

National Treatment Agency for Substance Misuse

Harm Reduction Strategy – Guidance to support adult drug treatment planning 2009/10

1. Introduction

The *Harm Reduction Strategy - Guidance for Treatment Planning* is intended to be a valuable addition to the suite of adult drug treatment planning and needs assessment guidance documents for 2009/10.

This updated version covers the same priority areas of reducing the spread of blood-borne viruses (BBV) and reducing drug-related deaths (DRD), but also provides additional information on general healthcare assessments and includes the key messages which are drawn from the recent joint National Treatment Agency for Substance Misuse (NTA) / Health Care Commission (HCC) improvement review¹; Drug Misuse and Dependence: UK Guidelines on Clinical Management (DH and devolved administrations, 2007)²; the existing harm reduction strategy guidance supporting the adult drug treatment plan³; and *Reducing drug-related harm: an action plan*.⁴

Included in this document is the Partnership Self Audit Tool (PSAT) which is provided for use by partnerships as a planning tool to assess current provision and need in preparation for the development of the 2009/10 adult drug treatment plan and updated harm reduction action plans. Partnerships are requested to use (and modify according to local requirements) the PSAT to help identify local priorities and submit the PSAT with the adult drug treatment plan in January 2009.

Whilst partnership plans will be primarily aimed at reducing the harm to drug users, they should also cover harm reduction activities that impact on reducing harm to the wider population. This would include, for example, partners and family members of drug users and the wider community. Up to date information and hyperlinks to current harm reduction research are included within the body of this document to assist partnerships.

2. Context and rationale

Recent trends among drug users, particularly injecting drug users (IDU), suggest that drug-related harms have increased in recent years. The Health Protection Agency (HPA) report, *Shooting Up: Infections among injecting drug users in the United Kingdom 2006, an update: October 2007*⁵ describes the high levels (48%) of sharing injecting equipment amongst current injecting drug users, with mixing containers such as spoons being the most commonly shared items. It is recommended therefore that the amount of equipment distributed should be increased, as evidence suggests that those in contact with needle exchange services do not receive enough equipment for all their injecting episodes.

These findings are further supported from the results of the joint NTA/HCC review, where findings suggested that access to needle and syringe exchange schemes is not universal across the

¹ Improving services for substance misuse. Commissioning drug treatment and harm reduction services. NTA May 2008. Available from www.nta.nhs.uk

² Department of Health (England) and the devolved administrations (2007). Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive' http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf

³ Available for download as part of the 08/09 TP guidance, at http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2008_09/templates_and_guidance.aspx

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850

⁵ [Shooting up. Infections among injecting drug users in the United Kingdom 2006. An update: 2007](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850)

country⁶. Increasing the number of pharmacy schemes is likely to offer the best opportunity for the rapid expansion of distribution sites, especially for out of hours cover, supported by robust local co-ordination and monitoring of needle and syringe exchange programmes.

3. A strategic, needs assessed, multi-agency response

There has been a re-invigoration of harm reduction interventions at all tiers of the drug treatment system. This reflects the response from partnerships and service providers to identify populations at risk through more robust needs assessment of the potential harms, and the development of a range of policies and interventions which reduce those harms.

Responding effectively to these harms requires a continued multi-agency approach, building on the strategies that have been developed and delivery across all aspects of a comprehensive adult drug treatment system. Strengthening care pathways between primary and secondary care needs to continue. Partnerships also need to review the competence levels across the workforce in the delivery of harm reduction services, and address gaps as necessary. Involvement of users and carers in developing harm reduction action plans is a critical element that should be fully integrated into the needs assessment and planning processes.

4. Defining harm reduction

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs.⁷

A harm reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for heroin misusers with support for abstinence from illegal drugs.

Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements (SLA), so that harm reduction interventions are available at the full range of locally commissioned drug services.

Harm reduction should not be considered as a service type, or something delivered within a single tier, but should be subject to a whole system approach to reduce or eliminate the harms (behaviours, diseases or deaths) associated with drug use. Such harms might include (but are not limited to):

- Spread of blood-borne viruses via injecting or sexual activity
- Overdose or unintentional injury (which might lead to premature drug-related death)
- Increased risk through co-morbidity (e.g. alcohol, mental health)
- Septicaemia, wound infections and other infections resulting from injecting
- Other general/primary healthcare issues, such as sexual health and dental health

5. Delivering harm reduction

Minimising the risk of drug-related harm is a key public health issue, both in protecting the health of this vulnerable section of the population and in protecting the wider community. It is expected that the lead for harm reduction/minimisation partnership work should come from the PCT Director of Public Health. The Director has a key role within the partnership's expert group.⁸

⁶ *Improving services for substance misuse: Commissioning drug treatment and harm reduction services*. Commission for Healthcare Audit and Inspection, 2008.

⁷ For further information, see United Kingdom Harm Reduction Alliance website: www.ukhra.org

⁸ See Section 2.2 *Needs assessment guidance for adult drug treatment*, National Treatment Agency for Substance Misuse, 2007, NTA, London: http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx

Full implementation of *Models of Care*⁹, together with a comprehensive system of service/clinical governance, effective care planning and treatment, low waiting times, high levels of successful retention and improved planned completion rates will all contribute to harm reduction. The objective of a harm reduction strategy is to reduce or prevent excess morbidity and mortality associated with (in particular) injecting drug use. To achieve this objective, partnerships will need to develop, as part of the needs assessment process¹⁰, a more sophisticated and clearer understanding of the population at risk. This includes identifying the risk factors/behaviours and, drawing on the evidence base, implementing a range of policies and initiatives which address them.

