Mind in Camden

MINOR TRANQUILLISER PROJECT
Service Review
1st Jan 2011 – 31st December 2011

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1. INTRODUCTION

Mind in Camden has been running the Minor Tranquilliser Project since 1988. It is open to all individuals aged 18 or over who are registered with a GP in Camden or Islington. We receive a block contract from Camden PCT with a total value of £48,425 per annum which includes part NHS funding and a £12,120 contribution from Islington. The service is delivered from Mind in Camden offices at Barnes House, 9-15 Camden Road, London NW1 9LQ.

It is a free and confidential service, which exists to support individuals who experience or have experienced difficulties due to their benzodiazepine use. We endeavour to help people withdraw at a sustainable pace, support people after withdrawal and educate GPs and patients about alternatives to prescribed medication. The helpline and support group also provide support for our clients' partners and relatives. The project is open five days a week, providing a variety of different services, with the ethos being harm reduction and client centred. The services are non-judgemental, specific and based on a therapeutic relationship.

Benzodiazepines are the most commonly prescribed drug in the UK and are also known as Minor Tranquillisers or sleeping pills. They are sedative drugs prescribed by doctors to reduce anxiety, to promote sleep or act as a muscle relaxant. They are also used illicitly to offset the effects of stimulant drugs such as cocaine, or with other depressant drugs such as alcohol and heroin. Our client group is drawn from those who are prescribed this medication, those who take it illicitly, and those who use it in combination with other drugs.

Benzodiazepines can relieve the symptoms of stress and anxiety and promote calmness, relaxation and sleep. They may soon become ineffective in doing this after as little as two weeks. Some users experience drowsiness, forgetfulness and confusion when taking these pills. Physical dependence can occur with users needing to take a larger dose to get the same effect. Withdrawal symptoms can last for months and may include anxiety, insomnia, nausea, panic attacks and occasionally convulsions. Some clients experience protracted withdrawals which leave them suffering symptoms for up to two years. Therefore dependency can be a difficult and lengthy process to reverse, should the user wish to embark on withdrawing from these drugs.

The service has for the last year been working with the Department of Health as a member of a 'round table working party of benzodiazepine experts'. This is intended to lead to a 'consistent and excellent' national service for people who take benzodiazepines. We have contributed to the development of national policy through

- a visit to MTS by a senior DOH policy advisor.
- attending a round table event with the minister for public health.
- liaison with the all party group for tranquilliser addiction (to lobby for specialist withdrawal services nationwide).

2. AIMS AND PRINCIPAL SERVICE OBJECTIVES

Referral Criteria

In order to be eligible to use the service a person must:

- Live in the London Borough of Camden and Islington.
- Be aged over 18.
- Be an existing, recovering, past or potential users of prescribed benzodiazepines; carers, friends or relatives of a Minor Tranquilliser user; or using Minor Tranquillisers illegally/illicitly or in combination with other drugs.

Principal Objectives

To provide safe and supportive interventions that enable service users to discuss the problems caused by benzodiazepine addiction. To promote harm minimisation, reduction in prescription and self-management of their condition.

Outcomes for service users

The service aims to improve the client's quality of mental health and life by means of:

- Stabilisation of drug use and compliance with the therapeutic dose.
- Reductions in drug use.
- Becoming drug free.
- The achievement of informed choice.
- Decreased side effects and withdrawal symptoms.
- Decreased isolation.
- Decreased risk of suicide or other self-harm.

3. WHAT THE SERVICE PROVIDES

- A telephone helpline/drop in. We ensure that the implication of any advice given is clearly explained to enable clients to make their own decisions and choices.
- Support groups facilitated by skilled group workers.
- Formal one to one confidential counselling support in weekly sessions, free of charge, either short term (12 weeks) or long term (up to one year) - a waiting list operates.
- Escorts and advocacy (accompanying clients to their GPs/psychiatrists or drug services and writing letters of support on withdrawal, prescriptions/benefit tribunals etc).
- Advice and information (factual information on the drugs themselves, safe ways to reduce, how to stabilise their use, as well as written materials produced by ourselves and other drug agencies/medical sources). The information is current, accurate and accessible. It is provided in a variety of format, styles and languages to reflect the local community.

Service Philosophy

- We are client centered. We believe that clients are best able to control and make choices about their own behaviour and so we exert no pressure on clients to come off drugs, although we do encourage them to do so. We offer information to make clear the problems created by long-term benzodiazepine use, and the necessary sympathetic support, empathic engagement, and encouragement to reduce dependence upon, or withdraw altogether from Minor Tranquillisers, should the client decide to do so.
- We aim to help clients cope with and take control of their dependency through well structured counselling. We believe that workers play a key role in motivating clients to persevere. We promote an empathic and understanding attitude and use activity based approaches, e.g. practical ways of making withdrawal easier, medication reviews to see if this is being adhered to, as well as analysing and discussing sensitively clients' emotions. Specific strategies are employed to build motivation and strengthen commitment to change with the emphasis on enhancing client confidence.
- Our clients come to us having experienced between them a wide range of treatment philosophies. Our client-centred policy is to work with, rather than against, all these various approaches. We adhere to a harm reduction model. This means that we address and help clients to manage the problems, which surround their drug use, such as crime, housing, benefits etc. as well as helping them to reduce drug use per se. Due to the impact of benzodiazepines on the body, complete withdrawal from use of the drug suddenly is medically dangerous and inadvisable. We work with awareness of this knowledge.
- We place the treatment of problem drug users within the scope of psychotherapeutic techniques. By offering a psychosocial interpretation of the users' behaviour, we facilitate a multi disciplinary approach. Different weight is given to different psychological or social factors when assessing each client.
- To help people achieve improvement, we offer a choice of services, rapid intake, proactive reminders and help to attend services, over a long period of time.

Staff Supervision, Support and Development

- Supervision and appraisal is provided in accordance with Mind in Camden's Supervision and Appraisal policy.
- The Minor Tranquilliser Manager is directly supervised by the director.
- The Minor Tranquilliser Manager, sessionals and volunteers have access to Mind in Camden's internal training and also external training as identified in an individual training needs assessment. There are appropriate levels of training for sessionals and volunteers.
- The Minor Tranquilliser Manager has fortnightly supervision with an external counselling supervisor and also benefits from membership of the London Drug and Alcohol Network.
- We create an open and welcoming environment for sessionals and volunteers.

Information Sharing

We have information sharing protocols between agencies and users sign a form to allow information to be exchanged. Information on service users is shared within the project on a need to know basis in line with Mind in Camden's confidentiality policy. We inform users GPs when they are receiving formalised counselling from us.

