Your toolkit for advocating in drug treatment :

ADVOCACY GUIDE

PART ONE : THE PRINCIPLES

Release
Drugs, The Law & Your Rights

Release

Drugs, The Law & Your Rights

The national centre of expertise on drugs and drugs law - providing free and confidential specialist advice to the public and professionals. The organisation campaigns directly on issues that impact our clients - it is their experiences that drive the policy work that Release does. Release believes in a just and fair society where drug policies should reduce the harms associated with drugs, and where those who use drugs are treated based on principles of human rights, dignity and equality.

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The Advocacy Toolkit was written by the advocates in Release's Drugs Team, Shayla Schlossenberg and Fenella Sentance.

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Finally, thank you to the people who access support from Release's Drugs Team: their knowledge and expertise, built from years of advocating for themselves and others, should be a footnote on every page in this Toolkit.

The toolkit is dedicated to Gary Sutton, our much-loved and deeply missed Head of Drugs. Without him Release's current advocacy work would not exist.

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Introduction

Founded in 1967, the aim of Release was to provide bail services to people arrested for drugs offences and to refer them to solicitors. In support of this aim, a 24-hour telephone helpline was set up and run by volunteers. Today, although the aims of the organisation have changed, the helpline continues to run, operated by Release's Drugs and Legal teams.

In the many years of the helpline's operation, Release staff have become aware of a great number of ways in which people who use drugs experience mistreatment from diverse institutions; educational, health, criminal legal, housing, and family ones to name a few. Most frustrating of all of these are the ways which drug treatment services can specifically work against people who use drugs under the guise of providing care to them.

There are drugs services around the country which are fantastic, where treatment systems work with patients in a collaborative way, and people are enabled to live happier and healthier lives. However, tactics of control which are deployed by some treatment services can destabilise people's livelihoods and relationships, and trigger deteriorations in both mental and physical health. If you are reading this, then maybe you have been harmed by such tactics already. Perhaps this was harm experienced in your own treatment, or harm felt as a loved one, or as a worker attempting to coordinate meaningful care for people who use drugs, in a system which does not easily award them nor you with any power to craft and carry out a 'treatment plan' that is in any way bespoke to that patient's needs.

Whatever your relationship to the drug treatment apparatus, we hope that this guide enables you to resist tactics of control and demand the provision of true person-centered care.

TREATMENT: WHO, WHAT, WHY?

Who can get drug treatment?

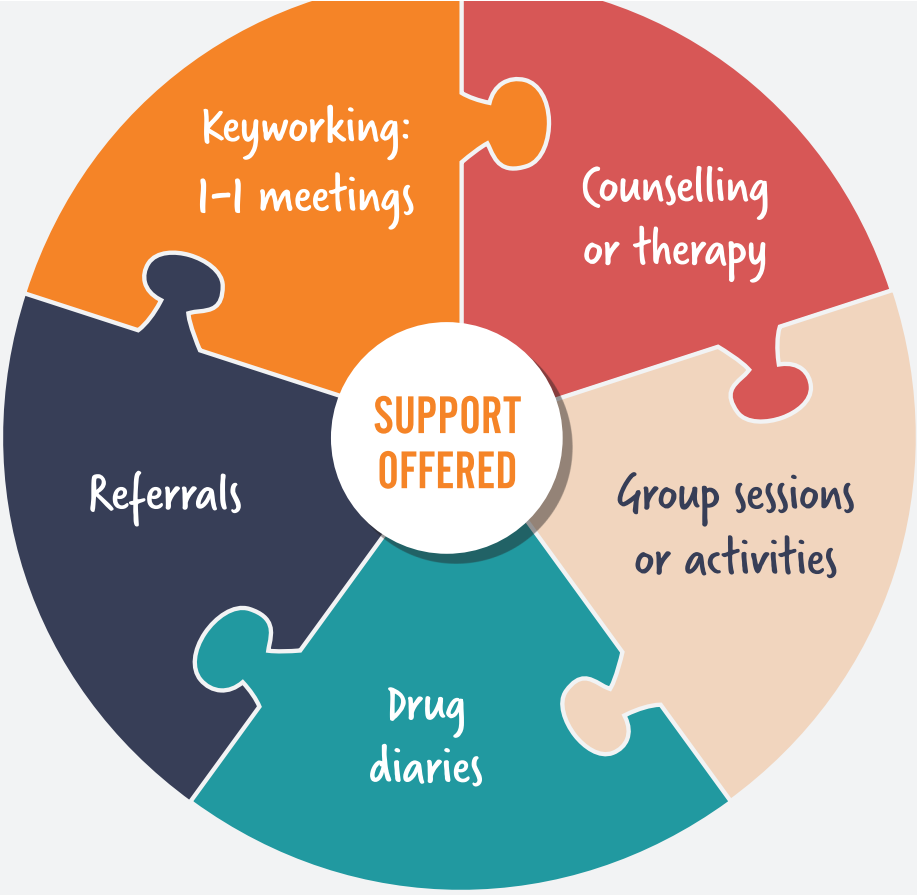
Drug treatment is for anyone struggling with their drug use and wanting support to make their use more manageable. You can access drug treatment if you are living in the U.K., including if you don't have recourse to public funds (though that may affect accessing in-patient facilities).

