Hospital.

Whilst Sheila was being cared for in hospital, Dave had managed to secure a place for her at Broadway Lodge in Weston-Super-Mare. The lodge had sent a brochure to Sheila with information on the care and treatment she would receive. She tells Dave that she is really worried about what the treatment entails. Dave explains the treatment to her, but Sheila is worried about not being up to taking part in the aerobics that she has seen listed as part of the treatment regime! She has been bedridden for a month recovering from her drinking binge and tells Dave that she is far too weak to be able to take part in aerobics. Dave reassures her that the staff at Broadway Lodge will take her state of health in to account.

Sheila asks Dave if he would be able to take her home for an hour so that she can pick up some nightclothes and a set of clothes to wear next Monday when Dave takes her to Weston-Super-Mare. (Sheila's family are fed up with her drinking and are not visiting her very often. When they do visit, they usually forget to bring the items that have been requested). She also expresses concern about her flat.

Dave asks the nursing staff if it is okay to take her home for an hour and reminds them that we will be picking her up at 09.00 the following Monday to take her to Broadway Lodge. We slowly make our way out of the ward and, at Dave's jovial encouragement - "It's good exercise" - we walk down the stairs. There follows some good-humoured jibing between Dave and the client as he sought to raise her morale. During the drive over to her house, Dave asks Sheila how her relationship with her exhusband is, how much she sees of her sons and what they were all doing now. In this manner, Dave is attempting to gather information on the long-term stability of her relationships and whether any further family support can be expected. As we pass a certain section of the road, she reminds Dave about a car accident she had been involved in there. Dave starts to laugh and says how funny it had been. She says, "It might be funny looking back, but it wasn't funny at the time." "Go on," says Dave, "I thought it was very funny at the time!" Yet another very comfortable relationship!

The housing warden meets us at the flat with the front door key - Sheila can't remember where her key is. Once inside, we get the necessary clothing packed into a case and sort through the mail. She becomes agitated about a housing form that is amongst the mail. She tells Dave that she won't be able to fill the form in because she cannot concentrate or hold a pen for any length of time. Dave tells her not to worry as he will go through the form with her and would make sure that it is posted.The warden of the flats says that she needs Sheila's National Insurance number for forms that she has to fill in concerning the flat. Dave says that he also needs the number for forms he has to fill in for Broadway Lodge. Sheila tells us that the number can be found on her benefit book that her son is looking after.

Dave asks her to phone her son to get the number and then to pass it onto him and he would see that the warden gets it. Dave later explains to me that although it would have been easier and quicker for him to call the son, he had felt that it was an opportunity to encourage contact between the pair.

On the drive back to the hospital, Sheila points out where she used to work and where she used to live when she was married. She tells me all about her sons' academic achievements, their present careers and her grandchildren. As she speaks, her pride in her family is obvious and she recognises it all could be lost. She berates herself for getting into her previous state and acknowledges that if she carries on drinking, she will kill herself.

17.00: We are back at the hospital. We settle Sheila back on the ward and go over the housing form with her. Dave reminds her to be dressed and ready to go by 09.00 on Monday for our trip to Broadway Lodge. We tried to visit the other female client but are told that she has been discharged. Dave is annoyed that he had not been informed prior to this lady being sent home. He had specifically had a reminder attached to the patient's notes to say that he wanted to be alerted when this person was due for discharge. He had wanted to ensure that support was immediately available for her upon her return home.

17.30pm: We arrive back at the Centre. Dave returns to his desk to complete his daily wrap-up process - write up his diary, check his messages and make some follow-up phone calls. I make my way home, my mind buzzing with all the day's events and praying that my daughter has made a start on supper!

Day 3
09.00: The day begins with a coffee and informal chat with staff members at WGCADA. Dave is called away to take a phone call from the parents of one of his clients.

09.30: It is time for the weekly team meeting to begin and Norman, the Centre manager, waits 'patiently' for his staff to take their places. Norman informs the team that he won't be staying for the entire meeting as he has a report to write, but first he has a few items that he wants to discuss. The first item on Normans' agenda is getting me to explain to the team exactly what I am doing at WGCADA. It transpires that Dave and Norman have been "pulling the legs" of some of their co-workers with regard to my activities and my report "on the value for money from their contributions". I had just been wondering why everyone was keen to make me coffee! The next item discussed is the sponsored walk planned for the following weekend. Norman wants to confirm who is doing what and when. Every member of the team is involved in one way or the other, from actually taking part in the walk to making sure the 'watering holes' are manned. They all seemed genuinely enthusiastic about the event, even though it means giving up some of their weekend free time.

The upcoming auction is now discussed. Norman reminds us that he is expecting a donation for the auction from every staff member. He 'warns' us to make sure the item we bring is something that he can have fun auctioning! Norman tells the group that two commodes have been donated, one large and the other much smaller. He senses he can have real fun with them at the sale! One of the Centre's counsellors asks if he can return a plate depicting 'Christmas in the summer (!?!)' that he had been 'forced' to buy last year even though he admitted, on reflection, that he might actually be getting attached to it! Norman says that he would allow it because peoples' taste change and he might have a bit more luck raising money with it this time round. Permission is then requested for a letter to be read out to the group. The letter had been written by a couple that, by chance, had ended up camping alongside a camp-party from the Centre at Port Eynon last year. Mr. and Mrs. Johnson had enjoyed themselves so much that they were wondering if a camping trip was being planned

for this year as well. If it was, they asked, could they meet up again? A few of the team members present at the meeting had also been on the camping trip and recollected the chance meeting with the couple. A group of about 15 centre clients and staff had made camp. They were enjoying a barbeque and sing-song when the man from the motor home next to them came over to ask if they were associated with an AA organisation. Mr. Johnson went on to explain that he and his wife had noticed that no alcohol was being consumed and had thought it odd that a group of young people were not drinking. Staff members told Mr. and Mrs. Johnson a bit about WGCADA and the couple asked if they could join the party. Mr. Johnson told the group leaders that if he or his wife wanted a drink, they would only drink inside their motor home out of respect for the group. The couple joined in the treks and evening singsongs for the rest of the camping trip. Norman says that it is lovely to get feedback like this but it is a pity that there aren't more members of the general public who are as perceptive and thoughtful. Before he leaves, Norman asks if any team member had anything in particular they needed to discuss with him.

