From FDAP in association with WIRED

DDN
Drink and Drugs News

27 February 2006
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ALCOHOL STRATEGY
Diary days bring the theory to life

LOCAL CHALLENGE
A RAPt initiative delivers services to the door

COMMENT
Giving up the weed – a priority for young people

PRESCRIPTION FOR LIVING
Nurses learn the script on controlled drugs

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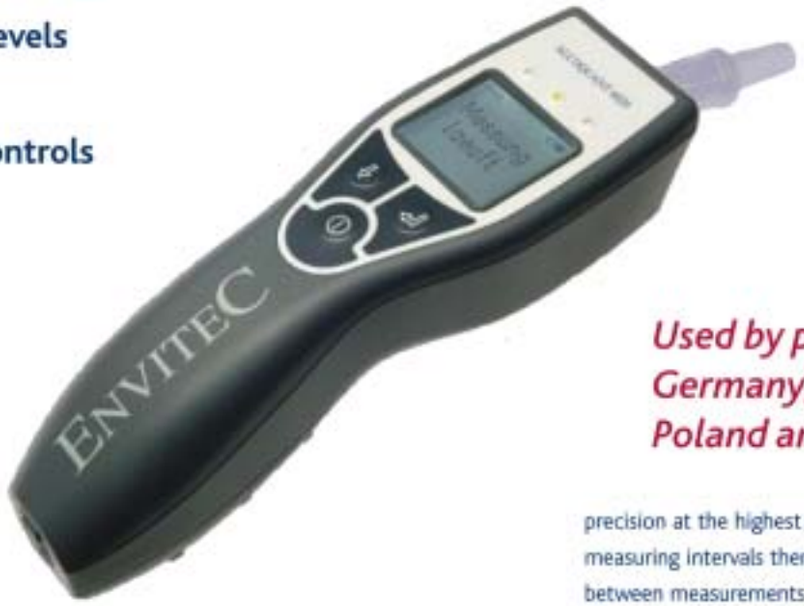

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Drink and Drugs News

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Editor's letter

At a prison conference in Leicester this month, colleagues from all areas of the prison and probation services, and those who work with them, declared their need to work more closely together. If their services were to appear cohesive to the client then remote communications were not enough. Links that began at their first brush with the criminal justice system would need to support them when they came out, and join them to housing, social services and everything else that qualified them as a member of society again.

For many prisoners, coming into contact with their CARAT worker is a revelation that a dedicated professional will be there for them throughout Counselling, Advice, Referral, Assessment and Throughcare. But are CARAT workers getting enough help in paving their client's way to the outside world?

RAPt – the Rehabilitation for Addicted Prisoners Trust – knows all about helping prisoners off substances and back into society, not least through running CARAT services in 17 prisons. Their recently opened Island Day Programme in Tower Hamlets takes their knowledge and experience of what works in rehabilitation and plants it squarely in the community, responding to the needs and diversity of the area.

Early signs from those who have been involved in the programme for a few months reflect not only the strength of the programme, but the support of their family and community. Clients talk about relating the service to real life from the word go. There is no escapism, no recuperating in a backwater miles from temptation. When they live the programme at Island, they know they will have to wake up with the same pressures as when they used drugs or alcohol. Surely this – and services like this – are a cost effective and practical rehearsal for going it alone.

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In this issue

Creative Challenge

Hazel Stewart, a Hepatitis C services trainer, is raising sponsorship to enable her to take part in the Hepatitis C Trust's Trek to Nepal at the end of October 2006. The purpose of the trek is to raise awareness about Hepatitis C and the issues affecting those who have the virus – particularly crucial in the UK, where so few have been diagnosed and where treatment delivery for Hepatitis C is notoriously the worst in the developed world, because there has been insufficient investment in service network structures.

The Hepatitis C Trust's venture is not simply another charity trek, but particularly unusual – all the participants either have, have had, or are personally affected by, Hepatitis C. This should make the journey of 100 km at high altitudes an inspirational challenge both for participants and sponsors, and help to spreading the word on Hepatitis C to the larger population.

She will be attending the Unhooked Thinking conference in Bath in April, in the hope of linking with creative and supportive individuals.

'If people have read about the trek and the conference beforehand, they know I'm there and can seek me out, as well as me approaching them,' she says. I'll also be attending the fourth Hepatitis C Mentoring Conference in Glasgow with my collecting buckets and sales pitch to raise sponsorship.'

With the support of Michele Martinoli, the photographer behind the Department of Health FaCe It Campaign, Hazel hopes to get coverage in national magazines with a wider readership than drugs services professionals and service users. She's also booking a slot on local community radio, Radio 19, to talk about the Nepal Trek, so people on her e-mailing list will be able to listen online to the programme.

Hazel, a writer, poet, performer and creative tutor, probably caught Hepatitis C more than 20 years ago during what she describes as a 'brief love affair with Morpheus,' although she has several tattoos and piercings, acquired before wide awareness of blood-borne virus safe practice. When first diagnosed six years or so ago, she was appalled at the lack of health provision and information.

'My time at the CAAAD Project has been fascinating and inspirational,' she says. 'Provision in Bristol seems to be fairly good now – the care pathway has been developed from systems which were already in place.'

Hazel Stewart works for the CAAAD Project (Community Action Around Alcohol And Drugs, a harm reduction drugs agency, which is part of Barton Hill Settlement in Bristol). Meet her at the Unhooked Thinking conference (details at www.unhookedthinking.com).

For information on the Nepal Trek, go to www.hepctrust.org.uk and to contact Hazel Stewart, email hazels@bartonhillsettlement.org.uk

New figures show alcohol services are falling far short of need

Only a tiny proportion of people across England are getting the support they need to stop drinking, according to new figures released by the Department of Health.

In a written response to a Parliamentary Question by Kelvin Hopkins MP, chairman of the All Party Group on Alcohol Misuse, Public Health Minister Caroline Flint revealed that on average, only one in 18 people is able to access treatment services across the country.

The north of England is suffering the worst. In the north east, only one person in 102 is able to get the help they need, with Yorkshire and Humber still significantly above the average, at one in 46.

In response, Alcohol Concern highlighted that alcohol kills 22,000 people every year and is one of the biggest public health problems in this country.

'The reality is that the vast majority of those with a drink problem cannot access any treatment at all,' said AC's director of policy and public affairs, Geethika Jayatilaka. 'Government has to make alcohol services the priority they so urgently need to be.'

- Alcohol Concern is offering advice to public health professionals who are developing regional approaches to the government's Programme of Improvements for Alcohol Misuse. The guidance includes ideas for securing quick wins to reduce alcohol misuse. Visit www.alcoholconcern.org.uk /servlets/doc/1070

Edinburgh shakes up drug and alcohol services

A review of Edinburgh's alcohol and drug services has highlighted the need for much better efficiency and co-ordination between services.

Edinburgh Council has approved a restructure plan for services, based on Action on Alcohol and Drugs in Edinburgh's comprehensive report. Service level agreements between funders and service providers and better monitoring and evaluation are at the heart of the restructure. Commitment to a single shared assessment will give clients an easier route to entering services – currently a complicated process because of clients' chaotic lifestyles and the number of services they might be accessing.

The new model, applying to both statutory and voluntary organisations, will aid free flow of information and help address the city's priorities and local needs. It is also intended to streamline funding to services, and establish a three-year funding regime to free the time agencies need to spend on fundraising.

Donald Anderson, leader of the City of Edinburgh Council said the proposals would tackle the twin scourges of drugs and alcohol by delivering improved, better co-ordinated, and more accurately targeted treatment.

'Drugs are a cancer eating away at society, while alcohol misuse causes a huge range of social and behavioural problems for individuals and families,' he said. That's why this review is so important.'

The plan prioritises certain areas of work, including alcohol users, young people, families, pregnant alcohol and drug users, chaotic drug users, co-morbidity, and disengaged or vulnerable groups, such as released prisoners and sex workers. New arrangements are set to be in place for the beginning of the next financial year in April.

Mentor UK invites entries for alcohol prevention

A national awards scheme is being launched by Mentor UK to recognise those working to prevent alcohol misuse in children.

Using funding from drinks company Diageo, the charity aims to promote excellence in alcohol misuse prevention and education, while emphasising the need for early intervention before drinking patterns become established.

Awards will be made in three categories – schools, communities and young people's involvement – and are open to the public, education, health and social care professionals and children.

Mentor UK is particularly interested in projects and activities that address risk factors such as boredom and lack of aspiration, and work that protects young people from alcohol misuse by encouraging achievement and motivation. Chief executive, Eric Carlin, said the awards programme was 'designed both to showcase the excellent work already being done, and to demonstrate good practice for alcohol misuse prevention work'.

Three winners will each receive £10,000 and a further £10,000 worth of mentoring and practical consultancy support. The closing date for completed entries is Friday 14 April 2006.

Download an application form from www.mentorfoundation.org/uk/awards. For more information, email awards@mentoruk.org.

Pharmacists want greater freedom to prescribe controlled drugs

New legislation allowing pharmacists to act as independent prescribers does not go far enough, according to *Pharmaceutical Journal*.

Authors of the article, all health professionals in the treatment of addiction, want independent prescribing extended to controlled drugs, such as methadone and buprenorphine (Subutex), which it does not include at the moment.

At present the pharmacist's prescribing role in relation to controlled drugs is restricted by a clinical management plan that has been agreed with the patient and their doctor. The authors argue that pharmacists, who have prolonged periods of training and experience and regular contact with patients, should be more closely involved in these prescribing decisions.

'The requirement for daily dispensing and supervision of methadone and buprenorphone often means a pharmacist will see a patient six times each week… contact with the pharmacist will almost certainly exceed any contact with the doctor,' the article points out.

