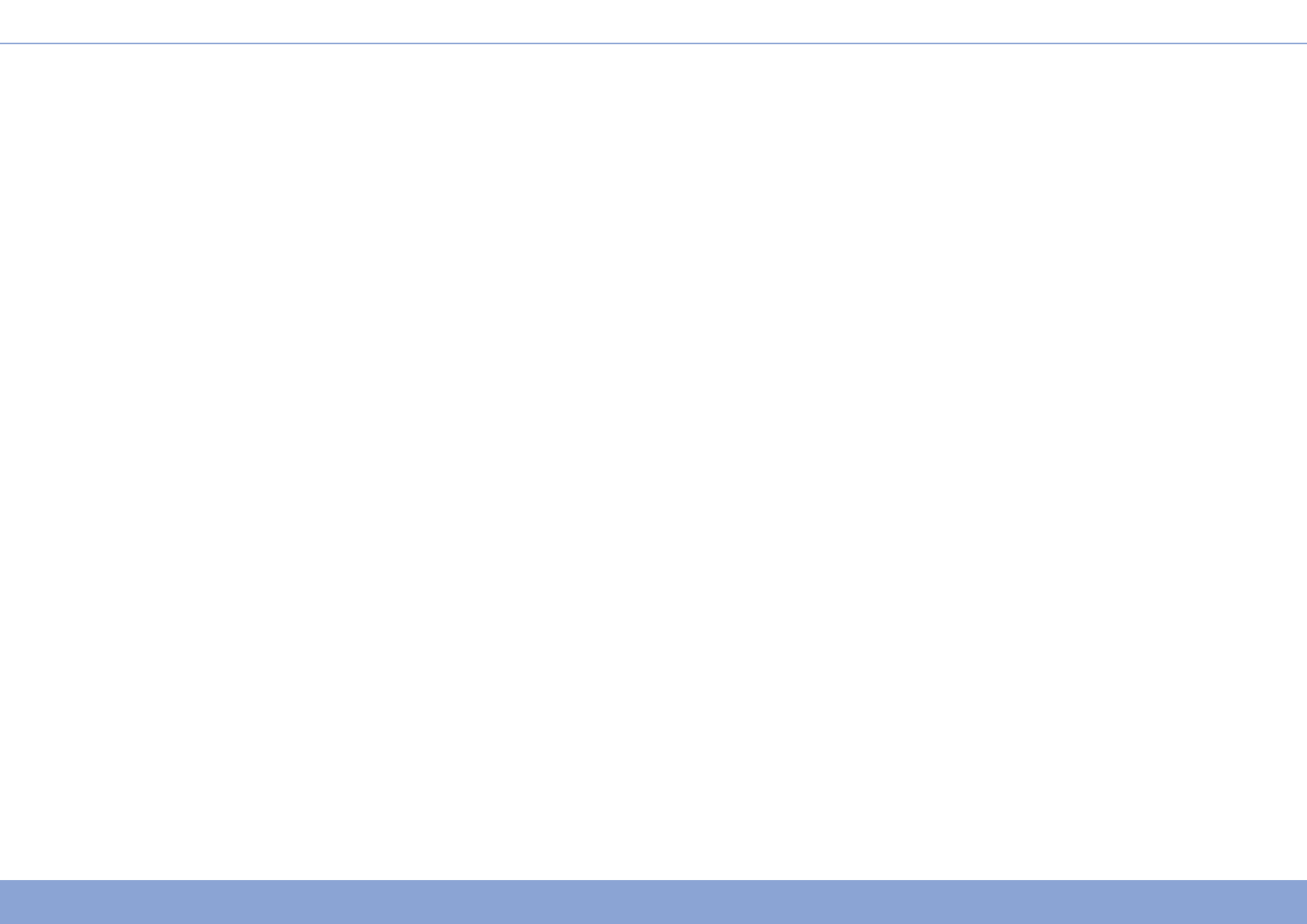


## Harm Reduction Strategy 2008 - 2011

Reducing the harm caused by the misuse of drugs and alcohol in Norfolk



## List of Contents

1. What we want to achieve with the Harm Reduction Strategy	1
2. Context - Norfolk Drug & Alcohol Partnership direction for Harm Reduction	2
3. Context - National Treatment Agency direction for Harm Reduction	3
4. Defining Harm Reduction	4
5. Implementing the strategy	5
Strategic Objective 1 - Provide and monitor a strategic framework to promote harm reduction	5
Strategic Objective 2 - Promote harm reduction to substance users and their carers, families and friends	7
Strategic Objective 3 - Workforce development	9
Strategic Objective 4 - Continuous improvement of service provision for drug users	11
Strategic Objective 5 - Reduce the transmission of Blood Borne Viruses (BBVs)	13
Strategic Objective 6 - Reduce the incidences of overdoses and drug related deaths	14
Strategic Objective 7 - Harm reduction in custody/ Integrated Drug Treatment System	15
Appendix 1	16
Glossary	18



# 1. What we want to achieve with the Harm Reduction Strategy

**1.1** The Norfolk Drug and Alcohol Partnership (N-DAP) has one overarching aim: to reduce the harm caused by the misuse of drugs and alcohol in Norfolk. To achieve this aim, we have clear local outcomes to work towards – and this strategy focusses principally on outcomes 1 and 2. These outcomes are:

1. a reduction in drug-related ill health
2. a reduction in drug-related deaths
3. a reduction in drug-related offending
4. a reduction in the supply of illegal drugs
5. a reduction in alcohol-related harms
6. today's young people prevented from becoming tomorrow's problematic substance misusers.

**1.2** This strategy provides the framework in which N-DAP members will work together to reduce the varying harms arising from the misuse of substances. This includes how N-DAP will work towards reducing the number of deaths and suicides associated with substance misuse. It has a particular emphasis on health-related harms, such as the spread of Blood Borne Viruses (Hepatitis, HIV) and other health problems that can affect substance misusers.