Dave Watkins raises his hand but Norman, knowing that Dave's request is going to be of the 'please can I be excused kind', studiously tries to ignore him! Dave eventually gets Norman's attention and tells him that he needs to be excused from the professional seminar being held at the Orangery in Margam this coming Monday, as he has to take a client to Broadway Lodge. Norman says that someone else could do that journey and he feels that Dave should go to this meeting. Dave appeals to me for back up. "She's a very vulnerable client isn't she, Cheryl? Feels comfortable with us, doesn't she?" Norman looks around the group then back to Dave and says, "I think you need to go away and take a look at why you are trying to avoid this meeting. Go away and think about it, then come back to me with your thoughts". Before he leaves, Norman tells the group that he wants to see each group counsellor individually after the meeting. It is quite fascinating to see the dynamics between the Centre's manager and his team. The meeting continues with each team member in turn providing a review of some of his or her clients. This might be a client who has finally realised that they need the support given by the Centre and are now ready to engage in the pre-treatment programme, or a client who has been progressing well through the rehab programme and is now in a position to offer support to other clients. Several of the current counsellors had followed this latter route to eventually become full-time workers at the Centre. Clients who are causing concern are also discussed. The concerns range from a client not turning up for their 'one-to-one' or group session, to clients displaying inappropriate behaviour at the Centre or whilst in a group meeting. The staff member experiencing difficulty with a client is then able to call for support from the rest of the team. The background of new clients to the Centre is also discussed, giving the team the knowledge that would help them deliver the best service possible to that individual. The weekly team meeting also provides staff with an opportunity to work through any problems they were experiencing within the team. This section of the meeting generates healthy, if sometimes heated, debate. The meeting closes after the office diary is read through, reminding each member of staff about any meetings or visits that they have booked for the coming week.

12.00-12.30: Lunch-break and time to stretch my legs out in the Centre's garden. Clients from the Centre tend the flowerbeds and they have done a wonderful job. For once, the Centre is quiet so I take the opportunity to soak up some sunshine whilst drinking my coffee at one of the garden tables. The garden is a little oasis that both staff and clients can enjoy.

12.30: Our lady client, Mrs. A arrives as promised ready for us to take her to the AA meeting. She is obviously very anxious and keeps saying that she isn't sure that she can do this. As Dave and I lead her through to the staff room to make her a coffee, I can smell the alcohol on her breath. She is still denying that she has had a drink and goes back over the

same story she told us at our first meeting. We manage to calm her enough to get her into the car to take her to the AA meeting. In the car, Dave tells her how proud she should be of the huge step she is taking by attending this meeting. He outlines the course of a typical AA meeting and explains that she won't be expected to share her story with the group until she is ready.

13.00: We both accompany Mrs. A into the meeting and Dave introduces her to one of the 'older' group members. He knows from experience that this man will take good care of her. We are both pleased to see that Brian, our 'homeless' client, is at the meeting – the Nun's have taken him in. I spot a few other familiar faces from the Centre as well. Dave edges me outside. I am surprised because I had thought that we were staying in case Mrs. A needs support. Once outside, Dave explains that he thinks it is better for her to do this alone, but that we should wait outside the centre in case it gets too much and she needs to leave.

Whilst waiting, Dave gives me a run-down on all the locations and times that AA meetings are held. I am surprised to learn how many meetings are recommended for a newly recovering alcoholic or drug user to attend – 90 meetings in 90 days. If you manage to achieve that, research shows that you are in with a good chance of recovery. As we speak, an elderly gentleman comes over to chat with Dave - just to catch up on what is happening before going in to join the meeting. Within minutes, a car pulls up alongside us and a young woman jumps out, puts her arms around Dave and gives him a hug! Dave introduces us and then asks the young woman how things are going for her. He encourages her to drop in at the Centre soon, but she says she is doing okay for the moment and so doesn't feel as though she has a need. By now, I am not at all surprised to see that even clients who are no longer engaged with the Centre still like to stop and chat with Dave.

14.00: The meeting ends and our client (plus her 'minder') come over to tell us how it has gone. We are impressed because not only did Mrs. A stay for the entire meeting, but she 'shared' as well. Her 'minder' asks her to promise to come to another meeting the following week and she promises that she will. Dave congratulates her on the huge step she has just taken. He tells her that it is not uncommon for someone to go to these meetings for over a year before they were ready to share their story with the group.