Pharmaceutical Journal is the weekly publication of the Royal Pharmaceutical Society of Great Britain. This article was in the 11 February issue, archived at www.pharmj.com

Prisons conference shapes agenda for future

'Good and effective drug treatment meets both health and criminal justice agendas,' Martin Lee, head of the NOMS Prison Drug Strategy Unit told the 'Prisons and Beyond' conference in Leicester last week.

Getting more people into drug treatment lay at the heart of government strategy, he said. But there needed to be a culture change to merge prisons and probation and put the offender at the heart of services.

The Criminal Justice Act aimed to make sure only the right people came to prison, and there needed to be greater visibility of community penalties, said Mr Lee. The Drug Intervention Programme (DIP) had been the 'most important initiative in years' and there was now 'much more certainty than a year ago'. Drug treatment workers now had a key role in keeping drugs out of prison and there were new initiatives underway to engage families in drug treatment.

The conference would bring direct feedback to NOMS on what worked and what didn't, said Mr Lee. 'Be controversial,' he urged delegates. 'Your opinions will reach the wider policy-making audience.'

Full reports of the conference with feedback from sessions will shortly be appearing on www.fdap.org.uk, and there will be a special prisons issue of DDN.

NTA remains champion to 2008 and beyond

Following the conclusion of the ALB Review (independent review by the arm's length body) the NTA is now planning for a long-term future.

Ministers have indicated that they see the NTA playing a vital role beyond the end of the current drug strategy in 2008 and will continue to be the national champion of drug treatment leading positive change to deliver improvements in health and reductions in crime.

NTA Regional Teams will continue in their current roles, probably until April 2009. It is anticipated that by this time the new regionally based Strategic Health Authorities will have demonstrated their capacity to deliver both the health and crime aspects of the local performance management of drug treatment to Ministers satisfaction.

The central function of the NTA will continue beyond 2008/9. Although the post 2008 role has not yet been formally agreed it is likely to include oversight of the effective national delivery of drug treatment on behalf of Department of Health and Home Office, including:

- National guidance on drug treatment commissioning and practice
- Information analysis, quality assurance through the setting of national standards, and
- Providing a centre of excellence for research and policy development.

The NTA says it is delighted that the ALB Review has endorsed the agency's contribution to drug treatment since 2001 and identified a clear ongoing role helping services and partnerships deliver the post 2008 drugs agenda.

Notes from the Alliance

Daren Garratt takes a laid-back look at the soundtrack of cultural change and empowerment over past decades – with a serious message for the power of the user's voice.

Culturally, I tend to think of things from a musicologists perspective. For me, music has always been the most effective and prescient barometer of national mood and a backdrop to cultural change, and I can think of moments in the past five decades where there's been an unparalleled 'Year Zero' of musical/cultural importance:

- 1956 – Elvis Presley released Heartbreak Hotel (and Rock n Roll was born).
- 1966 – Beatles released Revolver (and Psychedelia was born).
- 1976 – Sex Pistols happened (and Punk was born).
- 1986 – Smiths released The Queen Is Dead (and although nothing was 'born', the fact that it's become socially ingrained justified the decision of many working class youths like myself to reject macho, conservative, heterosexual and nationalistic norms).
- 1996 – Prodigy released Firestarter and Underworld released Born Slippy (and, arguably, ensured that hedonistic club-life and recreational drug-taking was no longer an underground activity).

So what is it with the sixth year of a decade and a shift in cultural norms, and what's this tenuous link got to do with this column? Can't answer the former, but I honestly feel that if we play this year right, we'll herald unprecedented strides for the user involvement movement. We're already seeing unique partnerships being made between user-led organisations and national bodies that will only serve to influence and improve a user's treatment journey; partnerships that I personally feel will elevate the user experience, expertise and voice, and sow the seeds for sustainable future development.

Take the Department of Health and their decision to fund a National Model Of Advocacy. It's unprecedented. The government is releasing funds so that drug users can support other drug users and ensure they get adequate scripting, job opportunities, and, well… respect!

Take the Royal College Of General Practitioners (RCGP) and their recent decision to accept the Alliance's basic advocacy training as an entrance exam to their own Certificate in the Management of Drug Misuse in Primary Care; the latter being an established, prestigious and unique training resource that further validates the integral role that users have in the treatment process.

Take the National Treatment Agency and the specific focus that has been placed on independent, user-led advocacy in this year's treatment planning cycle. This, coupled with their decision to fund advocacy commissioning and best practice guidance alongside documents designed to support users in the workplace, will ensure that local partnerships have to work proactively with users as providers and equals.

This is a massive year for us. When else have we had 'the establishment' turn round and say, 'OK. You say you can do this, so do it!' It's never happened before, and now's the time for us all to pull together and prove that we can do it.

So is it fair to say that users being given a clear directive from the state to work as joint, equal partners with providers, clinicians and government is a cultural Year Zero? I should co-co!

'But what's the soundtrack?', I hear you cry... Well, Das Fringe and The Nightingales are both recording albums this year, and if that doesn't make the earth move then you've not got ears. You have been warned and remember you read it here first.

Daren Garratt is development manager at The Alliance. He also happens to be drummer with Das Fringe and The Nightingales.

Trouble at Tier 3

We read with interest the article by Sebastian Saville (*DDN*, 30 January, page 8). It is an interesting and thought-provoking piece. Given the sums of money involved, the topic is highly important.

We are interested in the estimated proportions of good, acceptable and poor quality Tier 3 Services from Mental Health Trusts. We think that the argument can be taken further by considering the management arrangements of substance misuse services within Mental Health Trusts.

We took a decision three years ago to reorganise and create a substance misuse directorate within a Mental Health Trust. There is therefore a clear substance misuse presence on our Trust Board, with heads of service accountability for service delivery and all areas of service governance at a local level.

We manage and are accountable for all substance misuse investment. Our view is that 'Trouble at Tier 3' can arise when substance misuse services are swamped by Mental Health Trusts' wider priorities rather than being a strong and influential player within the Trust. Management structures and effective leadership, which is focused on and steeped in substance misuse, are key to this.

Dr Louise Sell, associate clinical director, and Cath Moran, service director, substance misuse directorate, Bolton, Salford and Trafford Mental Health and NHS Trust.

Cleaning up drug practice

I have worked as a GP in the drug field now for over 20 years. It is an area of work that I enjoy and believe is of value. It is sometimes difficult but always rewarding.

BUT it also never seizes to amaze, frustrate and anger me how badly this area of medicine is sometimes practised. I had never heard of the practice of 'blind reduction' until I read about it in Daren Garratt's article 'keeping it dirty' in 30 January's *DDN*. I must admit that I didn't really believe it could happen, as the practice seems ethically and morally corrupt and appallingly bad medicine. So I set out to investigate – and discovered to my horror that it does happen, and some practitioners almost seemed proud of the practice. This appalled me almost more than the practice, as there was a sense that the practitioner felt they were getting one over the person receiving the prescription, who was obviously not to be trusted and a lower form of life. I was called naive and collusive when I questioned these attitudes.

'I had never heard of the practice of 'blind reduction' until I read about it in Daren Garratt's article 'keeping it dirty' in 30 January's DDN. I must admit that I didn't really believe it could happen, as the practice seems ethically and morally corrupt and appallingly bad medicine. So I set out to investigate – and discovered to my horror that it does happen, and some practitioners almost seemed proud of the practice.'

Anyhow, back to the practice of blind reduction – what is anyone trying to achieve with this practice? I am at a lose! Methadone maintenance can be a vital part of good treatment, if used well. It allows people to sort out other parts of their lives and improve their health, until (and if) they want to move on to detoxification and abstinence. Non-consented slow methadone reduction is still a common treatment modality in the UK, but has no value and has proven harm with increased risk of overdose and death. Blind reduction is even worse! In my exerpience, people who use drugs have an enormous knowledge and experience of drugs. The people who I have spoken to who have been subject to this blind reduction regime felt humiliated and dirty; of course they knew it had been diluted so what does that person do – take it or get nothing? In what other area of medicine are people treated in such an inhumane way? If the person is topping up it is very likely they need more methadone, not less!

If that argument is not won, what about the evidence? Let's think about diabetes instead: somebody needs 20 units of insulin morning or night, but the worker or doctor thinks that is too much – plus the person had admitted to eating cakes so the insulin is diluted and given to the person. In this case when it was discovered, the doctor or worker would be up before the GMC before you could say diabetes; why is it different in drugs? I leave you to answer that one.

If any service or GP is undertaking this barbaric, unethical treatment, please stop. It would also be helpful if the NTA would come out firmly against this practice. And if any person using services has experienced this practice and would like to challenge it, please give the Alliance a ring.

Chris Ford GP, SMMGP GP Adviser and Alliance board member. *(The Alliance's phone number is 020 7837 4379.)*

Alcohol-free is fun

It was encouraging to read the feature on Hope UK's important drug education work and the timely Thirst for Life campaign (*DDN*, 13 February, page 8).

When I was a social worker in London's East End for over 20 years, I worked with many people who were harmed by alcohol. Increasingly I have been convinced of the need for a major national campaign to highlight the benefits of healthy and safe alcohol-free lifestyles.

More people would choose this option if they were aware that people can enjoy life and have fun without alcohol. I would be glad to hear from other readers who have a similar view on trying to reduce Britain's biggest drug problem.

I feel strongly on this issue because I last drank alcohol when I was 13. Since then I have had a tremendous amount of fun and am now a fit and healthy 61-year-old who still loves playing cricket – and I can't wait to get my pads on again and my bat in my hand!

John D Beasley, press officer, United Kingdom Alliance

Kingdom of the blind

Simon Morton's letter 'Come on NTA!' (DDN, 13 February, page 11), comments on an article written by Daren Garratt which referred to a conference presentation reporting the practice of 'blind methadone reduction' in a single locality in the North East of England.