**1.3** The Harm Reduction Strategy is one of a number of N-DAP strategies and does not stand alone – there are particular links to the Commissioning Strategies for Adults and Young People's services. The Alcohol Harm Reduction Strategy in particular addresses outcome 5.



## 2. Context – Norfolk Drug & Alcohol Partnership direction for Harm Reduction

**2.1** N-DAP's 2008/09 Adult Treatment Plan reported that during 2007/08 the demand for drug treatment services in Norfolk remained stable, while an increasing number of alcohol referrals were received. As a rural county, N-DAP continually seeks to address the issues related to rurality (e.g. transport, access to services). In 2008, needs assessment work on the needs of substance misusers who are not engaged with the drug treatment system in Norfolk will continue. The outcome of this work will feed into the work of the Harm Reduction Governance Group – along with the wider commissioning activity to complete N-DAP's commissioning strategies.

**2.2** In the 2006/07 Healthcare Commission and NTA joint improvement review, which focussed on harm reduction, N-DAP scored 'good' overall, but only 'weak' or 'fair' on certain areas related to harm reduction, including: whether a strategy was in place, the response of the partnership to Hepatitis C, protocols for staff safety in relation to BBV, service user testing/vaccination against Hepatitis, strategy for drug related deaths and training (staff and service users) with regard to overdose incidents. This strategy and the establishment of the Harm Reduction Governance Group seeks to address and improve on these areas.

**2.3** Drug related deaths in the East of England 1996 – 2004: An update to INpho 19<sup>1</sup> notes that a total of 1058 drug-related deaths occurred in the East of England<sup>2</sup> over the period 1996 – 2004, and the highest number of drug-related deaths (106) occurred in Norwich. Eighty-four percent of the drug-related deaths in the

East of England involved opioids and fifty-seven percent of drug-related deaths were of people under 35 years of age, and eighty-four percent of those were male. Overall, males accounted for eighty-one percent of drug-related deaths in the East of England.

