

# Getting it Right in Practice: Collaboration not Competition

Thursday 19 and Friday 20 April 2007  
Hilton Birmingham Metropole

## Getting it right in practice: the person not the drug Chair's Welcome and Introduction

**Chair:** Steve Brinksman  
GPwSI Substance Misuse, Birmingham Drug Action Team  
Birmingham DAT, Ridgacre Surgery

## **CONTACT DETAILS**

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## **Biography**

GP in Quinton, Birmingham for 16 years, after making the mistake of asking a question at a post graduate talk on substance misuse I was incessantly badgered until I agreed to prescribe for one of the Community Drug Teams stable clients who was a patient at our practice, this quickly led to taking on another 2 patients and then I was offered a job at the CDT! After 6 years as a CDT prescriber and getting involved in the local SCMG I started a position as part time Lead GP for Birmingham DAT, a role I enjoyed for 3 years before returning to full time General Practice. As well as this I have been the RCGPs regional lead for substance misuse for the past 3 years and have spent 4 years working as a GPSI for the Coventry Young Persons service. You will find me easy to talk to but harder to shut up!

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## The person not the drug

**Speaker:** Phil Barker  
Psychotherapist and Visiting Professor,  
Trinity College, Dublin

## CONTACT DETAILS

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## Biography

Phil Barker is a psychotherapist in private practice, Visiting Professor at Trinity College Dublin and Honorary Professor in the Medical School, University of Dundee. He was the UK's first Professor of Psychiatric Nursing Practice at the Medical School, University of Newcastle England from 1993-2002 and previously was the Director of Studies at the Department of Psychiatry, University of Dundee. He has published 18 books, over fifty book chapters, over 250 academic and professional papers and articles and has delivered more than 300 conference addresses and countless workshops in Europe, Australasia, North America and the UK.

He was elected a *Fellow of the Royal College of Nursing* in 1995 and was awarded the *Red Gate Award for Distinguished Professors* at the University of Tokyo in 2000. He was awarded an honorary *Doctor of the University* at Oxford Brookes University in 2001 and has been Visiting Professor at several international universities including Barcelona, Tokyo, Auckland, Adelaide and Sydney.

## **Abstract**

Society tends to assume that people are rational animals and that drug taking behaviour is not 'reasonable'. However, traditional 'logic' has been of little help in addressing, far less resolving, the 'problem' of drug taking.

In this presentation I shall discuss the value, if not the virtue, of recognising that people have their own 'personal reason' – the logic of experience – which often is a world away from our traditional notions of 'reason and logic'. If people want to address or otherwise 'deal with' their drug taking, then anyone who wishes to help them must try to get a sense of this 'personal logic'.

*"At the end of the day, it is all about human relationships"* (Robert Flaherty)

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## Getting it right with users

**Speaker:** Tony Birt  
Regional Advocate, The Alliance

## CONTACT DETAILS

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## Biography

Tony is currently the Alliance advocate for the West Midlands after being rescued from a fifteen month waiting list four years ago, for a 24 year opiate and polydrug dependency, by Alan Joyce the then sole and national advocate for them.

Now four years on with much volunteering under his belt, and the inevitable first 'burn out' that goes with that, he made that difficult transition from S/U 'done good' to the 'professional' as a community mental health worker with a large mental health charity.

Work which was an honour and privilege but coincided with the restructuring of the NHS and therefore added another bow to his arsenal, closing down a service for the incredibly ill and most vulnerable.

As a public governor of his local mental health foundation trust (to be), Gloucestershire, he now works from within and at strategic levels as well as the coalface work as an advocate.

As the first independent chair of the west midlands service user forum is where he is most at home and also where the future could/should lie for SUI. With beginning the RCGP/SMMGP cert two this year it could possibly be the best year of his life so far.....watch this space.

## **Abstract**

The journey to this platform has been long and hard but full of real life. Five years ago I was dying, quite literally and rapidly, on the waiting lists for secondary care in this country for my chronic, severe and enduring opiate dependency and chaotic polydrug use.

The three reasons I stand here to tell my tale are The Alliance, Evidence based practice and this vital mission to augment provision in primary care, to normalise, destigmatise and offer a holistic approach to the problems of my peers.

Unfortunately I have to admit that primary care had absolutely nothing to do with me being here today but it is the reason I turned up, stand up and step up.

Five years ago whilst on 'deathrow', the waiting list, for 15months, I was told time and time again by my GP that **'we are a non prescribing practice Tony and I would love to help you but.....'**

- My partners would never stand for it you see
- I am not permitted to prescribe for you
- We have to follow the protocols
- I just don't know what to do for the best
- I only had an hour drugs training and I was away that day, I think I had a cold or something.

