

Getting it Right in Practice: Collaboration not Competition

Thursday 19 and Friday 20 April 2007
Hilton Birmingham Metropole

Opportunities In Partnership Chairman's Introduction

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

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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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From exclusion to inclusion

Speaker: Peter Bates
Senior Consultant, National Development Team

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Biography

After training as a Social Worker, Peter Bates worked in probation, the employment service, social services, the NHS and audit before moving to the National Development Team in 1999 where he provides consultancy to mental health and learning disability services. Recent customers include the Care Services Improvement Partnership, the Social Exclusion Unit, the Scottish Executive and many local services. Publications include *Working for Inclusion* for the Sainsbury Centre for Mental Health; the *Day Service Modernisation Toolkit*, official guidance to local authorities on commissioning employment services and how to respond to the Scottish Mental Health Act and 60 other items on empowerment, disability and inclusion. He is constantly in demand as a lively speaker and effective trainer.

Abstract

The government's publication of *Mental Health and Social Exclusion* in 2004 drew together a wealth of evidence about the relentless and oppressive reality of exclusion for people who use mental health services, while the White Paper *Valuing People* adopted social inclusion as one of the four pillars of an effective service for people with a learning disability. With its mission of *Inclusion Made Possible*, The National Development Team have been intensively involved with many local services that are striving to turn the rhetoric into reality. This presentation will introduce some of the resources that we have developed to assist staff in meeting the challenges of the social inclusion agenda and invite conference participants to consider if they have applicability to work with people who misuse drugs.

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United we stand.....

Speaker: Dr Francis Labinjo
Consultant Psychiatrist, Kent and Medway NHS and
Social Care Partnership Trust

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Biography

Dr Francis Labinjo has over 12 years experience of treating a broad range of psychiatric and substance misuse problems within the NHS and independent sector both in adults and younger people and within community and secure settings, including a 16 bed drug unit for young offenders (OASIS). He has been the only consultant psychiatrist for West Kent with specialist responsibilities for drugs and alcohol problems, but also with general adult psychiatry commitments within Kent and Medway NHS and Social Care Partnership Trust for over three years and is approved under section 12 of the Mental Health Act. His substance misuse commitments are to continue within the independent sector through a newly appointed provider. He also holds a Home Office licence for the prescribing of diamorphine (heroin) and has special expertise with patients on injectable opioids (methadone, morphine and diacetyl morphine). He is fully up to date with developments in evidence-based psychiatry and has been actively involved in training and supporting GP's within shared care. He is also trained in child and adult protection.

Abstract

Divided we **fall, fail**, or both. This presentation argues the potential of every individual to make a difference to the service which they are working in and are committed to and that teams of patient-centred individuals can truly transform the way they work. New Ways of Working for Psychiatrists NWW has implications for the risk exposure of GP addiction specialists and for shared care, as consultant psychiatrists will no longer see follow ups or cases other than complex ones, making more use of advice and consultancy to the multi-disciplinary team for less complex cases. If we are to reduce drug taking, harmful behaviour and drug-related deaths we need to promote better engagement with service users. BWW Better Ways of Working for Drug medical specialists can improve the quality of drug treatment within primary care but we need common ownership of the agenda and to identify change champions, communicate better, co-ordinate referrals, record outcomes and change our working culture, which is currently too 'territorial.'

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Beyond prescribing...new opportunities for better care

Speaker: Linda Harris
Clinical Director for Wakefield Integrated Substance
Misuse Services and Director, RCGP SMU

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Biography

Dr Linda Harris is the Clinical Director of the Wakefield Integrated Substance Misuse Service, (WISMS), an “umbrella term” used to describe the local treatment system that combines community and criminal justice drug treatment teams, shared care, the alcohol team, and a 106 bedded substance misuse unit at HMP New Hall.

Linda has been a Professional Executive Committee member of the PCT for over 5 years as its primary care mental health lead and ten years prior, a GP principal.

As clinical lead she is involved in the commissioning of local prison, mental health and substance misuse services and is currently working with the PCT to develop a social enterprise model for integrated substance misuse provision for the local population

Since 2005 Linda has been the Director of the RCGP Substance Misuse Unit, (SMU) with responsibility for coordinating the national accredited training programme for practitioners in primary care substance misuse and represents the SMU on the College Professional Development Board.