Who provides drug treatment?

Drug treatment services are separate from the NHS but are still government funded. Treatment is provided by free 'drug treatment services', commissioned by the Local Authority. The treatment services are usually charities or NHS services which compete for a particular Local Authority contract to provide treatment in that area.

What is drug treatment?

Drug treatment is a social and healthcare intervention that normally takes place in the community, rather than in hospital or in-patient facilities. It can last different lengths of time and can take lots of different forms, depending particularly on your drug(s) of choice.



Almost always though, it will involve key-working, regular medical reviews, and psychosocial support; for people using non-opioid drugs – like crack or powder cocaine, methamphetamine, GHB, or ketamine – treatment will primarily consist of this.

The support offered is a range of:

- **Keyworking: 1-1 meetings** with a support worker who can help you monitor progress towards your goals, give harm reduction advice and relevant supplies, and should give you overall support
- **Counselling or therapy** from staff employed at the drug service
- **Group sessions or activities**
- **Drug diaries:** records of how much you use and potential use-triggers, to accurately monitor your use and possibly support you to reduce
- **Referrals** to other support services, like community mental health, SMART recovery, which does mutual-aid meetings, or to a legal clinic for help with any housing debt or benefits issues.

For people using opioids, treatment will usually also involve prescribed medicine in the form of a substitution opioid. In this country, that kind of treatment mainly exists for people using opioids and is known as 'Opioid Substitution Therapy' (OST).

For people using benzodiazepines, treatment may include some substitution prescribing, but it is rare. Some services or GPs will be willing to prescribe a tapering dose of benzodiazepines, usually by stabilising someone on an equivalent amount of diazepam, and then steadily reducing their dose.

If you need support accessing this sort of treatment, contact Release.

Why would someone choose to get drug treatment?

The value of drug treatment is different for different people: it can

- improve quality of life
- improve health
- reduce the potential harms of using drugs
- prescribe alternative opioids when there's no safe supply on the market
- reduce mortality and overdose
- reduce risk of criminalisation
- reduce transmission of blood borne viruses like HIV and Hepatitis C
- provide an entry to meet other people and access other services

There is no evidence that treatment lengthens the overall duration of dependence.

What are my choices in drug treatment?

Your choices in drug treatment will be determined partly by the drugs you are using. Although you can access drug treatment for dependence on many substances, the most common questions arise in relation to substitute prescribing, which is only available for opioid dependence. For that reason, the bulk of this guide focuses on Opioid Substitution Therapy. However, there are still choices that will apply to everybody, like do I need to go to a detox facility? Do I want to take part in group sessions? For these elements of drug treatment, this guide may still be of help.

Detoxification and abstinence:

Drug detox is the physical process of a drug's presence leaving your body, often gradually, because you have stopped taking it or are trying to reduce your use to zero.

People often self-manage a detox of any drug and often have no choice but to do so, because of the limited services in the U.K. But a sudden detox of certain drugs – benzos, opioids, GHB and alcohol – is very dangerous. When detoxing or once abstinent, a person's tolerance to the drug(s) they used previously lowers. The risk of overdose is then higher if the patient were to resume their drug use at their previous levels.

If you are dependent on opioids, a detox can first involve a prescription of OST, usually methadone or buprenorphine. A substitute dose can allow you to stop your non-prescribed opioid use, after which your prescribed dose can also be tapered to zero. Like anything, this treatment choice must be patient-led.

Many people detox with a long-term aim to become 'abstinent'. Abstinence describes somebody's choice to stop using a particular drug entirely. It could refer to someone who does not use prescribed or non-prescribed opioids or to someone who has an OST script but has stopped other drug use.