Service Users' Responsibilities to the Service include:

Observing behavioural rules, as defined by the service (e.g. not using alcohol or drugs on the premises, not sharing medication, treating staff and service users with dignity and respect, observing diversity and no smoking policies).

Exclusion criterion

The service will seek to accommodate as wide a range of need as is practicable, however, where absolutely necessary to ensure the wellbeing of other service users and the best use of resources, the following exclusion criterion applies:

- People not using, or who have not used, Minor Tranquillisers or 'Z' drugs
- People who are not currently in a position to engage in one to one counselling or group work due to behavioural difficulties (e.g. incoherent communication, extreme hyperactivity)
- People who may put the recovery of others using the service at risk – e.g. people dealing or otherwise supplying drugs illicitly, or who have a recent history of physical or verbal abuse in group settings

There may be occasions where people can only use a part of the service e.g. they may be excluded from the group due to recent patterns of abusive behaviour towards vulnerable people, but could still access the 1-1 counselling service.

4. HOW THE SERVICE OPERATES

Service Environment

Our service is easily accessible. The project is provided with an office at Barnes House where it is possible to meet with clients, carry out counselling sessions and supervise workers. Literature is available in the office to clients, their family and friends as well as to the wider community. The project also has an allocated time space in this office for counselling clients, and the Helpline/drop in two afternoons weekly. Clients' files are kept in a locked filing cabinet and a fax machine can be accessed in the

adjoining admin office. An upstairs room is used every Thursday evening for the weekly support group. Should extra space need to be made available, there is the option to use counselling rooms at MIC's premises at Swiss Cottage.

Accidents and incidents are recorded in an accident book and any necessary action taken. There have been no recorded incidents since the last report.

Office Accessibility

- The office is currently not accessible for service users who are unable to climb the flight of stairs in the entrance of Barnes House (8 stairs). However, arrangements can be made to have meetings in the day centre building, which is on the ground floor, if necessary.

Workplace Composition

The Minor Tranquilliser Service Manager provides management support to the service. The service also receives the support of the Administration and Finance teams. The Minor Tranquilliser Service Manager is provided with a job description, outlining her role, responsibilities and duties.

* Sessional = worker paid on a sessional basis.

Staff	Hours	Meetings/Supervisory
Service Manager – Melanie Davis	Currently funded to work p/t 28 hrs weekly	Included in the working hours
*Sessional Workers – 3	2.5 hrs weekly – group facilitator 1 hr weekly sessional counsellor doing initial client assessment 1 hr weekly – counselling supervisor	Additional unpaid hours of meetings/supervision totalling approx 1 hr a week for the group facilitator and assessment counsellor
Volunteers – 3	A maximum of 12 hours a week shared between these volunteers, counselors on p placement and one admin worker/group cover	Additional meetings/supervision totalling 1 hr a week per volunteer

Cover Arrangements

In the absence of the service manager, sessional workers and volunteers report to the director. No cover has been arranged for the long-term absence of the service manager since it hasn't occurred in the time of the current manager. The service manager covers for the volunteers and sessionals when they are off sick or on annual leave if no other volunteers or sessionals are available.

Group

A sessional worker and the service manager take the group as facilitator and co-facilitator. If either is unavailable, a volunteer is asked to cover. For last minute cancellations and unforeseen circumstances, a trusted group member is asked to help lock up and assist with the practical tasks of the evening. The group is cancelled if it means there is lone working.

Helpline

The service manager operates the helpline/drop in.

Counselling

Short-term absence of counselling results in cancellation of the session. Long term, provision would be made to change to a different counsellor. Every effort is made to allow clients to finish with the counsellor they began with. If a counsellor leaves, then they attend in the evenings to complete the sessions.

Counselling and Project Supervision

This takes place fortnightly for two hours with an outside counselling supervisor and all of the team in the service attend. A log of client sessions is kept by each counsellor and the clinical supervisor signs these once a year. The supervisor keeps a log of counsellor attendance to ensure that baseline supervision is adhered to.

Usual Criteria for Placement Counselling Volunteers:

1. Have already completed a diploma in counselling skills and theory (1 year)
2. Presently attending a Diploma in Counselling (which is approved by BACP for accreditation purposes - usually 2 years) and to be in the second year or final year of this course
3. Presently be working in the field of personal therapy (a requirement of any approved course)
4. Be willing to attend clinical supervision and take responsibility for their practice
5. Abide by BACP ethics
6. When we are providing placements for trainee counsellors, we liaise with the training organisation concerned, to ensure practice guidelines are in place and adhered to and that the training organisation has assessed the trainee counsellor as being ready to work with clients. With the introduction of the CORE system, our experienced sessional counsellor conducts the initial assessment with the client.

Criteria for Sessional Worker Assessment Counsellor:

1. Have completed 1, 2, 3 above
2. Agree to 4, 5 above
3. Be accredited with BACP or registered with UKCP or be presently applying for accreditation with BACP within time limit ……(150 hrs year)
4. Willingness and ability to carry out the CORE assessment system

Management Supervision

The Manager meets with new volunteers after 3 months in the post. After that, each sessional worker and volunteer is seen for management supervision every 6 months. Informal supervision takes place on a weekly basis.

Advisory Meetings

Our advisory meetings take the place of team meetings. We meet every two months for an hour to look at ways forward for the project and discuss more practical and organisational matters than in the counselling supervision.

Purpose of the Advisory Group

The advisory group is accountable to Mind in Camden's organisational management and policy, but authorised to advise the project. The group also provides an authoritative forum for issues facing the project including matters relating to the content of the service i.e. admin, structure, day to day management, staffing etc, as well as matters relating to the subject of the project e.g. drugs, preventive work, educational materials. It is a forum for consultation of policy and practice and both are reviewed here.

Composition of Advisory Group

The group comprises all current volunteers, sessional workers, the Minor Tranquilliser Service Manager, the director, and two user representatives. We would like to include a GP and members with the skills and experience to complement and extend the range of the project staff e.g. drug workers from other agencies, representatives from the health and local authorities, pharmacists etc.

Frequency of Advisory Group Meetings

The advisory group meets six times a year, dates are planned in advance and are altered as little as possible. Minutes are circulated to all members.

Policies

All policies are reviewed at least annually and are shaped by contributions from service users, front line workers and discussions in the advisory meeting. The philosophy and purpose will reflect the current needs of the service. The project also uses and is bound by general MIC organisational policies. Volunteers and staff are trained up on these policies.

5. SERVICE FINANCE

Camden and Islington Primary Care Trusts funded the service this year. (The budget for 2011-12 is attached - see Appendix 1).