6. Reducing drug-related harm: an action plan

*Reducing drug-related harm: an action plan*¹¹ sets out the actions to be taken in England to enhance harm reduction activities within the drug treatment sector. The aim is to progressively reduce the number of drug misusers either dying through a drug-related death or contracting blood-borne virus infections. It will be delivered using an integrated approach at national, regional and local levels. The Department of Health (DH) and NTA are jointly overseeing implementation and will involve other expertise as appropriate. The plan focuses on three key areas:

- Increased surveillance and monitoring
- Improved needle exchange and drug treatment delivery
- Public health campaigns focused upon those most at risk

This programme of work will include: publication of guidance for commissioners and providers on the provision of needle exchange services; pilot training programmes for users and carers in overdose prevention; and publication of hepatitis C prevalence data by partnership area in October 2008 as part of the next HPA *Shooting Up* (forthcoming) update. Commissioners will wish to incorporate relevant findings, linked to the national action plan, in the adult drug treatment plans for 2009/10.

National Institute for Health and Clinical Excellence (NICE) guidelines¹² regarding the provision of psychosocial interventions and detoxification, and the 2007 Clinical Guidelines¹³ reinforce the need for harm reduction interventions to be embedded throughout the treatment system. Commissioners and providers should ensure that the services comply with these, and other relevant good practice guidelines. As part of the planning process, the following sections provide guidance which partnerships are recommended to follow.

See section 1 “Strategic Management” of: *The Partnership Self Audit Tool*, for suggested actions for local partnerships.

7. Blood-borne virus (BBV) action plan

An expected result of developing a needs-led harm reduction strategy will be a comprehensive multi-agency action plan, signed off by the partnership, to control the spread of hepatitis B and C, and HIV (and other communicable diseases) among IDUs.

Controlling the spread of BBV is a key public health issue. As such the development of the Action Plan should be endorsed by the Primary Care Trust’s Director of Public Health and should be

⁹ National Treatment Agency for Substance Misuse, 2006, *Models of Care for Treatment of Adult Drug Misusers: Update 2006*, NTA/DH/Home Office: http://www.nta.nhs.uk/areas/models_of_care

¹⁰ National Treatment Agency for Substance Misuse, 2007, *Needs assessment guidance for adult drug treatment*. NTA: London: http://www.nta.nhs.uk/areas/treatment_planning/needs_assessment.aspx

¹¹ National Treatment Agency for Substance Misuse, 2007, *Reducing Drug-related Harm: An Action Plan*. NTA/DH: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850

¹² See NTA website for information on NICE guidelines: http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/cgl_update0607/nice_guidelines.aspx

¹³ Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive’

jointly agreed with the local Health Protection Unit which has expertise in surveillance for, and control of, communicable diseases.

A range of services should be in place to reduce the harm associated with injecting drug use such as:

- Needle exchange schemes; pharmacy, centre-based, or if appropriate, outreach
- Comprehensive protocols to raise awareness of risks from BBVs which promote and deliver testing and appropriate pathways into treatment for hepatitis B, hepatitis C and HIV, and vaccination against hepatitis B
- Programmes that move people away from injecting drug use
- Appropriate substitute opioid doses and quality treatment
- Treatment for co-existing alcohol misuse risks
- Improved through care and after care from prison

7.1 Hepatitis C: Hepatitis C is the most significant infection affecting IDUs with 41% of IDUs having been infected. There is marked regional variation with a prevalence of 22% in the North East to a prevalence of 57% and 60% in London and the North West regions respectively.

The prevalence of hepatitis C infection amongst current IDUs in England increased from 39% in 1998 to 44% in 2006 with approximately half being unaware of their infection. Injecting crack cocaine has an association with a higher prevalence of hepatitis C infection (59% prevalence compared to those who had not injected with a prevalence rate of 39%), and evidence shows the use and injecting of crack-cocaine is becoming more common¹⁴. Furthermore, since 2000 there has been an increase in the incidence of hepatitis C infection amongst new injectors, indicating that transmission may be increasing. Alcohol use and misuse is the single biggest contributory factor to those with hepatitis C infection developing fatal liver disease¹⁵.

Key Messages

See section 2 “Blood-borne virus infections” of: The Partnership Self Audit Tool for suggested actions for local partnerships

Suggested actions for providers:

All clients to have access to testing and referral for treatment for Hep C and HIV

If treatment cannot be delivered on site, then to have clear integrated care pathways in place, to ensure effective referral to and joint working with relevant treatment services.

If clients are unwilling to access treatment then encouragement to adopt healthier lifestyles can support in reducing the likelihood of harm to themselves and transmission to others.

Suggested actions for commissioners:

Ensure that screening, referral, and treatment are commissioned in specialist services or if necessary through links to generic health care.

7.2 Hepatitis B: In the UK, hepatitis B is usually acquired in adulthood, with sexual activity or injecting drug use being the most commonly reported routes of infection. Infection with the hepatitis B virus typically causes an acute infection, with a small number of those infected going on to develop chronic disease. Infection with hepatitis B is preventable using a safe and effective vaccine, but continues to cause serious ill health in IDUs and their communities.

In 2005, the percentage of IDUs with evidence of past or current hepatitis B infection was 19% (613 of 3,175), which is similar to rates since 1995. There is substantial variation between regions,

¹⁴ [Shooting up. Infections among injecting drug users in the United Kingdom 2006. An update: 2007](#)

¹⁵ [Ibid.](#)

with North West having the highest rates of 31% (221 of 777), and the lowest in the Yorkshire and the Humber region at 5.5% (14 of 253). Results published in the HPA's *Shooting Up* report provide evidence that the proportion of IDUs in the UK who report having had hepatitis B immunisation, has more than doubled from 25% in 1998 to 59% in 2005.

However, it is worth partnerships noting that the NTA second *Annual Service User Satisfaction Survey (2006)*¹⁶ reported that 20% of IDUs requested hepatitis B vaccination but did not receive it; just fewer than 30% did not receive a general healthcare assessment; and over 33% reported not receiving the overdose prevention training they felt they needed.