Abstract

The needs of our patients and populations are changing. Whilst primary care can take much of the credit for the revolution in the management of substance misuse through its contribution to the implementation of Models of Care we must now tackle new challenges associated with an aging population and the negative public health consequences of communities struggling with poor housing and high levels of relationship and family breakdown

There is no doubt that investment in recent years into the substance misuse field has greatly improved clinical care pathways but there is now an urgent need to widen the outcomes from “traditional” therapeutic goals to those of well being, employability and total family support

Healthcare reforms detailed in the government white paper ‘Our health, our care our say’ and moves to establish “clear blue water” between commissioning and provision place GPs in the driving seat in commissioning against locally determined priorities

In addition the new GP contract continues to offer opportunities for local and national enhanced services and Local Area Agreements are gaining in importance, unlocking funding streams linked to shared targets around health, well being and worklessness

Running alongside the drive to commission care “differently” is the growth of social entrepreneurship which gained momentum in 2006 with the establishment of the Department of Health Social Enterprise Unit and the emergence of several social enterprise pathfinder sites that marry the expertise of the health sector with social business leading to benefits for patients and communities from improved access to public services.

So what does the “brave new world” hold for the provision of substance misuse treatment? This presentation describes the opportunities and potential pitfalls associated with the increasing ‘market place’ that is health and social care and asks the question **“What’s in it for *our* patients and the workforce who serves them?”**

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Parallel sessions Session A Partnership with the criminal justice system

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

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Building bridges with the criminal justice system

Speaker: Mark Williamson
Chair, RCGP Secure Environments Group

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Biography

After spending 10 years in general practice on Teesside, during which he was a GP trainer, an LMC vice chair and a Health Authority non-executive, he left to become a medical adviser at the East Riding and Hull Health Authority. During that time he became interested in and has since dedicated much of his time and energy to social exclusion issues and improving health services for offenders, firstly at a local then regional level, and now as a national adviser. In addition to supporting the establishment of the Hull York Medical School, he has also worked over the last five years as a PCT medical director. He continues to practice in the homeless practice, the Quays, in Hull and in HMP Hull. He also acts as the clinical lead for the national programme for IT at the Yorkshire and Humber SHA.

Abstract

The challenges

There are 138 Prisons in the UK (128 public, 10 private) housing approximately 80 thousand prisoners and the population is slowly rising, in 1992 the figure was 42 thousand. Of these 5% are female and there are a small number of child prisoners, and approx 1000 lifers. There are about 135 thousand prisoners incarcerated per year, (and logically) a slightly smaller number released, and about 50% serve less than 6 months. These figures mean that there are nearly a million relatives affected by imprisonment annually. England and Wales has the highest imprisonment rate in Western Europe, related to relatively high crime rates though other countries are notably increasing their use of this sentence, e.g. Netherlands. Prison is relatively ineffective with an 80% recidivism rate within 2 years of release. The offender population and their families are a significant part of the socially excluded population and they share similar issues of health, health care needs and difficulties in respect of accessing health and social care services.

In 2006 a review by the author of papers relevant to the primary care of offenders for the Sainsbury Centre for Mental health, revealed a litany of health and social care need and disadvantage in the offender population. One of the notable features about the needs of offenders is that they commonly overlap, for example: mental health and substance misuse; substance misuse and communicable disease; primary care, sexual health and public health; and social exclusion with all. The co-representation of these issues contributes to the tendency in care providers to allow the marginalised and vulnerable, including offenders, to fall between the stools of the care providing structures and systems, classically 'dual diagnosis'. It must equally be credible that this reality will contribute to the recidivism and ill health of prisoners after release.

Meeting the challenges

Health and social care services for offenders are dependent on a shared approach between security and health and social care. This joint approach was built, and will be built in to the future, upon shared values, shared principles, and a shared vision of what is needed and how it should be delivered. There are joint programmes of work underway at national, regional and local levels and over the last few years great improvements have been achieved particularly in relation to reducing deaths in custody. However, significant challenges remain and there is now a sense of renewed impetus following the recent transfer of commissioning for prison health care to the NHS. The need to work in partnership and address in particular the needs of younger offenders is particularly highlighted by the above list of issues.

Bridges between the two cultures of security and health and social care are needed at many levels, but the main pillars for these bridges are already in place. On the side of health and social care, the need for high levels of security is essential to enable an appropriate therapeutic relationship between

the service user and care provider. On the side of security there are many shared core values with the health and social care system in relation to duty of care, respect and building autonomy. In this most challenging of environments there are opportunities for significant synergy of effort and mutual support.

Though there is engagement between the structures and policy streams between health and social care and the criminal justice structures and policy there remains a relatively low level of involvement from the service users themselves. This is perhaps understandable but there are significant representative national groups and many individuals who can in the future be invited to contribute more to strategic developments at national regional and local levels.