Maintenance:

Maintenance describes being prescribed a dose long-term. For people dependent on opioids, it will usually be a dose of methadone or buprenorphine (see 'Medication choices' below for more info).

Maintenance treatment begins with 'titration'. This is the medical term for increasing your dose until it's at the right level for you, at which point you will be considered as 'stabilised on a dose'. This first step of titration can happen in the community or in an in-patient facility.

The goal should be to establish you, as quickly and safely as possible, on a dose that prevents withdrawal and reduces the need to use other opioids. Insufficient dosing or blanket policies on maximum doses make patients sick and often forces people to have to buy other opioids and self-medicate in lieu of an adequate dose of medication.

After that initial titration phase, people's doses may still vary through the years of treatment and there should still be semi-regular medical reviews to check up on how you are getting on.

Psychosocial support:

Some level of engagement with keyworking will usually be expected if you are in drug treatment. You don't pick your keyworker, but if you are struggling to build a good relationship with your worker, your service should respect your right to request to work with someone else.

You'll also be expected to attend medical reviews, sometimes as infrequently as once every 3 months if you have been stabilised in treatment for some time.

Any other psychosocial support like group sessions should not be a requirement; however, services do sometimes disrespect that principle – exercising a policy, perhaps, that group session attendance is a requirement for OST. If that's your situation, check out 'Booklet II: the Manual', which has a section on accessing OST.

Medication choices:

Choice is crucial in drug treatment. Sadly, it is limited by the U.K.'s guidelines and prescribing practices. Even something that has a strong evidence-base in another country may not be available here.

The options in the U.K. are:

Methadone:

The first-line treatment for opioid dependence in the U.K. since the 1970s. Often still known as physeptone.

It is a synthetic opioid, long-acting, a full agonist, and taken orally.

It is usually a 1mg/1ml mixture (green liquid), though very rarely services will prescribe a more concentrated 10mg/1ml mixture.

Methadone is also available as tablets (5mg) and injectables.

Prescribing methadone tablets is unlicensed so you may face some hesitancy when asking for a prescription; but they can be prescribed at a service's discretion.

Meanwhile, methadone prepared for injection is licensed for the treatment of drug dependency, but also still rare because of hesitancy around prescribing injectables. Currently, it comes in strengths of 10mg/ml and 50mg/ml.

A starting dose of methadone is usually 30mg/ml with dose increase across 2-4 weeks. The standard dose is between 60mg/ml and 120mg/ml. But it can be higher.

A good methadone dose should keep you comfortable for at least 24-28 hours without withdrawal. Common unwanted side-effects are grogginess, nausea, and constipation.

Buprenorphine:

Another first-line treatment for opioid dependence, first prescribed in 1999 in the U.K. Usually this is prescribed as either subutex or espranor.

It is a semi-synthetic opioid, long-acting, and a partial agonist. Subutex tablets are taken sublingually, meaning they are dissolved under the tongue; espranor comes as a thin wafer which dissolves on the tongue. Some pharmacies will crush up buprenorphine tablets for you, which is a common off-label prescribing practice.

Buprenorphine is available as 0.4mg, 2mg and 8mg tablets. The recommended dose range is 12-16mg but, again, that should not be needlessly restrictive. Espranor may be prescribed at a slightly lower dose than subutex as it is usually more easily absorbed into the bloodstream

One thing that is particular to buprenorphine is the need for a patient to be in withdrawal before commencement on a script, in order to avoid 'precipitated withdrawal' that buprenorphine can cause if other opioid agonists (such as heroin or methadone) are still present in your body.

Bupe/naloxone combination medication:

A now less common medicine, buprenorphine can come as a sublingual tablet combined with naloxone ('suboxone'). This is a prescribing practice which prevented people from crushing up and injecting buprenorphine.

Long-acting buprenorphine depot injection:

An increasingly offered OST option, licensed in the U.K. since 2019.

It is a long-acting injected form of buprenorphine, requiring weekly or monthly subcutaneous injections (carried out by a clinician, and so not to be confused with take-home injectables). The product name in the U.K. is Buvidal.

Slow-release oral morphine:

Not a first-line treatment for opioid dependence in the U.K. and prescribed off-label. In theory, it's available for those struggling to stabilise on first-line treatments like meth or bupe.

Slow-release oral morphine options are MXL capsules, supposed to last 24 hours, and MST Continus tablets, supposed to last 12 hours.

Most commonly, MXL and MST come in 30mg capsules/tablets, but they do come in other sizes.