This list could go on into the realms of my madness or even anger over all those Tony's out there and especially those who never made it here today or even saw the sunrise this morning because their GP, or anyone else with the professional capacity would or could not help.

I accept, or at least hope, that everyone here today are the converted and do not point my skinny finger at anyone. Please for a moment those who know in their heart that they have allowed a Tony to slip through theirs and could not tell me where he/she is right now, if not in the cemetery as is the case with all but one of my peers from the age of eighteen. Think, remember and make a change.

If you have, by not repeating that mistake you help try and restore the faith and trust of those we have all 'helped', as a society, to disempower, marginalise and isolate at some point without a thought of or for humanity.

I respectfully suggest to this house that it is the PSU (Problematic Substance User) who needs to trust, accept and believe in primary care and not the other way around. This would be a huge step to **'getting it right with problematic substance users'**.

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## Working with the patient not the drug

**Speaker:** Dr Chris Ford  
GP, Lonsdale Medical Centre and Clinical Lead  
SMMGP

## **CONTACT DETAILS**

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## **Biography**

Dr Chris Ford has been a GP in North West London for 22 years and has special interests in working with people who use drug and/or alcohol, HIV and hepatitis and sexual health.

She is one of the founders of Substance Misuse Management in General Practice (SSMGP), is advisory editor of 'NETWORK' (SMMGP Newsletter) and is the GP Advisor for SMMGP. She is a member and former chair of the RCGP Sex, Drugs and HIV Task Group. She is a member of the executive committee to the RCGP Certificate Programme for Substance Misuse and CPD Lead for the programme.

She is a director and former chair of The Alliance, a drug user led organisation, which encourages drug users and professionals to work together to try and improve drug services. She is also a founder member of the UK Harm Reduction Alliance (UKHRA) and a patron of FDAP

She has published widely about the care of people who use drugs in general practice and is the lead author on a number of guidance documents developed for primary care on the use of buprenorphine, working with cocaine and crack users, use of methadone and the currently being developed guidance's on 1) Guidance for prevention, testing, treatment and management of Hepatitis C in Primary Care and 2) Guidance for the use of benzodiazepines.

## **Abstract**

Helping people with drug problems has traditionally focused on control of substance use rather than considering the person as a whole and understanding the use of drugs in a person's life. This starting point has often led to the development of services that are difficult to access and at times appear antagonistic to the people that they are designed to serve. When presenting for help, people with drug problems are often viewed as untrustworthy and incapable of recognising their own needs.

Any label is diminishing to the individual, but that of 'drug user' or 'addict' can overshadow everything else that a person is. The belief that people who have drug problems can never be trusted is pervasive. This presentation will argue that this is a destructive generalization that reduces the effectiveness of services at every level and is counterproductive for both patients and staff.

At Lonsdale Medical Centre we work by listening to and trusting our patients. We work with them, where they are and not where we think they ought to be. We are continuing to develop this model of patient-centred care, using client-centred psychotherapy, motivational interviewing and good general practice skills. This model focuses on empowerment of patients. We recognise that practitioners cannot solve a patient's problems we can only assist the patient to solve these for themselves. Our collective aim is therefore, to enhance the patient's self-esteem and appreciate their self efficacy and motivation.

Working with the person involves attempting to move clinical practice beyond fear and control. Rather than just attempting to coerce drug users to stop taking drugs we can also adopt listening and supportive strategies, with a view to empowering people to take control of their own lives.

The person centred approach is essential in facilitating this process. It raises many issues, and in particular it challenges our attitudes and prejudices towards our patients and their drug use. We must be mindful to deal with the individual, not the generalization, when we discuss on their choices and behaviour.

By using a series of case studies, this presentation will consider the influence and extent of patient centred principles and how they can be applied as a model of support and treatment for patients with drug problems in a general practice setting. After discussing the theory, we will move to the practical issues surrounding the building and maintaining a patient centred relationship and how this can be used to support each treatment modality including harm reduction initiatives and substitute prescribing.