Dave points out another "old" client that still cycles over 40 miles weekly to attend the meeting. The cyclist stops by and offers our new client words of encouragement drawn from his own experience. We make our way to the car to return to the Centre. During the journey she tells us about the meeting – she still cannot believe she has done it! Once at the Centre, we give Mrs. A the list of dates and times for the AA meetings in our area. Suddenly, she becomes very agitated, saying that she has made a mistake. She shouldn't have come here and she even accuses Dave and I of being part of a conspiracy with her husband! After some time, we manage to calm her down and get her to drink a glass of water. Dave is called to the telephone and almost instantly Mrs. A becomes very agitated. She says that she doesn't want to be a nuisance, that she shouldn't waste any more of our time and that she wants to leave. I try to calm her by reassuring her that she is not wasting our time and that we think that she has done very well that day. Dave returns and she again apologises for wasting our time and thanks us for our patience, but says that she has to go. Dave asks if we can give her a lift home, but she seems horrified at the suggestion. Dave offers to drop her at the end of her street if that would make her feel more comfortable than being dropped outside her front door, but she refuses the offer, saying that she wants to go and sit in the park for a while.

15.00: Dave wants to revisit Dan on the detox ward at Cefn Coed to check that he will be able to stay on the ward over the weekend and to give him an update on his application for

rehab. On our way to Cefn Coed, we drive past the park to make certain that Mrs. A is okay. She is sitting quietly on a park bench. I ask Dave how you can tell that it is 'safe' to let a client leave after such an emotional episode. He tells me it comes with experience, that you can only do so much and then the responsibility has to lie with the client.

15.20: Dave introduces me to the staff on the detox ward and it is confirmed that his client will be able to stay on the ward until the coming Tuesday. There is also the possibility of an extension beyond that date, if Dave still hasn't managed to secure a place on rehab – the possible hold-up is still the missing GP's letter. Three new patients have been admitted to the ward since our last visit, two male and one female. Dave knows both male clients, but before talking to the new arrivals, he spends some time with Dan discussing the ongoing difficulty he has contacting the GP for the letter. None of Dave's phone calls have been returned. Dave reassures Dan that he will try again first thing Tuesday morning, as we will be away all day Monday. If necessary, he will drive over to the surgery and pick the letter up personally. Dan thanks Dave for all his efforts and says that he wouldn't know what to do without him.

Dave has arranged for me to have a chat with the charge-nurse. She takes me through the day-to-day running of the unit and speaks about some of the problems that she has come across whilst working on the detox ward. With there being only four beds on the ward, it means that any emergency case has to be admitted to either Ward 4 or 6, the general psychiatric wards. She feels that this is not an ideal situation for someone who is going through drug withdrawal and all that it entails. Another issue that she highlights is the lack of a social worker attached to the unit. The nurse speaks of a patient who had been discharged from detox with no money, no place to go and no rehab programme in place. He had no address so could not claim benefits. In turn, that meant that he has no money; without money, he cannot pay rent. A vicious circle. This is the kind of situation that usually results in a call being made to Dave or his colleagues. The nurse also expresses her disgust at the 'academics' that are left to decide where the money from the drug and alcohol fund is spent. She suggests that they should get in touch with the real world by getting out into the community and experiencing some of the problems faced, on a day-to day basis, first-hand.

Before we leave, Dave has a chat with the new arrivals to catch up on what has been happening in their lives since they last met. As this is the last call of the afternoon, we return to the Centre where Dave gives me a pile of literature and a couple of videos that he thinks will help me get a better understanding of the issues around substance misuse – my homework!

Day 4

08.45: I arrive at the Centre as arranged with Dave so that we can pick our client up from Morriston Hospital at 09.00. Dave is not there and I am told that he is stuck in a traffic jam caused by a motor accident.

09.00: Dave arrives at the Centre with a client in tow. John is in his 50s and he has a very serious alcohol problem. I can see straight away that John isn't doing well - he is breathless and having difficulty walking. Every few steps he stops to hold on to the wall until he can catch his breath. Dave brings him through to the staff room where I make us all a cup of coffee. As John tries to lift the coffee cup to his mouth, I can see how badly his hands are shaking. Anne, the Centre's financial manager, comes into the staff room to talk with John. She knows of him because he lives in her village. Dave takes this opportunity to tell me about the callout he had the previous night that has resulted in John being with us today.

Dave's local GP had phoned to ask if he would accompany him to the home of one of his patients who was in withdrawal. I ask if this is 'normal'. Dave explains that he knows the GP personally so, of course, the GP knows the line of work that Dave is in and was asking for a favour. When they arrived at the house, they found John lying on the settee in his lounge in a puddle of urine. There was urine all over the floor and the client had been to the toilet on the kitchen floor as well. They could see that John had attempted to clean this up but Dave said that only made the job more difficult! Aware of the dangers and pain associated with alcohol withdrawal - the shakes and the risk of fits - the GP gave his patient some diazepam to help reduce the symptoms and risks. Dave had cleaned up the mess and got the client settled for the night, promising to return to check on him the following morning.

09.15: Anne asks if Dave will be able to get the staff at Broadway Lodge to admit John today because he is so obviously ill. Dave says that he doesn't think they will be able to because no funding has been secured yet for John. However, Dave feels that at least an assessment will be done. Anne feels certain that the residential staff will not be able to turn a man away in this condition. Dave remains unconvinced. He explains that it doesn't only come down to what the staff feels is needed in this kind of situation. It is all to do with securing the funds. If the money isn't there (from the client's Local Health Authority Trust or Local Council), the patient doesn't get the treatment!

09.30: Dave can see that John isn't doing too well – he has the shakes quite badly. When Dave asks him how he's feeling, John says that he has a headache, feels hot and can't stop shaking. Dave asks him when he last took his medication and checks the dosage written on the label. He reminds John that he needs to take another dose. While we wait for the medication to take effect, Dave makes sure that the client understands why we are taking him to Broadway Lodge. Anne reminds Dave to keep an eye on the John in the car in case he starts to 'fit'. I have the feeling that Dave doesn't need reminding! We slowly make our way out to the car.