Diamorphine assisted treatment:

This is a treatment option in the U.K. which is rarely available though efforts are being made to change that.

Diamorphine is a semi-synthetic opioid, fast-acting, a full agonist, and usually injected. It is the pharmaceutical name for heroin.

Take-home diamorphine is no longer an available choice for new-starts in treatment, though it is still prescribed to a small community of people, previously given it under the 'British System' or 'old system' of prescribing.

In the U.K., some diamorphine prescribing is taking place in supervised clinics. The roll-out of these clinics is very small-scale and your access to it depends entirely on if there is a commissioned DAT clinic in your area.

Below is some additional terminology you may hear around medication choices in treatment.

Full opioid agonists strongly activate the opioid receptors, but each opioid agonist drug will then affect the receptors differently. Methadone and heroin are examples.

Opioid antagonists block the opioid receptors in the brain so that other opioids do not affect them. Naloxone is an example.

Partial opioid agonists, like buprenorphine, activate the opioid receptors, but less strongly than a full agonist would.

Synthetic opioids are opioids that are made entirely through a chemical process, like methadone.

Semi-synthetic opioids are opioids that are chemically processed from the natural opiates found in the opium poppy (morphine and codeine). Heroin and buprenorphine are examples of semi-synthetic opioids.

Off-label or unlicensed prescribing is the prescribing of a medication in a way that is not specifically covered by its product licence. But this does not mean that this prescribing is unsafe.

What should I expect from drug treatment?

Your care should be **PERSONAL***:

Person-centred: you should be at the centre of your care and involved in decisions.

Evidence-based: all treatment should be based on evidence not opinion or ideology.

Rights-led: treatment should be founded on the belief that you are an equal partner in your treatment and have a right to health and privacy.

Seeing the whole person: your treatment should help you to get better support for your physical and mental health more broadly, not just support with dependence.

Open, independent and challenging.

Nothing about us without us: people who use drugs should be listened to by the service on a larger scale and should be part of wider policy decision-making.

Action focused.

Living life in the community: treatment should not prevent you from living; it should not prevent you from seeking employment, meeting friends, raising a family, or going on holiday – to name a few things.

This is the framework that the NHS recommends for care and treatment reviews but can be applied to all of drug treatment.

In addition, although guidelines are not law, your drug service should be mindful to follow the 2017 Orange Book guidelines, titled 'Drug misuse and dependence: UK guidelines on clinical management' and relevant NICE guidelines. The 2017 Orange Book guidelines are particularly relevant: they set the standard for a reasonable clinician and outline the evidence-based treatment options.

* This framework is taken from an NHS guide, 'Guide for CTR experts by experience'. This can be accessed here: https://www.england.nhs.uk/wp-content/uploads/2017/03/easy-read-expert-experience-info-upated.pdf

Unfortunately, many people's experiences of drug treatment are **NOT PERSONAL** or in step with the guidelines. That is where advocacy comes in.

THE FUNDAMENTALS OF ADVOCACY

When advocating for yourself, remember that:

1. You are the expert of your own treatment.
2. Your memories and knowledge of your treatment and drug use should never be underestimated.
3. Your advocacy will benefit if you are clear with yourself and your service about what outcome you want to see. Putting and sending these things in writing can help.
4. You should keep notes. Having a record of what was said is essential.
5. You can bring somebody with you to appointments for moral support, even if they are not your Advocate.

When advocating for somebody else, remember that:

1. The person you are advocating for is the expert of their own treatment.
2. Their memories and knowledge of their treatment and drug use should never be underestimated.
3. Your voice is there to amplify their voice; you are not there to replace it.
4. Both of you can attend appointments and meetings together; again, you should not replace them.
5. No decision about their treatment can be made without their involvement.
6. Any information you share about them with their service should be information they have agreed for you to share.
7. You should keep confidential notes of developments, so that you can be confident in the accuracy of any statements you make about any previous events.
8. You must have their ongoing consent to be their Advocate and be able to present evidence of this consent to the service.
9. You must maintain confidentiality.
10. You must take care of yourself. If you are advocating for someone at the same drug treatment service as you and are worried your treatment is being changed as a result, contact Release at ask@release.org.uk or on 020 7324 2989 for support.

How do I present evidence that I have someone's consent to advocate for them?

11. You can ask the person to email their treatment service to confirm that they have consented to you acting for them.
12. You can ask the person to write a signed and dated letter, confirming that they have consented to you acting for them.
13. As an Advocate, you can ask the service to contact the service user to get verbal confirmation and consent that they agree to you being their Advocate.

