

**Substance Use**  
Guidance on Good Clinical Practice  
for Nurses, Midwives and Health Visitors

**ANSA**

**Working with  
Children & Young People**

Association of  
Nurses in  
Substance Abuse

# ANSA

The Association of Nurses in Substance Abuse was formed in 1983 for nurses and allied professionals working directly and indirectly with individuals, families and communities affected by drug and alcohol use.

It is a membership organisation with an elected National Executive Committee. Activities include:

- a three-day annual national conference
- one- and two-day local conferences and training events
- quarterly branch meetings
- publication of a conference journal and three bulletins per annum
- publication of clinical guidance booklets on substance misuse within different branches of nursing
- membership of the Joint Committee of Professional Nursing, Midwifery & Health Visiting Associations (England)
- representation of members at appropriate national policy forums
- support and advice on nursing and substance use related issues to: ANSA members; Drug Action Teams (DATs); service purchasers and providers (Stat/Non Stat); government agencies and other relevant national bodies.

*Further information on membership details can be obtained from:*

ANSA, Professional Briefings  
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# FOREWORD

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As part of the Government Strategy, Tackling Drugs Together, the Department of Health undertook to discuss with relevant medical and nursing professional and statutory bodies, the scope for providing appropriate training and education on drug misuse issues. The subsequent report of the Task Force set up under the chairmanship of the Reverend Dr John Polkinghorne, looked, among other things, at services for young people and the role of the primary health care team.

This booklet, one of three to be produced by the Association of Nurses in Substance Abuse, has taken discussion forward into action and I am very pleased that the Department was able to find the funding to facilitate the work.

I know what hard work it has been to draw together the material for this guidance on good practice, the consultations with colleagues, the writing and editing, and I congratulate the organisation for producing three extremely useful publications. I know they will prove to be an invaluable aid to nurses, midwives and health visitors as they work with patients and clients who misuse substances, whether drugs, alcohol or cigarettes.

A handwritten signature in black ink that reads "Yvonne Moores". The signature is written in a cursive, flowing style.

YVONNE MOORES  
CHIEF NURSING OFFICER/  
DIRECTOR OF NURSING



# Preface

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As we approach the new millennium the fact that nurses will increasingly find themselves providing care for people with substance related problems is inevitable. The phenomenon of substance misuse is complex and does not offer immediate or easy solutions. The costs of addiction, physical, emotional, legal, and economic not only affect the individual user but can render local communities, countries and indeed continents vulnerable.

Effective collaboration, at both macro and micro levels, from countries complying with international treaties on drug controls and supply, to the development of interdisciplinary and interagency partnerships among health and social agencies at a local district level, is one aspect of the needed response which is acknowledged to be crucial.

The nursing profession, as one element of a response framework, has a key role in preventing, reducing and eliminating the harm caused by substance misuse. As the single largest group offering health care within the United Kingdom, there are enormous opportunities open to the profession to significantly halt the progression of addiction.

I hope that this publication, as part of a series of booklets on substance misuse and specific branches of nursing, will facilitate colleagues in their pursuit of these opportunities. I trust that any failure of belief which might exist that nurses have a role in tackling substance related issues within their clinical practice will be dispelled, and that lack of knowledge and competencies to offer effective interventions will be bridged.

This booklet is a testimony to what can be achieved through collaboration, reflected in the different branches of nursing and professionals from other disciplines represented on the National Steering Group. In addition, many colleagues, through their constructive comments, contributed to the wider consultation.

It is a privilege for ANSA to have the support of the Nursing Group within the Department of Health, who funded this project. We heartily acknowledge the commitment of the Nursing Group to the area of substance misuse and trust that this initiative will result in the promotion and consolidation of good clinical practice in the challenging years which lie ahead.

I would like to extend my gratitude to Professor Hamid Ghodse (St George's Hospital Medical School) for his encouragement and to all those who have been directly and indirectly involved in this project for their support, in particular, to ANSA's National Executive officers and members whose work within the field of substance misuse has been the source of inspiration for this booklet.

*Carmel Clancy*

Chairperson, ANSA  
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# Section One: An Overview

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## 1.1 The purpose of this booklet

This booklet is for specialist nurses, and those developing their expertise, who work with people who are at risk of, or who are experiencing problems with alcohol and/or drug use.

Over ninety percent of the population enjoy the occasional drink, a third of adults smoke tobacco, minor tranquilliser use is estimated to be in the thousands, and although prevalence figures for illicit drug use are patchy at least 6% of the population are believed to take an illegal drug (Department of Health, 1995).

### *Clinical guidance*

This booklet is a **guidance document and not a set of guidelines**. It is structured so as to provide guidance on issues related to substance use from a clinical, managerial, educative and research basis. As such it offers suggestions which can be interpreted within the context of the nurse's own clinical practice. Additional information includes: consideration of 'special issues', contact addresses, references and recommended reading.

### *Specialist nurses in the field of substance use and misuse*

There is an increasing number of nurses who are specialising in the care of those communities, families and individuals who may develop or who have developed problems with alcohol and/or drugs. These nurses work in:

- community drug projects, providing information and advice;
- needle exchanges providing clean injecting materials, condoms, and education;
- GP surgeries providing advice, counselling and joint care planning with Primary Health Care Teams.
- specialist community assessment centres,
- brief therapy centres, in out-patient and hospital settings
- specialist treatment centres e.g. methadone programmes (detoxification & maintenance), complementary therapies.
- statutory services e.g. drug dependency clinics as primary nurses; in local authorities as community care assessors;
- non-statutory services e.g. nursing homes; therapeutic communities, and outreach agencies.
- hostels and halfway houses.

## 1.2 Definition of terms

*Substance use* is used to denote use and misuse ( experimental, recreational, dependent and problematic use) of drugs and alcohol unless otherwise stated. When referring to a *nurse* the feminine pronoun is used throughout the text to mean both him and her.

*Substance misuse services* covers all known terms for services for drug/alcohol users, statutory and non-statutory.

## 1.3 Assumptions and Stereotypes

There are many myths, unhelpful assumptions and stereotypes, which negatively affect both users of drugs and alcohol, their families and friends, and those who attempt to provide them with help.

*“It is someone else’s problem”* *No.*

Research clearly shows that doctors and nurses have a high prevalence of drug and alcohol misuse (Ghodse,1995).

*“Drug and alcohol misusers are hopeless people”* *No.*

Most people with problem alcohol and/or drug use, hold down jobs, manage households or manage services.

*“Addicts are beyond help”* *No.*

People have different paths of recovery, taking different amounts of time, most people do modify their drug and/or alcohol use, often without help, and move away from harm, risk, and potential or actual dependence.

*“All clients are dependent”* *No.*

Many clients have problems with alcohol and/or drugs, a proportion are physically and/or psychologically dependent. Many specialist nurses work only with prevention projects, as opposed to working with people with “problem alcohol and drug use”.

What is true is that people with substance use problems come from all backgrounds, are of all types, and are not “so different” from ourselves; and that people can have drug/alcohol related problems without being “dependent”.

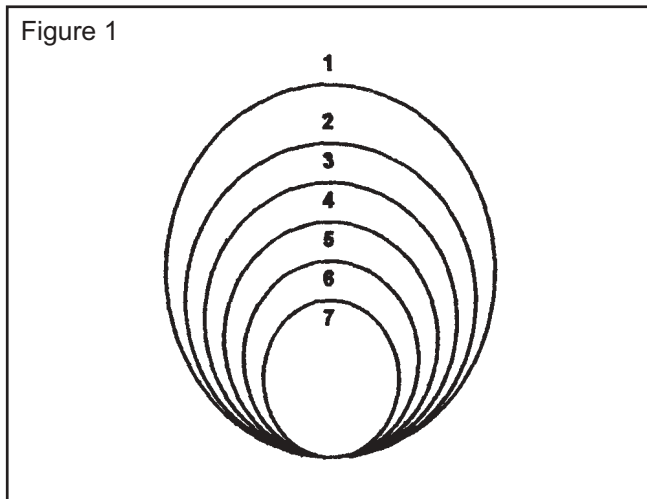
## 1.4 Drug and alcohol use in context

*Substance use in our society*

Substance use has no boundaries and can affect individuals from all levels of society regardless of race, religion, sex or age. It is important to recognise that the use of substances is common in society. Substance misusers are not a homogeneous group and the reasons for the onset and continued use are varied and complex. Examples may include: the elderly widow who misuses night sedation and enjoys a little more than a

glass of sherry to cope; the colleague drinking excessively to cope with the pressures of work or exams or the injecting heroin user who demands drugs from the local GP surgery. Irrespective of the presentation the need for a ‘crutch’ is the same but the reasons and choices of drugs may vary.

Figure 1 depicts the “*Universe of substance users, abusers, and addicts/dependents*”



**Legend:**

- |                                |  |
|--------------------------------|--|
| 1. Total population            | 5. In treatment - voluntary or coerced |
| 2. Users                       | 6. Require public funding              |
| 3. Users at risk               | 7. Treatment inadequate or ineffective |
| 4. Serious abusers and addicts |  |

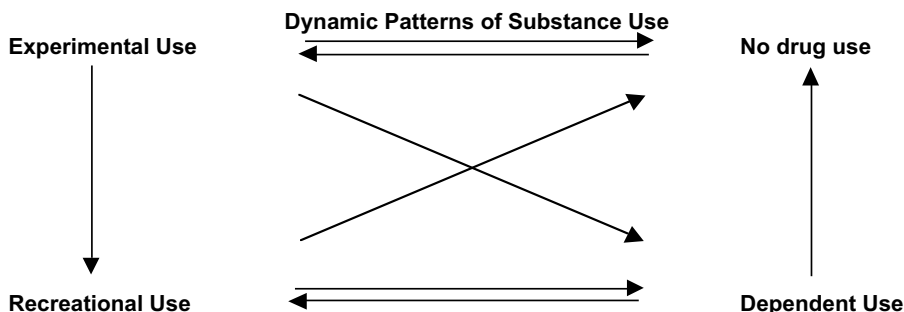
(Source: Kimmel, W. A. (1993) Need, Demand, and problem assessment for substance abuse services: technical assistance publication series number 3. Rockville; U.S. Department of Health and Human Services. (p.9))

*Patterns of Substance use*

People have different patterns of alcohol and/or drug use, which invariably start with ‘experimentation’. Many people do not take the use of alcohol or drugs much further; some, if they choose to use them again, will use them ‘recreationally’ e.g. with a meal, only at celebrations, visit to a concert, or at a ‘rave’. Some people, however, do go on to use substances on a regular basis, with a psychological compulsion and physical need (i.e. ‘dependency’).

Clear distinctions between experimental, recreational and dependent use are difficult to define. Instead, it may be more helpful to focus on whether the use of the substance is

problematic. The latter is generally accepted to include physical, social, psychological and legal problems related to intoxication, excessive consumption or dependence resulting from use of a substance(s). The diagram illustrates the dynamic patterns of substance use.



### 1.5 Models and Approaches

A knowledge of the theories associated with substance use is necessary to understand the rationale behind different public health strategies and treatment regimes. There are different theories associated with drug and alcohol use: those associated with the cause e.g. biochemical (Bonner and Waterhouse 1996); psychological i.e. excessive appetite (Orford 1985); those associated with the process e.g. career model and natural history model (Strang, Gossop and Stimson 1990); those associated with helping e.g. relapse prevention (Marian and George 1984); and those to do with nursing e.g. self care (Orem 1985); or maturation of the personality (Peplau 1988).

|                    | Moral   | Disease   | Symptomatic   | Learning   | Social   |
|--------------------|---|---|---|--|--|
| Aetiology          | Weak or bad character                             | Biological factors, possibly genetic  | Another primary mental disorder   | Learned, behaviour disorder  | Environmental factors                            |
| Focus of treatment | Control of behaviour through deterrent punishment | Abstinence to stop progression of disease   | Improved mental functioning   | Learning behaviour alternative to or incompatible with substance misuse  | Improved social functioning                      |
| Advantages         | Responsibility for change lies with user          | Not blaming or punitive   | Not blaming or punitive. Emphasis on importance of diagnosing and treating co-existing mental disorders | Not blaming or punitive. Holds user responsible for new learning   | Easily integrated into other models              |
| Disadvantages      | Punitive  | Absolves user of responsibility to change. Ignores cultural and environmental factors | Implies treatment of mental disorder is sufficient  | Tends to ignore personality - disabling consequences of excessive substance misuse and irrationality of human beings | Implies change of social situation is sufficient |

Source: Produced by Dr K. Chęcinski (1996) Department of Addictive Behaviour, St. George's Hospital Medical School, London.

# Section Two: The Facts

## 2.1 Introduction

Provision of facts is both necessary and reassuring. However facts have a way of changing and caution is advised when interpreting information related to substances.