Therefore it is vital that the provision of, and the opportunities to, vaccinate all IDUs be taken as appropriate. The courses are highly recommended to be completed, which means having all three vaccines, to allow the best possible prevention from hepatitis B infection. Accelerated vaccination schedules could be more conducive to some IDUs' chaotic lifestyles, and commissioners may want to discuss the agreed locality position on vaccination provision and recommended immunisation schedules with their PCT Directors of Public Health.

Key Messages

See sections, 2 "Blood-borne virus infections" and "Needle Exchange" of: The Partnership Self Audit Tool, for suggested actions for local partnerships

Suggested actions for providers:

Ensure clients receive enough injecting equipment for each injecting episode.

Ensure that clients are able to obtain injecting equipment outside normal office hours.

Suggested actions for commissioners:

Increased coverage of local areas by pharmacy schemes to maximise opportunities for distribution.

Identify a responsible officer to ensure the coordination and monitoring of needle and syringe exchange programmes.

Ensure local needs assessment and treatment planning processes match provision of services to local need.

Provide adequate resources to maximise the opportunity of enough injecting equipment for each injecting episode.

7.3 Human Immunodeficiency Virus (HIV): HIV infection among drug users remains relatively uncommon in the United Kingdom but there is some evidence of both increasing prevalence and transmission. The prevalence of HIV infection in current IDUs in England and Wales in 2005 was 2.1%, the highest prevalence ever seen. In London the prevalence in current IDUs was 4.3%, which is similar to recent years, but elsewhere in England and Wales the prevalence in current injectors was 1.6% which is more than double the prevalence in 2004. There is some evidence of an age-related cohort effect. Among those injecting for less than three years tested in 2005, a prevalence of 1.3% was found which again is the highest prevalence ever seen in this group.

7.4 Site infections: There are continuing problems with infections associated with injecting including tetanus and wound botulism. These can result from poor skin hygiene, environmental conditions, and/or poor injecting practice. Conditions can be exacerbated by the adulterants used in illicit drugs and direct contamination of the drugs.

¹⁶ National Treatment Agency for Substance Misuse, 2007, *Second Annual Service User Satisfaction Survey (2006)*, London: NTA: http://www.nta.nhs.uk/publications/documents/nta_2006_survey_of_user_satisfaction_in_england.pdf
Harm Reduction Strategy – Guidance to support adult drug treatment planning and Self Audit Tool – Revised Guidance for 2009/10

7.5 Crack cocaine and BBV: There are growing concerns over the high prevalence of hepatitis C infection, HIV and hepatitis B infection being associated with people who inject crack cocaine. For example, 43% of IDUs who have a history of injecting crack cocaine have evidence of previous hepatitis B infection, compared to 24% of IDUs who have not injected crack cocaine¹⁷. Locally derived needs assessment on crack cocaine use will allow local commissioning decisions to be made in relation to harm reduction services when considering BBV intervention programmes.

8. Reducing drug-related deaths action plan

Evidence suggests that the recent downward trend in drug-related deaths has unfortunately reversed in recent years and has begun to rise.¹⁸

It is recommended therefore that each partnership should have arrangements in place to monitor risks of drug-related deaths and develop an appropriate multi-agency action plan to reduce these risks and investigate any resulting deaths. This should include:

- Procedures for undertaking confidential inquiries into drug-related deaths
- Mechanisms for rapid communication of acute risks across partners, including providers and user groups, as appropriate
- Overdose awareness and training for IDUs and their family/carers
- Provision of Naloxone for ambulance crews and others, as part of agreed local protocols
- Provision of a programme of overdose training supported by overdose agreements between agencies, e.g. ambulance services

Guidance for drug treatment providers on *Reducing Drug Related Deaths* was issued in 2004¹⁹. This guidance is currently under review and revised guidance will be published in due course.

Key Messages

See section 4 “Drug-related deaths” of: *The Partnership Self Audit Tool*, for suggested actions for local partnerships

Suggested actions for providers:

Clear policies and procedures should be in place in the event of client death. Many services (such as NHS providers) will have relevant statutory requirements and frameworks for such activities.

Rates of non-attendance (or ‘DNA’s) should be monitored and reported to the relevant multi-agency group (see below) to identify any correlation with rates of drug-related death.

Suggested actions for commissioners:

Establish a multi-agency group which regularly monitors the number of incidents where a death could have occurred as well as actual deaths and takes action accordingly.

Embed the monitoring of drug-related deaths as part of service level agreements with providers²⁰.

9. Service delivery

Harm reduction initiatives will require participation from non-specialist providers particularly ambulance services, the police, and accident and emergency departments, all of whom are key to the reduction of harm and reducing drug-related deaths. Additionally, because of their likely contact with drug users out of contact with structured treatment services, they are an important point of contact for dissemination of harm reduction information. There is also a requirement for the

¹⁷ [Shooting Up](#), 2007, op. cit.

¹⁸ Office of National Statistics, 2006, *Health Statistics Quarterly*, Vol. 29 Spring 2006, p.7

¹⁹ National Treatment Agency for Substance Misuse, 2004, *Reducing Drug Related Deaths: Guidance for drug treatment providers*, NTA, London:

http://www.nta.nhs.uk/publications/documents/nta_guidance_for_drug_treatment_providers_drdpro.pdf

²⁰ Updated confidential enquiries guidance will be published in spring 2009.

Coroner's involvement to develop confidential enquiry processes into drug-related deaths and rapid communication of acute risks. The previously published guidance for the conduct of confidential enquiries is currently being updated as part of the national strategy *Reducing Drug Related Harm – an Action Plan*²¹.