What are the common issues people might face in drug treatment?

If you are advocating for yourself, or are an Advocate in treatment yourself, then these common issues may already be familiar to you.

However, if you are newer to the world of drug treatment, these are areas where you are likely to hit snags, and so helpful to be aware of:

- **Getting into treatment.** Treatment access should be without barriers.
- **Getting the best medication for you.**
- **Getting the right dose and staying on it.** For example, getting increases when needed, or stopping forced reductions.
- **Issues in relationships with prescribers and keyworkers.** These relationships should be a 'therapeutic alliance' and centred on the patient.
- **Stopping supervised consumption.** When people begin treatment, they may have to take their prescribed OST in the pharmacy under supervision. Unless there is a clear reason, this should not be enforced once somebody has stabilised on their prescription.
- **Moving services.** Patients can feel that there is a risk of their prescription changing if they move service. Moving service is not a clinical reason for changing a prescription, so new services should honour existing prescriptions.
- **Accessing OST in hospital.** The delay to receiving daily OST meds when in hospital can cause people to delay seeking medical care in hospital or to discharge early against medical advice.

What steps can I follow?

When advocating, don't forget **G.E.A.R.**

FIND OUT THE **GROUNDS** FOR ANY TREATMENT DECISIONS,

GATHER **EVIDENCE**,

ADVOCATE AND ARGUE USING YOUR PERSONAL EXPERIENCE AND NATIONAL GUIDELINES,

AND GET A **RESPONSE** FROM THE SERVICE.

Following the GEAR steps will help you with advocacy, whether it's for yourself or another person, in person or through letters:

What are the **GROUNDS** for the decision? Any clinical decisions should be made on the basis of what your needs are and what the risks/benefits are. You have a right to know what the reasoning is.

Is there any **EVIDENCE** you want to provide? Of course, the most important things are your voice and personal experiences; however, if you can provide external evidence of what you are saying, it could help you to feel more confident when advocating.

What *outcome* are you **ADVOCATING AND ARGUING** for? Just as the service might lay out their various grounds for doing something, you want to be able to provide a sound argument for doing something different. This can draw on your personal experience, any evidence, and the Guidelines.

Has the service **RESPONDED** to you? Make sure that there is a dialogue between yourself and the service, and that may mean you have to be assertive to get your view across. Keep reminding your keyworker or prescriber that you would like a response.

Further information on each of these steps is given in the next section.

GROUNDS:

Find out from the service what their clinical justification is for their treatment decision.

If you have been left on daily pick-up for 12 months, why? If you are being taken off your medication, is it for a clinical reason or a practical reason, such as a shortage?

Understanding the underlying reasons will help you to negotiate with your prescriber and come up with an agreed plan.

You could find out the reasons by writing to your prescriber or service directly to ask. Alternatively, ask during a medical review or ask for a copy of the service's risk assessment of your case. You can request this informally or, if there is no response, by making a **'Subject Access Request' ("SAR")**.

How can I make a Subject Access Request ("SAR")?

You have the right to request all information held about you by an organisation (under Section 45 Data Protection Act 2018, sometimes also referred to as the UK GDPR (General Data Protection Regulation)).

You request this via what is known as a 'Subject Access Request'. This would allow you to see:

- Notes your prescriber has taken during your meetings,
- Notes your keyworker has taken,
- Copies of your treatment plan or care plan,
- Risk assessments that the service should have conducted.

Organisations should usually respond to a 'Subject Access Request' within 1 calendar month of it being made, though it can take longer if they need to ask you for more information before completing it. They can also ask for an extra 2 months if it's a complicated request but normally the type of information you'll be asking for won't need an extension.

You can make a Subject Access Request by emailing the service directly, if your keyworker says they aren't the best person to contact about this they should tell you who is. Alternatively, you can make it verbally, though writing it is helpful as you then have a record of it.

Your SAR should:

- Say that it is a subject access request,
- Write the date that the request is being made,
- Give your name and contact details,
- Ask for all and any information the service has about you,
- Specify how you want to receive the information (e.g. over email or print),
- Remind the service that they are required to respond to the request within 1 month.

EVIDENCE:

Gathering pieces of evidence may make you feel more confident and supported in the argument you're making. Evidence is by no means essential, but it could help: don't worry if you can't get any evidence – you can still make your challenge or complaint.