Consideration should be given to the following points:

- Laws governing the use and storage of drugs can change
- Levels of drug purity alter (especially drugs prepared for illicit use)
- Different levels of concentration of the chemical occur i.e. alcohol by volume (ABV)
- Drug names are generally translated into slang terms which can be regional and interchangeable
- Clients often presents being knowledgeable about substances but their knowledge may be inaccurate, incomplete, and secondhand
- Facts that relate to adult use of substances can be different for young people

## 2.2 Types of Substances

| Drug  | Street Names                     | Appearance  | Associated Equipment  | Mode of use  | Effects of use  | Possible Adverse Effects  |
|---|----------------------------------|---|---|--|---|---|
| Alcohol   |                                  | Various   | None  | Swallowed  | Loss of inhibitions, exuberance, slurred speech, argumentative  | Hang-over, depression, accidents, coma, death, gastritis, pancreatitis, liver failure, cardiomyopathy, diabetes, strokes, cancer, dependence  |
| Amphetamine   | Speed, whizz, sulphate, buzz     | Powder in various colours, off-white, pink, yellow. Tablets & capsules various colours, sizes & shapes  | Straws, needles & syringes, metal foil, rolled up bank notes                    | Swallowed snorted or injected. Sometimes mixed with cannabis or tobacco for smoking        | Increased energy, sleeplessness, loss of appetite, hyperactive, very talkative, may be aggressive                       | Lethargy, fatigue, depression, irritability, panic, dry mouth, diarrhoea, increased urination. Fatal overdose is possible especially with inexperienced users. Increase in blood pressure with increased risk of stroke. Weight loss, mood swings paranoia & psychosis. Physical dependence is rare but psychological dependence develops in regular users. |
| Anabolic Steroids                                   | None known                       | Capsule & tablet form in various colours and as injectable liquid   | Needles & syringes  | Intramuscular injections, swallowed  | Increase in muscle growth, and body bulk. Greater stamina and strength  | Bone growth irregularities, high blood pressure & heart diseases, liver & kidney damage, cancers, hepatitis, shrinking of the testicles, uncontrollable erections, impotence, mood swings, aggression & irritability, damage to foetal development, development of breast in males, & irreversible enlargement of the female clitoris                       |
| Benzodiazepines                                     | Benzos tranx, pills              | Tablets & capsules: various colours, sizes & shapes   | Needles & syringes  | Swallowed. Evidence of rise in use by injection  | Light intoxication drowsiness, headache confusion, ataxia   | Hang-over type effect. In high doses the user may experience violent mood swings, aggression, bizarre sexual behaviour, deep depression, lethargy. Physical & psychological dependence and liver damage.  |
| Cannabis - herbal resin & oil                       | Hash, puff draw, herb dope, blow | <i>Herbal</i> - dried plant material, greenish brown. <i>Resin</i> - dried and compressed blocks various colours and shapes. <i>Oil</i> - thick ranging in colour from dark green to brown. Distinctive smell like rotting vegetation | Rizla papers, home made pipes, cling film wraps                                 | Commonly smoked but can be put into cooking or made into a drink                           | Light intoxication, relaxation, silliness, giggles, 'munchies' (i.e. increased appetite), talkative                     | 'Red eye', clumsiness, inability to concentrate, may seem drunk Potential for cancer, bronchial problems, short term memory loss, demotivation A physical habitation is considered rare, however reported withdrawal effects can include disturbed sleep patterns, anxiety, panic, restlessness   |
| Cocaine   | Coke, charlie, snow, white lady  | White crystalline powder, occasionally in paste form  | Straws, bank notes, shiny surface (eg tin, mirror), pipes, needles and syringes | Usually sniffed, paste form can be smoked in pipes, can be dissolved in water and injected | Energy rush, heightened awareness, confidence, chatty, affable, agitated  | Lethargy, fatigue, panic, paranoia, depression, irritability, weight loss, delusions & violent behaviour Can lead to collapsed veins or skin ulcers at the injection site Regular use by snorting can damage nasal passages Dependence  |
| Crack Cocaine                                       | Rock, stones, crack, nuggets     | Crystals of varying size and colours, from clear yellow or pinkish yellow to waxy white   | Crack pipe, perforated coke can, metal foil                                     | Smoked   | Increased euphoria, indifference to fatigue   | Lethargy, fatigue, depression, irritability, severe paranoia, anxiety, psychosis accompanied by bizarre and often violent behaviour Increased risks of lung damage Dependence   |
| Ecstasy (MDMA) (3,4-Methylenedioxy methamphetamine) | E, XTC, pills, Erics             | Tablets & capsules various colours, sizes & shapes. Powder in an off-white colour   | None  | Generally swallowed, but can also be snorted   | Increased energy, loss of appetite, loss of inhibitions, euphoric feelings, sweating, grimacing, muscle cramps, gagging | Mood swings, nausea & vomiting, overheating (hyperthermia), high blood pressure, dehydration, convulsions & sudden death  |

| Drug                                | Street Names                             | Appearance   | Equipment                                | Mode of use  | Effects of use  | Possible Adverse Effects   |
|-------------------------------------|--|--|--|--|---|--|
| G.H.B. (gamma hydrox butyrate)      | GBH, Liquid X liquid 'E'                 | Colourless liquid, sometimes in capsule form   | GHB bottles                              | Swallowed  | Loss of inhibitions, hallucinations, muscular tremors, grimacing  | Muscular pain, depression, fatigue, coma, death.   |
| Heroin                              | H, smack, skag, junk                     | Brown/pink or off-white powder (very rarely pure white)  | Needles & syringes metal foil            | Injected, smoked, can be snorted or taken orally                 | Emotional detachment, pain relief, comfort, euphoria  | Lowered breathing & heart rate, severe constipation. Problems associated with IV use (eg HIV, Hepatitis, access). Dependence   |
| Ketamine                            | Special 'K' vitamin 'K' kit kat, 'K'     | Tablets, capsules or as soluble crystalline powder   | Straws, needles & syringes               | Snorted or injected  | Intense hallucinations, euphoria, depersonalisation   | Cramps, fatigue, severe depression, irritability, vomiting, heart failure, violent reactions, flashbacks similar to those experienced with LSD.  |
| L.S.D. (Lysergic Acid Diethylamide) | Trips, acid, micros, dots, tabs          | 1/2cm squared pieces of paper usually painted with a design. Very small tablets                            | None                                     | Swallowed or dissolved on the tongue                             | Hallucinations: visual, auditory and tactile. Can range between being extremely pleasant and unpleasant | Accidents while hallucinating. Reoccurrence of hallucination many weeks or months after stopping using the drug, commonly referred to as 'flashbacks'. Use may precipitate the onset of latent psychiatric disorders.  |
| Magic Mushrooms                     | Mushies, shrooms                         | Several varieties, all very different in appearance. Identification can be difficult, mistakes often made  | None                                     | Swallowed  | Euphoria, high spirits and well being, bouts of laughter and giggling, visual & auditory hallucinations | Dizziness, nausea, possibility of long-term mental health problems. Major danger in accidentally picking wrong type of mushroom which is poisonous.  |
| Methodone                           | Doll, red rock, juice, 'script'          | Small white tablets, clear injectable ampoules & brown, orange or green linctus & mixture                  | Needles & syringes, medicine bottles     | Swallowed, injected  | Relaxation, bodily warmth, suppression of the withdrawal effects of heroin dependency                   | Bouts of sweating, disruption of the menstrual cycle, constipation, nausea, itching & tiredness. Dependence.   |
| Methyl-amphetamine                  | Crystals-ice, glass Powder tablet - meth | Large clear crystals, various sizes, appearance of ice or glass. Tablets or powder form in various colours | Straws, needles and syringes, metal foil | Crystal - smoked. Powder/tablet - swallowed                      | Euphoria, great strength, sustain high levels of activity for long periods without rest or food         | Increased blood pressure & body temperature with increased risk of stroke and heart failure, dehydration, dry mouth, diarrhoea and increased urination, severe disturbance of sleep patterns, violent mood swings & agitation, visual & auditory hallucinations, depression, panic, paranoia, psychosis. |
| Solvents                            | Glue, gas, can, cog                      | Commercial products  |  | Sprayed directly into the mouth or inhaled from bag, hankie, rag | Intense intoxication, loss of balance, auditory and visual hallucinations                               | Danger of sudden death, danger of accidents whilst intoxicated or hallucinating. Loss of short term memory and cognitive skills, personality changes, kidney damage, liver/bowel disorders, acute brain damage.  |

*Recommended reading: Emmett D and Nice G (1996) Understanding Drugs. A Handbook for Parents, Teachers and Other Professionals. Jessica Kingsley Publishers. London*

## 2.3 Drugs, alcohol and the law

### *Misuse of Drugs Act 1971*

This Act places ‘controlled drugs’ into three Classes (A,B,C). The penalty for illegal use of one of these drugs is dictated by its Class (Class A carries the heaviest penalties).

| Class A   | Class B  | Class C   |
|---|--|---|
| This includes heroin, methadone, cocaine, ecstasy, LSD, cannabis oil and magic mushrooms when prepared for consumption. | This includes amphetamine, methylamphetamine and cannabis herb & resin. Barbiturate based tranquillisers. Class B drugs which are prepared for injection automatically become Class A drugs. | This includes the benzodiazepines group (i.e. diazepam, temazepam etc.). Also, since 1996, anabolic steroids. |

The legal penalties for breaching the law in any class of drugs will depend upon the type of offense (possession, supply or intent to supply), the quantity of the drug involved, the number of different types of drugs possessed and the number of previous convictions for similar offenses.

### *Intoxicating Substance Supply Act 1985*

This Act makes it an offense for persons to supply to someone under the age of 18 years substances that they know or have reason to believe will be used to achieve intoxication (e.g. solvents)

### *Medicine Act 1968*

Ketamine is a prescription only medicine. Individuals in possession of this substance without a prescription may be prosecuted under the Medicine Act 1968.

### *Young People and alcohol*

There is no specific law which prevents an adult offering a young person over the age of 5 alcohol, or for a young person to consume alcohol, as long as this takes place anywhere other than licensed premises. There are extensive legislative provisions governing the selling and consumption of alcohol within licensed premises for young people under the age of 18 years. However, there are exceptions to these provisions which depend on the young person’s age.

## *The Children Act 1989*

The Children Act 1989 provides the framework for the care and protection of children, it establishes a range of court orders to protect children. The child's welfare is the court's paramount concern. The Act introduces the concept of parental responsibility and gives parents, and children, full opportunity to participate in court and any subsequent proceedings.

## *Regional Drug Misuse Databases*

These databases collect detailed anonymous information from most services that see drug users - medical and non-medical. They have been developed to inform authorities about the number of people presenting with drug problems in a locality and to provide information about patterns and trends. They also fulfil a requirement on Health Authorities to submit 6-monthly Korner returns.

The forms should be completed by any health professional who comes into contact with people who are using drugs. The system preserves the anonymity of individuals and is totally confidential. No information that could identify an individual is given to third parties.

## *Travelling Abroad*

Clients who intend to go abroad with prescribed drugs must ensure that they have medical permission, and have authorisation from both the Home Office and preferably the visiting country's relevant authorities.

For example, to take over 500mg and/or more than 15 day's supply of methadone abroad, a Home Office licence is required. The client must enclose a letter from the prescribing doctor, giving their name and address together with the strength, form and amount of methadone to be taken with them, the daily rate prescribed and intended dates of departure and return.

A Home Office licence is not necessary for amounts under 500mg, although it is advisable to carry a "to whom it may concern" letter from the prescribing doctor, confirming that possession of the drug is for legitimate medical purposes.

## *Driving and the law*

There are a number of restrictions placed on individuals in charge of a vehicle while under the influence of both prescribed and non-prescribed substances including alcohol.

## *Drugs*

The Road Traffic Act requires licence holders or applicants to tell DVLA of any disability likely to affect safe driving. They consider drug use to be a disability in this context.

## *Alcohol*

The current legal limit for alcohol whilst driving is 80mgs/100ml blood. There is no way of knowing what this means individually, in terms of the number of drinks. Many factors affect the rate of absorption into the blood stream including body size, whether food has been eaten, other drugs taken (illegal or prescribed) and for women the stage of the menstrual cycle.

*Recommended reading:*

Release (1996) *Drugs and the Law*. Release Publications, London. I.S.D.D. *The Misuse of Drugs Act Explained*. (1996) I.S.D.D., London. Royal College of Physicians (1995) *Alcohol and the Young*. Royal College of Physicians. London

## 2.4 Calculating Units of Alcohol

The following example is a useful reference guide for making quick calculations.

**One unit of alcohol** = **half a pint of ordinary strength lager/beer/cider**  
(3.5% ABV)  
= **one small glass of wine** (9% ABV)  
= **one single pub measure of spirit** (40% ABV)

The exact number of units in a particular drink can be calculated by multiplying the volume of the drink (number of ml) by the % ABV (Alcohol By Volume) and dividing it by 1000. For example the number of units in an alcoholic lemonade (e.g. Hooch) of 330ml with a 4.7% ABV is

$$\frac{330 \times 4.7}{1000} = 1.5 \text{ units}$$

## 2.5 Sensible Drinking Limits

The Health Education Authority recommends the following limits for sensible drinking. These have been drawn up for adults and not young people and it should be **assumed** that limits for young people are lower.

### *Males*

- Between 3-4 units a day or less constitutes no significant risks to health
- Regularly drinking 4 or more units a day constitutes an increasing health risk

### *Female*

- Between 2-3 units a day or less constitutes no significant risks to health
- Regularly drinking 3 or more units a day constitutes an increasing health risk

## 2.6 Substance Elimination Times

The elimination of substances from the body is dependent upon a number of factors:

- Amount and purity /strength of the substance
- Route of administration
- Whether substances have been combined
- Body mass
- General health of the user

Because of these variables the following table only provides approximate information on the length of time before a substance is eliminated from the body i.e. will not be detected through toxicological testing (urinalysis).

| Substance                      | Elimination Times               |
|--------------------------------|---------------------------------|
| Alcohol                        | 12 - 24 hours (1 unit per hour) |
| Amphetamines                   | 2 - 4 days                      |
| Benzodiazepines (e.g.diazepam) | < 30 days                       |
| Cannabis                       | 7 - 30 days                     |
| Cocaine                        | 2 - 4 days                      |
| Ecstasy                        | 2 - 4 days                      |
| Heroin                         | 2 - 4 days                      |
| LSD                            | 2 - 4 days                      |

Further information or advice can be obtained from your local Pathology Laboratory and/ or the National Poisons Unit.