This practice – also known as 'Fixed Volume Reduction (FVR)' – is more common in in-patient detoxification settings but also occurs in the community where a client is on a comparatively small dose of methadone (30mls and under) after a long period of stable substitution therapy and is having trouble ending their use of the drug altogether. In these circumstances, and on the wishes and fully informed consent of the client, a programme may be embarked upon where the same volume of liquid is dispensed (*eg* 30mls) but the amount of methadone in the mixture is decreased without the patient knowing what the rate of reduction is. When the patient has been taking a mixture without any methadone in it for some time (for example two weeks) then they are informed of this and they are then asked to agree the next steps in their care plan with their prescribing clinician.

The evidence base regarding this

practice is limited, although there is one study from the in-patient literature that suggests people do better in detoxification when they are well informed about what to expect. However, there is anecdotal evidence to suggest that this practice, providing there is a clear and unprompted desire on behalf of the patient to try this intervention after other more common strategies have been exhausted, can be effective. There are a number of caveats to this, such as ensuring there are safeguards in place for relapse onto street drugs and that other prescribing options (*ie* buprenorphine) are not suitable.

What this practice should never be (as suggested in Daren Garratt's column, DDN, 30 January, page 6) is some sort punishment following a urine test that is positive for non prescribed psychoactive drugs where a member of staff in the drugs services secretly waters down prescriptions at the point of dispensation.

With regard to the situation in the North East, the PCT/DAT Implementation Group concerned produced a comprehensive paper on prescribing issues in March 2005, which specifically alluded to FVR and co-facilitated an event with the NTA and CSIP (formerly NIMHE) to address this and other issues within the treatment system. The treatment service concerned denies that the practice of involuntary reduction ever took place. Added to this, the area in question only has pharmacy-based dispensation.

The NTA is committed to ensuring that there is high quality and effective treatment available to all, based on evidence and founded on therapeutic commitment. Central and regional NTA staff are in no way complacent and acknowledge that there is much to do in many areas to build on the rapid expansion of capacity and quality treatment services that the field has achieved in the past few years. With regard to the central point made in the original column by Mr Garratt, it is the NTA's view that high quality methadone maintenance (as part of a wider package of support) should be available to all who require it and abstinence should be seen as another option for intervention and not in any way superior.

Colin Bradbury, Regional Manager North East, National Treatment Agency for Substance Misuse (NTA)

Comment

Giving up the weed The recent Channel 4 documentary 'Giving up the Weed' screened as part of its Addiction week (Monday 20 to Friday 24 February) highlighted that away from the arguments surrounding the reclassification of cannabis, many young people are struggling to overcome its grip on their lives. Jonathan Akwue, of In-volve, explains.

The documentary featured the actor and rapper J Rock of Big Bruvas fame who had been smoking weed for 14 years and was desperate to give up. It charted J Rock's struggle to give up one of the constants in his life and witnessed how he coped without it.

'In-volve believes that the arguments over the legal status of cannabis have led to a polarised debate where the needs of young people with cannabis related problems have sometimes been overlooked. In our extensive experience of working with young people across the country we have found that cannabis is often their most pressing issue.'

Realising that he needed support, J Rock turned to In-volve who provided him with one-to-one with specialist coaching sessions on how to overcome his reliance on cannabis. The programme showed how misconceptions about the drug's effects have led to it becoming ubiquitous throughout society, and how some young people now believe that weed is legal and easy to give up.

In-volve believes that the arguments over the legal status of cannabis have led to a polarised debate where the needs of young people with cannabis-related problems have sometimes been overlooked. In our extensive experience of working with young people across the country we have found that cannabis is often their most pressing issue.

Where some services have tended to play down this issue and concentrate on class A drug use, In-volve has developed a successful model of addressing cannabis use that is based in part on exchanges that have been taking place over a number of years between our organisation and Danish treatment programmes for young people and adults that focus specifically on cannabis use.

The Danes have come to identify the need for programmes that target the nature of the drug and the experiences of the user in the same way as we have different treatment programmes for heroin use and crack cocaine use, rather than more generalist counselling or diversionary interventions that they have recognised as having little long term effect. They have also come to the conclusion that the continued use of cannabis during treatment programmes for other drugs has a significant negative impact upon outcomes. In some parts of the country, their statutory services are beginning to integrate voluntary cannabis intervention programmes into services for adult users.

The encouraging news is that these approaches to working with cannabis users clearly work. At the conclusion of the one-month intervention J Rock told the programme:

'I do a test to see whether I've still got THC in my system, and I pass. It feels amazing. It's the first time since I was 13 I've had no weed in my system. Beyond all my achievements, I'm most proud of this. No-one can tell me I'm a pot head any more. And I've realised you don't need weed in your system to be a heavy rapper. You don't need weed to be the best actor. You don't need weed for anything, you just need yourself.'

For more information contact akwue@in-volve.org.uk or see: www.in-volve.org.uk

A new *script* for nurses

The introduction of nurse prescribing has offered nurses a vital role in getting drug and alcohol patients onto the right medication to contemplate recovery. Senior nurse manager Robbie Corrie explains the difference it has made to the service at Windmill House.

Nurse prescribing is relatively new in mental health nursing and more so in substance misuse, but recent amendments to The Misuse of Drugs Regulations 2001, enable nurse prescribers to independently prescribe to treat acute alcohol withdrawals and supplementary prescribe controlled drugs in secondary care. These changes have the potential to empower nurses like myself, who are working in an acute tier 4 inpatient setting.

Supplementary prescribing is a massive development in the speciality of substance misuse. The National Treatment Agency for Substance Misuse has outlined the potential impact for prescribing in this field. They estimate that between 100 and 200 nurses in substance misuse will train, and by doing so will (after development of the clinical management plan) be able to initiate, titrate, continue and adjust doses of controlled drugs in secondary care.

As a senior nurse manager of an acute inpatient setting who has in practice been prescribing for doctors for some time, the introduction of supplementary prescribing will formalise this practice that has been evident for many years.

Situated within Surrey and Borders Partnership NHS Trust in Chertsey, The Windmill Community Drug and Alcohol Team provides a wide variety of treatment options to people who have drug and alcohol problems, either in a community setting or from within a 10 bedded inpatient unit, Windmill House.

Windmill House is a tier 4 service delivery and we frequently admit service users with serious medical or psychiatric complications in addition to their substance misuse problem. It is not uncommon for new admissions to arrive intoxicated, therefore delaying the commencement of medication.

Services and treatments that are provided in Windmill House include assessment, detoxification from drugs and alcohol, and stabilising medication. Patients can be transferred to other drugs including buprenorphine, be put on naltrexone, and have secondary complications treated. Day and home detoxification is offered, and there is a six-week therapy based programme. They can be transferred to tertiary care directly from Windmill House.

Because of frequent reviews, changes in practice (including prescribing) and a policy of listening to the needs of service users, more and more users are successfully completing treatment in Windmill House – particularly those who were opioid dependent. In my experience it is opioid withdrawals that users find most difficult to cope with and therefore put them at a higher risk of relapse.

This is supported by the National Treatment Agency which concludes from studies that successful completion of opiate detoxification is generally higher in inpatient settings than in outpatient settings. The introduction of nurse prescribing in Windmill House will potentially give service users faster and more effective access to medication, particularly out of hours.

Independent prescribers can prescribe from the Nurse Prescribers' Extended Formulary, and in doing so take responsibility for the clinical assessment, establishing a diagnosis, identifying the clinical management of the condition, and ensuring that the prescription is appropriate.

Having just completed the extended independent and supplementary prescribing module at Surrey University, I envisage that I will shortly be independently prescribing alcohol detoxification medication regimes to service users who have alcohol dependence syndrome. Currently our nurses are dependent on a doctor (usually a senior house officer), who joins us on a six-month rotation and with limited knowledge of the pharmacology of substance misuse. They prescribe after a short induction period, under the supervision of our consultant, and with the guidance of local policy that was devised jointly by our doctors and nurses.

To assist nurse prescribers, The National Prescribing Centre identifies seven principles of good prescribing. These are:

- Examine the holistic needs of a patient. Is a prescription necessary?
- Consider the appropriate strategy.
- Consider the choice of product.
- Negotiate a contract and achieve concordance with the patient.
- Review the patient on a regular basis.
- Ensure record keeping is both accurate and up to date.
- Reflect on your prescribing.

The drug of choice in managing alcohol withdrawals is a benzodiazepine. In Windmill House we use diazepam, in conjunction with acamprosate and vitamins. Local policy states that the starting dose of diazepam is estimated by taking into consideration the severity of withdrawal symptoms; any history of previous symptoms including seizures; the age, sex, height and weight of patient; and whether there is serious impairment of liver function.

Dependent on consumption and the above factors, a diazepam regime for a 40-year-old man consuming 80 units of alcohol could be 40 mg daily. Additional diazepam would be prescribed as required, should withdrawal symptoms persist.

The benefits of my independent prescribing for this condition are that as senior nurse manager, my availability to service users admitted to Windmill House is greater than any of the doctors working within our team. The prescription can be reviewed each morning, avoiding the delay until the doctor arrives on the ward.

This is a great advantage in the management of substance misuse, as service users often become anxious or irritable if they perceive that their needs are not being met. In some cases, particularly with users who are heroin dependent, they may self-discharge in order to return to illicit drug use. This is a key time in keeping service users in treatment and if a nurse prescriber is available to review their medication during this period, it may be sufficient to keep them in treatment at this point.

Supplementary prescribing is defined as a new form of prescribing that can be undertaken by non-medical professionals after a doctor has made a

diagnosis and developed a clinical management plan. The benefit of supplementary prescribing in Windmill House would allow the nurse to review (under the supervision of the doctor) methadone and buprenorphine reduction regimes in agreement with the service user. Commonly service users (in my experience) prefer to reduce 5 mg daily, and rarely 10 mg. This reduction can be reviewed each morning to best meet their needs – either by increasing, decreasing or stabilising within the prescribed regime.