**2.4** The interim report from the University of East Anglia for their needs assessment of drug misusers not in treatment, published in October 2007, contained details of their analysis of secondary data from 1st April 2004 to 31st March 2007. Analysis was completed through matching the sets of data collected with the National Drug Treatment Monitoring System (NDTMS) to identify people who had been in treatment in Norfolk. Mortality data identified between 64 and 94 possible drug related deaths occurring in the three year time period. The match with NDTMS was poor – 38% – suggesting that a low proportion of these drug-related deaths had had a previous NDTMS recorded episode of treatment. The final outcomes of this research will be available in October 2008.

**2.5** The National Treatment Agency guidelines Models of Care – Update 2006 forms the model for the treatment system that should be in place in Norfolk. Services are provided across the county by both statutory and non-statutory agencies. Forty-six practices in the Norfolk PCT area and two in the Great Yarmouth & Waveney PCT area are engaged in shared care (i.e. the provision of treatment for service users in primary care).

---

<sup>1</sup> Eastern Regional Public Health Observatory - Regional Drugs Health Information Unit

<sup>2</sup> Peterborough, Norfolk, Suffolk, Cambridgeshire, Bedfordshire, Hertfordshire, Essex, Luton, Thurrock, Southend-on Sea

**2.6** The objective of the Integrated Drug Treatment System (IDTS) is to expand the quantity and quality of drug treatment within HM Prisons, by; increasing the range of treatment options available to those in prison, notably substitute prescribing; integrating clinical and psychological treatment in prison into one system that works to the standards of Models of Care and the National Treatment Agency's Treatment Effectiveness Strategy and works to one care plan; and by integrating prison and community treatment to prevent damaging interruptions either on reception into custody or on release back home. The IDTS has to work closely with the Drug Interventions Programme to ensure that offenders receive seamless support and are retained in treatment after release. In Norfolk, HMP Wayland became an IDTS site in 2007 and HMP Norwich will become an IDTS site in 2008.

### 3. Context – National Treatment Agency direction for Harm Reduction

**3.1** The National Treatment Agency (NTA), in their guidance for drug partnerships in 2007 set out comprehensive information on recent trends among (particularly injecting) drug users, suggesting that drug-related harms have increased in recent years. This overview of the national context is given in Appendix 1.

**3.2** Reducing drug-related harm: an action plan<sup>3</sup> 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.



---

<sup>3</sup> 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](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850)

## 4. Defining harm reduction

**4.1** 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<sup>4</sup>. This strategy focusses on a 'whole system' approach to harm reduction for Norfolk's treatment system and services.

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

**4.3** Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements, so that harm reduction interventions are available at the full range of locally commissioned drug services. N-DAP's Adult Joint Commissioning Group have agreed that the principle of harm reduction will underpin service provision commissioned in Norfolk. The Adult Joint Commissioning Group also aim to support an abstinence approach for those service users for whom it is appropriate.

**4.4** National guidance advises that harm reduction should not be considered as a service type, 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 routes of administration (injecting and smoking related problems)
- Other general/primary healthcare issues, such as sexual health and dental health.

---

<sup>4</sup> For further information, see United Kingdom Harm Reduction Alliance website: [www.ukhra.org](http://www.ukhra.org)

## 5. Implementing the strategy

**5.1** The strategy has been drawn together by a working group of members from N-DAP. Following consultation on the strategy, some of the members of this group will invite others to join them in becoming N-DAP's Harm Reduction Governance Group (HRGG). The role of this group will be to oversee the implementation of the strategy and ensure effective progress against the strategic objectives and key actions stated in the strategy, through a defined process of meetings and annual reviews of the strategy, objectives and actions.