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## Parallel Sessions Session A

### Getting hepatitis services right into practice

Chair: Dr Steve Brinksman

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## The 'mad', the 'bad' and the 'difficult'

**Speaker:** David Mutimer  
Reader in Hepatology, Birmingham University and  
Consultant Hepatologist QE Hospital, UHB Foundation  
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## **Biography**

David Mutimer (MBBS, MD, FRACP, FRCP) is Reader in Hepatology at the University of Birmingham and Honorary Consultant Hepatologist to the Queen Elizabeth Hospital Liver and Hepatobiliary Unit, Birmingham. He graduated from Monash University, Melbourne in 1980 and commenced specialist training in Internal Medicine and Gastroenterology in Melbourne. In 1986 he came to the UK and worked as research fellow at the University of Newcastle-upon-Tyne from 1986-89. From 1987-89 he held the British Digestive Foundation Amelia Waring Research Fellowship. In 1989 he moved to the Birmingham Queen Elizabeth Hospital Liver Unit, and has worked there since that time. In 1996 he was appointed Senior Lecturer then Reader in Hepatology (B'ham University) and Honorary Consultant Hepatologist to the Liver and Hepatobiliary Unit. He is Clinical Service Lead for Hepatology at the Queen Elizabeth Hospital.

His main clinical and research interests have included viral hepatitis and antiviral drug resistance, and opportunistic infections complicating liver transplantation. In particular, his clinical studies have focused on the development of protocols for prevention and treatment of recurrent viral hepatitis (HBV and HCV) after liver transplantation.

## **Abstract**

Hepatitis C is the most prevalent blood-borne virus infection. The majority of injecting drug users is infected at a young age. Except for those with concurrent excessive alcohol consumption, quite slow progression of liver fibrosis can be expected. In the UK, most newly referred Caucasian patients have a history of drug use. The majority is infected with hepatitis C genotype 3, a type which responds well to antiviral therapy. Current antiviral treatment includes pegylated interferon and ribavirin, given for 6 months to those with favourable genotypes including genotype 3. Sustained virological response (ie cure) can be anticipated for 60 – 80% of genotype 3 HCV-infected patients. Current and recent injecting drug users should be considered for antiviral treatment, though many have more pressing health concerns. In the UK, most HCV treatment is hospital based and delivered by hepatologists, gastroenterologists, or infectious diseases physicians. In Birmingham, a protocol for direct referral from the blood-borne virus (BBV) team was established in 2003. Approximately 50% of HCV-positive drug users requested referral to the Birmingham Liver Unit. The truancy rate at first attendance and during subsequent outpatient follow-up was high. Some patients, however, received antiviral therapy and were cured of infection. As a proportion of those diagnosed by the BBV team, the number of patients cured of infection is few. Antiviral treatment in its current form is unlikely to have a significant impact on the spread of HCV in the drug-injecting community.

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## Getting it right in primary care

**Speaker:** Stephen Willott

GPwSI, The Windmill Practice and Drug Lead for Sex,  
Drugs and HIV Task Group and

**Speaker:** Kate Jack

Hepatitis Nurse Specialist, Nottingham City Hospital and  
The Windmill Practice

## **CONTACT DETAILS**

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## **Biography**

I am a GP in the inner city Nottingham, and also work at a drop-in centre as a "GP for the homeless" 2 sessions a week.

Of the 180 drug users we see regularly, about half have hepatitis C. We have made progress in the last 2 years with earlier diagnosis & community treatment by having a specialist hepatitis nurse in post. I also work as a GP specialist in Public Health for Nottingham City PCT, so I suppose that makes me a double GPSI.

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## **Biography**

Kate Jack trained as an RGN in Worthing and worked for 5 years as a hepatitis CNS in Infectious Diseases in Leicester. Kate took on a role in Nottingham 2 years ago in a project designed to take a secondary care HCV clinic, including the delivery of anti-viral therapy, into a community of hard to reach clients at a GP led methadone clinic. This GP surgery is situated in inner city Nottingham, and provides a specialist GMS service to substance misusers and the homeless, including a shared care model of opiate substitute prescribing.

Kate completed the MSc in Public Health in 2005, and has an interest in reducing the health inequalities emerging within the provision and access of HCV management.

## **Abstract**

There is a huge time bomb of as yet undiscovered people with hepatitis C virus (HCV) infection. The Hepatitis C Trust (2006) reports that there are approximately 8-9 fold more infected people than those known to have tested positive to date; at the end of 2005 there were 55 000 diagnosed (Health Protection Agency 2006), yet it is predicted there are up to 466 000 in the UK who are HCV positive, *and*, only 7000 have ever been treated.

As primary care clinicians, it is crucial that we pick up on missed opportunities for testing those at risk and ensuring more patients have access to the successful anti-viral treatment regime via an appropriate referral pathway. At the moment those who have ever been treated are fewer than those diagnosed each year. Clearly if this continues, the battle to reduce the burden of liver disease will never be won. This cannot be left to secondary care alone to try and deal with.