# Section Three: Principles of Good Practice

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## 3.1 Introduction

Nurses work in many different settings, with different approaches to care (Barker, 1990). Whilst there is no one right way of working, each nurse has a responsibility to work with the client in a way which is best suited to the individual, and within the context of the nurse's Code of Professional Practice (UKCC 1992).

Nurses' work is aimed at the health promotion of communities (individuals and small groups) via public health initiatives as well as the direct care of communities, families and individuals (WHO/Canadian Public Health Association 1986; Stimson and Lart 1991; Coyne and Clancy 1996). This booklet will attempt to address the public health and individual health work of nurses:

- Maintenance of health
- Promotion of health
- Return to health
- Alleviation of suffering
- Prevention of ill-health
- Protection of health

(International Council of Nurses 1986; Tannahill 1985)

### *National goals*

(International Council of Nurses 1986; Tannahill 1985)

The British Government's strategic document, Health of the Nation (Department of Health, 1992), aims to add years to life and life to years, and sets out a number of targets for health improvement, including sensible drinking targets, the prevention of the transmission of HIV, the prevention of accidents, cancers, and suicide. All of these targets are pertinent to the work of nurses, especially those working to prevent, and treat substance misusers.

Overall, abstinence is the current governmental goal of drug services (ACMD 1993). 'Sensible drinking' is the aim for alcohol services (Department of Health, 1992). Whilst harm minimisation is deemed to be of major importance, drug services need to be focused on the ultimate goal of a 'drug free lifestyle'. Prevention (HAS, 1996) and the reduction of alcohol and drug related crime are major aims for all services (Department of Health, 1995).

Nursing theories and practice generally focus on the four constructs of:

- Man or the individual
- Society or the environment of care
- Health
- Nursing, its nature and role

The theories which underpin many of the nursing models include:

- Stress and adaptation
- Growth and development
- Systems theory
- Rhythm theories

Manley, K. (1991) Knowledge for nursing practice. In Perry, A., Jolly, M. (eds) (1991) Nursing: as knowledge base for practice. London; Arnold, (p.10/11)

### *Barriers to clients seeking help*

There are a wide variety of reasons why individuals, families and communities do not seek help when harm is occurring due to alcohol and/or drug use:

- Fear of professional judgements e.g. “unfit parent”.
- Inconvenient opening times e.g. access to care by people who work
- Money and funding e.g. maybe unable to secure the funds for their chosen programme.
- Eurocentric service models e.g. services designed to meet the needs of the majority.
- Fear of being labelled as a “drug user” or “alcoholic”
- Lack of confidentiality e.g. that GP, the employer, or members of the local community might find out.
- Age - very few services for under 16s, and over 65s.
- Professionals with problem alcohol or drug use e.g. nurses and doctors, may fear professional recognition and the possible affects.

### *Engaging into treatment*

Nurses make care possible by ensuring services exist and are advertised so that potential clients know of services, and how to access them. This also involves offering services which are sufficiently flexible to allow as many clients, as there are resources, to attend e.g. open access services, evening services, women only services, appointment only services, GP referral services, outreach, street work, and hospital consultation. Of equal importance is the provision of environments which are respectful and acceptable to the

client group, for example, the availability of drinks, lavatories, appointment/drop-in services, creche facilities and written information. Clients may avoid helping agencies, because of a misunderstanding about what they do, and how they do it, therefore marketing and advertising are a major part of nursing care delivery (Nicholson and Ussher 1992; Hudson 1994).

## 3.2 Clinical Practice

### 3.2.1 Assessment

#### *Assessment skills*

Self awareness

Observing Interviewing

Identifying needs and diagnosing problems

Recording and disseminating information

Department of Health (1994)

#### **The nursing process:**

“the nursing process is educative and therapeutic when nurse and client can come to know and to respect each other, as persons who are alike, and yet, different, as persons who share in the solution of problems”, (p.9)

Peplau (1988)

#### *Recommended reading:*

Peplau, H.E. (1988) *Interpersonal relations in nursing: a conceptual frame of reference for psychodynamic nursing*. London; Macmillan.

Forchuk, C. Beaton, S. Crawford, L. Ide, L. Voorberg, N. Bethune, J. (1989) Incorporating Peplau's theory and case management. *Journal of Psychosocial Nursing*, 27(2) 35-38

#### *Why is assessment important?*

The importance of assessment cannot be overstated for many reasons. It is the first stage in the development of:

- a therapeutic relationship
- understanding the individual, family and/or community
- intervention/treatment matching
- clarifying the treatment process through the planning of care
- identifying the goals of the individual, family and/or community

Assessment should be carried out in a safe, confidential environment, with sensitivity towards the individual, the families, or the community's race, culture, gender, sexuality,

religion and age. Personal awareness of one's own attitudes, as in any treatment situation, towards these issues, is of paramount importance for the client to obtain equal access (Clancy and Coyne 1997).

### *Client-centred approach*

The nursing process is designed to ensure that the health needs of individual clients is kept to the fore. Clients can instill a sense of parental responsibility in the nurse by disowning their problems and demanding immediate care and attention. Nurses need to be aware of such pressure and consider the negative influence a parental approach may ultimately have on the therapeutic relationship, such as conflict, disempowerment and further dependency.

The internal world of the client needs to be assessed by explicit exploration of their own world, through assessment. Nursing care needs to be focused on the empowerment of the client to manage their own lives, in a way that enables them to use their potential in constructive ways (Seedhouse, 1986). Clients may take a long time before they feel able to trust an individual worker or agency, some develop their trust over several visits, in some cases over several years, which is perhaps not surprising if one considers the marginal and negatively judged lives of some clients e.g. those working in the sex industry (McKegancy and Barnard 1996). Clients are likely to appreciate therapeutic relationships where they are enabled to identify their own needs and problems, their goals and objectives, and are assisted to successfully achieve them (Egan 1990).

### *Confidentiality*

A clear policy on confidentiality is needed, so that clients know what boundaries exist before they begin divulging information. They need to know that their personal information will be respected within the team and agency, and will be divulged on a "need to know" basis e.g. in supervision, in multi-disciplinary meetings, to social services if harm to children is suspected. Information can be requested by courts, and may have to be presented. Furthermore, information can be provided to third parties on the client's behalf, if written permission is provided by the client (UKCC 1996; Lambert and Coyne 1993 ).

### *Motivation*

When a client attends a specialist service there is usually some level of awareness that a problem exists. However, if the specialist nurse is working within another area such as general hospital wards or primary health care settings, the client may not be aware of the existence of problems caused by their substance use. The degree to which a person is aware of their substance use, their desire to, and actual seeking of, help is directly related to their motivation to consider and make changes in their alcohol and drug using behaviour. Some clients present for treatment as a result of external pressure e.g. family,

partners, children, courts and physical ill health or through internal pressures e.g. unhappiness, despondency, decision to change life style. A good assessment will assist the nurse and the client to clarify the current complex of motives for seeking help at this point (Clancy & Coyne, 1997).

### *Setting boundaries*

This is an essential characteristic of work with clients, and needs to be established at the outset of the working relationship. Confidentiality needs to be explained, as a “need to know” issue for nurses. Respect for the clients’ choices, both to seek and use help, or reject help is needed. Unacceptable behaviour on the part of the client needs a clear, calm and precise response. Team and service boundaries for aggression, prescribing, non-collection of medication, attendance, non-attendance and discharge need to be explicit, and known by all staff. The need for such boundaries is particularly important when working outside of structured environments e.g. on the street, community settings. Clear, therapeutic boundaries, fairly and firmly implemented, will help clients to feel respected, confident and safe. An example of a boundaries protocol used by Manchester Drug Services is provided overleaf.

## BOUNDARIES

Manchester Drug Service (1996)

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### Statement of aims:

This service is committed to help people to reduce the risks that they run whilst using drugs. During contact with us you are entitled to respectful attitudes and to equal treatment regardless of race, colour, sex, creed, disability, age, national origin, sexuality or political views.

Whilst Manchester Drug Service tries to keep rules and regulations to a minimum, it is helpful for you to understand how we operate. The following sets out what you can expect from us and what we expect of you in return. If you feel unable to follow these rules you should seek treatment elsewhere.

### Your rights:

1. When you are accepted as a client, a member of staff - your “Key Worker” will be allocated to you. Your key worker is available to give counselling and advice. You have right of access to your key worker at mutually agreed times.
2. The service will not reveal information from a client to anyone outside the team without the client’s permission unless a child’s welfare is at risk. You cannot receive a prescription, however, unless your GP is informed.

3. You can make a complaint about your treatment to the service manager at any time.
4. Anyone can ask for advice, but to be treated by the service you must:
  - live in Manchester (though you can be homeless)
  - get a GP as soon as possible after starting treatment if you don't already have one.
5. This service accepts referrals from anyone, including self-referrals.

### **Your Responsibilities:**

1. On the premises the following behaviour will not be tolerated and may result in temporary or permanent withdrawal from service:
  - a. Aggressive, offensive or violent behaviour towards anyone in our buildings,
  - b. Bringing illicit drugs into or consuming alcohol on the premises.
  - c. Theft of property on the premises.
  - d. Bringing stolen property onto the premises
  - e. Dealing in drugs on the premises including your own prescribed drugs.
2. Outside the premises: the Manchester Drug Service relies on the co-operation of GPs, chemists and our neighbours. If your behaviour towards others tends to bring the Service into disrepute, a decision may have to be made to bar you from further services.
3. Prescriptions: if you receive a prescription, it is your responsibility to collect it, to take it to the chemist and keep it safe. Lost prescriptions or medication will not be replaced by us or your GP. If you alter, or allow someone else to alter, your prescription in any way, you are committing a criminal offense and your prescription will be stopped until such time as the service decides further prescriptions are appropriate.

### *Initial Assessment*

#### Triage And Screening

Nurses assess health status, of which alcohol and drug use are a part. Identifying if there is a problem is a basic intervention which can be used by specialist and non-specialist nurses (Clancy & Coyne, 1997). Screening and assessment tools can be used to assist the nurse in collecting baseline data e.g. CAGE, SADQ, and the cycle of change (Bernadt, 1991).

Initial assessment may be brief, but needs to follow a professional format. The triage assessment is a specialist assessment, requiring experienced nurses, with advanced nursing skills (Edwards 1994). It may last only 2-3 minutes with the purpose of clarifying the degree of emergency. Situations where nurse triage is practiced include both face-to-face and telephone consultations often providing access 24 hours a day, seven days a week.

Once the degree of problem has been established and it is not necessary to refer on, the nurse should conduct a brief screening assessment to establish the main reasons why the

client has presented, their use or non-use of drugs and alcohol, and the immediate consequences which is affecting their health status (i.e. physical, mental, social, spiritual).

Should significant risk or problems with drug and/or alcohol use be uncovered, a more in-depth, and comprehensive assessment is needed.

#### *In-depth Assessment*

##### **Assessment may include:**

- Identifying the referral sources -self, GP, other medical, family/friends, occupational etc.
- The reasons for referral and clients acceptance of reason
- Current involved agencies
- Current alcohol/drug use - pattern, mode of use, frequency, amount, when and with whom
- Past alcohol/drug use
- Evidence of withdrawal symptoms/dependence
- Periods of abstinence
- Prescribed medication
- Physical health
- Psychological health
- Social/family/occupational both current and history
- Legal status current and history
- Health protection strategies e.g. harm minimisation, risk reduction
- How does client view current problems
- Previous Treatment
- What does the client think would help the current situation
- What does the client want from services

*Identifying the client's reason for attending. Why has the client come to your attention at this point?*

Whatever abilities or motivations nurses have when operating as specialists in the area of substance misuse, the client must be the centre of care. Their specific reasons for seeking help, and seeking help “now” needs to be the focus of the response. Therapeutic outcomes result from a growth-producing climate in a therapeutic relationship which develops from the core conditions of genuineness, understanding and acceptance (Mearns and Thorne 1988). Clients need to believe that the nurse is truly interested in them, their agenda and well-being, and that they will not set them up to fail. Such conditions will facilitate the client to disclose their feelings, thoughts, | behaviours and allow for the exploration of their motivations and hopes for the future.

Consequently, a clear understanding of the client's current needs and wants and reasons for seeking help now, helps to clarify priorities, and to identify those issues that the nurse can assist with, and those that they can not assist with. Where needs can not be managed by the nurse, alternatives need to be explored and secured. Whilst nurses may not be the main care provider, they often remain the co-ordinator of packages of care -provided by different personnel, disciplines, teams and agencies.

*Focus on physical/psychological/social/spiritual. Is there more to the client than their alcohol and drug use?*

Assessment of the whole person and system is needed, as well as the drug and alcohol assessment. Clearly there may be many reasons for drug and alcohol use e.g. pain control, anxiety management, prevention of withdrawal symptoms - as well as desires to escape unhappiness, and to socialise confidently. Drug use in communities is often associated with peer pressure and economic systems.

### *Physical screening methods*

A variety of physical screening methods exist, which may be observed and prescribed by the nurse or another member of the multi-disciplinary team (Ghodse 1995):

- Urine toxicology (for drugs and alcohol)
- Blood testing - Liver function tests, Hepatitis B/C antibodies
- Breathalysers
- Temperature, Pulse, Respirations, Blood Pressure
- Weight
- Physical signs e.g. gait, "track marks", abscesses, injection sites, skin pallor, pupil size, irritability, drowsiness, smell of breath
- Hair analysis

#### Supervision of Urine Tests

On occasions the Care Team may decide that a client needs to be asked to provide a supervised urine sample e.g. for court cases, child care reviews, suspected illicit use on top of their prescription. This process involves intimate and invasive observation of the client during urination. Consequently consideration needs to be given to the justification of such a request being made and once mandated, the human dignity and privacy of the client must be paramount. Attention should be given to the client's gender, cultural and religious belief system.