The Department of Health describes a clinical management plan as the foundation of supplementary prescribing, and obligatory before prescribing can take place.

Information must include:

- Name of the patient.
- Illness or conditions which may be treated.
- Date the plan takes effect and review date by independent prescriber.
- Reference to the class or description of medicines to be administered.
- Any restrictions or limitations as to the strength or dose of medicine.
- Relevant warnings about known sensitivities.
- Circumstances when supplementary prescriber should refer to independent prescriber.

Medication that could be prescribed in opioid dependence include methadone, buprenorphine, lofexidine, and naltrexone.

Methadone is an opioid drug that is used to prevent withdrawal symptoms in service users with opiate dependence, including persistent intravenous heroin users. Regular use causes physical dependency and once users stop, they will experience withdrawal symptoms. It is a class A controlled drug under the Misuse of Drugs Act 1971. A schedule 2 drug, it is legal to possess only if prescribed by a doctor and administered in accordance with the doctor's instructions.

The Royal College of Psychiatrists identifies methadone as probably the most widely used agent for the treatment of opioid dependence in the UK. In my experience it is the most difficult drug for service users to withdraw from. Never have I witnessed any service user reduce and complete a methadone reduction regime without the need for additional substitute medication.

Buprenorphine is becoming an increasingly popular option for the treatment of opioid dependence. It has been described as equally effective as methadone if administered at equivalent doses. As it is a partial opioid, it demonstrates low level of withdrawal symptoms when stopped suddenly. Some service users prefer it, as they report a feeling of 'clear-headedness' in comparison to methadone.

Dependent on dosage also, service users may experience a sense of euphoria in comparison to other drugs. In our unit we do not commence buprenorphine until methadone has been reduced to 25 mg administered, and then a period of at least 24 hours has elapsed before administering the first dose of buprenorphine. Methadone has by now been reviewed and discontinued.

'The National Treatment Agency for Substance Misuse has outlined the potential impact for prescribing in this field. They estimate that between 100 and 200 nurses in substance misuse will train, and by doing so will... be able to initiate, titrate, continue and adjust doses of controlled drugs in secondary care.'

Another dilemma is: buprenorphine versus lofexidine? The nurse prescriber can educate the service user as to the benefits of both drugs, how they are administered and for what period. Lofexidine appears to be the drug of choice by service users on prescribed methadone doses of less than 50 mg daily, and buprenorphine for those on doses greater than 50 mg.

On some occasions however and for a variety of reasons, some service users have had 'bad experiences' with either, and are clear as to which medication they require.

Recent changes in legislation relating to nurse prescribing in substance misuse give nurses the potential to enhance service delivery in this speciality. Medication is the key to keeping service users in treatment and if it can be prescribed, reviewed or increased at the earliest opportunity, then it may be a tool in assisting more and more dependent people to remain in treatment and secure abstinence.

Although nurses working in substance misuse are latecomers to prescribing, in comparison to general nurses, they now have the opportunity to administer legally, a practice that many have been advocating to doctors for years.

Surely we would be fools not to?

Robbie Corrie is a senior nurse manager in Windmill Community Drug and Alcohol Team within Surrey and Borders Partnership NHS Trust and has recently secured the Extended Nurse Prescribing qualification at Surrey University. This article is based on his fully referenced essay for this course.

Drug and alcohol users are finding help within their own community through RAPt's new day programme in Tower Hamlets. DDN went to see a service already in demand.

A stone's throw from the shiny sharp-suited thoroughfare of London's Canary Wharf, RAPt is celebrating the official opening of its Island Day Programme.

It's a brave move for the organisation, whose full name is The Rehabilitation for Addicted Prisoners Trust, as for the last 14 years their work with drug users has been based in prisons. This is the first time they have set up a service within the community, and as RAPt chief executive Mike Trace points out, people have to turn up in a prison setting. The community programme depends on each individual's commitment.

'It's interesting to see whether people can go home, deal with problems, and still commit to this programme five days a week,' he says. 'First indications are good – and we're very excited about that.'

Councillor Judith Gardiner is only too aware of how much Tower Hamlets needed the service. Before entering local politics she was a probation officer and had difficulty finding places for clients. Services were directed at white heroin users, taking no account of the area's ethnic diversity, and alcohol services were very difficult to get hold of.

Measures like alcohol exclusion zones merely move problems on, says Cllr Gardiner. She welcomes services that will reach people and change their behaviour before they get entangled in the criminal justice system.

Tower Hamlets' DAT co-ordinator Gilly Cottew said the new day programme provided realistic options at last for those who could not contemplate rehab as a practical option. Many people, particularly in the Bangladeshi community, had strong family ties, and 'didn't find it appropriate to go halfway across the country', she said.

'It's important to say that there are other options other than residential treatment,' says RAPt senior manager, Dave Mulvaney. Along with Lifeline, based just around the corner, The Island Day Programme aims to catch people in their net of services before they are pulled back into the criminal justice system.

But, as Mike Trace puts it, RAPt does not 'just parachute in'. Dave Mulvaney explains that the programme looks for 'a fundamental change in attitude and behaviour' from all those who become involved.

The drug free environment requires commitment to abstinence, he says, and participants are breathalysed or swab-tested to make sure they are drug and alcohol free within 48 hours. Then the serious work begins – gently at first, with motivational enhancement therapy and skills training to prepare them for treatment; then with 12 weeks of individual counselling, group therapy, life stories and embarking on steps one to three of the 12-step programme. Fellowship meetings with Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous and Marijuana Anonymous are an important part of the programme, particularly as clients move into their aftercare phase of support and relapse prevention.

Peer support and role models also play a vital part in the programme. Since it opened its doors to clients last October, the centre has welcomed and nurtured people of all ages and backgrounds, all of whom want to stay in their local community. Those who are relatively new to the programme tell of the support and inspiration they get from those who are further into recovery.

Ronnie, a smart young 32-year-old in a suit, has dropped into the centre on his way home from work in Carnaby Street, to be part of the official opening ceremony. He contacted the service five months ago because he had reached the stage of wanting to die. Addicted to drugs for more than 20 years, he realised he had hit rock bottom. 'I had no job and the bailiffs were banging on the door, ' he says. 'I sellotaped up the letter box… my life was absolute hell.'

When his brother and then his best friend decided to seek help for their own addiction, they persuaded him to go to Narcotics Anonymous – who put him in touch with the Island Day Centre.

'When I came in I just cried,' says Ronnie. 'I couldn't do it anymore. I felt like a loose cannon. Staff said I was like a World War Two bomb, jumping around in water.'

The programme has not been easy, but it helped Ronnie get on course to change his life. He realised that he had 'kept doing the same things over again, expecting a different result'.

Now he's making progress, and although he's 'still crawling like a baby', Island has helped him to lay foundations to start living the rest of his life. 'Everyone here cares about you,' he says, which has helped him put new value on his life. 'We may suffer from the disease of addiction, but it doesn't make us any less worthy.'

Sarah had used crack and heroin for 15 years and been in and out of jail for eight years, before coming to Island. She had benefited from Clouds – 'a fantastic rehab' – on the suggestion of her counsellor at HMP Cookham, but realised when she emerged that she had no structure in her life.

Island filled the gap, helping her to integrate back into her community – an experience that Cathy is also now benefiting from. Approaching 50, and with 30 years of opiate use while she struggled to bring up her son, she had been 'slave to the chemist and the doctor' and describes her life a short time ago as torment.

She will have been 90 days 'clean' next week and says the most important achievement for her is being able to live in her old familiar neighbourhood, knowing she can be strong.

And so the stories of hope continue. Taz, a Bengali, was suicidal six months ago from nine years of coke and crack use.

Bringing services to the door

Dave Mulvaney: The programme looks for a fundamental change in attitude and behaviour... The drug free environment requires commitment to abstinence and participants are breathalysed or swab-tested to make sure they are drug and alcohol free within 48 hours.

Chris had spent 14 of his 30 years on crack and heroin, reaching such a low point that 'going to prison saved my life'. Forty-six-year-old Charles found himself flung from a stable job and loving family by being introduced to crystal meth.

For each of these people, Island is proving to be the bridge back to their community, and to reality.

'It was OK being in rehab, but it was a cotton wool environment,' says Chris. 'Here the real work takes place… I'm finding out a lot about myself.'

Between the prison CARAT workers and the team at the Island Day Programme clients are being given the support they need to integrate back into society.

Ronnie is an inspiring example of someone coming out the other side. 'I have a job and responsibility. People look up to me at work. I'm about to go on holiday,' he says, as if he can hardly believe it himself. Considering he wanted to die just a short while ago, that's not a bad five months' work. **DDN**

For more information on RAPt's Island Day Programme, call 020 7538 0184 or email info.island@rapt.org.uk.

Supportive ANSA for nurses

ANSA has supported nurses working in the substance misuse field for the past 23 years. Now, more than ever, the association plays a key role in representing the nurse's voice to decision-makers, as Malcolm Carr explains.

The Association of Nurses in Substance Abuse was formed in 1983 as an interest group for nurses working in drug and alcohol services. Many who work in the field now will have no memory of those dark (and sometimes heady) days as the field of substance abuse (as it was then called) moved care from the Regional DDUs (Drug Dependency Units) to the CDTs (Community Drug Teams) during the last 15 years of the twentieth century. Strange to think now that in those early years of ANSA's existence, many nurses worked in unsupported and isolated situations and, as a single professional organisation, ANSA was often the only support system available.