Open access drug services, such as needle exchange, can provide a crucial interface with drug users who are not currently engaged in structured drug treatment and who are often, by definition, at greater risk of drug-related harm. In a harm reduction context, open access services provide immediate services (e.g. drug using paraphernalia, safer injecting advice, access to general/primary health care services and screening/testing or crisis intervention), and are also able to work with drug users to support their eventual engagement in structured treatment interventions.

Key Messages

Suggested actions for providers:

Ensure clients receive enough injecting equipment for each injecting episode.
Ensure that clients are able to obtain injecting equipment outside normal office hours.

Suggested actions for commissioners:

Increased coverage of local areas by pharmacy schemes to maximise opportunities for distribution.

Identify a responsible officer to ensure the co-ordination and monitoring of needle and syringe exchange programmes.

Ensure local needs assessment and treatment planning processes match provision of services to local need.

Provide adequate resources to maximise the opportunity of enough injecting equipment for each injecting episode.

It is important that specialist drug treatment services provide on-going assessment of the general health and harm reduction needs of their clients as part of their care plan. As a minimum this would include:

- Regular general healthcare checks with referral to other health care services as appropriate
- A regular assessment of the user's risk of intentional or accidental injury or drug-related death
- Provision of advice and materials to reduce harm from injecting drug misuse such as injecting paraphernalia
- A sexual health assessment/access to safer sex advice and materials; linked to the local PCT sexual health strategy

In addition, services should also provide up-to-date advice and information to all their service users about reducing harm, overdose prevention, first aid and so forth.

Specialist providers' clinical governance or quality assurance leads will have a significant contribution to make to the process of developing an integrated harm reduction strategy, as will clinicians and service leads.

9.1 Specialist and pharmacy based needle exchange programmes

The model of delivery for needle exchange (specialist centre based, detached, outreach or pharmacy-based) will vary according to locally defined need. It is key that needle exchange services are pro-actively commissioned by partnerships according to assessed need, and that service standards and performance are defined within appropriate SLAs or equivalent contractual

²¹ Department for Health/National Treatment Agency for Substance Misuse, 2007, *Reducing Drug Related Harm: An Action Plan*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850
Harm Reduction Strategy – Guidance to support adult drug treatment planning and Self Audit Tool – Revised Guidance for 2009/10 7

arrangements. Consultation with the local pharmaceutical committee would be advisable prior to any contractual agreements being agreed.

As discussed above, needle exchange and open access services offer an opportunity not only to provide access to safer injecting materials but also to engage with service users who are not in contact with more structured services. They provide health promotion advice, information and materials, brief interventions, healthcare checks, and referral on to other specialist services.

9.2 Supervised consumption

Supervised consumption with an appropriate professional provides the best guarantee that substitute medication is being taken as directed. The need for supervised consumption should take into account the client's social factors, such as employment and childcare responsibilities. If supervised consumption conflicts with these and is still felt necessary, it must be made available at a time that allows the client to attend without compromising their job or family. In most cases, all new clients being prescribed methadone should be required to take their daily dose of medication under the direct supervision of a professional for a period of time which may be around three months, subject to assessment of the client's compliance and individual circumstances. A range of durations of supervised consumption is likely to be seen for different clients ranging from just a couple of weeks in highly compliant, working clients, to many years in those who fail to respond to conventional treatment. The decision on when to relax the requirement for supervised consumption is one for the individual clinician.

9.3 The role of users and carers

Users and carers are able to bring important contextual information to add to the local epidemiology of risk behaviour. They are also able to identify strengths and weaknesses in service provision, local drug culture practices, and the information and support needs of those affected by drug-related deaths. Partnerships may want to consider both service users and carers as part of their harm reduction workforce in terms of peer education and prevention of overdose.

Key Messages

See section 3, "Needle Exchange", of the Partnership Self Audit Tool for suggested actions for local partnerships.

Suggested actions for providers:

An emergency protocol to be in place supported by training to ensure that the following is provided should clients experience difficulties while attending the service.

- Resuscitation and recovery
- Rapid ambulance call
- Competent preservation of the airway
- Procedures to be in place for the administration of Naloxone where the settings are deemed as appropriate

Suggested actions for commissioners:

Ensure the provision of accessible overdose training for users and carers, targeted at those most at risk from drug-related deaths.

Monitor the implementation and use of emergency protocols as part of service level agreements with providers.

10. Workforce

Partnerships will need to ensure that staff are competent to make assessments and provide interventions that reduce harm and have been trained, where appropriate, to the required standard²².

²² Drug and Alcohol National Occupational Standards: <http://www.alcohol-drugs.co.uk/DANOS.htm>

Whilst drugs workers are key professionals in identifying harm and will need to be able to provide accurate information on a range of health issues competently and sensitively, they may not always be best qualified to respond to those needs. It is important that services match the skills and qualifications of staff appropriately to the task and to ensure that structures are in place to obtain advice and/or make referrals to specialist services that will best meet the needs of the clients. For example, during the pilot study for the Treatment Outcome Profile (TOP) it was found that some staff did not feel equipped to ask questions of service users with regard to sexual health. Therefore appropriate and partnership-agreed pathways for signposting individuals towards sexual health and or family planning services as well as dentistry are vital to ensure clients are being supported through this part of their care pathway.^{23,24}

See section 5, "Workforce", of the Partnership Self Audit Tool for suggested actions for local partnerships.

10.1 Occupational health

It is important that drug treatment providers have in place appropriate protocols and procedures to minimise the risk of occupational exposure for staff to communicable diseases, vaccinating all at-risk staff against HBV and providing access to advice and testing after any accidental staff exposure that may carry a BBV risk. Staff should be trained in standard or universal precautions²⁵ for hygiene and personal safety about minimising the risk of exposure to BBVs, and have access to, and advice on, post exposure prophylaxis (PEP) in the event of occupational exposure to BBVs²⁶.