Evidence could be a diary that makes a note of the different withdrawal symptoms you experience each day – for example, you may want to do this if you are being under-dosed but find it difficult to explain how this feels when you're put on the spot. A written-down record could help.

Other things you might want to use include:

- **Letter from your GP** - about any physical/mental health symptoms and changes to medication,
- **Patient summary/GP records** (even if the GP won't write a letter for you, they have to give you your records if you ask for them – the patient summary will include details of your main conditions, medications and dose, and most recent consultations),
- **Discharge summary** from hospital,
- **Letter or records from the Community Mental Health Team, counsellor, or other therapist,**
- **Letters from other organisations** who are involved in your life, like Children's Services for children you care for,
- **Letter from your employer** (if they already know, or you feel comfortable telling them, about your drug use/treatment),
- **Letters or statements from friends or family members** (these may not carry as much weight as letters from professionals but can still help).

Remember: your report of your experience is what is most vital. Evidence is just a bonus.

ADVOCATING AND ARGUING:

You will want to be able to present clear reasons to the service for why you disagree with their treatment decision. You might present this argument in a formal letter to the service or in person.

Your argument should outline the reasons you disagree with the service's treatment decision and feel it is negatively affecting you. It can draw on your current personal experience, your treatment history, and any relevant guidelines.

As a starting point for writing a letter, take a look at the template letters in Booklet II, "The Manual" and the two tables below, which include probing questions on 1) the current impact of the treatment matter and 2) historic information relevant to resolving the treatment issue at hand.

Table 1: How you are doing now

If you have recently faced a change in your treatment, or you are facing an ongoing issue, then you will want to show the different ways it is negatively affecting you.

Is this having a physical effect on you?

For example:

- Withdrawal symptoms like sweating, muscle pains, tearing up
- Weight loss or gain
- Insomnia or sleep problems
- Heart palpitations

Table 1 - Continued...

Is this having an emotional effect on you?

For example:

- Are you having panic attacks?
- Are you experiencing serious anxiety and stress?
- Are you struggling to concentrate?
- Are you experiencing depression?
- Are you having thoughts of self-harm or self-harming?
- Have you had to change or increase anti-depressant or anti-anxiety meds in response to the stress?
- Are you feeling less motivated in your treatment?
- Has it affected your relationships?

Is this having an effect on your drug use?

For example:

- Are you struggling to take your script?
- Have you begun to buy other drugs? If so, what? How is this affecting you?

If you are having to supplement your OST prescription with opiates bought independently, that indicates that the dose you are receiving is insufficient.

There can be value in discussing additional drug use, both for building an open relationship with keyworkers/prescribers and for finding the right dose.

Please note that whilst a good therapeutic relationship should open discussion about drug use, people justifiably often do not want their prescribers to know due to fear of punishment or excessive caution (due to clinician's fear of overdose). For instance, sometimes people might fear disclosing their other drug use if they think that it would

Table 1 - Continued...

result in their methadone dose being reduced or their pickups increased or returned to supervised.

Sometimes these fears are warranted, and these discussions may not result in the outcome you want to see. However, reducing or removing scripts as a consequence of use of other drugs on top of an OST script is against guidelines and should additionally be challenged if it occurs.

How is this affecting your life more generally?

For example:

- Have you had to take time off work as a result of this decision?
- Have you had to take time from education or voluntary work?
- If you've taken time off, can you pinpoint why? For example, because of time-constraints from daily pick-up? Because of the emotional impacts of the change?
- Has it impacted family/friends arrangements? For example, if you are a carer, has it made it difficult to care for family-members?
- Are there financial costs for you because of the treatment decision? For example, the cost of having to buy other drugs to top up; the cost of travel to the pharmacy every day.
- Do you have any physical or mental health conditions that make the treatment decision especially challenging for you? For example, do you have mobility issues, making regular pharmacy attendance difficult? If so, do you receive any benefits like Personal Independence Payment (PIP) from the Government, which you can tell the service about to show the seriousness of these conditions?

Table 1 - Continued...

If something about your treatment is about to change but hasn't changed yet, try to highlight why you would prefer your treatment to stay as it is at the moment and the ways that the current situation has positively affected you.

- How would you describe your mental health?
- How would you describe your physical health?
- Have you reduced the drugs you are buying from the illegal market?
- Have you been able to pursue new things, like employment, volunteering, education, hobbies?
- If social workers were previously involved in your family, perhaps this has stopped or reduced since you've been in treatment?

Table 2: Past relevant information about your treatment history to use as evidence in your advocacy.