10.00: We arrive at Morriston hospital to pick up our female client, Sheila, whose assessment has already been arranged. She tells us that the nursing staff had told her that it was typical of a man to make a point of telling you to be ready at a certain time and then turn up late himself! Then she asks why we are so late. Dave explains that he had picked up another client to go up for an assessment as well. As soon as everyone is settled in the car we set off – in search of a garage for petrol! Dave's Sunday night call out has meant that he hasn't got around to filling the petrol tank.

10.15: The motorway traffic is really heavy, so progress isn't as fast as we would like. During the journey, John seems to be very confused and disorientated and needs constant reassurance that everything is going to be all right. Sheila seems really calm and is very chatty. She talks a lot about her past, and her relationship with her ex-husband and children. During the drive, Dave shares some of his awful jokes with us – this journey feels as though it could go on forever!!

12.15: We arrive at Broadway lodge more than an hour late! Dave parks the car close to the entrance so that John and Sheila don't have too far to walk. The Lodge is an impressive building that looks like an old manor house, set amongst beautiful gardens and surrounded by woodland. Once inside, we are shown to the waiting room and offered tea and coffee that we all gratefully accept. Several staff members stop to chat with Dave, some to enquire how former patients are doing now. John becomes agitated and asks Dave if he can go outside - he needs a cigarette. Dave asks if Sheila and I will be okay until he gets back. We tell him we'll be fine. Within minutes, Sheila is called through for her assessment with the resident doctor. This assessment will take about an hour and will cover the client's health,

life and drinking history. It will also assess the client's commitment to a change in lifestyle and is an important step on the road to recovery. Dave and John return just as one of the counsellors comes in to verify the time of John's assessment – about 14.30pm. After about 15 minutes, John becomes restless again and says that he needs a breathe of fresh air so Dave takes him back outside. They are back within 10 minutes – it's raining. John asks when we can leave. Dave explains that we have to wait until Sheila's assessment is finished and that John also has to see a councellor. John goes quiet for a while but then starts fretting because he only has two cigarettes left in his packet. Dave tells him that he will get him cigarettes from a garage on our way back home. This pacifies John for all of ten minutes!

13.30: John wants Dave to get some cigarettes NOW, so they set off to find a shop. As I'm there, Dave is able to leave Sheila. Five minutes later, Sheila's assessment with the doctor comes to an end and she tells me that she now has to wait for an interview with the admissions' officer who will explain the treatment plans and check financial details. Sheila begins to cry. When I ask her what is wrong, she says that a lot of the questions asked by the doctor were very personal. She hadn't realised that she would also be expected to talk about her childhood. These questions had made her realise that she had never been 'good enough' in her mother's eyes. She went on to tell me about her childhood and her relationship with her parents.

13.45: Sheila is called in to fill out the necessary forms for her admission. No sooner has she been called than Dave returns. John is sitting out in the car. He's finding it too claustrophobic in the waiting room. I tell Dave that Sheila is now having an admission's assessment, which will also take about an hour. Dave asks me if I would like a guided tour of the ground floor of the Lodge and the grounds. As well as being nosey, I am also grateful for a chance to stretch my legs. Dave shows me the reception area, the kitchens, dining rooms and conference/classrooms. Outside, we take a walk through the car park (stopping to tell John where we are going) and down around the back of the building. The garden here is landscaped and set in tiers. On each tier there are chalets that provide the living accommodation for clients during the second stage of their rehab programme. At this stage, the clients are learning to be independent so they are responsible for looking after their own money, buying and cooking food and keeping their accommodation clean. Our walk continues up and around the other side of the main building where we discovered a pond complete with a water feature and a sheltered seating area - absolutely beautiful. All in all, this seems to be an idyllic place to start the road to recovery.

14.15: We are back in the car park and make our way to check on John. He's still sitting in the car having a cigarette and immediately asks what time we will be going home. Dave tells him that he needs to go back inside first to wait for his assessment. The three of us take a slow walk back to the waiting room, stopping every now and then for John to catch his breath. Dave reminds John that it is time for him to take his medication. John asks why he has to have an assessment. Dave explains again that the assessment is needed to get John onto the rehab programme at the Lodge because if he doesn't stop drinking very soon, he will end up dead! John agrees but, obviously confused, says that he can't stay here, as he doesn't know his way home. Dave patiently tells him not to worry, as when the time comes for him to go home after the treatment, he will be well enough to get a bus or the train. John says that he can't do either of those things because he doesn't have any money and he doesn't know where the station is. Dave says that there is no need for him to worry about that right now because we are talking about admission in a couple of months time. John is now really confused and tells Dave that he can't stay here for a couple of months because he needs to go home. Dave patiently explains that John is only here for an assessment today and then we will be taking him home. John says he doesn't know where

the bus stop is and Dave tells him again that he doesn't need the bus today, as we will be taking him home in the car. One of the lodge's counsellors sits down for a chat with Dave. She tells him about a trip she and one of her colleagues made to Gibraltar to help with the opening of a rehab centre there. Previously, some of the Gibraltar centre's doctors had spent time at Broadway Lodge to pick the staff's brains. As part of this 'help', she had given a talk on how to get funding. She later discovered that they didn't have to worry about funding because their government covered all the costs! Dave said he wished the day would come when we didn't have to worry about funding in this country either. The counsellor calls Dave and John in for the assessment.

14.40: Sheila's second assessment of the day is over and she returns to the waiting room. She seems much happier now and says that she is looking forward to starting her treatment now that she has seen the centre and met some of the staff.