The largest pool of infected individuals remains amongst substance misusers. This presentation describes a novel approach between a hospital clinic and shared care GP surgery that provides a successful alternative to the traditional hospital model of HCV management. One third of clients attending an opiate substitution clinic were eligible for pegylated interferon and ribavirin, and half of these accepted the course of treatment; for none of them a liver biopsy was essential, nor was the need to be completely drug free.

Come to find out more about how you could test and treat more hepatitis C in the community.

P.S.... for further info, the RCGP Substance misuse unit will be running two 1 day events on Hepatitis C (29.5 London & 17.7 York) which will incorporate the launch of the new document "Guidance for prevention, testing, treatment and management of Hepatitis C in Primary Care"

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## From testing, through treatment and beyond

**Speaker:** John Howard  
Patient and User Representative, Reading User Forum

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## Biography

John was an injecting drug user for the best part of 20 years and is now on a break from drugs, last using in October 2001.

John formed a drug user group, Reading User Forum (RUF) in the early summer of 2004.

RUF have made good progress and gained charitable status in March 2005. RUF are now an established, locally and nationally recognised charity who work with current and ex drug users across the West of Berkshire. One to one support and mentoring, an independent peer led advocacy service, voluntary and training opportunities and peer led harm reduction workshops/ training on Hep C and overdose prevention and response are some of the services RUF offer. RUF represents users at every level of treatment planning, design, delivery and commissioning.

## **Abstract**

The presentation is my personal story of having the hepatitis C. I caught the virus in 1997, I know it was this time because I used to get tested for hepatitis c and HIV around every six months. I was diagnosed just before Christmas 1997 and was initially given a clear result but was then called by my GP a couple of days later saying I was given the wrong result and was HCV positive. I was concerned but at the time my drug use was more important than my health. When I stopped using in 2001 I started worrying about my well being and was already feeling ill from my hep. After a biopsy in 2004 I was offered treatment and spent 47 weeks of 2005 on combination therapy, this was a struggle and I found it very difficult, as did my wife and daughter!

This presentation is my experience of living with the hep c virus and my journey through treatment.

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## Parallel Sessions Session A

**Offering the range - don't forget detox  
and abstinence based treatments**

Chair: Anne Steel  
GP Liaison Manager, Birmingham Drug Action Team

## **CONTACT DETAILS**

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## **Biography**

Annie Steele trained as a Registered General Nurse and after working in Accident and Emergency for several years, in 1996 moved into the Swanswell Charitable Trust to work within the substance misuse field in Warwickshire as a GP Liaison worker. Since then she has worked in the alcohol and drug field and was Senior Service Manager for Coventry and Warwickshire Community Alcohol Services. Last year she was seconded to Birmingham Drug Action Team as GP Liaison Manager and supported the Drug Action Team in achieving 58% (322) of GPs in Birmingham covered by Shared Care prescribing. She now holds the post of Assistant Director of Operational Services for Swanswell Charitable Trust who provide Drug Solutions Birmingham (DSB). DSB are a shared care drug service and also provide DIP and Criminal Justice interventions and currently work with 1500 individuals who are in treatment.

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## Abstinence: The Who? Why? Where? When?....and Huh?

**Speaker:** Gordon Morse  
GP, Medical Consultant to Clouds House, Trust Specialist  
and Lead Clinician for West Wiltshire Specialist DA  
Service, RCGP Regional Lead

## CONTACT DETAILS

**Gordon Morse**

**Primary Care Specialist in Substance Misuse, GP, Medical Consultant to  
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## Biography

His current appointments include being a single handed GP principal in rural Wiltshire, and since 1995 he has also been Medical Consultant to Clouds House, one of the UK's longest established abstinence-based residential treatment centers for chemical dependency. At Clouds he has been responsible for the detoxification and medical care of more than 5000 chemically addicted patients. He is also Trust Specialist to the West Wiltshire Specialist Drug and Alcohol Service where his patient's average daily dose of methadone is a shade under 80mg (range 35-250). He is serving on the Wiltshire Shared Care Monitoring Group and has been involved in Generalist substance misuse training throughout the South West. He is Clinical Director to Drug Treatment Ltd.

He has been closely involved with the RCGP Substance Misuse Training Unit since it started and has been delegate or speaker at many conferences over the past decade. He spoke at the RCGP national conference 2001 on "Developing a Core Curriculum for Certificate Training – What we Need to Know", and in 2004 on "The Holy Grail of Abstinence". He is also a founder member of the International Society for Addiction Medicine. He has published numerous articles and contributed chapters to the revised "Caring for Substance Misusers in General Practice – a Harm Minimisation Approach", and in 2005, "The RCGP Guide to The Management of Substance Misuse in Primary Care".