Chaperoning may need to occur to protect both the client and nurse.

### *Relapse and assessment of high risk situations*

Situations, both emotional and physical, may play a significant part in returning to drug and alcohol use. For some people visits to the supermarket may trigger the desire for alcohol. For others, the sight of a pharmacy, needle, dealer or other drug user may trigger memories of illicit drug use, and the associated arousal of the lifestyle, consequently leading to lapse or relapse of their substance use. A clear understanding by the client and the nurse of significant triggers can lead to the development of simple and clear strategies to avoid and manage the more significant triggers (Marlatt & George, 1984; Wanigaratne et. al. 1990).

### *Systemic issues/significant others*

Assessment of clients may initially focus on the “here and now” elements of their drug use, and their reason for seeking help. However, an understanding of the important people and factors in their lives is important as the client may not appreciate the influences of friends and families, nor the consequent effects of their drug and alcohol use. Clearly humans operate within complex systems (von Bertalanffy, 1968).

For some clients to change their substance use behaviour, partners or other family members need to be included in the care plan. The family may need to be educated so they understand that for some people “one little drink” may be the beginning of the end of their sobriety. Community alcohol detoxification programmes are likely to be more successful if the client has a relatively stable and supportive relationship (Cooper, 1994).

### *Previous treatment*

Clients may attend for help at varying stages throughout their drinking/drug career. Knowledge of previous treatment episodes, with respect to their effectiveness, can have implications on current or future treatment programmes offered. Clients need to be matched to appropriate interventions (Glaser, Greenberg and Barrett 1978), consequently re-assessment at each presentation for help is required, since major alteration in attitude e.g. self-efficacy, self-esteem, knowledge and experience may have occurred.

### *End of assessment and reassessment*

Ideally, at the end of the assessment the nurse should know how the client views their problem, and what alternative to their present situation they want to achieve. The nurse should be aware of the client’s general circumstances, their strengths, and the resources both internally and externally, which will contribute to the solutions sought. On-going assessment may be needed, through the evaluation and re-evaluation process.

A framework for an in-depth assessment of the patient's substance use.

| <b>Question</b>   | <b>Purpose</b>  |
|---|---|
| When did you last smoke/drink alcohol/sniff solvents/use other drugs? (Specify name of drug, quantity, route of administration) | Identifying the type and range of substances used. The quantity and route of administration should indicate the level and extent of substance use, and associated risks.  |
| What age were you when you first tried these substances?  | Establishing the length of use. The lower the age of initiation the greater the potential for subsequent harm.  |
| Has there been any change in the amount and way you uses substances?  | Ascertaining whether the use is/has been experimental, recreational or dependent.   |
| What days did you use these substances last week? (use 2, 3 or 4 weeks if use infrequent)                                       | Ascertaining whether the use is /has been experimental, recreational or dependent.  |
| What times of the day do you usually use?   | Establishing pattern and severity of use  |
| Where do you usually use?   | Identifying the environment where use occurs to ascertain potential risks   |
| Do you use alone, or with others?   | Establishing whether use is a solo or group activity. Whether partner is involved.  |
| What mood are you generally in before use?  | Identifying any specific events which trigger use of substances (For example arguments with peers, girlfriend/boyfriend, as part of preparation to go out with friends or at parties/raves, in response to pressure at work.)         |
| How do the substances generally make you feel?  | Identifying attitudes towards substance use and contributing to assessment of whether use is experimental, recreational, dependent.   |
| Have you ever experienced any bad effects?  | Identifying physical (e.g.: overdoses, gastritis) psychological(e.g.: low moods, depression, suicidal ideation), social(e.g.: loss of friends/employment, family conflict), legal(e.g.: getting in trouble with the police, arrests). |

## Question

## Purpose

Has anyone ever told you they are worried about your use of substances?

Identifying whether substance use has come to the attention of others

Have you previously tried to change your substance use?

Identifying periods of abstinence, strengths and weaknesses, successful strategies for change

Are you worried about your use of substances?

Eliciting from the patient their perspective of how serious they consider their use of substances

Would you like to do anything about your current substance use

Eliciting from the patient their perspective of how serious they consider their use of substances

### Recommended reading:

Clancy C, Coyne P (1997) Specialist assessment in a multidisciplinary setting, in Rassool, H. Gafoor, M. Addiction nursing: perspectives on professional and clinical practice. Gloucester; Stanley Thornes

### 3.2.2 Goal setting for client change and nursing intervention

Skills of planning care  
Identifying solutions  
Setting goals  
Formulating plans  
Communicating  
Producing the plan

Department of Health (1994)

#### *Aims of treatment*

I The aims of intervention, following identification of the individual's, family's or community health needs, will vary and depend upon both the desired scenario and the I resources which are available. With the help of the nurse the client will clarify their I general aims, and specific objectives, taking into account the prioritisation of needs, I their motivation and desired outcomes.

I It is important for both the client and the nurse to have some idea about what the client | is motivated to actually consider or do. The following offer possible starting points:

- unwillingness to accept alcohol/drug use as a problem, but willingness to accept
- related problem exists
- prepared to explore possibility that a problem exists
- accepts a problem exists and willing to explore behaviour needed for change
- has made changes to drug/alcohol behaviour and wishes to maintain change

These possibilities, are a few of those states of motivation that a client, family or community may be in, and is described by Prochaska and DiClementi (1983) in their cycle of change.

#### *Areas where clients can be assisted through nursing interventions*

- Health promotion (physical, mental, social & spiritual)
- Harm minimisation
- Risk reduction
- Abstinence
- Controlled drinking
- Maintenance/stability
- Palliative care and a pain free death
- The development of an effective support system
- The alleviation, or treatment of primary causative conditions
- Matching to appropriate helping services
- Empowerment

- Keeping families together

*Set targets*

Care plans need to have clear and achievable targets and time scales e.g. process targets would include identifying the number of sessions that the nurse and client intend to use; the venue where care/intervention will be offered; the involvement of others. Outcome targets would include changes and gains in health: physical, social, psychological and spiritual e.g. healed injecting sites, drinking within normal limits, ceasing polydrug use. If compliance with the developed care plan is to be achieved, the objectives and methods of implementation need to be realistic (Green 1987; Egan 1990). The Department of Health Task Force suggest a mechanism for reviewing outcomes.

**TASK FORCE REVIEW OUTCOMES**

| <b>OUTCOME DOMAIN</b>  | <b>MEASURE</b>  |
|--|---|
| DRUG USE   |   |
| PHYSICAL AND PSYCHOLOGICAL HEALTH  |   |
| SOCIAL FUNCTIONING AND LIFE CONTEXT  |   |
|  | <ol style="list-style-type: none"> <li>1. Abstinence from drugs</li> <li>2. Near abstinence from drugs</li> <li>3. Reduction in the quantity of drugs consumed</li> <li>4. Abstinence from street drugs</li> <li>5. Reduced use of street drugs</li> <li>6. Change in drug-taking behaviour from injecting to oral consumption</li> <li>7. Reduction in the frequency of injecting</li> </ol> |
|  | <ol style="list-style-type: none"> <li>1. Improvement in physical health</li> <li>2. No deterioration in physical health</li> <li>3. Improvement in psychological health</li> <li>4. No deterioration in psychological health</li> <li>5. Reduction in sharing injecting equipment</li> <li>6. Reduction in sexual risk taking</li> </ol>   |
|  | <ol style="list-style-type: none"> <li>1. Reduction in criminal activity</li> <li>2. Improvement in employment status</li> <li>3. Fewer working/school days missed</li> <li>4. Improved family relationships</li> <li>5. Improved personal relationships</li> <li>6. Domiciliary stability/improvement</li> </ol>   |
| <p><i>Department of Health (1996) The Task Force to Review Services for Drug Misusers.</i></p> |   |

*Relapse prevention*

Relapse prevention is a major goal of drug and alcohol treatment. Identifying high-risk situations, cues to craving for drugs or alcohol, or triggers for lapse and relapse, is a

technical and significant piece of work. Clients need to develop an understanding of the system of stimulus and reward that they operate in, and need to understand that they can change the system, develop alternative adaptive responses, more successful ways of interacting and more constructive ways of managing stress. The plan to assist clients to move into a spiral of success, rather than a spiral of disappointment, needs to be explicitly negotiated with the client.

### *Physical/psychological/social/spiritual goals*

These goals need to be explored. For some the whole idea of hope is the core of their current existential confusion, and the core of a sense of unhappiness which is alleviated by drugs. Spiritual goals, (not necessarily religious) may be philosophical e.g. humanistic; or may be aesthetic e.g. art and beauty, and may begin to help a client to find a meaning in their life. Clearly goals aimed at alleviating or resolving social problems e.g. domestic violence, unemployment, child care, can be the contextual support that allows an individual to have the space to make serious changes in their drug and alcohol using behaviour.

Spiritual well-being is defined as when the person experiences wholeness within the self, with other human beings, and in transcendence with other realms. Spiritual integrity is demonstrated through acts that show qualities such as love, hope, trust and forgiveness (Laburn 1988).

### *Matching*

The outcome of assessment, as a result of the needs identified and the outcomes sought, may indicate that the client requires more assistance than the nurse can provide. This is not a sign of failure, it is usually a fact.

Some clients will have multiple needs and problems, and each will require an individual care plan. The additional services which a client may need to be matched to may include:

- a crisis service e.g. A&E, battered women's home
- a nurse or therapist of a different gender or race
- a nurse or therapist with different knowledge and skills
- a different professional e.g. a doctor, a lawyer
- a different type of service e.g. social service, a service for women, a different paradigm e.g. Minnesota or methadone maintenance.
- a community service
- a residential service
- a brief intervention service
- a long-term intervention service
- a particular philosophy e.g. religious, concept house, community skills training.

Matching to services and interventions will alter along the course of a client's drug and/or alcohol using career (Glaser, Greenberg, and Barrett 1978). For example, initially the client may need a risk reduction service e.g. a needle exchange, at another point they may need residential crisis services; and again later on they may need personal psychotherapy, or a self-support service such as Narcotics Anonymous (Wells 1990).

Few organisations can offer all clients every possible option. Matching is not about avoiding responsibility, or just "passing on" clients. It is about ensuring that the care needs of clients are considered beyond the immediate concerns, by attempts to reach out to the client's own future. As such, a major role of nurses is to help clients to match their short, medium and long-term needs to appropriate services. To perform this role, specialist nurses, need to gain a wide and deep understanding of the whole host of helping services, both generic and specific, available to clients, and the methods of referral and placement. The role of specialist nurses in the area of alcohol and drug use does require both well developed nursing knowledge and experience, and also broad and deep understanding of alcohol and drug use and nursing care.

### 3.2.3 Implementation - care provision and self-care

*Skills of implementing care:*

Planned intervention

Motivating

Managing

Teaching

Meeting personal care needs Organisation

Department of Health (1994)

#### *Care management*

Most community and in-patient services now operate a key-worker (named nurse, case manager, primary nurse) system. Once the care package is agreed it is the responsibility of that person to ensure it is implemented, monitored and evaluated. Flexibility must remain a key element in this approach and on-going assessment should indicate whether the client's needs have been met or have changed.

#### *Negotiated care-planning*

The nurse-client relationship is enabling i.e. therapeutic. This is the core of on-going health improvement. It is the role of nurses to work with clients to identify needs, to prioritise them, to identify resources and to create realistic, achievable plans. The client needs to feel that they own the plan, and can view the nurse as a source of help. Clients need to know what is expected of them and what they can expect of the service they are using.

Care planning and reviewing requires assertive and respectful challenging skills. It is often necessary to highlight contradictions between verbal intentions or statements and actual behaviours e.g. people may say that they have stopped using drugs, but urine samples suggest otherwise. Punitive, and aggressive challenging is not helpful. Clear behavioural consequences operated in a firm but fair manner are needed.

*HIV: safer behaviours - reducing the risks and harm*

“We conclude that changing the unsafe sexual practices of drug users is a crucial aspect of curbing the spread of HIV. Success here has been elusive, and more needs to be done by all services, specialist and generic, which deal with drug users. The promotion of safer sex needs to be more clearly defined, more closely monitored, and regularly reviewed.” (ACMD(1993) AIDS and drug misuse: update. P.40)

Recommended reading:

Foucault, M. (1976) *The history of sexuality: An introduction*. London; Penguin

*What can nurses provide?*

- accurate information
- advice - both verbal and written, and in different languages
- liaison
- co-ordination and development of neighbourhood prevention projects
- relapse management
- individual counselling
- health education and advice
- responsible dispensing and administration of drugs
  - detoxification, maintenance, curative (e.g. antibiotics for TB)
- vaccination - hepatitis B
- screening/testing - HIV, hepatitis B,C, breathalyser, Liver Function Test, Sexually Transmitted Diseases
- nutritional e.g. vitamin B
- complementary therapies
- group work
- anxiety management
- relaxation
- sexual health screen
- family planning
- family work
- specialist assessment and report writing
- co-ordination of multi-disciplinary/multi-agency care

## *Specialist Interventions Associated With Substance Use*

- Methadone Maintenance
- Relapse prevention
- Controlled drinking
- Safer sex education
- Safer drug use education
- Safer injecting practice education
- Assessment and matching
- Day programmes for Stimulant users
- Minnesota methods
- Support groups: AA, NA, Families Anonymous
- Residential rehabilitation centre: Concept, Christian, Minnesota
- Cue exposure
- Needle exchanges and disposal arrangements
- Outreach
- Antabuse therapy

Ghodse and Maxwell (1990)

### *Detoxification*

This may be a life saving intervention, which can be offered from a variety of settings including outpatient, in-patient and community. Detoxification from alcohol, benzodiazepines and barbiturates is generally viewed as the most important, since they are designed to prevent epileptic fits, which are sufficiently common and dangerous to be prevented by a detoxification programme. For clients with serious alcohol dependency, Delirium Tremens (DTs) which can result from the abrupt withdrawal of alcohol is a life threatening condition which requires urgent medical attention. Detoxification from opiates is often undertaken primarily to overcome somatic elements of the withdrawal, and also to overcome the psychological cravings for the drug of dependence.