15.00: Dave and John return to the waiting room and we all make our way to the car. Dave decides to take a drive down to the pier before we start our journey home. It is intended to relieve the stress and tension of the day, but it is cold, grey and dismal and no one wants to get out for a walk! John is totally disinterested and tells Dave it's all very nice but he wants to go home. The journey home turns out to be a very long one. We get caught up in three very long traffic jams. John remains on edge and shakes throughout the whole of the journey. Sheila is calm, communicative and alert. The physical and mental conditions of John and Sheila, are poles apart.

18.00: We finally arrive at Morriston Hospital. We leave John in the car while we settle Sheila back on the ward. She tells Dave that she needs him to get a backdated sick note from her GP, as the hospital can't supply the one she needs. Dave tells her he'll get on to it first thing tomorrow. We take John back to the Centre.

18.30: Back at the Centre Dave makes us a cup of coffee and reminds John to take his medication again. Dave asks John if he would like to go to an AA meeting at 7.30pm, reminding him about the great support he will receive there. John agrees, but without conviction. Dave asks him how he feels about going into Broadway for rehab but John is still worried that he won't be able to get home because the Lodge is so far away. Dave goes to check his messages while John and I finish our coffee.

19.00: We all leave the Centre, me to go home whilst Dave and John are going on to the AA meeting. As I drive home, recollecting the events of the day, I marvel at Dave's patience and consideration. His reassurance to John was repeated many, many times during the day. I'm still not certain that John will remember why he went on the trip. But with Dave's support and supervision, John has got through a particularly bad day and hopefully has made a start on the road to recovery.

Day 5.

09.00: Dave starts the day by returning a phone call from Colin's parents. They want Dave to know that their son is talking about going back to work! Dave promises to go and have a chat with him. The next phone call is to Dan's GP to chase up the assessment/referral letter, followed by a phone call to Sheila's surgery to ask for a backdated sick note to be written up.

10.15: This morning the clients are given the choice of either going to the allotments or swimming. Most opt for swimming, leaving five clients (two female, three male) who want to do some gardening. I feel a bit disappointed that so few want to visit the allotments (could 21 this be because it is raining!) and even wonder if it is worth going. Dave puts me

in charge of the mini-bus, whilst he follows in the car. Dave explains that there must be a car at the allotments in case of an emergency. Brian, who is visiting the allotments for the first time, asks me where it is, what it's like and what he will be expected to do there. The ladies on the bus have soon given him all the details.

Dave arrives about five minutes behind us and has two more clients in tow. First order of the day is to get the kettle on. Terry volunteers for the job. He gets confused over who is having what and it takes several minutes before he understands that five are having coffee and two are having tea. We can hear him repeating over and over "five for coffee and two for tea" but he still manages to serve up five coffees and three teas! Somehow I manage to get the blame, but I remind him (tongue in cheek) that he has to take responsibility for his own actions. Coffee break over and Dave soon has everybody up and working. Gill and I are dispatched to the strawberry bed. We put hay down to help keep the strawberries dry and do some weeding. Marge is on greenhouse duty, tying up tomato plants and pruning. Brian is putting down fertilisers for the vegetable crops, whilst Ed, Andrew and Dave are also busy weeding. Terry is busy washing up the coffee cups in readiness for the next coffee break.

As we busily tend the strawberry bed, Gill asks me what it has been like working with Dave. I tell her that it has been really interesting and extremely busy. She says that if it weren't for Dave dragging her to an AA meeting over a year ago, she wouldn't be here today. For months previous to that she had stayed in her house drinking until she couldn't stand. She rarely ventured outside her front door. In fact, she shudders to think of the state she was in when Dave literally carried her to that meeting. Now, she takes part in many of the Centre's activities, including the allotments and the IT Training. The sun comes out just as another coffee break is called for and this time Terry has the tea/coffee ratio right. Brian tells Terry that he is sure that he knows him from somewhere but can't figure out from where. After some deliberation, they work out that they used to drink in the same pub years ago. Brian says that he can't believe how much weight Terry has lost since he last saw him. They then catch up on each other's lives. Andrew asks Dave if he can make an appointment with him for this afternoon for some help with a benefit problem. Coffee break is almost over and Dave decides to show us a magic trick. This involves a glass jar, a thin circle of rubber and a coin. Dave asks if we believe that he can make the coin go through the rubber and into the jar without tearing a hole in the rubber? No one believes he can do it, but "Hey Presto" one minute the coin is resting on top of the rubber and the next it is in the jar! Dave's tricks are more Tommy Cooper than Paul Daniels but they get everyone laughing. Dave says that he'll show me how to do that trick on my last day at WGCADA. "Oh, but that won't be happening now," he says with a wide grin, "because you're going to become a volunteer, aren't you?" Back to work and Dave explains about the different types of fertilisers that are available. He tells us which type should be used for leaf growth and which should be used for root strengthening. Impressed, I ask him how he knows all this stuff and he says that he's picked it up from the gardening programmes on TV! When he finds the time to expand his encyclopaedic knowledge by watching TV is beyond me. There is still some watering to be done, slug pellets that need to be put down and coffee cups that need washing, so we all busy ourselves with these various tasks. My gardening tasks completed, I join Dave who is sitting having a chat with Brian and Andrew.

Brian is telling Andrew about his recent detox, voicing his fears about getting 'clean', staying 'clean' and getting his life back in order. In an effort to help Brian, Andrew shares his 'drinking history' that includes his own brush with death little more than a year ago. His abuse of alcohol over a period of many months had led him to lose his business, his girlfriend and even more importantly, his health. Dave joins the conversation and says that he remembers how ill Andrew was and how the doctors thought he would not survive. Dave recollects how swollen Andrew's stomach was and the numerous tubes that were going in

and out of his body. Looking at Andrew today, you would never guess all that he has gone through. His life is back on track; he is sober, looks healthy and is holding down a responsible job.