Reflecting on the last eight years we have seen the introduction of a Drug Czar, long term strategic planning, the development of the NTA and millions of pounds poured into services. None of this was conceivable in 1983. Services developed during the life of ANSA have indeed undergone many changes and have rapidly expanded.

Throughout its existence, ANSA members have discussed, supported and raised concerns about the way services have developed. Recent hot topics have been Nurse Prescribing, which ANSA has broadly supported (with an awareness that it is an area which needs ongoing development, both for individual practitioners within specialities and for the nursing profession as a whole) and the health agenda. For many nurses a real issue continues to be the need to keep the health of service users as high on the agenda as socio-economic issues, particularly in relation to the harms associated with alcohol and drug use. ANSA has always included tobacco in its scope.

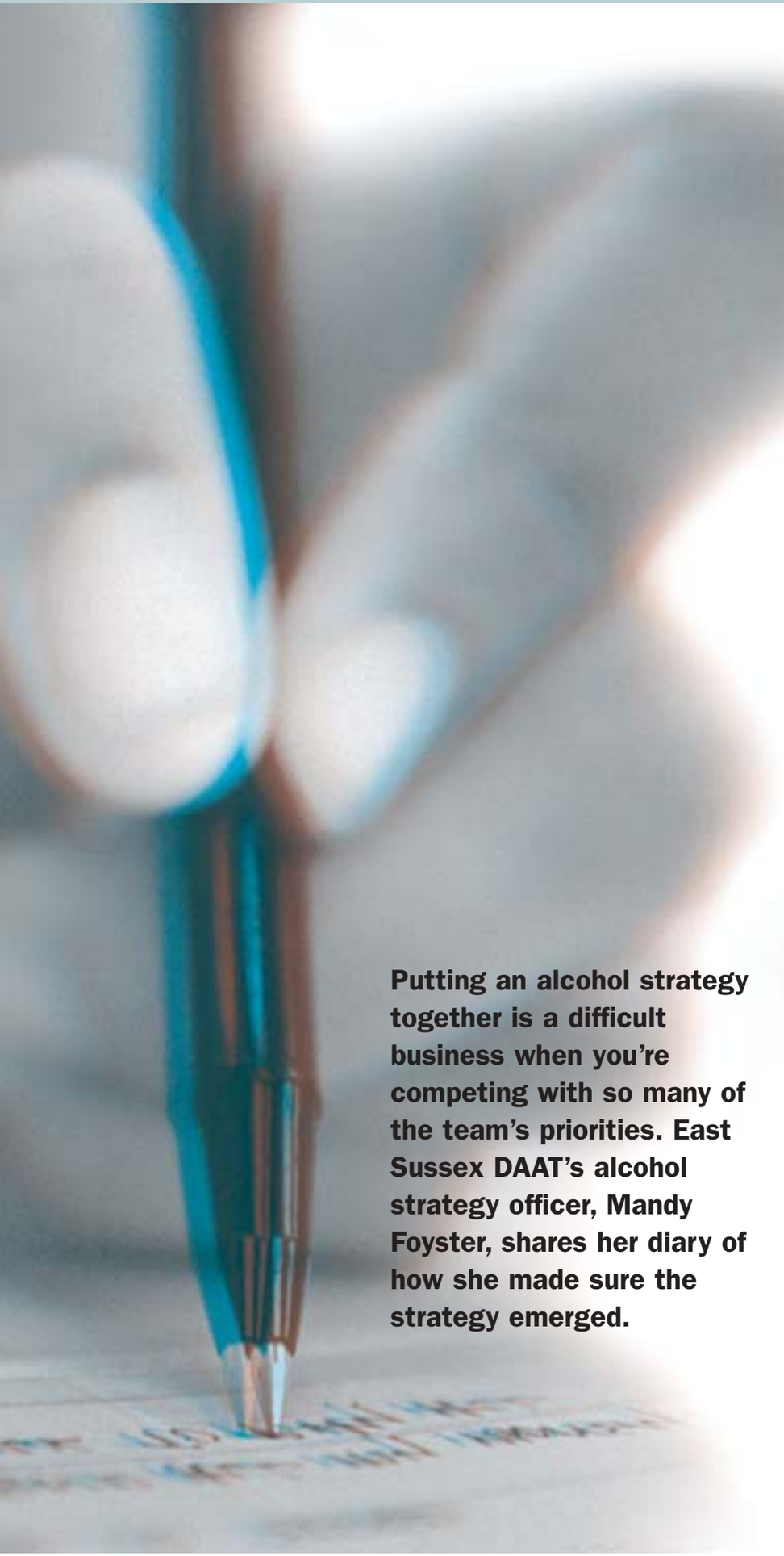
One of the coming hot topics will be the role of the nurse and recognition of nurses as specialist practitioners within the field of substance misuse. Nurses are skilled professionals who have a major contribution to make to the workforce and whether a mental health trained nurse or a general trained nurse, the contribution is a key and important one. As a professional group, nurses may not always have been very articulate at describing their contribution but are key players in the multi-disciplinary team. Because nurses train with a health remit, they are able to interject health needs into care in a different way to generic drug workers and counsellors. Those nurses who move into the substance misuse field, either from a psychiatric or general nurse background, are able to add a unique and disparate knowledge set into their role.

ANSA is a membership organisation; its officers are elected at an annual three-day conference and are unpaid. We welcome members from other disciplines as associate members but only nurse members have full voting rights.

We recognise that nurses no longer work in isolation and indeed ANSA recognises that as an organisation, it cannot stand in isolation – but we are unashamedly a nursing organisation, and will continue to be so. ANSA has over the years given input to the Department of Health, Home Office, NICE, NTA, ACMD, RCGP and many other working parties. In doing so we are able to speak directly to our membership and give them opportunity to feedback their thoughts to the corridors of power.

The ANSA booklets which cover several different aspects of the nurses role in the field should be available (in PDF) on the ANSA web site which is due to be re-launched in a few weeks at www.ansa.uk.net. Watch this space for an announcement.

Malcolm Carr is vice chairman of ANSA. To enquire about membership, call 0870 241 3503 or email ansa@profbriefings.co.uk.



Diary of a local alcohol strategy

Putting an alcohol strategy together is a difficult business when you're competing with so many of the team's priorities. East Sussex DAAT's alcohol strategy officer, Mandy Foyster, shares her diary of how she made sure the strategy emerged.

Alcohol is certainly in the news these days! Concerns about the Nation's health and about alcohol related crime and disorder are often expressed in media headlines, and the costs both social and economic are high. With a sound drug strategy in place and robust work going on in the illegal drug field, East Sussex Drug and Alcohol Action team knew that the time was ripe to focus more attention on alcohol.

January 2005

I'm appointed to the Post of Alcohol Strategy Officer, situated within East Sussex Drug and Alcohol Action team. With a background in education and prevention I know that it's going to be a steep learning curve but am clearly unprepared for quite how steep. The structure of the county's management is complex. We have five district and borough councils, four primary care trusts, five crime and disorder reduction partnerships and Sussex Police operate five districts within the county. Needless to say, these bodies don't all share the same boundaries and the various areas are not homogenous and subsequently have widely differing needs and problems.

Within the various districts are wards with high levels of deprivation alongside wealthy, middle class communities. Alcohol, however, affects them all. We are fortunate in having a dedicated voluntary alcohol service but there is no dedicated money for alcohol and uncertainty about how the situation can be improved.

We establish an alcohol group with senior representation from all the key stakeholders. The first meeting is well attended, the terms of reference are agreed and I'm charged with the initial task of an alcohol audit or review, in order to begin the process of shaping a local alcohol strategy for publication early next year.

February

I begin to realise how big this job is. Sometimes it seems a shorter task to list the areas which are unaffected by alcohol than to identify the areas which are! The London Drug and Alcohol Network/Alcohol Concern Toolkit provides an invaluable source of help in structuring my approach, as do various colleagues within the PCTs, Sussex Police, CDRPs and the county council.

Two of our PCTs already have Alcohol Strategies (obviously specific to their own areas). Fora for partnership working are well established across the county but despite this I know that balancing the different agendas will be challenging.

April

Data collection proves an enormous challenge. Action for Change (our voluntary alcohol service), collects basic client data but doesn't have the

resources to carry out outcomes monitoring. They naturally respond to requests for data from their various funders but (unlike illegal drug services) have no duty to provide the DAAT with data. The staff always respond helpfully to my requests but already it is clear that improving data collection and availability will have to be a priority.

Where data does exist, it is often not collected consistently across the county, so comparisons are difficult. One PCT collects information about average unit consumption of alcohol and only information relating to numbers drinking above government guidelines. Charts and tables get bigger and more unwieldy until, in the end, I wonder if they have any value at all!

I begin to realise how big this job is. Sometimes it seems a shorter task to list the areas which are unaffected by alcohol than to identify the areas which are!

May

Alcohol Concern is currently consulting carrying out a consultation exercise about the proposed Models of Care for Alcohol Misuse (MoCAM). We establish a local group in order to collate a county-wide response. As well as identifying various gaps, one of our main concerns is the question of what influence the document will have, especially with commissioners. Despite these concerns we hope the final MoCAM will be published soon, as it has to inform the direction of our local strategy.

July

We hold a consultation event on the final draft of the Review. It is well attended and constructive. By the end of July we are able to complete the final document and post it on our website. This information and the long list of recommendations will form the starting point for our strategy.

The thematic headings for the strategy are agreed. These are: young people, families, adult support, identification and treatment, and crime, disorder and the alcohol industry. There are areas of overlap between each of these, and a significant amount of cross-referencing will be required. Thematic focus group meetings are arranged in order thrash out our real priorities. This will be very difficult and time consuming work; balancing the aspirational with the achievable.

There is so much potential work that could be done and so little money. Senior colleagues within the county council are currently working with partners on the development of the new Local Area Agreements and exploring the links between the emerging priorities within these and within the alcohol strategy.