As part of training needs assessments, harm reduction knowledge and skills should be assessed and built into training and workforce plans. All organisations should reflect their responsibilities for protecting staff through the appropriate occupational health procedures. These should be monitored through the normal contract monitoring process.

Organisations with Occupational Health Departments (both NHS and non-NHS) will have qualified staff to advise local commissioners of current practice. PCT and NHS Trust clinical governance leads and occupational health managers should be consulted as to the local implementation of training programmes and up to date policies and procedures.

11. Partnership delivery as part of the adult drug treatment plan 2009/10

Partnership delivery as part of the 2009/10 adult drug treatment plan should continue to focus on efforts to control the spread of blood-borne viruses, ensuring the provision of needle exchange and arrangements for appropriately assessing the general healthcare needs of drug users. This delivery should be supported by appropriate plans to address gaps identified as part of the needs assessment. Whilst this by no means represents the totality of harm reduction/minimisation efforts required, they are key areas of delivery which are measurable from National Drug Treatment Monitoring System (NDTMS) data and/or local contracts, SLAs or equivalent commissioning documentation, and will allow the partnership insight into the effectiveness of its wider harm reduction/minimisation strategy.

The following points need to be factored into the setting of partnership expectations across the drug treatment system for harm reduction initiatives.

11.1 Hepatitis B vaccinations

A central objective in effectively controlling the spread of hepatitis B is to ensure the provision of hepatitis B vaccination. Vaccination should be promoted to **all** drug users presenting to drug treatment, irrespective of whether they are injecting drug users due to risk of sexual transmission.

²³ http://www.nta.nhs.uk/areas/outcomes_monitoring/default.aspx

²⁴ [Choosing better oral health: An oral health plan for England : Department of Health - Publications and statistics](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003818)

²⁵ Blood-borne viruses (BBVs) and occupational exposure, Department for Health, 2005,

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4003818

²⁶ Reporting of occupational exposure to blood-borne viruses – history and how to report

Every effort should be made by agencies to ensure that vaccinations offered are accepted and courses completed by their clients. A *Models of Care*²⁷ compliant assessment tool requires discussion of the immunisation status of all clients presenting to treatment services. Therefore, the total number of clients offered hepatitis B vaccination should be equal to the number of clients expected to enter treatment in 2009/10.

However, some drug users will already have been properly vaccinated, some will be immune due to prior exposure and some will ultimately refuse the vaccination. The partnership expectation for the number of people who take up the vaccination should therefore take these factors into account, with appropriate capacity commissioned to meet the likely demand predicted.

11.2 Hepatitis C testing

Hepatitis C is most commonly spread through injecting drug use. All drug users that present as current or previous injectors should be offered a personal test for hepatitis C if they do not know their hepatitis C status confirmed by a HEP C test.

Knowledge of hepatitis C status enables drug users to take positive action to protect themselves from further harm. This could include restricting alcohol consumption, accessing hepatitis A immunisation and compliance with a hepatitis B immunisation programme. Contracting hepatitis B (and/or A) 'on top of' hepatitis C increases the likelihood of more severe liver disease and reduces the likelihood of a successful response to hepatitis C treatment. IDUs should be enabled to make an informed decision when considering accessing appropriate treatment as outlined in the *Hepatitis C Strategy for England*²⁸. This also enables people to make informed choices about potential risks of onward transmission. Testing should be accompanied by appropriate pre- and post-test counselling/discussion, by a suitably trained and competent member of staff. It would be expected that hepatitis C testing is undertaken as part of an overall hepatitis treatment pathway in keeping with the recommendations of the *Hepatitis C Strategy*.

12. General healthcare assessment

As part of their assessment and care plan, all drug users require a general healthcare assessment²⁹, which appraises and responds to (by direct intervention or referral) their risk of, for example, injecting-related wound infection, blood-borne viruses, overdose (accidental or intentional), sexually transmitted disease or poor dental health, and also includes a basic health screen carried out by a trained professional. A *Models of Care* compliant assessment tool contains an assessment of drug users' general health that is appropriate to the needs of the client. The assessment is completed by staff who are competent as defined by DANOS standard AF3³⁰. Where clients present with more complex healthcare needs, these should be dealt with by appropriate referral to relevant resources. It is recommended this is followed up with the client as part of the care plan review.

Typically, the initial part of the assessment will cover general health issues related to injecting practice/sites and infections, risk of BBV exposure, immunisation/test status, sexual practices, dental health and diet. It would also establish whether the client has a GP, has had any recent overdoses or is doing anything that might pose an overdose risk, is currently, or has previously, been in contact with mental health services.

See section 6, "General Healthcare" of: The Partnership Self Audit Tool for suggested actions for local partnerships

²⁷ National Treatment Agency for Substance Misuse, 2006, *Models of Care for Treatment of Adult Drug Misusers: Update 2006*, NTA/DH/Home Office: http://www.nta.nhs.uk/areas/models_of_care

²⁸ Department of Health, 2004, *Hepatitis C Action Plan for England*, DH: London: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084713.pdf

²⁹ National Treatment Agency for Substance Misuse, 2006, *General healthcare assessment*, NTA: London: http://www.nta.nhs.uk/areas/treatment_planning/docs/NTA_General_healthcare_assessment_guidance.pdf

³⁰ Drugs & Alcohol National Occupational Standards: <http://www.alcohol-drugs.co.uk/DANOS.htm>

12.1 Supporting the general healthcare assessment

NTA general healthcare assessment guidance³¹ provides some basic definitions of a general healthcare assessment and the associated health areas that should be considered. In addition, partnerships and PCTs are encouraged to also consider the availability of sexual health and dental services to support the treatment of drug users and the impact of both alcohol and tobacco on the overall health of the substance misusing client.