13.15: It's time to start packing up before we return to the Centre. Dave asks if anyone wants to pick any lettuce, spring onions or cabbage to take home. Both ladies do and comment that it's a pity the tomatoes aren't ripe because then they would have all the makings for a salad. Dave turns to me and asks if I know how to make a sweet and sour sauce in less than five minutes. I tell him that I usually use a tin of tomatoes, a tin of pineapples and some cider vinegar, but it takes a bit longer than five minutes to cook. Try tomato sauce mixed with orange juice, put it in the microwave for a couple of minutes and there you have it, says Dave. Another handy tip he got from the TV! Marge, who hates cooking, says it's even easier to buy it in jar but this little diversion by Dave has released the emotion and seriousness of the earlier conversation I have really enjoyed my morning at the allotment. The smaller group meant there was more of a chance to get to know the clients on a one-to-one basis. I can now understand why Dave hasn't rushed to put another worker in charge of the allotments. The time he spends there gives Dave a chance to get away from the hustle and bustle of his usual working day and at the same time provides him with a more relaxed setting to interact with his clients and on an individual basis, if necessary.

13.45: The centre is very busy. The clients for the IT class are there along with the clients returning from swimming and the allotments. The laptop computers are already being set up ready for the IT lesson. I chat with some of the 'swimmers' to find out how their morning has gone. They tell me that they had a great time at the Leisure Centre, but it was a little too packed to actually do much swimming.

14.00: The IT class begins and I go to the Centre's library to get some information on drug rehab. Dave checks his messages, prepares for his afternoon appointments and returns phone calls.

15.00: Jackie is Dave's first appointment of the afternoon. She needs some help filling in a Disability Living Allowance (DLA) claim form - that would be better described as a booklet, to ensure that this benefit will be paid for the next twelve months. She is a single parent whose child has recently been allowed back home after spending some time in care whilst Jackie was in treatment/recovery. Jackie hasn't drunk alcohol in over a year but she suffers from stress and severe panic attacks. The form presents a challenge to her. Dave guides her through it, advising her on the parts she has to complete and those that do not apply. Although providing the interpretation of the form, Dave makes sure that Jackie uses her own words to complete the various sections, including her description of her illness. She manages to complete most of the form herself but needs Dave to show her the parts of the form she needs to fill in.

15.30: Andrew asks Dave if he will phone the Department of Health and Social Security (DHSS) on his behalf. Andrew has an ongoing problem with his benefit payment. The DHSS have reduced his weekly money because they think he has savings. On four occasions, Andrew has taken his bank statements to show them that he has no money saved. On one of the occasions, Dave accompanied him. After each visit, a letter has followed from the DHSS asking for the proof yet again! Andrew is now at the end of his tether. He is too frightened to phone the department himself in case he loses his temper. Dave makes the phone call and outlines the saga. Dave is told that the bank statements will have to be shown once again and an appointment is agreed. Dave tells Andrew that he will meet him outside the DHSS building at 08.30 the following Monday. Andrew explains his problem.

Twelve months ago, he did have a lot of money in his bank account but that was before he drank it all away. The DHSS officials were having difficulty believing that anyone could spend that amount of money on alcohol in such a short time and wanted to see receipts. Of course, there are no receipts to show!

16.00: Dave's next client is a young man in his early 20s called Billy. He wants to get on to a detox and rehab programme as quickly as possible. He has been using heroin and cannabis and takes dihydrocodeine (DF118) daily because of back pain. He also admits to having diazepam. Billy says that he has let his mother and his girlfriend down by going back on the heroin. Dave asks him what made him do it and he says he was just bored and that he'd only 'done the one £5 bag'. Dave asks if that was just the 'taster' from the drug dealer to get him back in? Billy says no, it was just the one bag. Dave asks Billy how often he smokes cannabis and he says that he only has it every now and then. Dave asks about the DF118's, can he stay off them if he gets accepted onto a detox programme? Billy says he can't because he has too much pain with his back. Dave asks how many diazepam he takes, but Billy says he doesn't use them because he can get a fiver a go for them if he sells them on. Dave asks him again how much heroin he has used and he now admits to using on three separate occasions. Dave asks him what makes him think he's ready for rehab? Billy says that he's got to do it or his girlfriend won't have anything more to do with him and he doesn't want to let his mother down again. Billy is now becoming very fidgety and the sweat is running down his face. As he wipes his brow, he says how hot he's finding it in the room. The temperature in the room is actually quite comfortable. I suspect that the young man is starting to experience 'withdrawal'.

Dave's questioning continues for about 20 minutes, going over and over the same questions. At first, I find this quite tedious and wonder what Dave is playing at. Then it becomes obvious. As the questioning continues, the amount of heroin used goes up. Young Billy loses track of his story under the continuous probing. Finally, Dave agrees to get Billy into a counselling session at the Centre the following week. He warns Billy that he will have to prove to his councellor that he is ready to commit to detox/rehab. Billy's mother had brought him to the centre and is waiting for him downstairs. Whilst Billy is talking with some of the other clients, she takes Dave aside. She expresses her concern about the amount of heroin that her son has been using and asks Dave if he had seen the fresh 'tracks' that were covering both arms. He tells her that he will arrange for Billy to start treatment at the Centre next week. After they leave, Dave expresses his concern over Billy's reasons for seeking help. Dave feels that, unless Billy wants to get well for himself, his chances of successful recovery are slight.