August

Some exciting ideas are beginning to emerge. Limited funding does encourage creative thinking and in certain areas we feel we can improve services by reviewing the way they operate and making operational changes. However, we also want to introduce some new ways of working within the county and hope that these will include a Family Alcohol Service, with dedicated workers able to identify and work with parents with alcohol problems in the context of their family situation. We are also considering how to establish an ambulatory detoxification programme, which would enable more patients to access detoxification on a more cost efficient basis.

October

The focus group meetings go well. Partners are very committed to producing a document which will have real influence across the county. This means demonstrating clearly what the problems are, what we are already doing – and the evidence-base for effective interventions. Once completed, the strategy will run up until 2008, to mirror our drug strategy. We need to be realistic about what is achievable within this timescale and accept that not all our concerns will be addressed. However, one central theme of our understanding is the need for a cultural shift in our relationship with alcohol, which will be required in order to effect real change. We have to accept that this will be a long process and only achievable through concerted efforts, both nationally and locally.

The consultation process never really stops and I attend as many meetings across the county as I am able, making presentations where possible. In between these, the evolving draft document is emailed out to key partners and one-to-one meetings and phone calls are ongoing. The document changes and grows on a daily basis. As local priorities begin to emerge, framed by our partner's key aims and targets, I try to dovetail them to fit with national guidance and legislation.

Leaving the office with a colleague one afternoon, the body of a street drinker is discovered on derelict space adjacent to our building. This is both a shocking and deeply saddening experience for all our team. Over the next few days, various conversations take place and thoughts are exchanged. I detect an increased resolve to improve support for those with alcohol affected chaotic lifestyles.

November

The DAAT Annual Stakeholder Conference takes place at the beginning of the month and in addition to presentations about alcohol, there are opportunities for the delegates to participate in workshops. The day proves invaluable in identifying gaps and inaccuracies and moving the strategy another stage closer to completion.

One of the main challenges in the production of this document has been working in a constantly changing environment and trying to keep abreast of new developments. On the 24th of this month the 2003 Licensing Act comes into force. Our licensing officers have been working hard and rigorously to process all the applications and opinion is divided as to what the impact of the Act will be on our town centres.

At the same time we are anticipating changes within other local structures, including Sussex Police and the primary care trusts. These structural changes will hopefully provide opportunities for establishing improved partnership working, but they also cause some uncertainty. There is still no sign of MoCAM!

December

The final draft of the strategy is completed and the Alcohol Group and ESDAAT Board give their approval subject to some final amendments. We want this document to be easily accessible to all the stakeholders and it has been agreed that the detailed actions required to address our priorities will be set out within the implementation plans which will support the strategy. We identified four existing DAAT subgroups who will each take responsibility for overseeing the implementation of the strategy and monitoring its progress. Formatting and layout of the final document is underway and the document will be formally launched (in one of our local hostelries, of course) on 29 March 2006.

All in all, 2005 has been a challenging and stimulating year. I suspect, however, that the real work starts now!

My son is a heroin addict who is injecting. He has taken subutex and I thought he was clear. I need help to support him onto another program, but where do I start? He is a nice person under this mixed-up mess and I love him very much. Problem is, that last time he was on drugs we became estranged because he was uncontrollable. I do not want to lose him again and he does not want to lose me. PLEASE HELP to put me in the right direction, as I do not know enough about my son's problem.

Brigitte, by email

The right direction

Dear Brigitte
I'm sorry to hear of your problems with your son's heroin use.

To answer your question concerning not knowing enough about his problem, but wanting help to support him, you should be aware that there is now lots of support for parents and concerned others in most areas of the country. This usually takes the form of support groups and helplines.

I suggest that you contact your local drugs agencies or DAAT for details of the groups that provide support in your area. These groups are often run by people who have experienced similar situations to yourself, and usually have lots of information and contacts that would be of great help to you. They are free, totally confidential, non-judgemental and non-discriminatory, and often just talking to others who attend can have a huge effect on helping to address the issues involved.

We run such a group in Gloucestershire, and can confirm that the majority of people who contact us and/or come along to our meetings realise that they are not alone, and that discussing the issues with others in a similar situation is of tremendous help. Remember that you count too, and to help your son you also need to take care of yourself.

Find a group Brigitte, and let them support you while you support your son. Good luck!

Ian MacDonald, Cheltenham Parent Support Group (CPSG), Tel: 01242 222872 www.cpsg.org.uk

Two sides to the problem

Dear Brigitte
Your question contains such strong and sadly, familiar feelings: frustration, disappointment, a sense of helplessness and a fear of loss. It is all the more poignant because of the love you feel for your son and that he feels for you. Addiction – his relationship to heroin – has got in the way and threatens you both.

One thing we have learned is that there is always hope and expressing your need for help is an important first step. You are very clear. You want to know where to go and what to do.

There are two sides to this. Find out more about addiction and how it affects the user. This will help remove some of the mystery and confusion. It will not of course provide you with a magic bullet with which to make your son recover. You can tell him you love him and fear for his wellbeing. You can find out all the treatment options for your son and offer this information to him but you will not be able to make him take any of them, as I'm sure you realise. That is up to him. You will be there to support him in seeking help, if he wants you to.

In the meantime, you are suffering and we would advise getting some support for yourself to try and reduce stress, find ways of coping and lift your spirits and self-esteem. There is no point in letting addiction claim two people. Families Plus was set up to respond to the needs of family members in our position and if you would like to get in touch we will tell you the variety of things we have to offer or point you in the direction of others who may be able to help. There is absolutely no guarantee, and you must not approach self-help with that in mind, but sometimes when family members start to look after themselves, the addicted person moves in the direction of seeking help for themselves.

Tessa Barrett, Head of Clouds Families Plus. Tel: 01722 340325. Email: admin.familiesplus@clouds.org.uk. Website: www.clouds.org.uk/family.htm

PS In our next issue we will publish a letter from a mother who found herself in a similar situation to you, and found strength from contacting the Clouds Families Plus Service. Please look out for 'Letter to Georgie' in the 13 March issue of DDN, as we hope it might help you.

Support yourself first

Dear Brigitte,
Firstly may I humbly suggest that you seek some support for yourself. There are now more and more good active groups for carers – in my area we have two very good ones, one of which is run by a good friend.

Secondly, your story rings so true. I sat on a certain daytime t.v. show in desperation, only to have the whole thing turned round on me. A certain lady told my mother that there were services to deal with my body when found in an alley, after doing as she was told to do by the audience – to throw me out.

Please do not give up on him, evidence shows that it takes a minimum of seven to ten attempts at treatment until you truly engage. By the same token, I think even a mother knows in her very essence when she has lost you. My message is don't give up trying – my life is proof. Maybe a correct dose of Methadone with a good individually tailored care package (pathway) would be of benefit.

For inspiration or carer contact, please contact me. (My details are with the editor.)

Tony B, by email

Reader's question

We'd like to provide a better service in our rehab for people with learning difficulties or cognitive impairment. Can anyone advise me on inspiring programmes, materials or methods that would help us?

Meg, North Yorkshire

Email your suggested answers to the editor by Tuesday 21 February for inclusion in the 27 February issue of DDN.

New questions are welcome from readers.

(Some) counselling maximises methadone's cost-effectiveness

***DDN* starts its trawl through the back issues of *Drug and Alcohol Findings* to summarise key 'Nuggets' from the 165 published to date, highlighting important new studies. The first extract is from issue 1 published in 1999.**

Findings: For the first 24 weeks, 100 US clients starting methadone maintenance were randomly assigned either to minimum support (monthly counselling session), intermediate (three sessions a week), or enhanced support (seven sessions a week plus medical, psychiatric, employment and family therapy services). More support led to better drug problem, crime and health outcomes. The cost of services actually delivered (as opposed to available) per patient abstinent from heroin and cocaine was lowest for the intermediate option; further enhancements improved outcomes but were not cost-effective.

In context: Service enhancements absorb resources which could otherwise be used to expand basic treatment slots; is it best to spread thin but wide and catch more clients, or do more work with fewer? This study suggests that increasing the availability of counselling modestly buys more abstinence per dollar than offering daily access plus other services.

Practice implications: The ceiling beyond which services supplementing methadone are no longer cost-effective may be quite low for many people though higher for those with greater problems. To gain worthwhile further benefits, extra services geared at reintegration may need to forge links with external agencies such as those dealing with education, housing and employment.

There is also a floor below which investment in methadone treatment is partly squandered through inadequate support. Cost-effectiveness is probably maximised by making more intensive, well managed counselling and other services available. UK prescribing services could meet these needs more systematically.

Featured studies: Kraft M.K. *et al*. 'Are supplementary services provided during methadone maintenance really cost effective?' *American Journal of Psychiatry:* 1997, 154, p. 1214-1219.

More information and free downloads at www.drugandalcoholfindings.org.uk or phone Findings at the National Addiction Centre, 020 7848 0437.

The drug experience: heroin, part 1

In his latest Background Briefing, Professor David Clark sets the scene for forthcoming Briefings on the heroin experience. He emphasises the necessity to consider the role of drug, set and setting when considering the impact heroin has on lives.

Heroin is the illegal drug that has the worst reputation. The popular press never tires of informing us of new 'heroin deaths'. Government considers heroin to be the cause for much of the acquisitive crime that occurs within the UK. Local officials will often ignore heroin problems in the community because of the stigma associated with the drug.

Heroin is also the drug that myths are made of. In their book *Heroin Century*, Tom Carnworth and Ian Smith point out that no drug has been subject to more misinformation and moral panic.

Here is a drug that is pilloried on the one hand, and yet is used (diamorphine) in the UK without controversy to treat severe and intractable pain, such as that arising from illnesses such as cancer.