- **Sexual health**

Sexually transmitted infections (STIs) and HIV cause a wide range of illnesses and are significant causes of long-term and serious disability in the UK. Drug users who use or share equipment that break the skin can be at risk of a range of infections. A number of BBVs can be passed on through unprotected sexual intercourse where body fluids shared in significant quantities could be of moderate or high risk.

During a general healthcare assessment, it is recommended that the client be offered support and guidance on how to protect themselves and others from potential/preventable infections consider their family planning needs. A sexual health review can incorporate advice on the prevention of catching, or passing on, sexually transmitted infections (STIs), and preventing an unwanted pregnancy.

Access to local sexual health services is a Public Service Agreement (PSA) target. PCTs are responsible for ensuring compliance with these targets through their own Local Delivery Plan (LDP) targets which the drugs partnerships may want to consider within their local strategies.

Commissioners and service providers developing referral routes should contact their local PCT for site venues and opening times. It is important that particular attention is paid to the confidentiality arrangements which apply to these services³².

- **Dental Health**

Since April 2006, PCTs have been given responsibility for dental public health and they are now required to work with dental professionals to deliver improvements. This will enable oral health to become an integral part of local health services, delivered not only through the dental surgery, but also through health visitors and other parts of primary health care service. Dental health of drug service users should already be commissioned and form part of the general healthcare assessment. Necessary guidance on appropriate referral routes to support service providers with up to date and agreed care pathway direction should be commissioned and in place in all drug services

*Choosing better oral health: an oral health plan for England*³³ puts forward an action plan that sets out to inform and provide support for dental practices as they focus more on preventative care under new contractual arrangements which have been in place from April 2006. Designed to improve oral health both nationally and locally, this plan also sets out to assist and support PCTs in meeting their new responsibilities for dental services under the Health and Social Care (Community Health and Standards) Act 2003. This legislation extends their remit to assessing local oral health needs and commissioning the appropriate services to tackle long standing oral health inequalities.

³¹ National Treatment Agency for Substance Misuse, 2006, *General Healthcare Assessment*, NTA: London: http://www.nta.nhs.uk/areas/treatment_planning/docs/NTA_General_healthcare_assessment_guidance.pdf

³² Department of Health website, sexual health information: <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/sexualhealth/index.htm>

³³ Department of Health, 2005, *Choosing better oral health: An oral health plan for England*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

- **Alcohol**

Alcohol is a significant cause of death among young people through alcohol overdose, inhalation of vomit, hypoglycaemia, and accidents or violence. More generally, alcohol increases the risk of dropout from drug treatment and exacerbates mental health problems. Alcohol increases the risk of hepatic cancer in people who are hepatitis C positive. Most of these risks are increased when alcohol and other drugs are taken in combination (ACMD, 2000)³⁴.

The National Treatment Outcomes Research Study (Gossop *et al.*, 2001)³⁵ found 24% of the cohort at the start of the study were drinking above Department of Health recommended sensible limits, and 25% were doing so at the five year follow-up. Eight percent were drinking at definitely harmful levels. About one-third of clients receiving methadone have been identified as having a current drink problem and a further one-sixth have a history of a drinking problem (Senbanjo *et al.*, 2006)³⁶. It follows that clinicians working with drug misusers require:

- an awareness that alcohol misuse is not separate from misuse of other drugs
- competence at detecting problem drinking to be able to give harm reduction and;
- educational messages regarding misuse of alcohol to be able to manage alcohol misuse emerging alongside pharmacotherapies such as substitute prescribing.

It may be clinically helpful to think of different patterns of drinking associated with drug misuse:

- drinking that is substantially independent of other drug misuse.
- drinking that is interchangeable with the use of other psychoactive drugs.
- drinking, and often other drug misuse, as a supplement to a substitute prescription.

It is highly recommended that those working with clients who use both drugs and alcohol consult the *Drug misuse and dependence guidelines on clinical management 2007*³⁷ (section six) for further information.

- **Tobacco**

Most clients in drug treatment smoke tobacco, and this is often the only drug dependence that is not addressed. This is despite smoking-related diseases being highly prevalent in drug misusers, with a likelihood of causing premature death. Smoking may act as a cue for the misuse of other drugs that are consumed in the same way. Therefore smoking may increase the risk of relapse into drug misuse.

- **Smoking Cessation in drug treatment**

Evidence suggests that smoking cessation help may be associated with improved drug treatment outcomes. Similar processes apply to smoking cessation treatment as to treatment for other types of drugs, e.g. coping with cravings and preventing relapse. Despite this, most drug treatment services do not offer smoking cessation to drug misusers. This may be because staff have not been appropriately trained, believe that it will interfere with drug treatment, or a lack of evidence and clinical experience of using smoking cessation treatments in this patient group.

³⁴ACMD (2000) *Reducing Drug-related Deaths: A report by the Advisory Council on the Misuse of Drugs*. London: Home Office.

³⁵Gossop M, Marsden J and Stewart D (2001) *NTORS After Five Years: Changes in Substance Use, Health and Criminal Behaviour During the Five Years After Intake*. London: Department of Health.

³⁶Senbanjo R, Wolff K and Marshall J (2006) Excessive Alcohol Consumption is Associated With Reduced Quality of Life Among Methadone Patients. *Addiction*, 102, 257-263.

³⁷Department of Health (2007): *Drug misuse and dependence: Guidelines on clinical management 2007* http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf

There is a large evidence base for the effectiveness of smoking cessation treatment in the general population and in prisons, with the best outcomes from a combination of behavioural support and pharmacological interventions such as nicotine replacement. Given the high rates of smoking and the low quit rates in drug misusers, it may be reasonable to consider harm reduction approaches to smoking.³⁸

Staff encouragement of clients to stop or reduce their smoking and referral to smoking cessation services is recommended. This may be more achievable in primary care drug treatment where many GPs and pharmacists have smoking cessation services provided within the same premises. Specialist services may need to consider providing smoking cessation interventions as part of standard drug treatment. If so, staff will need to be competent in providing smoking cessation interventions and have undertaken an appropriate level of training as recommended by the PCT Smoking Cessation adviser and clinical governance lead.