16.30: Suzy is Dave's last client of the day. She is a single parent in her late thirties and is a recovering alcoholic in the early stages of treatment. Suzy has two sons, one of whom lives at home. She has come to Dave hoping he will be able to help her claim benefits for her 17- year-old son. Her son had been on a full-time college course until he broke his hand. Whilst he was in fulltime education, she was entitled to receive DHSS benefits for him. As he had been out of full-time education for so long (six months), the DHSS had asked for her books to be returned so that the benefit for her son could be deducted. Suzy's son is hoping to go back to college in September but meanwhile she needs money to support him. Dave explains that the boy will need to sign on for one of the youth employment schemes in order to get any money. She says that he isn't fit to work at the moment because he is suffering with depression and has recently tried to commit suicide. Dave asks if her son is receiving any medical care. She explains that he had been seeing a psychiatrist. After the psychiatrist had diagnosed that the boy's problems were related to him being a closet homosexual (which they weren't!), the boy had refused to go back.

Dave makes a phone call to the DHSS to see if there is any way that the benefit can be reinstated. The DHSS contact confirms that the boy needs to sign on for the youth employment scheme. Never one to be beaten, Dave suggests that we get out the Centre's reference files on benefits to see if we can come up with a possible solution. A section is found in the benefit file that seems to fit the young man's circumstances. We print a copy off for the client to take to the benefits office to help her make the claim. Dave reassures the client that he will accompany them if they need support.

17.30: Dave and I have a much-needed coffee break. Bob, one of the Neath WGCADA workers, is visiting the Centre. Dave asks him about John accessing the service in Neath, rather than having to travel over to the Swansea Centre. Bob has already heard about John. He will make sure that their Centre worker calls on him to encourage him to use the Neath facility.

18.00: Dave is returning to his desk to set about his usual end-of-day routine, returning phone calls and updating his diary. As it's the end of my five days of observing, I thank him for the co-operation, insight and patience he has shown me during our time together. Dave has the last word. "If you need more information, get in touch," he says and adds, "Come and see Norman about volunteering. I've already had a word with him. See ya, kid."

Conclusion.

'Shadowing' Dave was decided to be the best way of seeing what his job entailed. For continuity, sharing the experience in a diary format was felt to be the best presentation of this Community Drug Worker's 'week.' So, how has my time at WGCADA changed how I view the 'addict' and the services provided to aid their recovery? Although I am not a professional drug worker, I have never shared the stereotypical view of an alcoholic or drug addict; 'The dirty old tramp or bag lady wandering around town, begging for money and sleeping rough,' or; 'The high school drop out who spends all his money on drugs, taking from society and giving nothing back.' However, I was surprised at the many different walks of life that substance misuse affects. From your school dropout - to the top professionals. From young parents to old age pensioners. From the tramp living on the streets to the person living next door to you! Alcohol/drug addiction is a complex condition involving mind, body and spirit. The difficulties for health practitioners and support workers are compounded by the fact that people who abuse alcohol and/or drugs often present with other intimately related problems, e.g. no home or job, poor physical and mental health, history of criminal activity. Furthermore, research has shown that rates of relapse as high as ninety percent occur among treated populations. This finding further highlights that the key to successful recovery from addiction is not simply the addict stopping taking drugs, but rather the relationship between abstaining and the addicts ability to stay abstinent.

I was surprised to learn that the continuation of Dave's post as the Community Drug Support Worker is subject to WGCADA gaining sufficient funding annually. This situation is not just WGCADA's problem; it is a national problem. The short-term funding for drug workers is inadequate considering the long-term problem that substance misuse presents. Alcohol Concern recently estimated that alcohol misuse is costing the National Health Service alone up to £3billion a year. A similar amount is lost to the economy through absenteeism, unemployment, accidents, premature death and alcohol related crime. A report released earlier this year by the Home Office stated that drug abuse in England and Wales costs society up to £18.8 billion a year. This cost is incurred by crime, bringing offenders to justice, welfare benefits and costs to the National Health Service. Ninety-nine percent of this £18.8billion has been attributed to hardcore heroin and cocaine addicts. It has been estimated that hardcore heroin addicts and other problem drug users cost Britain approximately £11,000 a year each.

The problems with alcohol and drugs affect us all and society as a whole needs to wake up to the fact. The UK's drugs minister recently stressed the importance of treatment schemes and reiterated the findings of research – that treatment does work. It is through the successful treatment that not only the judiciary and health service practitioners benefit but the recovering addict, their friends and family also reap the rewards. Furthermore, society as a whole greatly benefits by the reduced costs that recovering substance misusers present. I think there will always be the ones we call 'the no hopers', For whatever reason, they appear unprepared or not ready to do the hard work that would be part of their road to recovery. BUT, with agencies like WGCADA there to offer all manner of help, advice and support, I truly believe that there is even a chance for the 'no hopers'. The problem will never go away until we are all prepared to do something about it. I know Dave and his colleagues won't give up trying, but what can you do to make a difference?

Think about it.
Cheryl Hancock

8.4. Appendix D: Principles of effective treatment: what we know

Research has shown key principles that facilitate the provision of successful treatment and it is worth looking at these briefly so the reader can refer back when reading about the approaches adopted by WGCADA. We detail the major points raised by the European Association of Treatment Agencies (EATA) in their document "Rehab - what works? 20 things you should know about rehabilitative treatment for substance dependency". We describe the principle and have added some additional lines from the report because we consider them particularly pertinent to our profile.

1. Rehabilitative treatment works

"However, it is essential that people are referred to the right type of treatment. Further, not all services are equally effective - many could be more effective than they are, and some, in spite of the very best intentions, may even make matters worse."