## **Abstract**

I have set out to attempt to address the important questions in planning abstinence treatment - case selection, models of abstinence, where treatment should be carried out, what sort of detox and so forth. But in 15 minutes this remit could only be treated in the most superficial and inadequate way, which is just as well as I am delivering it.

If any of you heard me at the Drug Treatment conference a month ago, this isn't the same (quite).

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**To detox or not to detox: whose choice  
is it anyway?**

**Speaker:** Ed Day  
Senior Lecturer in Addiction Psychiatry  
University of Birmingham

## **CONTACT DETAILS**

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## **Biography**

I have conducted a range of research projects around the issue of inpatient treatment for drug and alcohol misuse. These include a randomised controlled trial comparing outcomes for inpatient and outpatient opioid detoxification, a Cochrane review of the effects of setting on detoxification treatment, and a national survey of inpatient drug treatment in England. I chaired the recent Specialist Clinical Addiction Network (SCAN) consensus group on the model inpatient service, and I am on the group revising the clinical guidelines for the management of drug misuse and dependence.

## Abstract

People addicted to drugs such as heroin are more likely to tell healthcare professionals that they want to detox than enter methadone maintenance. However, there is strong evidence from clinical research that detox as an intervention in its own right has poor outcomes, and may even be harmful. This presentation will use research evidence from a variety of sources to make a case for better integration of medically-assisted detoxification into the treatment system as a whole. It will highlight the lessons to be learned from 'natural recovery' studies, and emphasise the importance of considering abstinence as an option at all stages of an addiction career.

## Further reading

Best D, **Day E** & Morgan B (2006) Addiction Careers and the Natural History of Change. Research Briefing 20. National Treatment Agency for Substance Misuse, London.

Opiate Detoxification for Drug Misuse. NICE Clinical Practice Guideline (currently undergoing consultation process and available at: <http://guidance.nice.org.uk/page.aspx?o=DrugMisuseDetoxConsultation>)

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## Living with abstinence

**Speaker:** James Grieve  
Service User Advocate, Hertfordshire User Group and  
Chairman, National Users Network

## CONTACT DETAILS

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## Biography

James Grieve - voluntary service user advocate  
Chairman of N.U.N (national user network)  
Ex poly IDU of 32 years, currently abstinent.  
Ex medical/aeronautical engineer & safari jock & coffee dealer.  
Currently enjoying rebuilding his life

## **Abstract**

The Detox Experience

Non service users & service users need clarity on the issues, options & actions required to access treatment relevant to their region & location

A care plan that works you towards the eligibility criteria

Pre treatment planning options to help them choose the most effective setting.

- Primary care
- Specialist o/p
- Specialist / collaborative home detox
- Specialist I/P
- I/P kick-start & O/P with support & aftercare
- General Hospital
- Residential Re-hab

Re-tox & a safe client agreed fall back position if it's too soon & you don't succeed.

Post detox support that's realistic whether it's symptomatic prescribing or a peer group

Through care & aftercare that's care planned

Realistic wrap around & access to education & training.

No punitive response to failure.

Highlight the positives & applaud their efforts

Abstinence is a process & not an event & detox is on the route.

## **The DIY route to abstinence.**

Redefining & Redesigning your yourself.

The process of broadening your horizons.

Tips for releasing the past & embracing the future.

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## Parallel Sessions Question Time

**Chair: Steve Brinksman**  
GPwSI Substance Misuse, Birmingham Drug Action Team  
and 2007 Conference Chair

## Panel Members

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Director of Quality, National Treatment Agency

**Kevin Ratcliffe**  
Lead Pharmacist in Substance Misuse, Birmingham Drug  
Action Team

**Simon Greasley**  
Specialist Nurse and Prescriber, Kakoty Practice

**Dr Marcus Bicknell**  
GP, Beechdale Surgery, Nottingham

**John Mann**  
MP, Bassetlaw

**Glenda Daniels**  
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## **Biography**

Kevin has been a community pharmacist for almost 17 years, and during this time has held a number of management positions within the Boots Company before finally taking the decision to leave the fun-filled world of management behind to focus on a more clinical role. His current role is that of Lead Pharmacist in Substance Misuse for Birmingham Drug Action Team, responsible for the development, commissioning and clinical governance of pharmacy-based services to substance misusers across the city. He has also trained as a supplementary prescriber in this field. Kevin is currently one of the Clinical Directors of Birmingham East & North PCT and is also Vice Chair of Birmingham LPC.

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