<b>Strategic Objective 1</b>	
<b>Provide and monitor a strategic framework to promote harm reduction</b>	
<b>Why are we doing this?</b>	Harm reduction is a broad area, delivered by a wide range of agencies. N-DAP needs to ensure and monitor a consistent series of messages and approaches, along with support for agencies.
<b>How will we do this?</b>	The N-DAP Harm Reduction Governance Group, of key partners from within N-DAP, will monitor, review and check progress against key actions. This Group will also determine and agree the definition(s) for Drug Related Deaths, as part of working to reduce drug related deaths in Norfolk.
<b>What do we hope to achieve?</b>	A joined up approach across both specialist agencies and other partners that can influence the harm reduction agenda, resulting in better outcomes for service users and carers.
<b>Who will this affect?</b>	All service providers (particularly those providing Tier 2 and 3 services) and other partners, in terms of better support and knowing where to gain information and advice.
<b>Key Action</b>	<b>Framework for delivery and timetable</b>
1.1 Establish multi-agency strategy for harm reduction agreed across all partner agencies	Finalise and consult on strategy Implement strategy JCO to co-ordinate during Summer 2008
1.2 Establish Chief Officer lead for harm reduction strategy	Agenda item for N-DAP Chief Officers Group first meeting after consultation on this strategy
1.3 Draw up communication strategy for harm reduction, taking into account the need for 'real time' impacts of referrals/waiting lists on accessibility of services and how this is communicated to service users	Include as part of HRGG work plan First meeting September 2008

Key Action	Framework for delivery and timetable
1.4 Agree definitions of drug related death for: <ul style="list-style-type: none"> <li>- This strategy (including serious toxic events or 'near misses')</li> <li>- Triggering a confidential inquiry</li> <li>- Monitoring drug related deaths</li> </ul>	Include as part of HRGG work plan First meeting September 2008
1.5 Establish partnership Harm Reduction Governance Group to: <ul style="list-style-type: none"> <li>- Determine data to be reported as part of contracts/as part of confidential inquiries</li> <li>- Determine which services will report governance/quality assurance to the group</li> <li>- Ensure effective links are made with other relevant strategies/ groups, e.g. PCT Suicide Prevention</li> </ul>	DAAT to determine initial invitee list and set date of first meeting Agree Terms of reference for HRGG, to include confidential inquiries element of group role and how outcomes and trends from inquiries will be used/ communicated Other elements to include as part of HRGG work plan First meeting September 2008
1.6 Ensure all commissioned services have appropriate contract clauses re. drug related deaths, participation in service governance and monitoring	DAAT Contracts Officer to review and consult with JCO Autumn 2008
1.7 Develop benzodiazepine prescribing policy	NTA requirement – PCT to advise along with prescribing leads from services
1.8 Ensure consideration is given to deaths resulting from polydrug use, including alcohol	Ensure cross-referencing to Alcohol Harm Reduction Strategy development during 2008 and 2009
1.9 Consider broader related safety issues of substance misuse	Include as part of HRGG work plan – consider issues around drug driving and substance misuse linked to the night time economy First meeting September 2008
1.10 Ensure consideration is given to the needs of substance misusers who are not engaging in drug and alcohol treatment in Norfolk	HRGG to consider the outcomes of the University of East Anglia needs assessment of Norfolk drug misusers not in treatment work due to report in October 2008

<b>Strategic Objective 2</b> <b>Promote harm reduction to substance users and their carers, families and friends</b>	
<b>Why are we doing this?</b>	The National Treatment Agency recognise the importance of harm reduction, and N-DAP believes this is an essential element of a local treatment system and services for substance misusers and their carers, families and friends – leading to better outcomes from treatment.
<b>How will we do this?</b>	N-DAP will promote and develop a wide range of agreed approaches and initiatives, which are shared and monitored across N-DAP with support, advice and guidance available for non-specialist agencies.
<b>What do we hope to achieve?</b>	Better health for substance misusers and better outcomes from drug treatment interventions and fewer drug related deaths.
<b>Who will this affect?</b>	Substance misusers, their carers, families and friends – and the broader community. Treatment providers, in terms of achieving better outcomes with their service users.