6. MARKETING AND PUBLICISING THE SERVICE

We publicise the service via websites (our own and links on others), our Facebook page, leaflets and posters in all local GP surgeries, libraries, community groups. Furthermore, we personally visit GP practices, local drug and alcohol projects, psychiatrists and mental health teams. We regularly continue to contact local and national media.

Clients are referred by GPs and other providers of primary care, drug and alcohol services, CMHTs, concerned others, self and various support agencies, including housing and therapeutic sources.

Last year, the project was represented in the following ways:

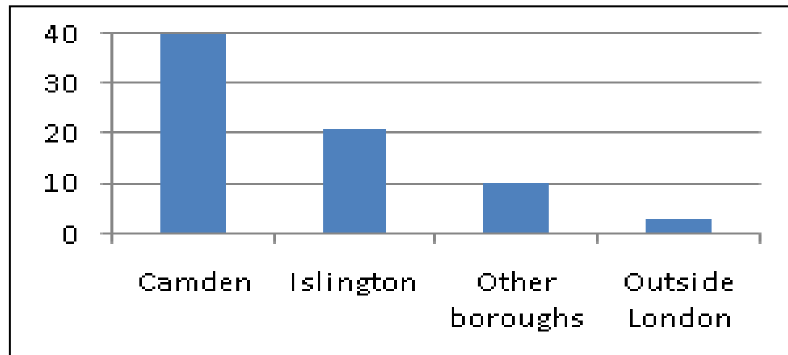
Jan – Yellow Pages Business section
Feb – Cindex update
March – London Irish Centre
April – April – Advice Solace Womens Aid
April – Leaflets to Hampstead Group Practice
May – South Camden drug project
May – Camden Alcohol Service
May – 184 Drug Project
May – CRI Camden DIP
May – Drugwatch.com
June – Contacted Lord Sandwich
June – Contacted SMMPG
June – Contacted Dr Chris Ford
June – Entry on Facebook page about benzo consultation
July – Face the Facts – Project Client speaking about benzos and this project
July – Client from this project tells his story - http://www.bbc.co.uk/news/health-14299501
July – Client from this project - http://www.independent.co.uk/life-style/health-and-families/health-news/professor-who-wrote-coalition-health-policy-was-paid-by-drugs-firm-2325928.html
July – User from this service appears in - http://www.addictiontoday.org/addictiontoday/2011/07/iatrogenesis-and-our-benzodiazepine-secret.html
Aug – Mail on Line – Comment with details about the service
Sept – CMHN – Mental Health news – article on the MT service
Sept – Tavistock leaflets stocked
Sept – DOH meeting, 30 participants including the service manager and a user representative
Sept – Earl of Sandwich phone conversation
Sept – Talk to MIC vols
Oct – Earl of Sandwich mentioned MT service in House of Lords
Oct – Letter from manager in DDN
Nov – Talk to Camden Alcohol Services – six members of staff
Nov – Talk to North Camden Mental Health Team – 20 members of staff
Dec – The manager met with Prof Lader

7. MONITORING INFORMATION

Outputs

74 CLIENTS REGISTERED WITH THE AGENCY Jan 11-Dec 11

Camden – 40
Islington – 21
Other boroughs – 10
Outside London - 3

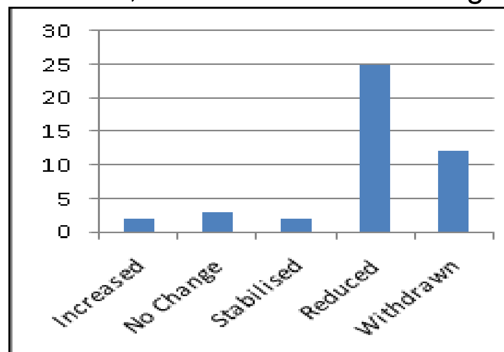


A note on borough stats - Those outside Camden or Islington use our Helpline, usually for one off advice and information such as requesting our Minor Tranquilliser booklet. Or contact the service by email or memo via the project's Facebook page. A few clients have moved to other boroughs since their initial assessment when they were Camden or Islington residents and maintain contact with us. Counselling, advocacy and group are all within the boroughs of Camden and Islington.

Outcomes Record

These are the outcomes for the clients, both Camden and Islington that we have regular contact with – 45.

Increased – 2
No Change – 3
Stabilised – 2
Reduced – 25
Withdrawn – 12



Outcomes

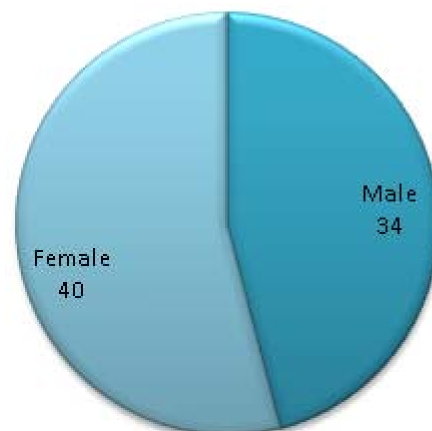
The biggest category is reduction, as the goal of the majority of our clients is to take smaller amounts of minor tranquillisers. Most of our regular attendees are in the process of slowly tapering their dosage. Clients are encouraged to taper the dosage at their own pace but not more than 1/8th of the total dose every 2 weeks as per the BNF guidelines and Prof Ashton withdrawal protocol. Most clients do not withdraw faster than 1 mg every month – this can mean in practice that for someone on a 10mg prescription for valium that it will take them at least one year to withdraw.

For one off callers/dropins who take information from us and then are not in touch with the project again we have no way of telling the outcome (e.g. the amount of drugs they were on at time of first contact we generally are given, but we have no means of knowing subsequent progress). We do have a "how are you" system which we use if we have had regular contact with a client and then don't hear from them; but we have to get the agreement of the client before we can contact them, which we are unlikely to receive from someone who does not want a full engagement with us. Also, when people do ring in, as we are client centred we concentrate on whatever

they wish to discuss at the time, which may be other related issues besides the amount of medication they are currently using.

This record only includes the results from known clients with whom we have had regular contact over the dates in question, and excludes any recent clients for whom it is too soon to establish any sustained change in patterns of drug usage. For those who we don't hear from regularly, it is hoped that they have taken on board the information given and in some cases will have started withdrawal programmes, but other than where I am fully aware of the current situation I have not included these occasional clients in the results above.

I haven't shown any decrease in the use of other substances and alcohol, which would apply in some cases.