Detoxification regimes are normally designed with reference to professional protocols.

### *Complementary therapies*

Complementary therapies are becoming increasingly popular. In accordance with the UKCC guidelines (UKCC 1996) the nurse must be convinced of the relevance and accountability of the therapy being used and must be able to justify using it in a particular circumstance.

Detoxification teas, sleep teas, auricular and full body acupuncture, shiatsu, visualisation, and aromatherapy are now commonly used by clients who are seeking to reduce their misuse of drugs, and are often provided by trained nurses.

## *Testing and Results*

A multi-disciplinary and multi-agency approach may be needed. Clients need to understand why a test is being done, and should give informed consent (UKCC 1996). Results should be communicated clearly, simply, and accurately. There needs to be clear local policy for multi-disciplinary viewing of test results. Specific pre- and post-test counselling may be needed particularly in relation to HIV testing, hepatitis, and pregnancy.

## *Advice and information*

The provision of written information on all aspects of treatment available for the clients to take away and read in their own time should be considered. For example there might be leaflets on:

- Community and in-patient detoxification
- Controlled/sensible drinking
- Relapse prevention
- Group therapy
- Rehabilitation (residential)
- Psychotherapy
- HIV/hepatitis

## *Health Promotion/Health Education*

Health promotion work is often best carried out as part of an overall strategy, which involves healthy alliances with other professionals and agencies. Consideration should be given to forming partnerships between

- Schools
- Youth centres
- Leisure and sport centres
- Local health/social care agencies
- Trust's Health Promotion Departments
- Police
- Local businesses i.e. tobacconists, off-licences
- Primary Health Care Settings (e.g. Occupational Health, General Practitioners, Health Care Centres)

These “healthy alliances” can build on local and national health promotion initiatives i.e. “No smoking day”, “Sensible drinking limits”, “National drugs helpline”.

Health promotion leaflets, posters and flyers can be obtained from local health promotion departments and distributed to clients in schools, GP surgeries, hospital waiting rooms etc. A list of contact addresses offering such resources can be found in Section Five of this booklet.

*Recommended Reading:*

Hibble A and Elwood J (1992) Health Promotion for Young People. Practitioner. 236(1521) 1140, 1142-3. Dec.

Ewles L and Simnett I (1990) Promoting Health. A practical guide to health education. John Wiley & Sons, Chichester.

### 3.2.4 Evaluation of the care plan

*Skills of evaluating care*

- Defining results
- Obtaining feedback
- Assessing results
- Identifying process changes required
- Creating opportunities
- Reviewing overall performance
- Managing success/failure in achieving goals
- Recording and communicating

Department of Health (1994)

The purpose of a care plan review is to identify if the needs of a client are being met, with a clear sense of objective attainments, and also a clear awareness of the client's satisfaction with their own progress, taking into account that a client's needs will alter over time.

#### *Non-Achievement Of Goals*

In the event that goals are not being achieved the nurse may wish to consider the following possible reasons and courses of action.

| Non-Achievement Of Goals   | Possible courses of action  |
|--|---|
| <ul style="list-style-type: none"><li>• The client's goals were unrealistic</li><li>• The nurse's goals were unrealistic</li><li>• The goals were not clearly identified and plans formulated</li><li>• Changes in the social circumstances of the client</li><li>• Lack of onward in-patient/ out-patient treatment options e.g. lack of local authority funding</li><li>• The agency's goals are unrealistic</li></ul> | <ul style="list-style-type: none"><li>• Re-assessment of the client</li><li>• Identify new goals</li><li>• Modify the care plan</li><li>• Refer the client to another agency or worker.</li><li>• Review the case in multi-disciplinary forum, or with line manager/clinical supervisor</li></ul> |

### *Opportunity to learn*

Most learning comes from the evaluation of mistakes. Approaches to the nursing care of people with problem alcohol and drug use, should be based on the belief that clients deserve care, and need to be respected as autonomous individuals or communities, with the right to choose, and the right to try again.

### *Care Plan Review*

Problems and needs can change during a period of care. While the fear of withdrawal symptoms may have been a major issue at the start of treatment for a client, other issues such as hopelessness may be a developing concern, or planning a family may emerge as an intention for the near future. Therefore a care plan review should not only focus on the original assessment. It should also be understood that specialist substance misuse workers are not the only helping services, and that ideally clients should link to other helping agencies as necessary.

### *Data Collection*

Formal data collection may be needed e.g. drink diaries, lapse charts, mood charts, attendance records etc. to form objective data for joint evaluation with the client. The client may have set objectives too high, or strategies may not be sufficiently robust.

### *Aftercare*

Although the major objectives of a care programme have been achieved, to increase the client's chance of maintaining their achievements, the provision of aftercare by the nurse, should be considered as part of the discharge plan. The precise nature of the aftercare needs to be clear and adhere to organisational policies and procedures. The responsibilities and roles of the nurse and the organisation, with respect to the health of the client, should be clarified. It is important for aftercare not to undermine other helping interventions. The boundaries and limits of the aftercare package need to be made explicit, and ideally be provided in writing.

### *Closing of work and care*

While an episode or programme of nursing care needs to be formally opened, so too does the closing of the work (Saunders,1986). Clients may become dependent on those who support them and provide care, making the ending of therapeutic relationships an emotionally difficult one.

Clear planning for discharge must include not only the health gain targets, but also the issues of the therapeutic relationship. Clients need to know well in advance about the

ending, and need to be able to talk about the relationship explicitly. They need to be aware of what is possible for the future. Emotions need to be respected. Episodes of care can also come to an abrupt end, for example when a client elects to drop-out of treatment or dies. Such closures need to take into account the effect on the nurse, and the team, that provided the client with care. Feelings of rejection, inadequacy, sadness and anger may occur. It is at these times that the overall supportiveness of teams, and of supervision, have obvious value (Yalom, 1985).

Strategies for future support need to be explored, and clarified (Egan 1990).

*Closing of a care episode because a client is not complying with minimum requirements*

Examples of non-compliance, where the closing of care may occur include: health status being reduced by chaotic binges of drug use, aggression, non-attendance. Clients need to be clear about the boundaries at the outset. Infringements need to be managed immediately both verbally and in writing. Warnings and the consequences of a warning being issued must be clear.

Discharges should be respectful and assertive. Opportunities to re-engage should be made explicit. Ideally the successes, both of process and health gain need to be listed and made explicit. A fair, assertive and firm approach is more likely to gain respect, than an angry, tardy and disorganised approach. Team working is of particular importance under such circumstances. “Splitting” on the clients’ part, or poor understanding of the aggression and violence policy on the staffs part, can make these encounters dangerous.

*Clinical Supervision: receiving and providing.*

Nursing has generally operated within a close system of clinical supervision, usually hierarchical. Nurse training has included clinical supervision of both competence to complete tasks, and to acquire and utilise information. As such clinical supervision has developed in recent years to include a much greater emphasis on the process of caring, the dynamics of the interpersonal relationship, the effects upon the nurse, the reflection and exploration of care, and the consideration of alternatives, as well as the quality monitoring function (Adams, 1991; Butterworth and Faugier 1992).

Central to clinical supervision is the nursing care provided by nurses to groups and individuals. It needs to focus on the managerial elements and the educative elements, and also needs to be of support to the nurse, or group of nurses receiving it.

Nurses begin to learn the process of clinical supervision during their training, through their supervision and mentoring of students, and thence through their supervision of staff at various levels. Nurses provide clinical supervision for nurses, but also formally and informally for other staff.

## **Clinical Supervision**

There are three distinct but interrelated aspects of clinical supervision. The formative or educational function aims to develop the skills, abilities and understanding of those supervised, by means of reflection and exploration.

The restorative or supportive function acknowledges that the therapeutic use of self means just what it says: nurses will, of necessity, be affected by the pain and distress which is suffered by the clients. The growth of primary nursing will inevitably increase this stress, and the need for clinical supervision.

Even those with most experience will have inevitable blind spots, human failings, areas of vulnerability and prejudice, of which they may remain unaware. The normative or managerial function of supervision supplies external quality control: it is up to the supervisor to ensure that the highest professional standards of nursing are upheld.

Department of Health (1994) Report of the Mental Health Nursing Review Team.

### 3.3 Management and administration

#### **Managerial work:**

Mintzberg, for example, classified managerial behaviour into three sets of roles, common to all levels of management (8). He describes these as interpersonal, informational, and decisional roles. In their interpersonal roles managers act as figureheads, leaders and liaison persons; in their informational roles as monitors, disseminators and spokespersons; in their decisional roles as entrepreneurs, disturbance handlers, resource allocators and negotiators. The importance of Mintzberg's work is that it highlights the uncertainty within which most managers operate. (p.66)

Farnham, D. Pimlott, J. (1990) Understanding industrial relations. 4th edition. London; Cassell.

Mintzberg, H. (1973) The nature of managerial work. New Jersey; Prentice Hall

Nurses working with drug and alcohol use, invariably operate as liaison persons, within organisations, with funders and contractors, with clients and helping agencies. They often lead projects, and manage organisations. Clearly they are actively involved with monitoring and evaluation, as well as the dissemination of marketing materials, public health materials, and often find themselves as spokespersons for their clients and their agencies (Coyne and Clancy, 1996).

More fundamental features of nurses work is the general management of personnel, conflict management, and resource allocation. This is often a dynamic set of functions, within entrepreneurial pursuit of more and better services for clients. Overall, nursing management is geared to ensure the best possible services within the resources available, which has meant a move towards greater primary care over the last 30 years; and a much better utilisation of specialist nurse practitioners (WHO 1978; Baradell 1994; Godfrey 1992).

### *Co-ordinating team in-puts*

Nurses rarely work solely on their own, they often work as part of a multi-disciplinary or multi-agency team, within participant and co-ordinating roles. It is important that clients understand the systematic nature of such work. It is also important to ensure that the client understands the value of a well constructed support system for themselves. Education about agencies and disciplines, how to work with them, and how to communicate with them is an important part of nursing care. Formal liaison, with the client's permission, may be a core component of the care plan.

### *Liaison*

Good lines of communication are essential for the client to receive comprehensive and consistent help. The client's permission should be sought when informing the GP and/or other agencies, and their wishes observed if they do not want anyone informed, unless under exceptional circumstances e.g. if the person is a danger to themselves or others. In the latter case, the client should be informed and given an explanation for such action. Consideration should be given to inserting a standard consent form within the client's case notes, which the client is asked to sign at the beginning of their treatment, clearly stating whether they consent to information being shared and with whom i.e. family members, outside agencies, etc.

In cases where the client is to receive medication e.g. for community detoxification, it is necessary to confirm with the GP that the client is not in receipt of any medication which would be contra-indicated.

### *Record Keeping*

Clear written notes should be kept up-to-date with reference to the UKCC's standard of practice (UKCC, 1996). Although notes can be multi-disciplinary, the care planning work of the nurse needs to be clear, accessible and accurate. Notes need to be presented in a format that is not only accessible to other colleagues, but accessible to courts, and to clients themselves.

### *Case Reviews*

Case reviews may take various forms, at the onset of treatment a timetable of reviews should be set and agreed with the client. The timetable may need adjustment as treatment progresses.

### *Joint care plan review*

Since clients generally seek help from a team, a review with a supervisor or a colleague, through a multi-disciplinary meeting is needed. The review may lead to the involvement of other members of the team, or other agencies. Clients need to be fully involved with this process. They need to know that they are achieving, and this needs to be explicit, even if the objective may seem small and insignificant. For example, turning up for an appointment, phoning to cancel an appointment or self-disclosing a failure, can be major treatment achievements for many clients. Likewise clients need to acknowledge if they are not meeting the goals set and new goals discussed.

### *Multi-disciplinary reviews*

These need to be co-ordinated. Usually a case-manager/primary nurse/key-worker will be involved. Joint notes, or systems for written and verbal communication need to be adequate. The client should ideally be part of review meetings.

### *Multi-agency reviews*

Multi-agency evaluations may be needed (Coyne & Dhanani, 1993). Written and verbal communication needs to be made, if the client gives consent, and should ideally support the actions of the client. The development of a support system is of paramount importance.

### *Individual/significant others*

Reviews not only need to occur amongst professionals and the client, but, where possible and desirable, with significant others, who are also involved. Partners, children, employers and friends, may benefit from a formal review process, which can offer the following opportunities:

- sharing of relevant information about successful behaviour changes
- education about the recovery process
- support.

As a quick guide to whether relevant management policy/ procedures are in place within your organisation the check list provided should be consulted. A negative response indicates a possible management deficit which should be brought to the attention of the line manager.

## Management Checklist:

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There are many aspects to the administrative and managerial work of nurses, which may be analysed by the following list of questions:

1. Are you aware of where you fit into your organisation's managerial and professional structure?
2. Are you aware of what and for whom you are responsible and accountable?
3. Are you clear about your role, and the roles of the other members of your team?
4. Do you have a clear job description and person specification for your post?
5. Are you formally appraised annually against your key result areas and performance targets?
6. Do you have access to, and an awareness of, the relevant UKCC guidelines for practice?
7. Do you have regular managerial supervision?
8. Do you have regular clinical supervision, from an experienced practitioner?
9. Does your organisation have a clear set of policies and procedures?
10. Do you have access to training?
11. Are there clear systems for the collection of data?
12. Are there regular opportunities for team meetings to ensure a coordinated approach?
13. Do you have access to the Trust's/Organisation's standard setting and audit process?
14. Has your caseload been agreed with management?
15. Are you aware of your organisation's press and publicity policy?
16. Does your organisation have a clear policy and procedure for communicating about clients with outside agencies including those within the criminal justice system?