References and Further Reading

The Harm Reduction Strategy - Guidance and the Partnership Self Audit Tool brings together advice and guidance from a variety of sources. A number of key documents and papers are presented below as further reading some having additional web links for quicker access, these are:

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http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf

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³⁸<http://www.nice.org.uk/PH010>

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National Treatment Agency for Substance Misuse

Harm Reduction Strategy: Partnership Self Audit Tool

Introduction

This Partnership Self Audit Tool (PSAT) was first published in October 2005. The purpose of the PSAT was to support partnerships in developing a systematic response to the reduction/minimisation of harm (to selves and others) that can be associated with drug use.

This Self Audit Tool can be used in a variety of settings including internal service provider exercises; Partnership rapid appraisals and consultation with a broad range of stakeholders as part of the 2009/10 needs assessment/adult drug treatment planning process.

The tool is designed to provide a structure for partnerships to re-visit priorities from 2008/09 and to identify remaining gaps for inclusion within the 2009/10 adult treatment plan and beyond.

The PSAT highlights six sets of suggested actions for partnerships to consider, including issues on prevention, surveillance and communication systems. The PSAT also highlights for consideration competencies for service delivery and incorporation into partnership contracts and Service Level Agreements (SLAs) or their equivalent, as part of the 2009/10 commissioning round.

The template below is for guidance only. The template can be customised by Partnerships to capture specific requirements or local issues as part of the Needs Assessment process.

Harm Reduction Strategy: Partnership Self Audit Tool

Note to Partnerships:

The titles under 'Lead agencies/individuals' are examples only.

Each Partnership may have developed job titles more specific or appropriate to your current job specifications for example: Treatment Effectiveness Manager instead of Models of Care lead or Drugs Strategy or Partnership Manager instead of DAAT or Partnership Co-ordinator. It is the responsibility of the Partnership to customise the template to match the current workforce allowing the document to become relevant to your local partnership.

RED	Not in place or not at standard required and significant needs/improvements identified			
AMBER	Progress being made but further work/investment required to meet identified need/standard			
GREEN	Provision in place and/or good progress being made against assessed need and required standards			
1. Strategic management		Lead agencies / individuals	Current (RAG) status	Issues / comments / actions
Partnership has a multi-agency strategy for harm reduction agreed across all partner agencies, including the local Health Protection Unit, which addresses sections 1 – 6 of this tool.		<i>Partnership Co-ordinator (or equivalent), and or Joint Commissioning Manager (JCM)</i>		
Partnership has a Chief Officer lead/champion for ensuring the delivery of the local harm reduction strategy		<i>Partnership Chair to agree with membership</i>		
Quarterly harm reduction progress reports are received by the partnership for discussion/action		<i>Partnership Chair, CG lead</i>		
Partnership has an identified clinical governance (CG) / quality assurance (QA) lead for all services to ensure clinical risk management and advice. Formal links to PCT CG lead are established		<i>Lead Clinician, PCT, service provider lead, CG lead QA lead</i>		
Partnership has communication strategy for harm reduction		<i>Partnership Co-ordinator (or equivalent). Communications dept. of Partnership host agency</i>		
Agreed protocol for local information sharing with regard to: contamination, purity issues/acute risks and communication across all agencies		<i>Partnership Co-ordinator, JCM, Public health lead , Police</i>		

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2. Blood-borne Virus infections	Lead agencies / individuals	RAG status	Issues , comments , actions
Service users who are BBV+ and/or have liver disease have access to secondary specialist services (referral, care pathways, co-working arrangements, monitoring of uptake and outcomes)	<i>MoC leads (or equivalent) GPs, PCT specialist Commissioners, service provider leads, JCM</i>		
Injecting equipment to be made available, supported by appropriate education to reduce equipment sharing made available for those in contact with the drug treatment system	<i>Service provider, JCM, Lead Clinician</i>		
Opiate-dependent clients (injecting or not) to be offered relevant advice and or counselling that includes information for avoiding exposure to blood-borne virus infections	<i>Lead Clinician, Service provider, JCM</i>		
All injecting drug users and their partners to be offered testing for hepatitis C; and vaccination against hepatitis B infection supported by routine repeat testing if the risk of exposure continues. Partnerships may want to consider offering the client, partners and family members a hep B booster dose at around 5 years (or as local PCT guidance recommends)	<i>Lead Clinician, Service provider, JCM, PCT Director Public Health, CG leads, MoC leads (or equivalent), PCT Pharmacy lead</i>		
Care pathways are in place for injecting drug users to access HIV testing, diagnosis and treatment.	<i>JCM, Service provider, Lead Clinician</i>		
Care pathways are in place for injecting drug users to access screening and treatment for tuberculosis and screening and immunisation for tetanus.	<i>JCM, Service provider, Lead Clinician</i>		

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3. Needle Exchange	Lead agencies / individuals	RAG status	Issues / comments / actions
Injecting equipment and paraphernalia relevant to need, is widely and easily available from a range of outlets: such as centre based, pharmacy based, outreach to priority groups	<i>Service user consultation, PCT , service provider leads</i>		
Local strategies in place to reduce the incidence of drug related litter	<i>Service provider leads , local authority , service user consultation</i>		