<b>Key Action</b>	<b>Framework for delivery and timetable</b>
2.1 Continue to implement Models of Care across N-DAP, including risk assessments for all service users	DAAT to continue to monitor with service providers Ongoing part of contract review work Ongoing agenda item at Treatment Implementation Group and Information Systems Strategy Group
2.2 Provision of information and training to service users and carers: - basic life-saving information - advice and information on the immediate and longterm risks of specific drugs and methods of use	DAAT and providers to continue to monitor use of referral/triage and assessment proformas (in helping to provide this information) Will continue to form part of contract specifications, where appropriate Ongoing part of contract review work Ongoing agenda item at Treatment Implementation Group and Information Systems Strategy Group
2.3 Provision of injecting equipment and paraphernalia to injecting drug users and provision of supervised consumption for service users, widely and easily available from a range of outlets	N-DAP to continue commissioning and evaluating countywide needle exchange and supervised consumption scheme DAAT to action, ongoing
2.4 Ensure provision of drug related death risks is available on nordat website – information for both service users and drug workers	N-DAP Information Group to review and update information as necessary Autumn 2008

<b>Key Action</b>	<b>Framework for delivery and timetable</b>
2.5 Ensure training in overdose prevention and management for service users and carers	DAAT to continue to monitor with service providers Will continue to form part of contract specifications, where appropriate Ongoing part of contract review work Continued use of service user involvement training sub-group bursary to support service users wishing to attend one day harm reduction awareness courses
2.6 Ensure referral pathways for access to dental health care are in place	DAAT to determine current pathways and discuss with N-DAP Implementation Groups By March 2009
2.7 Ensure sexual health promotion, screening and materials are available in specialist services	DAAT to determine current practice and discuss with PCT Sexual Health team and with N-DAP Implementation Groups By March 2009
2.8 Ensure access to healthcare advice, support and screening, with referrals to specialist services as appropriate	DAAT to determine current practice and discuss with N-DAP Implementation Groups By March 2009
2.9 Ensure service users are made aware of the dangers to children of take home medication, need for safe storage, child proof caps and lockable safes and containers	DAAT to determine current practice and discuss with N-DAP Implementation Groups By March 2009
2.10 Consider requirement for peer-led and/or accredited training for service users in harm reduction	DAAT Training & Workforce Development Officer to advise HRGG By March 2009

<b>Strategic Objective 3</b> <b>Workforce development</b>	
<b>Why are we doing this?</b>	N-DAP recognise the need for continual ongoing professional development. The staff working within N-DAP and staff from partner agencies are key to the successful delivery of this strategy. The key actions here will provide them with support and enable best practice.
<b>How will we do this?</b>	By providing effective support, information and advice on practice – and opportunities to feedback and enable continuous professional – and service – development.
<b>What do we hope to achieve?</b>	An effective specialist workforce, and generic workers, who are better supported, trained and who are confident in their abilities to help and advise in this important area of work.
<b>Who will this affect?</b>	Any professional who directly/indirectly engages with substance misusers, their carers, families and friends.

<b>Key Action</b>	<b>Framework for delivery and timetable</b>
3.1 Work to ensure effective links with primary care to ensure general health needs of service users are addressed and effective referral pathways between specialist agencies and primary care	Include as part of HRGG work plan First meeting September 2008
3.2 Work to ensure effective liaison between all acute hospital departments, A&E, drug and alcohol services and specialist substance misuse nurses working in hospitals	Include as part of HRGG work plan First meeting September 2008
3.3 Support staff and agencies to establish which elements of DANOS (Drug and Alcohol National Occupational Standards) ensure competence re. harm reduction	N-DAP to ensure agencies have mapped job descriptions to DANOS or NHS Knowledge and Skills Framework – where applicable, harm reduction competencies will be identified DAAT to continue to monitor on an ongoing basis
3.4 Ensure that staff have personal/professional development plans or organisational training plans to enable development of knowledge and skills to provide competent health risk assessments, harm reduction, health promotion advice and prevent drug related deaths	Contracts include workforce training and Continuous Professional Development – and contract reviews include an item to discuss NHS Knowledge and Skills Framework is applicable to NHS providers DAAT to continue to monitor on an ongoing basis