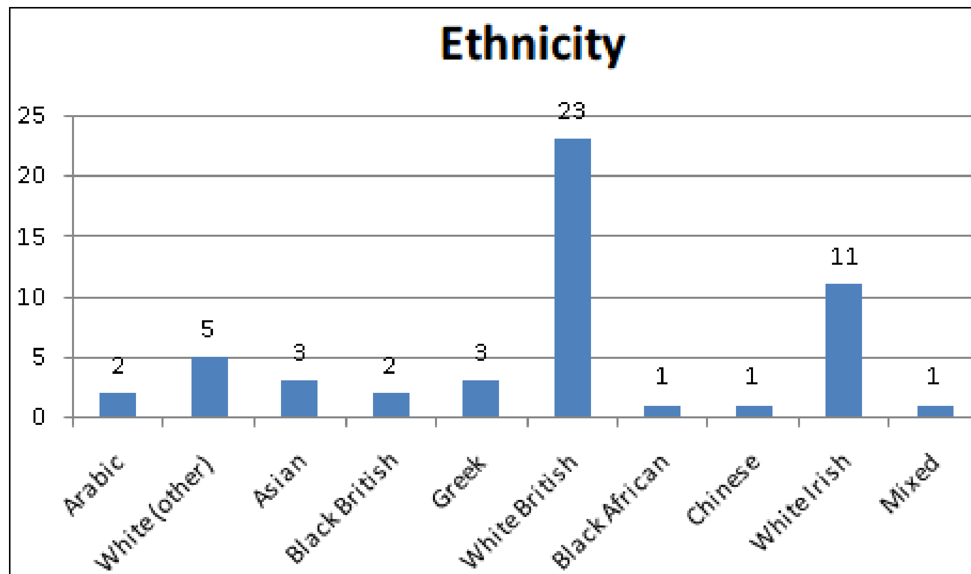


The project has always contained more women than men. This is consistent with the fact that twice as many women than men in Britain, Europe and the USA are prescribed benzodiazepines. Comparison figures from the National Treatment Agency show that this gender distribution is not typical of those using alcohol or illegal drugs. For that client group it is approx 70 per cent male and 30 per cent female - a reversal in gender to the benzodiazepine client. However, our support group contains more male members than female ones.

Age groups

26-39 years	**9**
40-49 years	**19**
50-59 years	**24**
60-64 years	**5**
65-74 years	**9**
75 years or over	**2**
Service User Declined	6

Our data suggests that clients of a benzodiazepine service are most likely to be in the 50-59 age range. This trend is typical of benzodiazepine users, since the drugs were more readily available before 1988 when their addictive potential was fully recognised. UK wide, the largest group taking these drugs are the elderly. Comparison data from the NTA suggests that drug services dealing with clients taking illegal drugs are likely to be younger. We have placed posters at the local university and maintain a Facebook page to attract younger clients. We have also contacted Age concern to offer our services to older clients.



The largest ethnic group using the service was White British, then White Irish and then White other. The largest ethnic group in Camden after White British are Irish. This is reflected in their being our biggest ethnic group outside white UK.

Research was undertaken in 2009 (documentation was circulated to the committee in 2010) which proved that ethnic groups are less likely to be prescribed benzodiazepines in the first place, therefore not presenting to our project for treatment for medication they are not dependent on.

NTA statistics suggest that illegal drug service users are more likely than benzodiazepine or alcohol users to be Black Caribbean, Black other and Bangladeshi.

The client group is still overwhelmingly white. We have been aware of this issue for some time and several attempts have been made to attract more clients from black and ethnic groups, including the following courses of action:

- Black volunteers have been enlisted. During their time with the service (several years), there was no upturn in black clients. The project team has always had a diverse ethnic mix, currently workers comprise - one Asian, one Black British, one Greek Cypriot, one Irish, one white other and three white British.
- Black groups were specifically targeted for mail outs.
- A black mental health befriender was recruited who works in Islington for our advisory panel to give out our leaflets when visiting her clients. Interestingly, she reported that all the people she saw were on antipsychotic medication and not benzodiazepines. The same pattern has also been confirmed by consultation with Fe-So (Mind in Camden's Black and Ethnic Minority Day Service) workers and those from our housing project that specifically targets young black men. It seems that black clients tend to be prescribed anti psychotic medication rather than minor tranquillisers and the low take up may reflect prescribing habits.
- The service manager attended meetings of New Roots who work with drug using BME groups to network with agencies working with different communities. Our black volunteer also attended their open day. We are giving the clear message that we are willing and able to work with members of the BME groups.
- Service Manager Presentation to New Roots on the work of the service.

- Service Manager invited manager of New Roots to the services away day to talk about work with BME groups.

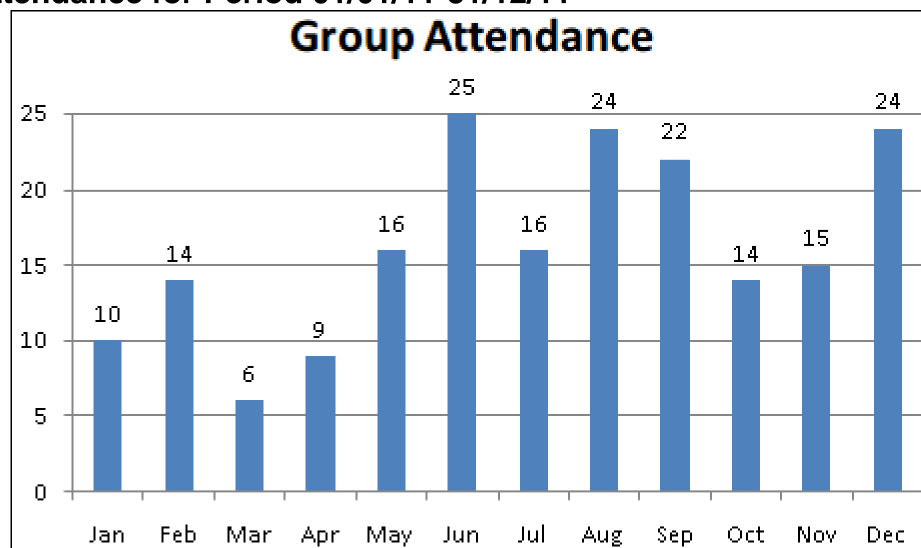
There is some anecdotal evidence that refugees and asylum seekers often seek treatment in non-specific drug services. Refugee specific barriers to service utilisation include fears that exposing drug use may jeopardise applications for refugee status. At local levels care paths would need to be developed to address this. However a move that the project has made in addressing this issue is that clients can access Camden and Islington PCTs interpreting service to request an interpreter free of charge.