It is a drug that is so controversial that when two Scottish researchers published a paper that identified 126 long-term heroin users in Glasgow who were not experiencing the health and social problems normally associated with the drug, there was an outcry from certain circles. Some people considered it irresponsible that such research was published.

In one sense, the first part of the title of this Background Briefing is misleading: 'The drug experience...' There is, of course, no single drug experience, rather a multitude of experiences. It is important to emphasise this point, particularly when considering a drug as controversial as heroin.

Heroin has terrible long-term consequences for some people who try the drug. They become addicted to, or dependent on heroin, and experience withdrawal symptoms when not taking the drug. They reach a point where the drug is more important to them than anything else. They need it on a daily basis in order to function normally.

Their addiction to heroin has many repercussions, which can include a deterioration in their physical and mental health, breakdown of family relationships, loss of employment, housing and material possessions, and participation in criminal offences to fund their habit. They risk overdose, as well as catching blood-borne viruses, such as HIV or Hepatitis C, from sharing needles and syringes.

However, only a small minority of people of people who try heroin take this drastic path. This is clearly evident from statistical data from the US National Household Survey. In the 1999 survey, just over 3,000,000 people were reported to have tried heroin at some time in their lives, but only 208,000 had used in the past month. Therefore, 93 per cent of people who had used heroin had either given up or were not using dependently.

'It is a drug that is so controversial that when two Scottish researchers published a paper that identified 126 long-term heroin users in Glasgow who were not experiencing the health and social problems normally associated with the drug, there was an outcry from certain circles. Some people considered it irresponsible that such research was published'

It is easy to consider drug effects in a simplistic, physiologically pre-determined fashion. However, as we have discussed in various Background Briefings, the subjective effects of drugs are determined by drug, set (*eg* a person's personality, expectancies, emotional state) and setting (the physical and social setting in which drug use takes place). This fact is no less relevant to heroin, than to other drugs that are considered less dangerous.

While some people experience great difficulty in stopping use of heroin, we described a large-scale study which showed that the vast majority of American soldiers who were addicted to heroin in Vietnam, did not show addictive behaviour in the 12 months following their return to the US (*BB*, 21 February 2005).

If we are to understand the factors that underlie problematic drug use and addiction, and help people recover so that they can lead healthy lives, then we need to look at the lives of people who use heroin (and stop or try to stop using the drug). Ethnographic studies dating back to the work of Robert Park and his colleagues in the US in the 1920s have provided important insights.

Chuck Faupel (1991), on the basis of interviews with heroin users in Delaware, talked in terms of heroin 'careers'. He described a career as 'a series of meaningful related statuses, roles and activities around which an individual organises some aspect of his or her life'.

Faupel provided a chart of four common patterns of heroin use which depended on two key elements: the availability of the drug and the underlying structure of the user's life. Structure was considered as a function of the regularity of social networks and patterns of behaviour.

Four types of user were described by Faupel: the occasional user, the stable user, the free-wheeling user and the street junkie.

The street junkie is the type of user most described by the popular press in the UK, the one that most people perceive as being the 'typical' heroin user. The street junkie is the most visible heroin user – and the one most likely to attend treatment services.

The most common route into 'junkiehood' is through lack of life structure. Many people who become street junkies do not have a life structured around conventional jobs and activities, and do not have a commitment to a conventional personal identity, factors which can help keep drug use under control. They commonly lack adequate funds to purchase heroin. In fact, many of these people have had bad life experiences (*eg* social deprivation, long-term unemployment, sexual abuse) before they started taking heroin.

In our next Background Briefing, we will look at the heroin experience from the perspective of people of whose lives have been seriously affected.

Recommended Reading:

Tom Carnwath and Ian Smith (2002) *Heroin Century*. Routledge.
Michael Gossop (2000) *Living with Drugs*. Ashgate.
James McIntosh and Neil McKeganey (2002) *Beating the Dragon: The Recovery from Dependent Drug Use*. Prentice Hall.

Better standards in drug testing: part five

Confirmation testing

The results of testing must represent the whole truth and nothing but the truth, says Phil Houldsworth in the fifth of his six-part series.

We have now arrived at a situation where we have screened the sample, either on site or in the lab, and have a positive result. If we have the donor and the screen result in front of us, we challenge them. Three possible outcomes present themselves: firstly, the donor agrees with the result and no further action is required; secondly, the donor disagrees with the results; or thirdly, the donor agrees with the result but you don't believe the donor. Outcomes two and three need laboratory confirmation. If the sample was screened by a laboratory, then they should automatically confirm the findings of the screen, if they have the right equipment and staff. (This is something you check.)

'What does it actually mean? Does finding morphine in the sample indicate that the sample donor has taken heroin, or that they have eaten poppy seeds? It is crucially important that the laboratory or some other body can provide you with expert advice.'

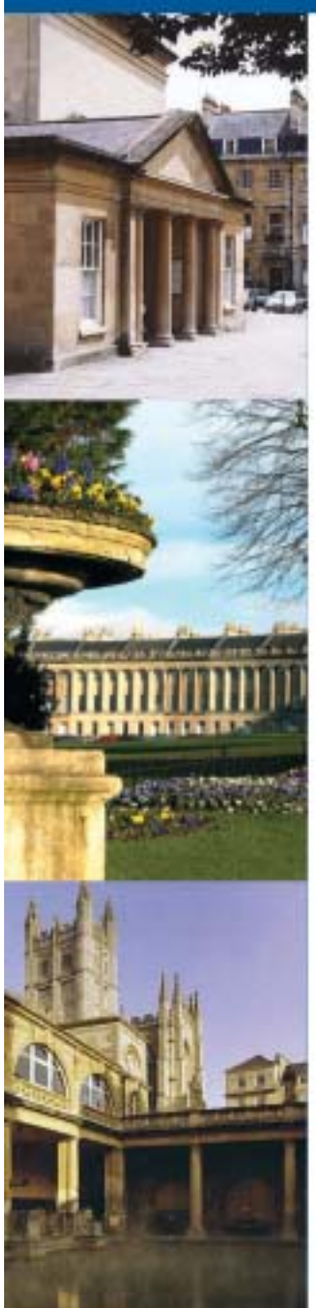
The laboratory will firstly confirm they have the correct sample and then carefully extract from the sample the drugs indicated by the screen. Once they have been extracted from the sample they are analysed by either GC/MS (gas chromatography/ mass spectrometry) or LC/MS (liquid chromatography/mass spectrometry) to determine conclusively what they are. The extracted sample is firstly separated into individual components by gas or liquid chromatography. What starts off as a complex mixture is separated into individual components. As the individual components are separated, they are then analysed using a mass spectrometer. The mass spectrometer shatters the individual components into fragments and these fragments are collected counted and arranged into a fragmentation pattern. It is a physical property of all drugs and compounds that they form unique fragmentation patterns inside a mass spectrometer. So from the time it takes the sample to travel through the chromatograph and the unique pattern of fragments formed by the mass spectrometer, we can conclusively identify the drugs or compounds extracted from the sample.

Another consideration now that you have a definitive answer for the sample content is – what does it actually mean? For instance does finding morphine in the sample indicate that the sample donor has taken heroin, or that they have eaten poppy seeds? It is crucially important that the laboratory or some other body can provide you with expert advice on this and other issues, and that the advice will stand up to scrutiny from others.

Confirmation testing is time-consuming and expensive, but absolutely vital if a high evidential value is required for the result. Confirmation testing should only be carried out by laboratories that have a proven track record and are accredited to a recognised standard. In my opinion, this list of recognised laboratories is limited to those that are accredited to ISO17025 by the UK Accreditation Service (UKAS). A list of these laboratories can be found on the UKAS website at www.ukas.org.

Phil Houldsworth is managing director of Tackler Analytical Ltd, which sets up and administers drug testing quality assurance programmes.

unhooked thinking



The Unhooked Programme

An unusual, international and multi-disciplinary conference enquiring into the nature of addiction

Professors
Bruce Alexander from Vancouver,
David T. Courtwright from Florida,
John B Davies from Strathclyde,
Stanton Peele from New Jersey and
Richard Velleman from Bath
will be joining film-makers, doctors, service users, writers, policy makers, psychologists and others to ask the unaskable:

- just what is addiction?
- Why do the billions governments throw at the problem just seem to make it worse?
- How can we make a difference?

Unhooked Thinking starts with a civic reception and dinner in Bath's historic Pump Rooms on **April 18th 2006**, then moves to the equally historic Assembly Rooms for 3 days of discussion, illumination and examination of the roots and culture of addiction. For all you need to know and bookings:

www.unhookedthinking.com

April 19th-21st, 2006,

Bath, Somerset, UK

supported by DDN Drink and Drugs News

www.unhookedthinking.com

addaction

Helping individuals and communities to manage the effects of drug and alcohol misuse

Towards Independence

Aftercare and the Drugs Strategy

These two identical day-long conferences in Newcastle and London will include speeches by leaders in the field and afternoon workshops on all aspects of aftercare. This is a major opportunity for practitioners to come together to share experience and practice and to move the aftercare agenda forward.

Just £20 + VAT

Newcastle Royal Station Hotel, Thursday 6 April 2006
London Brunei Gallery, SOAS, Thursday 11 May 2006

For more information or to make a booking:
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EATA

TACKLING DRUGS CHANGING LIVES

NECA Achieve™

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Are you searching for a database system that fulfils external data reporting requirements in the substance misuse sector?