### *Involving service users in service development and audit*

It is often helpful to ensure that the needs and views of service users are included before services are provided and should be included in the annual audit of clinical standards.

There are many active groups of service users, some of which have influenced local, national and international service development (AIDS-Forum D.A.H. (1993). By the use of action research methodologies, clients, members of local communities, purchasers, as well as service providers can be brought together to develop and research the effectiveness of service provision, in an immediate and collaborative manner (Susman & Evered, 1978; Holter & Schwartz-Barcott, 1993)

Users of health services have a right to comment on the services they receive (Patient's Charter); they have a right to complain, and should be supported to exercise this right.

## 3.4 Education and Training

Nurses have an on-going role as educator (Hamric and Spross 1989). This has been formally recognised for sometime, with the requirement to successfully complete a teaching assessment for basic registration. Education occurs vicariously from nurses experiences, each day, with clients and colleagues, and more formally from reading the literature and attending seminars, lectures, supervision, completion of formal courses and research investigations.

### *Professional development*

1. The professional development of nurses, as a life long necessity, is recommended by the ENB (1996), to be viewed within the context of “Creating Lifelong Learners”. The ENB view pre-registration preparation, as not only helping students develop the competence of registration, but to also develop the attitude and skills to be able to operate within the context of lifelong learning, in an ever changing health service.
2. Post registration competence, as proposed by the UKCC in its report “Standards for Education and Practice following Registration”, PREP requires that all nurses maintain their registration by:
  - completing five study days every three years
  - completing a Notification of Practice form every three years.
  - maintaining a personal professional profile
  - completing a return to practice course, if they have had a break of five or more years.
3. The ENB (1996) has identified that due to the growing problem of substance misuse, nurse practitioners need to develop the necessary skills, and need to be adequately prepared to meet the challenges of care, that come with this reality.
4. Since substance misuse is part of everyday life, the ENB (1996) has recommended that substance misuse should be included in all pre- and post-registration nursing, midwifery and health visiting curricula guidelines at a standard appropriate to each program.
5. Clearly nursing competence and expertise develops in stages, and for those who move into specialist practitioner posts, on-going professional education and supervision will lead to “expert practitioners” competencies. (Benner, 1984).

### *Education and training of others*

Specialist nurses are required to assess, design and provide a variety of education and training opportunities (Pendleton and Myles 1991; Faugier, Hayes and Butterworth 1992) for:

Nurses -

- on pre-registration courses, in college and whilst on placement
- working in other specialities, who are seeking to up-date themselves on substance misuse

- developing their expertise in the field of substance misuse

Other professionals-

- during their training in specialist areas
- during multi-disciplinary meetings - both formally and informally
- the police
- schools - both educators and pupils
- social services departments
- housing agencies
- medical schools
- non-statutory agencies

Clients -

- local community groups
- partners and parents
- children
- institutions
- individual clients

*Planning a training or education event*

Within a holistic philosophy of education and training, a training or education session requires planning, some of the essential points are summarised below:

1. Obtain some awareness of the environmental context of the audience e.g. inner city, rural
2. Assess the participants requirements
3. Clarify who should do the training
4. Identify what resources will be needed and ensure they are available
5. Formulate a contract with the purchaser and the individual or group receiving the training
6. Sort out financial matters- resources available, organisation's fee, invoice arrangements
7. Plan clear aims and objectives
8. Develop methods of teaching and training to achieve the objectives
9. Develop a method of evaluation
10. Clarify quality markers for the training

*Recommended reading:*

English National Board (1996) Substance use, misuse: guidelines for good practice in education and training of nurses, midwives and health visitors. ENB. London

### 3.5 Research and evaluation

#### *Nursing research:*

“Research in nursing takes a variety of forms. Broadly defined it may focus, among other things, on: nursing practices; nursing services and service delivery; the nursing professions and issues concerned with the workforce and its deployment; health promotion; complex health care procedures or patterns of intervention; and service systems within which nursing plays but a part along with other health care professions.” (p.8)

Department of Health (1993) Report of the Task Force on the Strategy for Research in Nursing, Midwifery and Health Visiting. London; HMSO.

There is a need for clients to receive the most effective form of care, within the context of the ethical distribution of scarce financial resources (WHO 1978; Drummond 1994). Equally, there is an increasing move towards evidence based clinical practice prompted by clear evidence that clients often receive interventions which are less effective and often more expensive than other forms of care (Walsh & Ford 1989). In response, there has been a considerable increase in the developing and setting of standards and protocols of care, and clinical audit (Manley 1992; Tallack & Coyne 1994).

These moves are also reflected in Public Sector Grants, which require the submission of project/research proposals for funding to be based on predicted, measurable outcomes - showing health and social gains for service users (Williams and Webb 1992).

Clients are entitled and indeed should be encouraged to complain about what they believe is sub-standard care. Nurses need to be clear about their clinical practice, the service delivery, the management, the education of staff and clients, as well as the systems for monitoring service delivery standards and their audit. Nurses working within the specialist area of substance misuse, where pioneering work in poorly defined areas is often the major characteristic of the care, must be aware of research findings, apply these to their work and be prepared to undertake further research.

There are a number of factors to consider when either undertaking or using research :

#### *Undertaking research*

- Get involved
- Identify the area to be researched (ensure that the client group is not over researched)
- Identify funding for research
  - Trust's
  - Health Authorities
  - Regional Offices
  - Professional groups
  - Research funding institutions

- Seek approval from Local Ethical Committee
- Arrange academic and clinical supervision
- Identify to whom research findings are to be submitted
- Agree in principle permission to publish findings
- Develop practice protocols, clinical standards and indicators based on research findings
- Throughout ensure that colleagues are aware of the research and enlist their cooperation

### *Reasons for using research*

- Evidence based practice
- Clients deserve to receive up-to-date treatment
- Specialist nurses provide a professional opinion for clients, other nurses, and other professionals.
- Evaluation of Health of the Nation (HoN) targets
- Develop models of care.
- To plan, and objectively resource, client services.

#### **Warning**

It should be remembered that research should be evaluated and critiqued. A piece of research may not have been carried out very well, and may not have useful results. It should also be remembered that what may be a fact for one sample population, may not be a fact for another, this is especially true for research carried out in different countries and societies (Burns & Grove 1987; Cohen & Manion 1995).

### *Developing nursing knowledge*

Nursing knowledge is unique, and is a major requirement for the professional accountability of nursing care - to both flinders and clients. There is an absence of such knowledge within the nursing profession and consequently within the general health and political arena. If this is not addressed then the clients that nurses see and care for will remain “out of sight and therefore out of mind” (Coyne & Clancy, 1996)

There are a variety of research paradigms, and a variety of research methodologies. For nursing there is a clear need to continue to describe the basic concepts of nursing as both an art and a science; whilst in some areas it maybe possible to develop predictive level theory from research of more controlled nature. The application of different paradigms, leads to different knowledge; of which all are equally valid (Hoshman, 1989; Simmons, 1995). The following is an example of a research standard and protocol form used in Riverside Mental Health Trust Substance Misuse Services.

## RESEARCH STANDARD AND PROTOCOL

|   |   |
|---|---|
| <b>Care Group</b><br><b>Standard Topic Sub</b><br><b>Topic Standard Statement</b> | <b>SUBSTANCE MISUSE SERVICE</b><br>Research<br>Research Proposals<br>All research proposals for studies involving staff, clients and carers is approved by internal, multi-disciplinary research committee.   |
| Structure<br>1.<br>2.<br>3.<br>4.   | UKCC Code of Professional Conduct available on site.<br>Riverside Mental Health Trust Ethical committee to discuss research proposals.<br>SMS Multi-disciplinary Research Committee occurring in the Service.<br>Ethical Committee application forms available on site.   |
| Process<br>1.<br>2.<br>3.<br>4.<br>5.<br>6  | Any research ideas will be discussed at the team level and proposals formulated.<br>Potential research proposals will be presented to the internal research group for evaluation and guidance.<br>Research by individuals will be compiled with guidance from lead professionals.<br>Research will be approved by the appropriate ethical committee.<br>Client involvement will include clear explanation and consent.<br>Research results will be made available to clients, staff and carers. |
| Outcome<br>1.<br>2.   | Research results will be made available to clients.<br>Clients will have had clear explanations for any research that they have participated in and have given their consent.   |

Source: Riverside Mental Health Trust Substance Misuse Service (1996)

*Recommended reading:* Cormack DPS (1996) *The Research Process in Nursing*. 3rd Edition. Blackwell Sciences. London

# Section Four: Special Issues

## 4.1 Introduction

There are many issues raised as a result of the use of substances, consequently it is not possible within this booklet to go into all of these in the depth required, it is therefore the intention of this section to raise these issues for the nurse, and to provide advice on further reading where appropriate.

## 4.2 Equality of access and under-represented needs

- All sectors of the local community should have access to specialist substance misuse services, and nurses. By working with local community groups, and by allowing them to have a say, they can have an influence on the development of services.
- Monitoring of under-represented needs, should occur regularly, and should be compared with service utilisation and community needs assessment.
- Under represented groups may include
  - ethnic minorities
  - pregnant women
  - gay, lesbian and bisexual people
  - women
  - children/young people
  - people of religious/spiritual persuasion
- Policies and services should be sensitive to under-represented groups, but it should not be assumed that clients will require or be seeking “different services”.

### *Recommended reading:*

Oyefeso A (1994) Sociocultural aspects of substance use and misuse. *Current Opinion in Psychiatry*, 7:273-277

Castro FG, Hammond WR, John R, Wyatt GE, Yung BR (1995) Panel IV: Risk-taking and abusive behaviours among ethnic minorities. *Health Psychology* Vol 14, No 7: 622-631

Ettorre E (1994) Chapter 6: What can she depend on? substance use and women's health. in Wilkinson S & Kitzinger (Eds) *Women & Health: Feminist Perspectives*. Taylor & Francis.

## 4.3 The Pregnant User

- The negative attitudes associated with alcohol and drug use, can be greater when a patient is pregnant or is responsible for the care of children.
- Service provision should be the same for all pregnant women and should be non-stigmatising.
- Clear and concise information about possible effects of drug use in pregnancy should be given.

- Early liaison with other professionals and shared care options are essential
- Maintaining a balance between confidentiality and professional responsibility is needed.
- Active involvement of the mother and significant others in pre-birth planning meetings should be encouraged.
- Pregnant women who use substances may have a number of concerns which prevent early presentation to services or non-compliance with treatment

*Recommended reading:*

I.S.D.D. (1990) Drugs, pregnancy and child care - a guide for professionals. London.

#### 4.4 Managing Emergencies

- Common emergencies can be predicted and local policies should be in place.  
Examples included:
  - Overdose - adults and children e.g. alcohol, opiates, tricyclic antidepressants Client presenting on Friday evenings at 5pm. Needle stick injuries Suicide
  - Mental health problems “lost prescriptions”
  - Delirium tremens (DTs), a life threatening condition
  - Epileptic fits from alcohol, benzodiazepines withdrawal
  - Aggression, violence and abuse e.g. racism, sexism
  - Child care e.g. illness of a single parent
- Nurses need to identify emergencies and to distinguish them from panic, agitation or pushiness.
- In some agencies, or work venues, especially those in the community, the nurse maybe the only health professional trained to respond.
- Liaisons with local A & E departments and psychiatric liaison teams should be established.
- A clear policy on minimum staff numbers and skill mix is needed, services may need to close if staff numbers are too low.
- The most important immediate response is to telephone the emergency services.
- Safety policies for community nurses need to be simple, clear and workable.

#### 4.5 Homelessness

- Clients with substance use related problems may be more prone to social disruption which can lead to periods of homelessness.
- As a consequence primary health care provision may be more difficult to access. It will be necessary to prioritise the presenting problems according to the client’s agenda. For example, they may not consider their use of substances a problem compared with their lack of shelter, food, benefits etc.
- Homelessness is a collective term for a variety of different situations: rooflessness - sleeping in the open air, doorways, parks temporary accommodation hostel accommodation sleeping with friends or relative, but with no rights
- Secure accommodation, albeit temporary, is often required before a client can gain

- access to treatment facilities. Help to access hostel accommodation will be needed.
- Local authorities will have a homeless person's unit, and usually a list of non-statutory accommodation bureaux. Homeless persons' units usually provide accommodation for those deemed "vulnerable i.e. defined by health status, which may require a letter of recommendation by a doctor, focusing on the vulnerability criteria.

*Recommended reading:*

Pleace, N. Quilgars, D. (1996) Health and homelessness in London: executive summary. York; University of York Centre for housing policy.

## 4.6 Partners and families

- An Individual's substance use and its consequences do not happen in a vacuum.
- Partners and families can be very useful resources in preventing and recognising the onset of substance use. They can be empowered through the provision of literature on facts and helpful hints i.e. Health Education Authority Literature
- Partners and families may contribute to an individual's use and continued use of substances i.e. co-dependency
- There is a need to understand models of addiction vis a vie generational and familial factors influencing substance use.
- Family involvement in treatment should be encouraged where appropriate and with the permission of the patient
- Partners and families may have their own individual needs separate to that of the patient and may require independent support e.g. Families Anonymous (FA)

*Recommended reading:*

Machensen G and Cottone R (1992) Family structural issues and chemical dependency: a review of the literature from 1985 to 1991. The American Journal of Family Therapy, Vol 20 No3; 227-239

Stafford D, & Hodgkinson L (1991) Co-dependency - how to break free and live your own life. Piatkus, London

Orford Jm Rigby K, Miller T, Tod A, Bennett G & Velleman R (1992) Ways of coping with excessive drug use in the family: A provisional typology based on the accounts of 50 close relatives. Journal of Community & Applied Social Psychology. Vol 2, 163-183.