Contacts of Camden councils telephone Helpline are printed on the Minor Tranquilliser leaflet, so that service users can arrange their own interpretation.

The service has its leaflets available in Somali and Bengali.

The sexuality of clients is currently not monitored, though we know from self disclosure that we have lesbian, gay, bisexual and transgendered clients.

Client Attendance for Period 01/01/11-31/12/11



There was one group cancellation in January as the group fell on a bank holiday so didn't take place that evening. One group was cancelled in March, April and December due to staff shortage.

In the group we offer support to benzodiazepine users and their families. We play an active role in harm reduction work including peer education in safer drug use, provision of drug related advice and information and service user advocacy. There is emerging evidence from the USA that the regular use of self help groups can be beneficial to client outcome from drug treatment (Florentine 1997; Hillhouse 2000). The latter researchers found that mutual aid groups can improve and sustain outcomes from compatible forms of drug treatment. Our groups are not purely self-help but self-help takes place within the groups. We are user focused and advocate for better benzodiazepine treatments.

Formalised Individual Counselling
We had two counsellors and one sessional counsellor assessor operating throughout the year. Our target as set in the service specification is to see 19 clients yearly in a mixture of long and short term work totalling 280 hours. Three quarter of the clients must come from Camden and a quarter from Islington.

Counselling is defined by the BAC as 'providing an opportunity for the service user to work towards living in a way he or she experiences as more satisfying and resourceful'. This activity takes place within a deliberately undertaken contract with clearly agreed boundaries and commitment to privacy and confidentiality. It requires explicit and informed agreement (BAC 1988).

Our counselling is formally structured and has clearly defined treatment goals and regular reviews as opposed to advice and information, drop in support and informal key working. Our formalised counselling is different from the use of counselling skills as part of our activity with clients. Formalised counselling is a skilled activity, which must be provided by competent and accredited counsellors. While our counsellors come from different modalities, they are able to demonstrate and use a variety of approaches within a structured programme. The project is client-centred.

We provide information to the client on the style of counselling offered, waiting times, and the place of counselling within the treatment offered. We do not currently tell them the characteristics of the counsellor. Service users may wish to have a counsellor who reflects their ethnicity, gender or sexuality. With only three counsellors operational in the service at the moment, it is not possible to offer this choice but it is something we may like to consider if we expanded.

We aim to retain clients in treatment for 12 weeks or longer and operate a planned discharge. All clients receiving counselling now have a care plan. We are no longer required to report to NTMDs for statistical purposes. We provided with information for 2 years and they thought our service was not appropriate to their remit. TOPS (Treatment Outcome Profiles) form was used to monitor drug related outcomes and monitored quarterly but is no longer required.

CORE (*Clinical Outcomes in Routine Evaluation)*
We continue to operate the CORE system for all our clients who receive counselling from us.

Commissioners implemented the use of the ***(CORE)*** form across all commissioned psychological therapies and counselling services to help them understand the level of need of Camden residents requiring psychological therapy intervention, benchmark across services and provide evidence of the outcomes of service intervention.

The expectation is that 80% of service users will report:

- Reduction/alleviation of presenting problems e.g. reduction in anxiety levels (recorded by CORE)
- Reduced use of local authority, health or other services or reduced dependence on welfare benefits
- Ability to maintain a job

- Specific change(s) they have made in their lives as a result of receiving the Service.

The CORE form is used for all counselling sessions and we ensure an appropriate version of this data set that is made available on a quarterly basis to commissioners for contract and performance monitoring.

On the service report to commissioners we also show outcomes around drug reduction and withdrawal, service duration, through-put and performance outputs such as how many clients are supported to access and maintain training courses, volunteering and job opportunities.

CORE DATA SUMMARY 2011

The project has been accessed by 43 individuals in total. The results show that the individuals benefit from the service offered by the Minor Tranquilliser Project.

- The Therapy Benefits chart gives an insight into the changes in quality of life of people who have gone through counselling with the Minor Tranquilliser Service. The data suggest that a proportionally large amount of individuals benefit greatly from the service. Twenty-eight out of 30 individuals reported improved personal insight/understanding. In other categories, similar results have been reported.

- The Change in Risk sheets show the reduction in risk ratings for clients who have received counselling from us. CORE items are rated on a scale from 0 (not at all) to 4 (most or all of the time). The sheets show that the therapists rate ratings have improved in most cases, most notably in 10 individuals who have had a lower rating (-2, -1) in suicidal thoughts than previously. These data are drawn from all closed clients with post-therapy OM.

- The Medication Change table indicates that the changes in medication have all been reductions, modifications or total withdrawal, so likely to be beneficial to the client. Overall, twenty-two clients have seen improvements in their use of medication. Two clients were not applicable as they were no longer taking medication when they began counselling with us.

- Two very important features of CORE are *reliable change* and *clinically significant change*. Reliable change is change that exceeds that which might be expected by chance alone or measurement error; it is represented by a change of 5 or more in the clinical score. Clinically significant change is indicated when a client's CORE score moves from the clinical to the nonclinical population and resides below the cut-off.
  As only clients with valid Pre- and Post Outcome Measures are included, the data are only collected from a total of 10. Four out of 10 have reported an

improvement. Out of the remaining six, one individual was already below the cut off for clinical and reliable change.

It may be helpful to realise that in small samples statistical data is more likely to be distorted. Whilst in a sample of 100, the .05 level can be achieved so long as no more than five scores in said sample deviate, in a sample of 20, only one score can deviate. This means that a single (‘deviant’) score may have a disproportionately large influence on the outcome of statistical significance testing. It is difficult to positively balance out any interfering factors.

Furthermore, any improvement achieved is still a great success – clinical populations may not improve for a long time as many factors could influence their well-being. An improvement is always an improvement, even if at the end of a period they still score above the cut off point.

Lastly, a comparison with the values from larger CORE samples is useful. The graph and table below show that in the clinical sample, the mean score lies somewhere around 20. The cut-off point that researchers have proposed is 10. This value is relatively low; this further illustrates that high-scoring individuals often have a long way to go in their recovery from the difficulties they face. Therefore, relative improvement in their score should be taken into account when it comes to evaluating their progress.