<b>Key Action</b>	<b>Framework for delivery and timetable</b>
3.5 Ensure protocols are in place for staff working with drug users to have access to Post Exposure Prophylaxis (PEP) for possible occupational HIV, HBV, HCV transmission and appropriate follow up	Include as part of HRGG work plan First meeting September 2008
3.6 Ensure HBV immunisation is available to identified staff working with drug users	The Needle Exchange & Supervised Consumption Scheme contract includes the provision of an immunisation service for pharmacy staff DAAT to continue to monitor on an ongoing basis DAAT to review contract clauses for the immunisation of staff in other agencies
3.7 Provide a range of training courses to support drug and alcohol workers and service users in understanding harm reduction and the risk of drug related deaths	The DAAT run overdose awareness and prevention courses on an annual basis
3.8 Provide input for mainstream training e.g. for social workers/nurses/custody staff/GP practice staff within pre registration and post qualifying courses	The DAAT have provided input for social workers/nurses and will accommodate future requests where possible DAAT Training & Workforce Development Officer to consider on an ongoing basis
3.9 Provision of safer injecting courses for staff working with substance misusers	Needle Exchange and Supervised Consumption Advisory Group to consider during 2008
3.10 Ensure appropriate links are made with the sexual health training programme to ensure staff are able to make effective use of sexual health promotion, screening and materials	HRGG to ensure links with PCT Sexual Health team

<b>Strategic Objective 4</b> <b>Continuous improvement of service provision for drug users</b>	
<b>Why are we doing this?</b>	N-DAP is committed to continually reviewing and learning from identified best practice in drug treatment and related services – and will work together to identify improvements.
<b>How will we do this?</b>	N-DAP will establish a Harm Reduction Governance Group to ensure that learning is shared and learning outcomes are acted upon within the partnership. Capturing all areas of identified good practice will allow for this to be translated into advice and guidance.
<b>What do we hope to achieve?</b>	The best possible provision of harm reduction interventions within specialist and other services.
<b>Who will this affect?</b>	N-DAP partners and service users, their carers, families and friends.

<b>Objective</b>	<b>Framework for delivery and timetable</b>
4.1 Establish information sharing protocol between the DAAT and Coroner, allowing for NDTMS checks on individuals to take place	In progress: JCO and Records and Client Access Manager, Adult Social Services, Norfolk County Council to finalise By May 2008
4.2 Ensure feedback from Confidential Inquiries/Clinical Governance group is effectively shared across the partnership, along with other sources (e.g. Office of National Statistics, national programme Substance Abuse Deaths)	Include as part of HRGG work plan First meeting September 2008
4.3 In partnership, consider development of alcohol interventions (including brief interventions) and alcohol interventions for drug misusers in line with Models of Care for Alcohol Misusers	N-DAP Alcohol Harm Reduction Strategy will detail any actions required Alcohol Harm Reduction Strategy due to undergo consultation summer 2008, accompanying toolkit due to be implemented August 2008 – May 2009 HRGG to consider as part of future work plan
4.4 Work to ensure that abstinence is used as part of an assessed, planned and properly resourced option for service users, where appropriate	Include as part of HRGG work plan First meeting September 2008
4.5 Ensure integrated approach with referral, advice, liaison and care co-ordination arrangements for people with a dual diagnosis	Include as part of HRGG work plan First meeting September 2008

<b>Objective</b>	<b>Framework for delivery and timetable</b>
4.6 Ensure individual care plans provide on-going assessment of general/ primary healthcare needs, including risk of drug related harm from sudden overdose, BBV and other communicable diseases	DAAT to continue to monitor with service providers Ongoing part of contract review work
4.7 Provide rapid access to substitute prescribing for those prematurely leaving residential rehabilitation, where appropriate	Include as part of HRGG work plan First meeting September 2008
4.8 Ensure that relapse prevention and BBV education and vaccination forms an integral part of programmes offered by Tier 4 services	PCT & Adult Social Services Lead Commissioner for substance misuse to include in the development and monitoring of new specifications for Tier 4 services
4.9 Consider links with services for pregnant substance misusers and substance misusers who are new parents	Include as part of HRGG work plan First meeting September 2008