If you are facing a change to your treatment that you have experienced before (for example, being put back on methadone after changing to something else) you could highlight how this affected you negatively in the past.

- What were the physical impacts?
- Did it reduce or increase 'on top' drug use?
- Was it not possible because of other health conditions? For example, stomach problems made worse by methadone.

For all advocacy cases, you may want to make general points about your overall time in treatment to demonstrate to the service that you have been stable over a long time or, alternatively, to show that the current arrangements have not worked and a change is needed.

Table 2 - Continued...

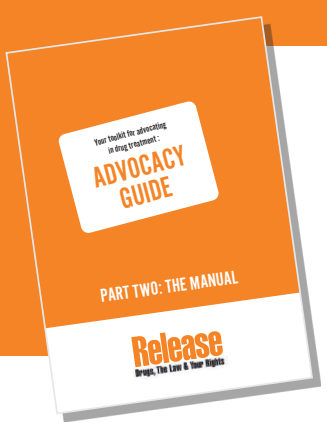
Services may be responsive to the following information:

- Have you regularly attended appointments?
- Has there ever been any issue with mismanagement of your prescription (for example, missing certain days)?
- Have you attended counselling or group sessions? (Attendance at group sessions should never be a condition of receiving treatment, so don't worry if not).
- Has there ever been an issue with diverting your prescription (for example, selling it)?
- If you are living with children, have you successfully installed a lock box and other safety measures?

After using information from the tables above, you can use the Department of Health and Social Care's 'Drug misuse and dependence: U.K. guidelines on clinical management' to firm up your case. These guidelines lay out best practice for prescribers and drug services. They contain information on standards of care that service users can expect.

To use the Guidance, think about the following questions:

- Do the Guidelines give any specific guidance on how services should respond to particular issues? For example, specific guidance for what to do if someone is buying drugs in addition to their prescription. This is why it is helpful to know the grounds for the treatment decision. See section 3 of the Guidelines for more detail on this.
- Is the service following this guidance?
- If it isn't following the Guidelines, has the service provided a justification for this?
- If it is following the Guidelines' overall advice, is there room for exceptions?



For specific extracts and quotations from the Guidelines, look at Booklet II, which gives advice on situation-based scenarios and includes relevant extracts from the Guidance. This booklet also includes some template letters. These offer examples of how to weave the Guidelines into your advocacy letters.

RESPONSE:

An important part of advocating is trying to secure a response from the service.

You could do this by setting a specific date that you would like the service to respond to you in writing.

If they do not respond, it may be a case of phoning or re-sending letters, asking again for a reply.

How can I make my case?