## 4.7 Elderly people and substance misuse

- There is increasing evidence of the misuse of drugs and alcohol, including prescribed medication and over the counter drugs by older people.
- Recognition of a substance use problem may be masked by the ageing process, and false assumptions.
- Many carers of older people find their situation lonely and burdensome, and may seek solace from the use of alcohol and/or other drugs.
- Bereavement counselling for older people is often not considered although they may be dealing with multiple losses e.g. partners, friends, children, social role.
- A patient's ability to report their situation may be poor because of impaired cognitive states e.g. onset of dementia

*Recommended reading:*

Goodman C & Ward M (1989) Alcohol problem in old age. A practical guide to helping older people with drinking problems. Staccoto. London

U.S. Department of Health and Human Services. (1994) Using your medicines wisely: a guide for the elderly. National Institute on Drug Abuse. Available from the National Clearing House for Alcohol and Drug Information. PO Box 2345. Rockville, MD 20852

## 4.8 Infectious diseases

- The links between the use of drugs and alcohol, particularly the latter, and unsafe sexual behaviour (e.g. lack of condom use) are well established.
- The consequences of this behaviour increases the patient's risk of contracting HIV/AIDS/hepatitis B & C
- Hepatitis B & C are an issue for drug/alcohol users
- Information about such risks needs to be provided so that informed and healthy choices can be made.
- The health care needs of substance using patients who are positive for HIV/AIDS/hepatitis are complex and require a multidisciplinary and multiagency response.
- Developing collaborative working arrangements with Genito-urinary Medicine (GUM) and communicable diseases services may be necessary for agencies offering treatment to these patients.

*Recommended reading:*

The Terrence Higgins Trust. (1995) Understanding HIV Infection and AIDS. The Terrence Higgins Trust, London.

Coyne,P & Clancy, C (1996) "Out of Sight-Out of Mind" in AIDS and HIV: The Nursing Response. Edited by Faugier, J and Hickson, I. Chapman & Hall. London.

Phillips,KA Coates,TJ(1995) HIV counselling and testing: research and policy issues. AIDS care, 7(2) 115-123

Stoakes,P(1994) HIV and problem drinkers: the issues for alcohol drinkers. Aquarius Publication, Birmingham

## 4.9 Mental health, alcohol and drug use.

- Many people have mental health problems associated with their drinking, with up to 45% of those diagnosed with mental health problems having substance misuse problems.
- There can be difficulties distinguishing signs and symptoms of drug and alcohol misuse, from withdrawals or rebound, and from mental health problems
- A period of abstinence from alcohol and/or drugs will be required in order to make an accurate assessment before making a diagnosis of a dual problem.
- The picture is usually complex (Franeay 1996).

- Nurses with training in mental health care can provide specialist care and assessments.
- Clinical personnel need to be aware that some clients self medicate by their use and misuse of drugs and alcohol, so cessation or withdrawal from drug taking can lead to the perception of great pain e.g. dental caries, back pain, fatigue, lability of mood, the perception of voices.
- When clients are due to be discharged from a substance use service, discharge procedures should comply with the Care Programme Approach and Supervised Discharge Procedures.

*Recommended reading:*

Rorstad P, Checinski K (1996) *Dual Diagnosis: facing the challenge*. Wynne Howard Publications, Kenley, Surrey

#### 4.10 Working with the criminal justice system and prisons

Prison Medical Officers, nurses and officers have compulsory drug education.

Specialist nurses work with and within prisons.

Compulsory urine testing is carried out in prisons.

Assessments of people on remand are common.

Confidentiality needs to be clarified at the beginning of any work, with written consent for disclosure, unless the circumstances are exceptional.

Nurses provide reports for courts, solicitors, and probation departments.

Condoms are made available by the prison medical service.

*Recommended Reading*

Department of Health, Scottish Office Home and Health Department, Welsh Office. (1994) *Substance Misuse Detainees in Police Custody. Guidelines for Clinical Management*. HMSO. London

#### 4.11 Nurses with drug and alcohol misuse problems

- Nurses are not immune to substance use problems.
- Coming forward for help may be hampered due to the nurse's fear regarding their professional code of conduct and impact on employment status
- Systems are often in place for staff with problems to be seen by specialist doctors and nurses, outside of their own organisation/district/Health Authority
- Nurses have a responsibility to be in a fit state to nurse, and not to put the public at risk.
- Nurses who suspect a colleague of having a drink or drugs problem need to know that there are professional counselling agencies who can help. Covering up the problem is not the answer.
- Each work place should have alcohol and drug policies for employees.

*Support:* Nurseline is a Helpline especially set up for all nurses and midwives. It is funded by the Lisa Sainsbury Foundation and is supported by the RCN. It is particularly concerned to provide support and links with professional help in matters of personal anxiety and work-related stress Tel: 020 8681 4030 Recommended Reading: Health & Safety Executive (1990) Drug abuse at work. A guide to employers. Health and Safety Executive. 30M IND(G)91L 6/90

## 4.12 Ethics and professional clinical decision making

- There are four major ethical principles associated with health care provision:

Do not do harm (non-maleficence)

Do good (beneficence)

Respect client's autonomy (right to choose)

Justice (equity and fairness)

- Expert decision making is made in relation to guidance about what is best practice, often found in research journals, major text books; professional guidelines. ( Benner 1984).
- What might be considered a useful clinical decision for one client, may not be considered the most suitable for another.
- Whilst clinical decisions need to be directed to the best possible outcome for an individual client, regard needs to be made to the health of partners and families, local communities and the health of the public.
- Some decisions should not be made immediately, and should evolve from discussion with others.
- Two different decisions may be equally valid.
- Frank client involvement in the decision making process is likely to increase a client's respect for the justice of a decision.
- Nurses need to know that they are accountable for their clinical decisions, and that the responsibility can not be placed elsewhere.
- If a nurse should feel that she is being pressurised to participate in un-ethical decisions and practices, these issues should be taken up immediately with their professional body, union and/or clinical supervisor.

### *Recommended reading:*

Hamric, A.B. Spross, J.A. (1989) The clinical nurse specialist in theory and practice. 2nd edition. London; Saunders.

Banner, P. (1984) From novice to expert. London; Addison-wesley.

## 4.13 Young people, alcohol and drug use

- For nurses the issue of confidentiality possibly poses most problems. Before a nurse should or can give the child/young person such guarantees, he/she needs to be aware of what, if any, local policies are in existence guiding practice. This is best done before the nurse is confided in by a young person.
- If there are no existing local policies then the nurse should approach his/her line manager to secure their development. One response to this issue is described by Harding-Price (1993) and involves criteria determining whether nurses can work with a drug misusing child/young person without parental consent. See below:

| Criteria determining whether nurses can work with a drug misusing child without parental consent  |
|---|
| The young person, although under 16 years of age, will understand the nursing/medical advice  |
| The nurse cannot persuade the young person to inform his/her parents, or to allow the nurse to do so, that he/she is seeking advice about drugs |
| The young person is likely to begin or continue using drugs with or without treatment   |
| Unless the young person receives drug advice or treatment, his/her physical or mental health, or both, are likely to suffer                     |
| The young person's best interests require the nurse to give advice, treatment or both, without parental consent                                 |

**(Source Northern Drug Services Child Care Group Working Party 1991)**

- Recent trends suggest that there is an increase among girls using substances, a lowering in the age of initiation of use and the emergence of polysubstance use as the norm (HAS, 1996)
- In the absence of any specialist service for children/young people using substances, nurses working within an adult service may be asked to respond to a number of demands.
- For most young people, drug and or alcohol use will only be a small aspect of their development between childhood and adulthood.
- The family is part of the child/young person's life system, and therefore can and should play a significant role in: preventing the onset of substance use; reducing the harm if use has been initiated, and assisting the young person in moving out of the cycle of substance misuse.
- It is important for the nurse to confirm that her enquiries are made out of concern for the young person's health and welfare, and for no other reason.

- It is important for nurses to be aware of the potential level of knowledge, skills and attitudes which young people attending mainstream schools are expected to have achieved by certain ages. The table overleaf outlines the National Curriculum Guidelines

*Recommended reading:*

ANSA (1997) Substance Use: Guidance on Good Clinical Practice for Nurses, Midwives and Health Visitors . Working with Children and Young People. Association of Nurses in Substance Abuse. London

Rogers P, Speraw S, Ozbek I (1995) The assessment of the identified substance-abusing adolescent. *Pediatric Clinics of North America* 42(2):351-70. Apr

Werner M (1995) Principles of brief interventions for adolescent alcohol, tobacco, and other drug use. *Pediatric Clinics of North America* 42(2):335-49. Apr

Bauman KE, Ennett ST (1996) On the importance of peer influence for adolescent drug use: commonly neglected considerations. *Review. Addictions* 91(2), 185-198

## Children and Young People’s Knowledge, Skills and Attitudes by Age Attitudes

|                                     | <b>Knowledge/Understanding</b>   | <b>Skills</b>   | <b>Attitudes</b>   |
|-------------------------------------|--|---|--|
| Age<br>5-7<br><br>Recp<br>Year<br>2 | <p>Know all medicines are drugs but not all drugs are medicines</p> <p>Know all substances can be harmful if not used properly</p> <p>Know and understand simple safety rules about medicines</p> <p>Know that some people need substances to live a healthy life</p> <p>Know who can be trusted and when to say no</p>  | <p>Communicating feelings such as concerns about illness and taking medicines</p> <p>Following simple safety instructions</p> <p>When and how to get help from adults</p> | <p>Looking after yourself</p> <p>Keeping safe</p> <p>Awareness</p>   |
| Age<br>7-11<br><br>Year<br>3-6      | <p>Knowledge of school drug policy and procedures</p> <p>Know there are legal, illegal, prescribed and over-the-counter substances and have some understanding of their effects</p> <p>Know how to make simple choices and how to exercise some simple techniques for resisting pressure from friends and others</p> <p>Know the important and beneficial role drugs play in society</p> <p>Know who to turn to for help</p> | <p>Problem solving</p> <p>Personal responsibility</p> <p>Self-esteem</p> <p>Coping with peer influences</p> <p>Getting help</p> <p>Safety procedures</p>                  | <p>Looking after yourself and others</p> <p>Risk-taking attitudes and Responses to alcohol and tobacco advertising</p> |
| Age<br>11-14<br><br>Year<br>7-9     | <p>Know the basic facts about substances including their health risks effects and relevant legislation</p> <p>Recognise personal responsibility or decisions about substance use</p> <p>Beware of myths, misconceptions and stereotypes linked with substance use</p> <p>Develop coping strategies to use in situations where substance use occurs</p> <p>Sources of advice and support</p>                                  | <p>Coping with peer pressure and influences</p> <p>Identifying risks</p> <p>Assertiveness</p> <p>Decision-making</p> <p>Personal safety</p> <p>Self-worth</p>             | <p>Stereotyping</p> <p>Socially acceptable drugs</p> <p>Drugs and drug</p> <p>Impact of media and advertising</p>      |

|               | <b>Knowledge/Understanding</b>  | <b>Skills</b>   | <b>Attitudes</b>   |
|---------------|---|---|--|
| Age<br>14-16  | Explore historical, cultural, political, social and economic factors relating to the production, distribution and use of drugs  | Autonomy<br>Assertiveness<br>Communication<br>Skills Personal safety and responsibility | Risk takers<br>Denial<br>Escape from problems  |
| Year<br>10-11 | Understand that we live in a drug-taking society and recognise the different patterns of use and their effects Be able to analyse levels of alcohol consumption Knowledge of school rules relating to medicines and legal and illegal drugs | Risk assessment<br>Management of conflict, stress and aggression                        | Respect for decision of others<br>Social and cultural influences<br>Licensing and retailing laws |
| Age<br>16-18  | Recognise unsafe drug use may be more detrimental than drug misuse itself <i>eg</i> : transmission of HIV infection, vomiting & choking   | Personal responsibility<br>Interpersonal and social skills<br>Reflection                | Understanding<br>Risk-taking<br>Social<br>Personal   |
| Year<br>12-14 | To understand harm reduction and personal safety in drug use<br>To be able to discuss addiction, experimentation and recreational drug use<br>Drug tolerance, dependence, addiction and withdrawal  | Realism and awareness<br>Risk assessment<br>Seeking help<br>Recognising problems        |  |

(Source: Curriculum Guidance, Document 5: Health Education, 1995)

#### **4.14 Travellers**

- Many travellers may have difficulty accessing specialist services
- Adhering to treatment programmes can be difficult due to transient life style
- Some people may not have been exposed to previous harm reduction and health promotion advice, therefore advice about risks associated with drugs and alcohol and injecting are an important component of care

##### *Further Information:*

Advisory Council for the Education of Romany and Other Travellers. Moot House, The Stow, Harlow, Essex. CM20 3AG Tel: 01279 418 6666

#### **4.15 Immigrants**

- People entering the UK from other countries may have very different views about drugs/alcohol according to other societal norms.
- The law on drugs and alcohol differs across the world. The nurse may find it necessary to ask the individual about the laws in their native country and advise the patient about the British law
- Purity and availability of drugs may differ across countries, and therefore advice about the risks of differing purities and taking unknown substances with which they are not familiar is important
- Language may be a barrier in providing care to patients. It may be necessary to involve interpreters.