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4. Preventing Drug Related Deaths and Confidential Inquiry Management	Lead agencies / individuals	RAG status	Issues / comments / actions
Preventing Drug Related Deaths			
Information campaigns co-ordinated and targeted on specific drug related deaths issues	<i>Service provider leads , Partnership</i>		
Partnerships and treatment providers to have access the full range of DH/NTA overdose prevention materials	<i>JCMs, Service provider leads , Partnership co-ordinator, PCT Health Improvement, Health Promotion lead</i>		
All treatment services have discharge protocols that include explicit warnings about the risks of overdose and that all referral and care pathways into substitute prescribing are available	<i>Service leads provider , Clinical Governance lead</i>		
Benzodiazepine prescribing policy including access to detoxification	<i>Clinical Governance lead, Practitioners in a prescribing role</i>		

Local training provided in overdose prevention and management for service users and carers	<i>Service user consultation, service provider leads</i>		
Service users and carers are made aware of the dangers to children of take home medication and the need for safe storage, child proof caps and lockable safes and containers	<i>Service provider leads , practitioners in a prescribing role , Clinical Governance lead, Community Pharmacists</i>		
All services have an emergency protocol that covers the management of drug overdose (including rapid ambulance call, competent preservation of clear airway and possibly emergency administration of Naloxone)	<i>Service user consultation, service leads</i>		
Suitable resuscitation equipment should be available for clinical settings, possibly including Naloxone, and the staff competent to administer it.	<i>Service provider, JCM, Clinician</i>		
A range of overdose measures is provided to carers of opiate misusers, which might include information, advice and training on avoiding overdose, recognising the signs of overdose and first aid, and might include the use of Naloxone.	<i>JCM, MoC lead (or equivalent)</i>		
Rapid access to substitute prescribing for released prisoners and those prematurely leaving residential treatment	<i>MoC lead (or equivalent) , service provider leads</i>		
Prevention and management of overdose in custody	<i>Police</i>		
Liaison between A&E and drug services, referral systems, care pathways, injecting equipment	<i>A&E , service leads , MoC lead or equivalent</i>		
Ambulance crews carry and trained to use Naloxone in opiate overdose incidents	<i>Ambulance</i>		
Local police/ambulance protocols in place to manage involvement in overdose incidents requiring ambulance response	<i>Police , Ambulance</i>		
Confidential Inquiry Management			
Identified Confidential Inquiry lead in Partnership or Multi-Partnership area	<i>Partnership co-ordinator (or equivalent) , Strategic Health Authority (SHA)</i>		

Multi-agency multi-disciplinary drug related death (DRD) review group established for confidential inquiries	<i>Confidential Inquiry lead , SHA</i>		
Partnership have Coroner involvement/engagement	<i>Coroners office , CI lead</i>		
Partnership have agreed Confidential Inquiry protocol in place with terms of reference	<i>Confidential Inquiry lead</i>		
Partnership have an agreed definition of drug related death (e.g. Advisory Council on the Misuse of Drugs definition)	<i>Confidential Inquiry lead</i>		
Partnership have an agreed minimum data set for the collection of drug related death data	<i>Confidential Inquiry lead , Partnership Data Manager</i>		
Partnership provide appropriate reports and dissemination of recommendations of review group	<i>Confidential Inquiry lead , Partnership Data Manager</i>		

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AMBER	Progress being made but further work/investment required to meet identified need/standard		
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5. Workforce	Lead agencies / individuals	RAG status	Issues / comments / actions
Personal / professional development plans or organisational training plans enable staff to develop the knowledge and skills to provide competent health risk assessments, smoking cessation, harm reduction / health promotion advice and prevent drug related deaths (ref: DANOS)	<i>Service provider leads , CG lead , Health Improvement , Health Promotion Lead</i>		
Training to incorporate feedback from drug related death review / local Confidential Inquiries	<i>Service provider leads , CG lead</i>		
Protocols in place for staff working with drug users to have access to HBV immunisation and Post Exposure Prophylaxis (PEP) for possible occupational HIV, HBV, HEP C transmission and appropriate follow-up	<i>Service provider leads , CG lead</i>		

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6. General Health Care	Lead agencies / individuals	RAG status	Issues / comments / actions
Relapse prevention, BBV education integral part of any treatment programme	<i>Service provider leads , CG lead</i>		
Individual care plans provide on-going assessment of general / primary healthcare needs, including risks of drug related harm from sudden overdose, BBV and other communicable diseases, bacterial endocarditis, skin botulism, septicaemia etc	<i>MoC lead (or equivalent) , service provider leads</i>		
Integrated approach with referral, advice, liaison and care coordination arrangements for people with a substance misuse and mental health problems	<i>Mental health , dual diagnosis lead , MoC and service provider leads</i>		
Dental Health			
Referral mechanisms for access to dental health care	<i>Service provider leads , PCT Commissioner , JCM</i>		
Sexual Health			
Sexual health promotion, screening and materials available in drug-specialist services including residential rehabilitation provision, in liaison with specialist GUM services	<i>Service provider leads , MoC leads, PCT Public Health/Health Improvement/Health Promotion lead</i>		
Access to healthcare advice, support and screening, with referrals to specialist services as appropriate	<i>Service provider leads , MoC leads, PCT</i>		
Smoking Cessation			
Clinicians should encourage clients to stop or reduce their smoking and refer them to smoking cessation services	<i>Service provider, JCM, PCT Smoking Cessation Advisor, CG lead.</i>		
Smoking cessation treatment opportunities are routinely offered to clients in drug treatment, as with the wider population	<i>Service provider, JCM, PCT Smoking Cessation Advisor, CG lead.</i>		
Alcohol			
Providing harm reduction and educational messages and the ability to manage emerging alcohol misuse alongside pharmacotherapies.	<i>Service provider, JCM.</i>		

Provision of advice on the location of Alcoholics Anonymous (AA) Meetings, and encouragement to attend AA meetings as part of their initial treatment programmes.	<i>Service provider, JCM.</i>		
Drug misusers who are dependent on alcohol are offered alcohol interventions (psychosocial and pharmacological)	<i>Service provider, JCM, PCT, CG lead. Lead Clinician.</i>		