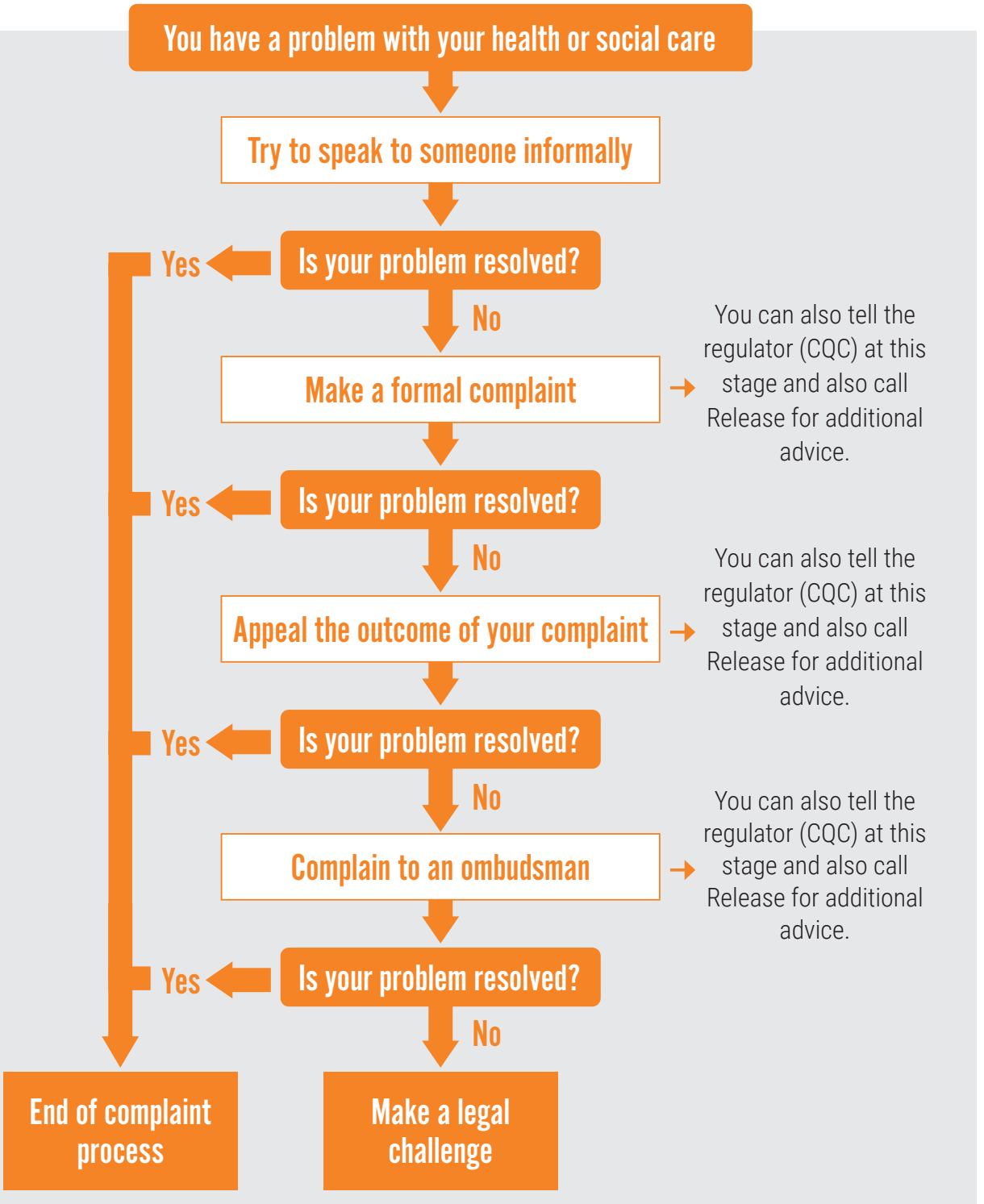
You can make a case in person or over email or letter, but no matter what form you take, you should maximise gathering written evidence whenever possible. For instance, if you have made a complaint in person, follow it up with an email to confirm that you have done that and ask for confirmation that this complaint was received.

Different organisations will have different complaint processes which may honour verbal complaints, but regardless of process you will want to make sure there is a written copy of the complaint agreed between you and the service, as if a service is only responding to a verbal complaint, it could be misinterpreted or it may be harder to hold them accountable to a particular outcome.

Flowchart: How do I make a complaint?

Please note If your problem is urgent, you should seek legal advice.

If you are being kept in hospital under a section of the Mental Health Act, and you want to challenge your section, you would follow a different process.



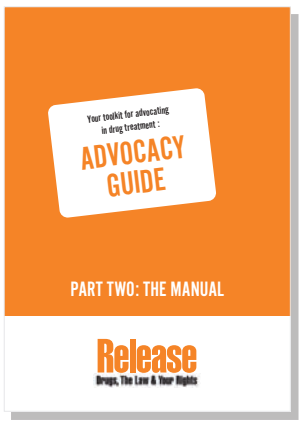
I'm stuck! What else can I do?

Unfortunately, even when the steps detailed above are followed and guidelines support your case, successful outcomes are not guaranteed. These processes often take a long time, which can be difficult to maintain even in the best of circumstances, and even more so in the sorts of circumstances that bring about these battles in the first place.

If you are stuck, do not be afraid to reach out for help! Anyone is welcome to call Release's helpline, 020 7324 2989 or email at ask@release.org.uk and support can be kept anonymous and confidential. Besides us, there are other local and national advocacy groups which you could also reach out to.

You could also identify your nearest service user or drug user organising group and seek support from peers in those spaces. Even if those spaces are within treatment services, such as service user feedback forums, you may still make useful connections with other service users which can help your cause.

You could also talk to your GP if that is available and a viable option to see if alternative treatment options could be available.



Where can I find Booklet II?

In Booklet II, "The Manual," advocacy strategies for different common treatment issues are written out, and template letters for various scenarios are provided. Even if your specific treatment matter is not included, this resource might be helpful in giving concrete examples of what your own advocacy letters or planning might contain.

If you need a copy of Booklet II and don't have it already, call us at 020 7324 2989 or email ask@release.org.uk and we would be happy to send you a copy.

PART ONE : THE PRINCIPLES

Release

Drugs, The Law & Your Rights