2. Treatment should be readily available

"The harder it is to access treatment and the greater the hurdles placed in the way of potential treatment applicants, the greater the proportion of people who will fall by the wayside before they get a chance to take up any available treatment opportunities."

3. 'Low motivation' should not be a barrier to treatment

"It is often assumed that treatment must be 'voluntary' to succeed and that it will only be effective for those who are highly motivated from the outset. In fact, outcomes do not appear to be related to pre-treatment levels of motivation, and external pressure from families, employers or the criminal justice system can actually enhance treatment effectiveness. It is unnecessary and counter-productive to restrict access to those who are deemed to be self-motivated, and motivation to change and maintain change can be enhanced through treatment."

4. If at first they don't succeed...

"Substance dependency is often described as a 'relapsing condition'. Many people, perhaps even a majority, relapse after receiving treatment – but even a number of previous 'unsuccessful' treatment episodes should not be a bar to further treatment. Many people require a number of attempts before they finally overcome their dependency and there is evidence that even an apparently unsuccessful treatment episode can still contribute towards someone overcoming their dependency in the longer term."

5. Abstinence and controlled use both have their place

"For some people with less severe problems, controlled use can be a viable and appropriate treatment goal. Controlled use is rarely sustainable in the long term, however, for people with severe dependencies."

6. Approach should reflect clients' beliefs and expectations
"Taken overall, the available evidence shows that no one theoretical approach yields treatments which are more effective than any other. There is evidence that some approaches may be slightly more effective overall for particular categories of client, but it

would appear the most important consideration in this regard is the client's own views & beliefs, and these should be taken into account wherever possible."

7. Treatment should be based on the individual's needs
"The length of treatment, setting, approach, range of issues addressed, use of medication etc should be tailored to the individual, based on a clear assessment of the individual's needs and expectations. Clients are not a homogenous group and a standard, one-size-fits-all approach is of limited value and may actually make matters worse. People's needs can change during treatment and treatment plans should be continually reviewed and updated where appropriate."

8. Treatment should seek to enhance motivation & self-efficacy
"Many clients' attempts to overcome their drug or alcohol dependency founder because they do not have the motivation they need to make and maintain the changes that are required. Similarly, many clients have very little confidence in their ability to change, and this also undermines their likelihood of success. Both motivation and self-efficacy can be enhanced through treatment and should be a central focus of treatment programmes."

9. Treatment should address unhelpful attitudes and beliefs
"Many clients have a range of unhelpful attitudes and beliefs which, if left unaddressed, will undermine their long-term chances of overcoming their dependency. Common examples include - 'I can't have fun without using', 'I need to use to cope with life' etc. Efforts should be made to uncover and address problematic attitudes and beliefs, although care should be taken to ensure that they are tackled in a non-confrontational way."

10.Relapse prevention is an important element of treatment
"Practical skills training for avoiding and coping with situations which might otherwise lead to a lapse can improve long-term outcomes. Exploring how a client might respond to a lapse in order to minimise the risk of it leading to a full-blown relapse can also be helpful."

11.Treatment must address associated contributory factors
"As well as focusing directly on clients' substance use, any medical, psychological, social, vocational, and legal problems which the client might have and which would otherwise increase the probability of relapse should also be addressed."

12.Co-existing psychiatric disorders should be addressed
"A full assessment should look for evidence of any psychiatric conditions, and where this is found treatment should focus on both the client's substance use and their mental health problems in an integrated fashion. Services should draw on specialist psychiatric support as required."

13.A supportive, non-confrontational style is most productive
"Whilst it is important to avoid collusion and to challenge manipulative and inappropriate behaviour, research demonstrates that a confrontational style may be counter-therapeutic and less effective than approaches which focus on internalising motivation for change."

14.Client engagement & completion rates should be maximised
"High client engagement is generally associated with high completion and good long-term outcomes. Factors associated with high engagement include: clear and explicit treatment plans, positive relations between clients and counsellors, high levels of client confidence in the treatment service, broad range of high quality ancillary services, and in-house provision of transport for those who would otherwise have difficulty attending treatment."

15.Treatment length matters, but…
"Overall, the longer people remain in contact with professional services the better their outcomes are likely to be, and there is some evidence to suggest that a total treatment length of less than 90 days is of little value with severe drug dependencies. However, even very brief interventions can often be of benefit, especially in the case of less severe dependencies."

16.There is a role for both residential & day care programmes
"Structured day care programmes can be highly effective and may be the setting of choice for many people."

17.Medication can enhance long-term outcomes
"There is evidence that, though they are of limited benefit on their own, pharmacological interventions can complement rehabilitative treatment and enhance outcomes … Where co-existing psychiatric conditions are present, appropriate medications for these conditions can be critical to outcomes."

18.Self-help groups & professional aftercare improve outcomes
"Intensive treatment, whether in residential or day care settings, should be followed-up with on-going professional aftercare. Without such follow-up, treatment is likely to prove of limited value. While it should not be seen as a substitute for professional aftercare, attendance at self-help groups can significantly enhance outcomes."

19.Treatment staff are key
"Treatment staff are central to the success of treatment. Research shows that staff should be well trained, closely supervised, confident in their work and empathic towards their clients. A high staff : client ratio is important, as is close support and supervision. Whether or not counsellors have themselves had a drug or alcohol problem appears to have little bearing on their professional abilities. However there is some evidence that a staff team which brings together counsellors who are in recovery with others who have no history of problematic substance use can be particularly effective."

20.Good organisational standards are essential
"It is important for a treatment service to have high organisational standards … Services with poor organisational standards are likely to have poor outcomes, no matter how good the staff or how well designed their treatment programme."