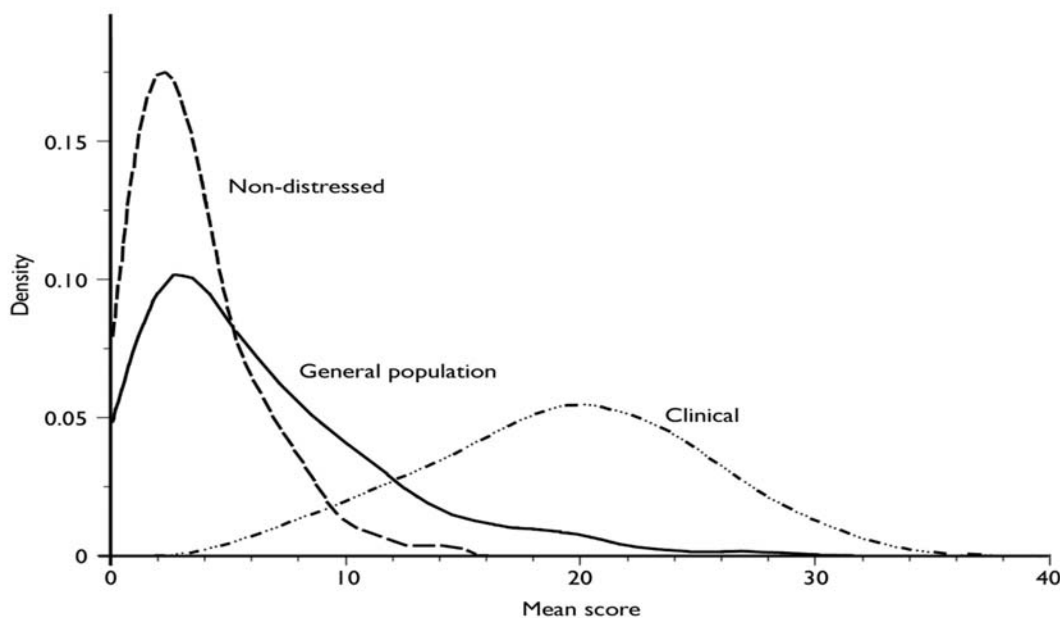


Figure 1. Graph showing a proposed cut-off point in CORE measures (Connell *et al.*, 2007)

Table I Distribution of CORE–OM clinical scores in clinical, general population and non-distressed samples

CORE-OM interval	Clinical sample			General population sample			Non-distressed sample		
	n	%	Cum %	Effective *n*	%	Cum %	Effective *n*	%	Cum %
0.0–1.9	65	0.6	0.6	144	26.9	26.9	52	44.1	44.1
2.0–3.9	170	1.6	2.2	149	27.9	54.8	47	39.8	83.9
4.0–5.9	292	2.7	4.9	84	15.7	70.5	14	11.8	95.8
6.0–7.9	399	3.7	8.6	56	10.5	81.0	4	3.4	99.2
8.0–9.9	482	4.5	13.1	37	6.9	87.9	1	0.8	100.0
10.0–11.9	686	6.4	19.5	34	6.4	94.3			
12.0–13.9	828	7.7	27.2	6	1.1	95.3			
14.0–15.9	995	9.2	36.4	10	1.8	97.1			
16.0–17.9	1118	10.4	46.8	5	0.9	98.0			
18.0–19.9	1095	10.2	57.0	6	1.1	99.1			
20.0–21.9	1191	11.1	68.0	2	0.4	99.5			
22.0–23.9	1074	10.0	78.0	1	0.2	99.7			
24.0–25.9	846	7.9	85.9	0	0.1	99.7			
26.0–27.9	628	5.8	91.7	1	0.2	100.0			
28.0–29.9	357	3.3	95.0						
30.0–31.9	294	2.7	97.8						
32.0–33.9	158	1.5	99.2						
34.0–35.9	58	0.5	99.8						
36.0–37.9	21	0.2	100.0						
38.0–40.0	4	0.0	100.0						
Total	10761	100.0		535	100.0		118	100.0	

CORE–OM, Clinical Outcomes in Routine Evaluation – Outcome Measure; Cum %, cumulative percentage.

(Connell *et al*., 2007)

References

Connell et al., (2007). Distribution of CORE–OM scores in a general population, clinical cut-off points and comparison with the CIS–R. *The British Journal of Psychiatry, 190*, 69-74.

Referrals

Primary Mental Health Team	1
Cam Psychological Services	2
Housing Agencies	2
Concerned Other	8
Self Referral	20
GP/other primary care worker	16
Drug project	16
Mind (in house or outside borough)	9

Self referral continues to be the most common referral categories, followed by those from GPs and other Drug Projects. Comparison with NTA data for drug services suggests that service users are roughly twice as likely to self refer and are less likely to be referred by a GP than benzodiazepine or alcohol service users.

Counselling Services Standards
Our counselling services aim to give the service users an opportunity to explore, discover and clarify ways of living more resourcefully and to develop a greater sense of well being through talking to a counsellor in an agreed set of counselling sessions. Only when both the user and counsellor explicitly agree to enter into a counselling relationship does it become 'counselling'. This standard specifies the level of training required for counsellors to enable us to provide counselling services of an appropriate quality.

The standard for counsellors
We ensure that all counsellors are appropriately trained and professionally developed to meet their responsibilities.
This is ensured as a part of the recruitment process.

- All counsellors work within the code of ethics of the national counselling and psychotherapy organisations (the British Association for Counselling and Psychotherapy (BACP), UK Council for Psychotherapy (UKCP), the British Psychotherapy Society (BPS) or equivalent) and are encouraged to take up membership.
- The code of ethics is included in our counselling policy and so all counsellors are required to adhere to it.
- All counsellors either have successfully completed a diploma course to practice as a counsellor, or are in the second/final year of such a course. Those that have qualified will be working towards accreditation or registration with a nationally recognised counselling and psychotherapy organisation. This is a requirement of joining us as a counsellor and is ensured as a part of the recruitment process.
- When we provide placements for trainee counsellors, we liaise with the training organisation concerned, to ensure practice guidelines are in place and adhered to and that the training organisation has assessed the trainee counsellor as being ready to work with clients.
- All counsellors maintain continuing professional developments.
- The counselling Supervisor informs and encourages counsellors to take up opportunities.
- All counsellors have the opportunity to train in specific clinical areas.
- The training and development plan takes in core areas and counsellors have an opportunity to partake in this.

8. How the Minor Tranquilliser Service Incorporates the User Participation Policy into the Project

Recruitment

- Volunteers and sessionals are interviewed by panels that include a user.
- The manager is aware that several users have expressed a preference for volunteers and workers who have had previous experience with tranquillisers or related issues. Due to equal opportunities and diversity we cannot positively discriminate for ex-users but we do advertise that such experience would be welcomed.
- Vacancies for counsellors appear in the London Drug and Alcohol Network website/magazine as well as the BACP website/magazine.