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# Section Five: Networking, Contacts and

## Resources

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### 5.1 National Help-lines and Self-help Groups

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| Organisation/Telephone  | Address   | Information  |
|---|---|--|
| <b>Action on Smoking and Health</b><br>(ASH) Tel: 020 7314 1360<br>Fax: 020 7222 4343 | Devon House, 12-15<br>Dartmouth Street,<br>London SW1H 9BL  | A campaigning group who promote non-smoking in general.  |
| <b>Adfam National</b><br>Tel: 020 7638 3700<br>Fax: 020 7256 6320                     | 5th Floor, Epworth House<br>25 City Road,<br>London EC1Y 1AA  | National charity which represents parents and families with drug related problems.   |
| <b>Al-Anon</b><br>A 24 hr help line service:<br>Tel: 020 7403 0888                    | C/O Al-Anon Family<br>Groups<br>61 Great Dover Street<br>London SE1 4YF                             | Al-Anon offers understanding and support for families and friends of problem drinkers where the individual affected is still drinking or not.  |
| <b>Alcoholics Anonymous (AA)</b><br>Tel: 01904 644026<br>Fax: 0190 462 9091           | England and Wales<br>General Service Office<br>of AA<br>PO Box 1,<br>Stonebow House<br>York YO1 2NJ | Self-help organisation offering local meetings and fellowship.   |
| <b>Al-Teen</b><br>A 24 hr help line service:<br>Tel: 020 7403 0888                    | C/O Al-Anon Family<br>Groups<br>61 Great Dover Street,<br>London SE1 4YF                            | Al-Teen is for young people aged 12-20 yrs who have been affected by someone else's drinking, usually that of a parent. For details of meetings throughout the UK ring the above telephone number. |

| <b>Organisation/Telephone</b>  | <b>Address</b>  | <b>Information</b>  |
|--|---|---|
| <b>Drink-line</b><br>National Alcohol Helpline<br>Tel: 020 7332 0150<br>Administration Fax:<br>020 7332 0127 | Weddel House,<br>7th Floor<br>13-14 West Smithfield<br>London EC1A 9DL  | Tel: 020 7332 0202 Helpline<br>(London area). 11a.m. to 11p.m.<br>Tel: 0345 32 0202 Helpline (rest<br>of UK, charged at local rates).<br>11a.m. to 11p.m. Tel: 0500 801<br>802 Freephone (Dial and listen<br>service with recorded message<br>on alcohol problems). 24 hours. |
| <b>Drug-line</b><br>Tel: 0800 776600   | Maudsley Regional Drug<br>Training Unit   | 24-hour freephone confidential<br>helpline offering advice, infor-<br>mation and referral to relevant<br>counselling.   |
| <b>Drugs in Schools Helpline</b><br>Tel: 0345 36 6666<br>Fax: 020 7729 2599                                  | 388 Old Street,<br>London, EC1V 9LT   | Confidential service for anyone<br>concerned about a drug incident<br>in school.  |
| <b>Families Anonymous</b><br>(FA)<br>Tel: 020 7498 4680<br>Mon-Fri 1.00pm-4.00pm                             | The Doddington and<br>Rollo Community<br>Association,<br>Charlotte Despard<br>Avenue, Battersea,<br>London SW11 5JE | Local support groups for the<br>relatives and friends of those<br>with drug related problems  |
| <b>Narcotics Anonymous (NA)</b><br>Helpline: 020 7730 0009<br>Publications: 020 7272 9040                    | UK Service Office,<br>PO Box 1980,<br>London N19 3LS  | Self-help organisation offering<br>local meetings and fellowship.   |
| <b>Nurseline</b><br>Tel: 020 8681 4030<br>Mon-Fri 9-5pm<br>Out of hours answerphone<br>Fax: 020 8681 5030    | 8-10 Crown Hill,<br>Croydon Surrey<br>CR0 1RZ   | Funded by the Lisa Sainsbury<br>Foundation and is supported by<br>the RCN. It is particularly<br>concerned to provide support<br>and links with professional help<br>in matters of personal anxiety<br>and work-related stress  |
| <b>Parentline</b><br>(formerly OPUS)<br>Tel: 01702 559900<br>Fax: 01702 554911                               | Endway House,<br>The Endway<br>Hadley,<br>Essex SS7 2AN   |   |

| <b>Organisation/Telephone</b>  | <b>Address</b>  | <b>Information</b>  |
|--|---|---|
| <b>Quit Helpline</b><br>Tel: 020 7487 3000   | 170 Tottenham Court Rd<br>London W1P 0HA.                         | A smokers quit line, offering advice on stopping smoking and local support services                               |
| <b>Release</b><br>Tel: 020 7729 9904<br>Mon-Fri 10.00am-6.00pm<br>Tel: 020 7603 8654 | (24) hour emergency helpline<br>388 Old Street<br>London EC1V 9LT | Offers advice on the legal and illegal consequences of drug use and provides a number of publications.            |
| <b>The Terrence Higgins Trust</b><br>Tel: 020 7831 0330<br>Fax: 020 7242 0121        | 52-54 Gray's Inn Road<br>London WC1X 8JU                          | Offers practical support, help, counselling and advice for anyone with or concerned about AIDS and HIV infection. |

## 5.2 Professional Organisations

| <b>Organisations</b>                                    | <b>Address/Telephone</b>   |
|---|--|
| Association of Nurses in Substance Abuse (ANSA)         | 120 Wilton Road, London SW1V 1JZ<br>Tel: 020 7233 8322, Fax: 020 7233 7779     |
| Community Practitioners and Health Visitors Association | 120 Wilton Road, London SW1V 1JZ<br>Tel: 020 7717 4000, Fax: 020 7717 4030     |
| Community Psychiatric Nurse Association                 | C/O Heather Crook, 13 Redwood Drive<br>Rossendale, Lanes BB4 6DR               |
| Queen's Nursing Institute                               | 3 Albermarle Way, London EC1V 4JB<br>Tel: 020 7490 4227, Fax: 020 7490 1264    |
| Royal College of Midwives                               | 15 Mansfield Street, London W1M 0BE,<br>Tel 020 7872 5100                      |
| Royal College of Nursing Substance Misuse Forum         | 20 Cavendish Square, London W1M 0AB<br>Tel: 020 7409 3333, Fax: 020 7409 1379  |
| Royal College of Nursing Practice Nurse Association     | 20 Cavendish Square, London W1M 0AB<br>Tel: 020 7409 3333, Fax: 02 0 7409 1379 |
| Royal College of Psychiatry, Substance Misuse Section   | 17 Belgrave Square, London W1X 4PG<br>Tel: 020 7235 2351 Fax: 020 7235 6051    |

## 5.3 Resources

| Organisation/Telephone  | Address   | Information  |
|---|---|--|
| <b>Alcohol Concern</b><br>Library<br>Tel: 020 7928 7377<br>Fax: 020 7928 4644                                     | Waterbridge House<br>32-36 Loman Street<br>London SE1 0EE     | Provide information on services offering advice, information and support to those experiencing problems with alcohol. A directory of alcohol services is published annually and is available from the address given.                           |
| <b>Health Education Authority (HEA)</b> Tel: 020 7383 3833 Fax: 020 7387 0550 Library direct line: 020 7413 1995  | Hamilton House<br>Mabledon Place<br>London WC1H 9TX           | Activities are directed mainly towards general health and social education. A resource list on drugs, alcohol and smoking education is available from the above address.   |
| <b>Institute for the Study of Drug Dependence (ISDD)</b><br>Tel: 020 7928 1211 Library direct line: 020 7803 4720 | Waterbridge House<br>32-36 Loman Street<br>London SE1 0EE     | Maintains a comprehensive reference library and produces information leaflets, health and social education materials and materials for training professionals.   |
| <b>The Advisory Council on Alcohol and Drug Education (TACADE)</b><br>Tel: 0161 745 8925<br>Fax: 0161 745 8923    | 1 Hulme Place<br>The Crescent<br>Salford Manchester<br>M5 4QA | Provides education, training materials and courses on drugs and other substances.  |
| <b>SCODA (Standing Conference on Drug Abuse)</b><br>Tel: 020 7928 9500<br>Fax: 020 7928 3343                      | 32 Lomond Street<br>London SE1                                | An independent membership organisation, providing a voice for drug services and others concerned about the effects of drug use on individuals and communities. Publishes a national directory: Drug problems - Where to get help, Update 1996. |

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## 5.4 General Information including relevant Internet Sites

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| Organisation/Telephone   | Address   |
|--|---|
| <b>Drugs Prevention Initiative</b>                             | Home Office, Horseferry House   |
| <b>Central Drugs Prevention Unit</b>                           | Dean Ryle Street London SWP 2AW   |
| Tel: 020 7217 8631   |   |
| Fax: 020 7217 8230   |   |
| <b>Drug and Alcohol Women's Network (DAWN)</b>                 | c/o Greater London Association of Alcohol Services (GLAAS), 30-31                 |
| Tel: 020 7253 6221   | Gt. Sutton Street, London EC1V 0DX  |
| Fax: 020 7250 1627   |   |
| SW1H 9AT   |   |
| <b>Home Office Drugs Division (C5 Division)</b>                | Home Office, 50 Queen Anne's Gate, London SW1H 9AT                                |
| Tel: 020 7273 2213   |   |
| <i>South East: Tel:</i> 020 7273 3727/3765/3815/3856/3530/3867 |   |
| Fax: 020 7273 26761  |   |
| <i>Midlands: Tel:</i> 0117 927 6736                            |   |
| Fax: 0117 925 5996   |   |
| <i>North: Tel:</i> 0113 242 9941                               |   |
| Fax: 0113 234 1192   |   |
| <b>National Database for Health Promotion in Primary Care</b>  | HEA Primary Health Care Unit<br>Churchill Hospital Headington<br>Oxford OX3 7JL   |
| Tel: 01865 226038  |   |
| Fax: 01865 741980  |   |
| <b>The National Poisons Information Service</b>                | The London Centre, Guys and St Thomas' NHS<br>Lambeth Palace Road, London SE1 7EL |
| Tel: 020 7635 9191   |   |

## Relevant Internet Sites

|   |  |
|---|--|
| American National Clearing House for alcohol & drug information. Office of Substance Abuse Prevention | <a href="http://www.health.org/">http://www.health.org/</a>  |
| Alcohol Concern   | <a href="http://www.alcoholconcern.org.uk">http://www.alcoholconcern.org.uk</a>                      |
| Department of Health  | <a href="http://www.open.gov.uk/doh/dhhome.htm">http://www.open.gov.uk/doh/dhhome.htm</a>            |
| ENB   | <a href="http://www.enb.org.uk">http://www.enb.org.uk</a>  |
| InterNurse (based in Liverpool)   | <a href="http://www.wp.com/InterNurse/">http://www.wp.com/InterNurse/</a>                            |
| RCN   | <a href="http://www.thebiz.co.uk/rcn.htm">http://www.thebiz.co.uk/rcn.htm</a>                        |
| UKCC  | <a href="http://www.healthworks.co.uk/hw/orgs/UKCC.">http://www.healthworks.co.uk/hw/orgs/UKCC.]</a> |
| World Health Organisation (WHO)   | <a href="http://www.who.ch/">http://www.who.ch/</a>  |

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## 5.5 Further Training and Education

A selected list of institutions and units offering a range of accredited multidisciplinary courses on the subject of addiction.

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| Organisation/Telephone  | Address   |
|---|---|
| <b>Education and Training Unit<br/>Department of Addictive Behaviour,<br/>St. Georges Hospital Medical School</b><br>Tel: 020 8725 2781<br>Fax: 020 8725 2914 | (ETU), University of London ,<br>6 Floor Hunter Wing<br>Cranmer Terrace, London SW17 ORE            |
| <b>HIT (formerly the Mersey Drug<br/>Training and Information Centre)</b><br>Tel: 0151 227 4012<br>Fax: 0151 227 4023   | Cavern Walks, 8 Mathew Street, Liverpool<br>L2 6RE  |
| <b>Leeds Addiction Unit</b><br>Tel: 0113 2926930<br>Fax: 0113 2926950   | 19 Springfield Mount, Leeds LS2 9NG   |
| <b>Liverpool John Moores University</b><br>Tel: 0151 231 4029<br>Fax: 0151 258 1224   | Social and Human Sciences Department<br>Trueman Building, 15-21 Webster Street,<br>Liverpool L3 2ET |

| <b>Organisation/Telephone</b>   | <b>Address</b>   |
|---|--|
| <b>North West Region Drug Misuse Training Programme</b><br>Tel: 01244 375 444                                     | University College Chester, Cheyney Road,<br>Chester, Cheshire CH1 4BJ |
| <b>Maudsley Regional Drug Training Unit National Addiction Centre</b><br>Tel: 020 7703 0269<br>Fax: 020 7703 0269 | 4 Windsor Walk, London SE5 8AF   |
| <b>West Midlands Regional Drugs Training Unit</b><br>Tel: 0121 544 3939<br>Fax: 0121 544 2094                     | 6 Unity Place, Albert Street, Oldbury,<br>West Midlands B69 4DB        |

## **5.6 Local Contacts**

The following list of agencies/services should have a remit for substance use/misuse locally.

1. Drug and/or alcohol services (may also be referred to as Substance Misuse Services/Community Drug and/or Alcohol Team)
2. Child and Adolescent Psychiatric Services
3. Accident and Emergency Services
4. Senior Nurse Child Protection
5. Social Services Child Protection Team
6. Local Authority Youth Service
7. Local Police (Community Officer)
8. Drug Action Teams (DATs) - Co-ordinator. Health Authority

# Section Six: References and Further reading

## 6.1 References

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