Primary Care Trusts, in partnership with Local Authorities, are now required to commission and design health care services within and without prison but despite the impressive statistics of need there are confounding realities which compromise offenders getting adequate care. Primary care engagement in care of the socially excluded is generally poor, and offenders themselves have a distrust and fears of stigma and diagnosis which prevent engagement. There is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release. There is no national guidance linking services for socially excluded populations and the prison population, despite a significant similarity in the population profiles. Current services in prisons tend to be specialist provided for mental health and sometimes substance misuse, they tend to focus on there more seriously ill patients and specialist ways of delivering care. Health and social care for offenders in prisons and upon release faces many uniquely difficult challenges with poor clinical information technology and support systems, staff shortages and poor planning of service integration. Offenders can be challenging to provide care for, with high consulting rates, poor reliability as historians and poor concordance with treatment planning, and health neglect and health damaging behaviours.

There is a relative dearth of research evidence, particularly UK based, about what works and therefore how we should aim to deliver care. This is likely to change as the emergent research networks focusing on offender health get in to their stride. There are many reports in the literature about one off projects which have had one effect or another but few which can claim to be clear evidence of best practice. These successful examples tend to share features of integration, continuity of care, multidisciplinary and multi-agency working. The following set of care pathways represent the range of key areas of evidenced need for offenders as a group, and should be considered by commissioners of health and social care provision, but only after a local health care needs assessment exercise.

- Primary care vulnerable and socially excluded GMS
- Primary care mental health service
- 2o Mental health service
- Substance misuse service

- Sexual health service
- Infectious diseases service
- Dental, Optometry, Pharmacy services
- Health promotion
- Chronic disease management
- Learning disability services
- Social care, Housing, Education, Leisure and Employment

Conclusion

There is a great deal which could be done, which is currently not being done to meet the health and social care needs of offenders, in the community, in prison and after release, of potential benefit to them, their families and society. To build a more coherent and seamless understanding of the needs of offenders and other marginalised and vulnerable people, we need a broader approach to evidence building and policy development. There is in particular, a moral imperative to try to prevent the continuation of the unacceptable level of mortality, morbidity and wasted human potential, suffered by offenders as they leave prisons.

The most important bridge to build across all care structures including the criminal justice system, is one that will carry socially excluded and vulnerable individuals back in to the heart of our society.

References

1. Improving the health and social outcomes of people recently released from prisons in the UK – A perspective from primary care M. Williamson, Sainsbury Centre for Mental Health. 2006.

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Integrated prison and community drug treatment services: addressing the issue for primary care

Speaker: Nat Wright
Clinical Director for Substance Misuse, Leeds and GP
Advisor, Department of Health Prison Health Unit

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Biography

Nat is currently the clinical director for substance misuse at HMP Leeds and a GP advisor to the Department of Health Prison Policy Unit. This entails developing drug services within the prison and working across the national prison estate to improve the quality of care offered to drug users. From 2003-2005 he was the GP advisor to the National Treatment Agency for Substance Misuse which entailed working nationally with key stakeholders to develop the primary care drugs agenda. At that time he was also the clinical director for the Leeds Integrated Community Drug Treatment Services. This involved providing clinical leadership, direction, training, mentoring, research and development support to over 50 practices in Leeds which are part of the shared care scheme for drug users. From 1996-2003 he was the lead partner at the NFA health centre for homeless people Leeds, during which time the practice became a first wave beacon practice and an NHS executive approved research practice. He is the chair of the RCGP Health Inequalities Standing Group and has published extensively on the topics of substance use, homelessness, health inequalities and primary care.

Abstract

Recently healthcare in prisons have been receiving increasing professional, policy and media attention. Providing healthcare that is equivalent to that offered in the community is a key aim of both professionals and policy leads. However achieving equivalence goes beyond just improving treatment interventions within prisons. It requires a whole treatment system that is integrated between community and all custodial settings. Drawing upon both empirical research and the presenter's own experience of clinical practice and policy work across both community and prison settings this presentation will seek to provide such an integrated framework. It will seek to highlight barriers to integration and practical solutions to improve the care offered to individual drug users.