Service Delivery

- An annual survey includes space for people to make suggestions about the development and policies in service, and, where it is possible to put any suggestions made into place, we do so. Clients report feeling included and their views are being heard.
- Two service users represent the service at the drug users forum for Camden and Islington.
- One user is a member of the advisory committee for the project, which involves the manager and considers all issues around the policy framework and service developments
- Draft policies are always circulated to support group members for their comments prior to consideration by the advisory committee.
- The manager asks at the group quarterly what members think of the service. Any improvements that are possible are implemented at the first opportunity. They are ratified at the advisory group and the policies and procedures are updated to represent the change in practice and/or ethos.
- In a review of the evening support group service users stated that they would like specific topics and activities to be introduced to each group. The topics are decided on by service users and examples have recently included a session with a relaxation tape, have a talk on how the pills work, and watching a film on Minor Tranquillisers together.
- During 2011 we were involved, and in turn involved service users, in a parliamentary working group on prescribing practice around MT, this presents important opportunities for the people who use our service to inform national policy with their lived experience.

b) Involvement in service provision

- A proportion of the Sessional workers and volunteers are ex users of mental health services, drug and alcohol services or both.
- We ensure users participate in the delivery of services in areas that do not breach therapeutic boundaries. This participation consists of:
  - Delivering regular talks about the service alongside the manager, to tell their story and answer questions.
  - The distribution of publicity leaflets, particularly ensuring the service is advertised in local GP surgeries
  - Helping with the practical aspects of the group, e.g. locking up, refreshments etc.
  - MT client representation on MIC's management committee.

c) Involvement in monitoring quality of service

- An annual service user survey is conducted. Those returned (on average 20 responses from 40 sent out), have been an average of 95% satisfaction rate over the last 2 years. .
- CORE is used to gauge satisfaction with and the therapeutic benefit of counselling, this involves the service user filling in a form with the counsellor at the start and at the end of counselling.
- We ensure users participate in the delivery of services where possible, which would be in areas that do not breach confidentiality and therapeutic boundaries. This participation consists of:

- Two members have attended the DOH meetings.
- Some of the workers and volunteers in the project have been ex-users themselves, particularly problematic drinkers and tranquilliser users as well as illegal drug users. They have by necessity for the reasons stated had to have come through our services other than this one.
- We have an effective complaints procedure. All service users are made aware of the existence of the complaints procedure, and it is included in their induction packs. There have been no complaints this year.
- The manager asks at the group quarterly what members think of the service. Any improvements that are possible are implemented at the first opportunity. They are ratified at the advisory group and the policies and procedures are updated to represent the change in practice and/or ethos.
- When someone attends the group and then doesn't follow up, we do ask what the reason for this was. Likewise with ending counselling. So far the answers have largely been around the users themselves, for example, not feeling able to undergo the rigours of counselling, other activities they wish to be involved with that clash with the group evening. We also do a "how are you" call on the Helpline when we have permission to do so, if we haven't heard from someone in a while. We record what the reason is that they are no longer using the service. It is frequently the case that the situation for which they sought advice from us has been resolved e.g. a successful withdrawal from Minor Tranquillisers.
- Clients continue to report satisfaction with the group room which was decorated in 2009.
- Feedback was positive for the group Christmas party.

Provision of Information

I ensure as the manager that service users know I produce quarterly reports to Camden PCT, a yearly service review and of any new ideas we are considering for ways forward for the project or any changes to the project.

9. SUMMARY OF ISSUES AFFECTING THE PROJECT CURRENTLY

- We have two counselling volunteers and a volunteer admin worker. All three sessional workers remain with us, providing continuity to clients and an atmosphere of stability to the service. We are now up to full capacity.
- Attendance figures for the group have remained constant, drawn from a pool of 30 members at any one time.
- Increasingly our clients have or have had problems with other drugs and alcohol besides benzodiazepines. I will continue to explore opportunities for developing the service to meet the specific needs of people with a dual diagnosis and to market it accordingly. During the year this largely resulted in me visiting other drug projects to let it be known to them that we welcome clients who also take other substances. The group continues to comprise a large percentage of people who are on programmes for other drugs and alcohol they use or have used.
- Having now had clients going through the CORE system, we have been able to produce reports with details of clinical and reliable change. Satisfaction has been reported from those clients going through, so we are able to evidence the

positive effect of the work that we do for example – a reduction in risk factors for the client, an improvement in relationships and all reporting increased benefit in exploring problems/feelings, expressing problems/ feelings and gaining insight.

10. Future Development of the Service

- **DOH** - The Minor Tranquilliser Service has been involved in inputting to two reports on Addiction to Medicine commissioned by the DOH. Following attendance at a DOH Roundtable meeting in Sept 2011, the service received action points from that meeting, which had been delegated to the RCGP. It was agreed that there needed to be development of updated guidance and training for healthcare professionals on addiction to medicines. The MT manager has volunteered to be part of this initiative and waits to hear from the RCGP.

- **APPGITA** - The manager and a client continue to liaise with members of The All Party Parliamentary Group for Tranquilliser Addiction. The manager and a client representative have been invited to an expert patients meeting in 2012.
- The manager wrote to Professor Malcolm Lader, an expert on benzodiazepine addiction and he agreed to meet with her in December 2011. As a result of that meeting, it was decided that using data from the MT support group could comprise a research project for an MSc student on a Kings College Addiction Sciences course. We are in the process of attracting a student to this proposition.
- The emphasis will continue to be publicising the service to gain more clients.
- We will encourage clients, both old and new to access counselling to meet our 19 clients seen yearly and 280 hours counselling target.
- We continue to experiment with providing different features in the support group e.g. relaxation tapes, specific topics for discussion. This different format to the usual format of the group takes place once a month.
- Refine procedures for collecting stats for the new systems and presenting reports to the commissioners.
- We will continue to seek to increase ethnic diversity in the service user group and continue to market our service to those that use other drugs in combination with benzodiazepines.
- The greatest problem that clients currently report is being taken off benzos too quickly. Sudden/rapid withdrawal seems to becoming more common. We have limited control over such situations as we are not prescribers. Therefore, we will continue to be in contact and forge links with drug user groups, GPs and policy makers in the borough to let them know our concerns with the aim of raising the issue of benzodiazepine dependency at a local and national level. Treatment centres/rehabs must be educated from treating benzodiazepines in the same way as other substances. In primary care there is a misconception that rapid withdrawal works. This is understandable when a patient is no longer asking for a benzodiazepine prescription. However, the service sees people who were taken off benzodiazepines suddenly and are now buying them from the internet or from illicit drug dealers.
- Our unique service may benefit those from outside Camden and Islington, so consideration of how the project could go London wide is an option. Since a very high proportion of investment in the project is dedicated to management

and monitoring of the project overall and is non-repeatable (i.e. is the same regardless of client numbers), it is envisaged that this would have the advantage of benefiting a considerably larger client base for significantly less net cost per client. Obviously this would require participation in funding from groups outside MIC who wish to benefit from the service.