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- Production of monthly data returns to the National Drug Treatment Monitoring System
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- Service Level Agreement Reporting
- Client evaluation tool
- Young Peoples Services data collection and reporting
- Harm Minimisation database
- Measurement of waiting times

To find out more regarding the above and other new projects in development, or to arrange a no obligation demonstration please contact:

INVESTOR IN PEOPLE

Keith McIntyre:
Telephone: 0191 2983544
Fax: 0191 2739371
E mail: keithmcintyre@neca.co.uk

Head Office address:
NECA, Thorne House, 88-89 West Road, Newcastle Upon Tyne, NE15 6PR.
Website address: www.neca.co.uk

For details of upcoming exhibiting dates please contact Keith McIntyre on the above number for further details

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Resolve

Education and Training in Motivational Interviewing

Motivational Interviewing Skills Training

Monday 10th and Tuesday 11th April 2006
Monday 12th and Tuesday 13th June 2006
Monday 25th and Tuesday 26th September 2006
Monday 27th and Tuesday 28th November 2006

Venue: 22, Lonsdale Road
Queens Park
London, NW6 6RD

For further information contact:
Heather Malcolm at SHOC
t: 0207 604 4826
e: shoc@gp-e84025.nhs.uk

Adfam

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NOMS National Offender Management Service

Working together to reduce re-offending

Partners in Prevention 2006

Engaging Families in Offenders' Drug & Alcohol Treatment and Resettlement

A one-day conference
Wednesday 29 March, 2006

Paragon Hotel, Birmingham, 9.30 am to 4.15 pm
Cost £60.00 (includes refreshments and report)

Keynote Speakers:

Andy Keen-Downs
(Conference Chair)
Director, Prison Advice and Care Trust (PACT)

Helen Edwards
Interim Chief Executive, NOMS

John Boyington
Director, Prison Health & Offender Management Partnerships, NOMS

Mary Wyman
Head of Service Development, Youth Justice Board

For further information please contact:
Jenny Clark, Adfam, Waterbridge House, 32-36 Loman Street, London, SE1 0EH
Tel: 020 7202 9430 Fax: 020 7928 8923 Email: j.clark@adfam.org.uk

There is a limited amount of exhibition space still available.

the WAREHOUSE DUDLEY DRUG PROJECT

The Warehouse (Dudley Drug Project) is an independent community based drug project (Charity no. 1020293) currently based on three sites incorporating both adult drug services and young people's substance misuse services, with a growing portfolio of partnerships (Community Safety, Police, Health, Probation, YOS), providing a range of counselling, information and treatment services for Dudley (West Midlands).

All posts are based within our adult service teams.

DIP Referral Worker - Full time (C1)

Drug Worker - Full time (C2)

Drug Worker - Part time – Hours to be negotiated (W1)

Salary scale for all posts A&C 6, £21549-£25212 pro rata

Senior Drug Worker (C3)

Salary Scale A&C 7, £26220-£30672

To complete our teams of paid and volunteer staff, we require 4 qualified workers (e.g. DipSW/Y&C, RMN/RGN, Dip Couns) with experience in the substance misuse field, to support, deliver and develop referral and treatment services

Closing date for receipt of applications: Monday March 13th at 4.00pm

For informal enquiries regarding C1, C2 and C3 posts Tel 01384 457866.

For informal enquiries regarding W1 Tel 01384 480058.

For application packs Tel: 01384 480058.

Charity no. 1020293

Oldham Drugs and Alcohol Action Team

Tenders are invited

to provide the coordination of education, training and employment support for adult substance misusers as part of the Structured Day Care Programme, in order to initiate a continuous support framework for personal development.

Numbers expected to be engaged and enrolled onto the programme are approximately 250 in the initial year. Minimum criteria for continued client attainment shall be set.

For further information please contact:
Mr. Perry Gunn, DAAT Business Manager,
Oldham Drugs and Alcohol Action Team, Positive Steps Oldham,
Medtia Place, 80 Union Street, Oldham, OL1 1DT
Tel: 0161 621 9323
Email: perrygunn@positivestepsoldham.org.uk.

Expressions of interest in tendering for the contract should be submitted in writing by 5pm 13/03/2006 Note that the return date for completed tenders is 5pm 27/03/2006.

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dat Hackney Drug Action Team

EXPRESSIONS OF INTEREST

DETOX PLUS SERVICE

Hackney Drug Action Team (DAT) is inviting expressions of interest from suitably experienced organisations to provide a residential substance misuse detoxification, stabilisation and aftercare service. The DAT has identified premises in Hackney from which the service will be provided, and the service provider will be required to sign a lease with the landlord.

The service will aim to reduce the harm of substance misuse to clients and others, by providing detoxification followed by aftercare support to facilitate clients' reintegration into the community, in line with national and local frameworks (eg Models of Care).

The service will form part of the DAT's community-based response to substance misuse in Hackney, and include the following components:

- Assessment and care planning
- Prescribing substitute medication
- Detoxification from illegal drugs and medication
- Counselling and motivational work, stress and anger management
- Relapse prevention, harm reduction advice and education
- Alcohol awareness
- Individual support and promotion of education, training and vocational experience
- Improved skills for activities of daily living, housing advocacy and resettlement work
- Aftercare and support, including support to access rehabilitation

The contract will be for a period of three years, commencing in June 2006, with an option to extend for up to two years thereafter.

Expressions of interest in tendering for this contract should be submitted in writing by Friday March 17th to: Annoesjka Valent, DAT Administrator, Hackney DAT, Maurice Bishop House, Reading Lane, London E8 1HH. Fax: 020 8356 2241. Email: annoesjka.valent@hackney.gov.uk

The DAT expects to send out the Tender documentation in the week beginning Monday 20th March 2006.

Hackney

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Dedicated Professionals, Substance Misuse, Expertise and Passion... make a difference

Scotland/Edinburgh

Altrix Healthcare PLC is a rapidly growing healthcare company marketing a revolutionary range of testing and reporting technologies for use in substance misuse clinics and the criminal justice system. The company has over 250 sites using its products and is now launching blood borne virus testing services in its current markets.

This newly created role represents a unique opportunity to enter the commercial world, where you'll spend your time with existing customers, working and building relations with a wide range of professional staff at the sharp end of substance misuse. The role will place a great deal of emphasis on the provision of training as well as the provision of management information.

A dedicated professional in an area such as health, probation or social care, you'll be passionate about providing outstanding customer service with a desire to make a real difference. With excellent communication skills, you'll be curious and inquisitive, well organised, self-motivated, analytical and service oriented. Naturally we'll provide all the necessary training but it's essential that you have a full driving licence and a flexible approach to your working hours.

To apply please contact our retained recruitment advisers COLIN SMITH or ANDREW EVANS, quoting ref. E873 by sending full career details to The Recruitment Management Group, The Maltings, Wilderspool Causeway, Warrington, Cheshire WA4 6PU. Fax: 01925 650088, email: recruit@rmg-uk.com or telephone: 01925 655222 for an initial discussion. Interviews will be conducted in Scotland.

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STAFF NURSES

POST 1: BAND 6 • £20,458 - £30,247 PA • REF: 00522
POST 2: BAND 5 • £17,049 - £24,198 PA • REF: 0818

Are Drugs and Alcohol your thing?

- Do you want to know about detox, stabilisation and front loading?
- Do you want to nurse challenging clients?
- Are you interested in learning new skills?
- Can you keep your head when others are loosing theirs?
- Is team work important to you?
- Can you have a laugh yet maintain your professionalism?
- Can you apply common sense to situations?

DASS Inpatients is a 12-bedded unit in Edgbaston offering a range of interventions to clients with substance misuse problems over a three week treatment period.

As well as learning evidence-based pharmacological and psychological interventions, you will provide clients with daily routine and structure in a safe environment where no interaction is insignificant.

This is also an opportunity to learn about the impact of drugs and alcohol on service users as many present with a wide variety of physical problems and conditions requiring medical intervention.

A high turnover of clients ensures a varied and interesting learning environment where no two shifts are the same and where clients often make remarkable progress.

If you have answered yes to all of the above and have a genuine interest in this field then please request an application pack from Recruitment on 0121 678 3210 or contact Magdalena Roskell, Ward Manager for further information on 0121 685 6258/6260. You can apply online at www.bsmht.nhs.uk click on working for us and follow the link to E-recruitment.

Closing Date: 13 March 2006.

Successful applicants are subject to a criminal records bureau disclosure.

On Track: Helping People Get Better

www.bsmht.nhs.uk

Oxford Safer Communities Partnership
Oxford City NHS
Primary Care Trust

Part-time Community Drugs Project Development Worker

Ref: 106C

Contract: 0.6 WTE 1-year fixed-term contract
Salary: Band 5 - £18,698 - £24,198 pro rata per annum
Hours: 22 per week

The postholder will be based in the Community Offices within the Barton Neighbourhood Centre.

This post offers the opportunity to work with the community to develop exciting ongoing work tackling substance misuse issues. The postholder will be based in Barton, Oxford, and will have opportunities to roll out initiatives to the neighbouring locality, specifically Wood Farm, in partnership with residents there and subject to local needs.

Ongoing initiatives include work to raise awareness of substance misuse issues; work aimed at preventing substance misuse; work to improve access to treatment and to address the specific needs of vulnerable young people and their parents, and substance misusers and their families.

There will be an emphasis on local people being involved in all stages of the process.

The project is funded by the Oxford Safer Communities Partnership. The postholder will be employed by Oxford City Primary Care Trust and be responible to a steering group which includes City Council representatives, representatives from local agencies and local residents. They would also become a member of the Community Drugs Partnership.

For more information please phone Mary Hardwick, Public Health Manager, on 01865 227146.

The successful candidate will be expected to apply for an enhanced Disclosure from the Criminal Records Bureau as the post involves working with vulnerable adults.

Closing date: 17th March 2006.

Applicants are encouraged to apply online at www.jobs.nhs.uk Alternatively e-mail HR.Admin@oxfordshire.nhs.uk or write to HR Dept, Richards Building, Old Road, Headington, Oxford OX3 7LG for an application pack.

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