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CJS worked for me

Speaker: Glenda Daniels
Service Manager, Oxford User Team

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Parallel session Session A

Opportunities for joint working

Chair: Nigel Modern
Lead GP, Birmingham Drug Action Team

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Biography

Nigel Modern is a GP who since the early 90s has been increasingly involved in the care of substance users in statutory and non-statutory services. After a brief flirtation with being a 'proper doctor' (his father's words) in General Practice early in the 21st century, from 2003 he has been Lead GP with Birmingham DAT, working full time developing Shared Care and Community Pharmacy services. Like many GPs he is surprised at how rewarding working in the Addictions field is and never wants to stop, unless it's to go sailing, canoeing or mountaineering, play his guitar, see his family and go to church. He has particular interests in developing Shared Care, the rational use of supervised consumption and the end of overly long and complex hepatitis B vaccination regimes.

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Dual diagnosis

Speaker: Tom Carnwath
Clinical Director, Addiction Services Tees Esk and Wear
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Biography

Tom Carnwath is Clinical Director for Substance Misuse in a large mental health trust covering County Durham, Teesside and North East Yorkshire. His team also provides addiction services to several local prisons. Previously he worked in Manchester for twenty years. He was recently Honorary Secretary of the Addiction Faculty at the Royal College of Psychiatrists, and Honorary Senior Lecturer in addiction studies at Imperial College, London and at Manchester Metropolitan University. He has also worked as a GP and a general psychiatrist. He has published extensively in substance misuse journals, and is also author of "Heroin Century", a general history of heroin, and of a successful behaviour therapy manual for primary care.

Abstract

Dual diagnosis tests and challenges the effectiveness of working relationships between different professions, and different members of the same profession. Nonetheless, if certain basic principles are respected, it can be a very satisfying area of medical practice. This talk addresses common problems, and suggests useful solutions

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Pain Management

Speaker: Lesley Colvin
Consultant/Senior Lecturer in Anaesthesia and Pain
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Biography

Lesley Colvin is a Consultant/ Senior Lecturer in Pain Medicine in the University Dept of Anaesthesia, Critical Care & Pain Medicine, Western General Hospital, Edinburgh, UK and Royal College of Anaesthetists Macintosh Professor 2005/2006.

She became a Fellow of the Royal College of Anaesthetists in 1994, and then did a PhD thesis on the spinal mechanisms of neuropathic pain, under the supervision of Prof Arthur Duggan, Royal (Dick) School of Veterinary Studies, Edinburgh.

She currently works full time in the Lothian Chronic Pain Service and the University of Edinburgh. Working jointly with Dr Michael Orgel, Consultant in Substance Misuse she has set up a combined service for patients with chronic pain and dependency problems. Her current research interests include acute and chronic neuropathic pain, phantom limb pain, opioids in chronic pain, and cancer pain. She has developed the Edinburgh Translational Pain Research Group, a research collaboration within Edinburgh integrating clinical and basic science research in the field of Pain Medicine.

Abstract

This session will address the problems of chronic pain and substance misuse. The extent of the problem will be assessed – looking at current evidence both in the UK and USA and presenting results from our own service. Successful management of these co-morbidities is unlikely unless both problems are addressed, ideally by specialist services working in a co-ordinated fashion. An approach to joint working is described, outlining service design issues and discussing potential routes to develop such services locally. The new guidance from the British Pain Society “Pain and Substance Misuse: Improving the Patient Experience” will also be discussed.

Useful reading:

1. British Pain Society “Pain and Substance Misuse: Improving the Patient Experience” – can be downloaded from the website: www.britishpainsociety.org.
2. Jage J. Opioid tolerance and dependence -- do they matter? European Journal of Pain: 2005; 9:157-162.
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Addiction as a human process and closing session

Chair: Nigel Modern
Lead GP, Birmingham Drug Action Team

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Beneath the underdogs: drug users, society and the media

Speaker: Harry Shapiro
Drugscope

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Biography

Harry Shapiro has worked at DrugScope (formerly ISDD) in London as an information officer, researcher, writer and editor since 1979. He is currently Director of Communications and Information. He is also editor of Druglink, the 'trade' magazine for the UK drugs field and is a press spokesperson for DrugScope

He has been a guest lecturer for the Centre for Drugs and Health Behaviour for their diploma course on drug addiction and given numerous other presentations and lectures on drugs over the years. He is a regular contributor to TV and radio broadcasts and the author of many articles and books on the subject of drugs and drug-related issues.

Abstract

A glance through drug stories in the popular media reveals people with serious drug problems as among the most reviled members of society. And while the emphasis on breaking the links between drugs and crime has seen unprecedented investment in treatment, that very association has done nothing for the popular image of the drug user - and indeed may have made it worse.

Harry Shapiro traces the roots of this fear and hatred as expressed in media representations back to the earliest days of tabloid journalism in the USA and poses the question, 'What is it about drug users?'