Melanie Davis Minor Tranquilliser Project Manager March 2012

For better
mental health

Mind in Camden
MINOR TRANQUILLISER
PROJECT

Minor Tranquilliser Service Review 2011

Completing this confidential and anonymous Questionnaire will help the Minor Tranquilliser Service improve its services for current and future clients. It is not compulsory, but we would appreciate if you spent a few minutes filling in this form, as it will enable us to make improvements in the future. Please give your honest opinion.

We wish to deliver and develop the best possible service to clients. The more people complete the questionnaire, the more comprehensive the information we obtain. Please tick the boxes of the questions relating to the aspects of the project you use or have used. Tick 'Not applicable', if you do not use this part of the service, or if you feel that you cannot answer a question. You do not have to fill out the additional space below each question. However, this space may provide an excellent opportunity for you to give us detailed feedback. Remember, we appreciate your feedback immensely, and we take it very seriously. We do our best to improve the service continuously; any issues raised will be dealt with immediately.

Please return this questionnaire in the SAE provided or put in the managers pigeon hole by **29 February 2012**. Thank you for your time.

1a. **Group:** How satisfied are you with the Support Group?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(1a.) Please elaborate on your statement, feel free to comment on things you like/dislike about the group. Have you got any suggestions for improvement?

1b. **Group:** Would you like the support group to change its start time or date?

- ☐ Yes
- ☐ No
- ☐ Not applicable

(1b.) If Yes, please inform us of your preference in the space below:

Day: ______________ **Start Time:** ______________ **End Time:** _________________

2. **Counselling:** How satisfied are you with the MT Counselling service?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(2.) Please comment on things you like/dislike about our counselling service, and things you find particularly helpful/difficult. Have you got any suggestions for improvement?

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3. Managers Letters to GPs/Visits to Gps/Tribunals/Advocacy/Escorts:
Overall, how satisfied have you been with this service?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(3.) Please comment on things you like/dislike about these services. Please let us know which service you are referring to. If you have any suggestions for improvement, we appreciate your input.

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___

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4. Staff and Volunteers: Overall, how satisfied are you with the support and help you receive from staff and volunteers?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(4.) Please comment on the support and help you receive from staff and volunteers. If you are not satisfied, could you please tell us what kind of support you feel we do not offer, or how we could improve what we currently offer.

___

___

___

5. Having your say: Do you feel that your views are taken into account by MIC when making its decisions?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Not applicable

(5.) Please let us know in more detail how you feel about this. Is there anything we could do to involve you more?

____

____

____

6. Physical environment: How satisfied are you with the physical environment of MIC?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(6.) Please write any suggestions for improvement, or things you are like/dislike about the environment:

____

____

____

7. Empowerment: Do you feel that through being involved with MIC as an organisation, your self-confidence and self-esteem have improved, and your independence has been promoted?

- ☐ It has helped me a lot
- ☐ It has helped me a bit
- ☐ It has made no difference to me
- ☐ It has hindered me a bit
- ☐ It has hindered me a lot
- ☐ Not applicable

(7.) Please elaborate, or give suggestions for improvement, if possible.

____

____

8. Diversity: Do you feel the service is relevant to and respectful of your ethnic and cultural needs?

- ☐ I am very satisfied
- ☐ I am satisfied
- ☐ I am neither satisfied nor dissatisfied
- ☐ I am dissatisfied
- ☐ I am very dissatisfied
- ☐ Not applicable

(8.) Please write any suggestions for improvement or things you are like about our diversity policy and practice:

____

____

____

9. Where did you hear about our project? ______________________________________

____

10. Any other views and ideas: Please write any other comments, suggestions or ideas you might have about the services provided by the Minor Tranquilliser Project.

____

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What happens next?

Your views are needed for service user feedback to enable us to improve the services we offer and to ascertain whether you are happy with the services we provide. We need to produce the information in statistical form so please return your completed questionnaires ASAP to allow for compilation. Our funders, Camden PCT have set us a target of 80 per cent satisfaction rates. All views will be held in strict confidence and names of participants will not appear on the final reports. Please call us if you have any questions or if you need further information. Thank you for your assistance and for taking your time in completing this Questionnaire.

Minor Tranquilliser Project – Satisfaction Questionnaire 2012

- In total, 24 questionnaires were distributed, and 14 replies were collected. Therefore, the return rate was relatively high at 58 per cent.

- The majority of service users were satisfied with all aspects of our service - a total of **91%** replied with very satisfied or satisfied. In fact, **62.8%** replied that they were very satisfied, making up the largest group of responses. Only **1 %** were very dissatisfied, citing that they felt that the group was not positive enough. The remaining **8%** held neutral views about the service. Most of the positive comments, on the other hand, stated that the group is very supportive, that the counselling is great, and that they felt empowered. Suggestions for the group included more psychological input: relating symptoms to childhood, history, external conditions (e.g. work, lack of work, social connections or isolation).

- Regarding a potential change of the support group day/time, most respondents (**69%**) found the current time ideal. The remaining respondents (**31%**) suggested Wednesday or Friday, as they were not always free on Thursdays. One respondent further suggested that during the winter months (October to February), it may be beneficial to start the group earlier (approximately 6 PM), as it gets dark much earlier.

- Users have found out about the project through other projects, newspapers or leaflets, friends, and some have also found out through their GP practice (either via leaflets or referral). One individual had a note slipped inside a repeat prescription form.

- Some respondents have offered help to the project, and would like to participate in public talks, for example.

- Most entries in the 'other views'-section were related to upcoming the project name change. A further comment in the 'other views'-section was the suggestion of a female-only group, as one of the service users felt that this would attract more female members.

Below is a selection of comments:

- *I'm very pleased about everything, THANK YOU. MIND has been a life-saver for me, so to speak.*

- *The group is very good as a place of trust, continuity and part of a weekly routine.*

- *I find the group very supportive. I have been attending on and off for nearly 20 years and this support is still important for me.*

- *I am so thankful for the support I have always received with letters and checks. Again, MIND is a unique organisation where they truly understand and give total support yet experienced enough to always give the correct support.*