<b>Strategic Objective 5</b> <b>Reduce the transmission of Blood Borne Viruses (BBVs)</b>	
<b>Why are we doing this?</b>	Historically, Norfolk has demonstrated one of the lowest levels of HIV transmission amongst substance misusers (injecting and sexual transmission) in the country <sup>5</sup> . N-DAP recognises that continual work will be required to maintain and build upon this platform, including all BBVs.
<b>How will we do this?</b>	By maintaining, monitoring and where necessary, adjusting and improving existing services – and by identifying gaps in service provision.
<b>What do we hope to achieve?</b>	The lowest achievable levels of all BBV infection and transmission and the best possible management of those conditions. The safest possible working environment and practices for staff.
<b>Who will this affect?</b>	All service users adopting high-risk practices – and those individuals working in treatment and prevention services.

<b>Key action</b>	<b>Framework for delivery and timetable</b>
5.1 Ensure effective care pathways for secondary care of individuals who are blood borne virus positive from testing in primary care	Include as part of HRGG work plan First meeting September 2008
5.2 Work in partnership to develop strategy to minimise inappropriate disposal of used injecting equipment by providing widespread access to secure disposal	Task Needle Exchange and Supervised Consumption Advisory Group to address issue as part of work plan From Autumn 2008
5.3 Ensure access to BBV testing and hepatitis B immunisation: both on site protocols and monitoring and off site care pathways, referral and monitoring	DAAT to continue to monitor with service providers Ongoing part of contract review work
5.4 Ensure BBV+ve service users and/or those with liver disease have access to secondary specialist services	DAAT to continue to monitor with service providers Ongoing part of contract review work
5.5 Ensure that Hepatitis B immunisation is available to all Tier 4 services residents and inpatients	PCT & Social Services Lead Commissioner for substance misuse to include in the development and monitoring of new specifications for Tier 4 services
5.6 Ensure key actions 2.3, 2.7 and 3.10 are considered as part of this strategic objective	Include as part of HRGG work plan First meeting September 2008

<sup>5</sup> Health Protection Agency Unlinked Anonymous Survey

## Strategic Objective 6

### Reduce the incidences of overdoses and drug related deaths

<b>Why are we doing this?</b>	N-DAP is committed to saving and improving lives of substance misusers.
<b>How will we do this?</b>	By better collation of information, better understanding, shared learning, agreed changes to practice.
<b>What do we hope to achieve?</b>	Reduction in drug related deaths and substance misuse related suicides and overdoses.
<b>Who will this affect?</b>	Substance misusers engaging in services – and those not currently engaging in services.

Key action	Framework for delivery and timetable
6.1 Continue information sharing re. contamination/purity issues/acute risks	HRGG to consider need to establish communication protocol First meeting September 2008
6.2 Improve responses to drug related deaths and near fatal overdoses for all service users and in particular consider the needs of: - new service users - under 19s - 18 – 25 year olds - stimulant users - poly-drug users	Include as part of HRGG work plan First meeting September 2008
6.3 Ensure needs of carers, families and friends are addressed	N-DAP strategy will detail actions required
6.4 Refresh local protocols re. police involvement in overdose incidents requiring ambulance response	Include as part of HRGG work plan First meeting September 2008
6.5 Continue to support ambulance crews who carry and are trained to use naloxone in opiate overdose incidents	Include as part of HRGG work plan First meeting September 2008
6.6 Run information campaigns targeted on specific drug related death issues	N-DAP Information Group to include as part of their work plan From Autumn 2008
6.7 Ensure service providers/users have access to full range of DH/NTA overdose prevention materials	DAAT to continue to monitor with service providers Ongoing part of contract review work
6.8 Ensure discharge procedures include explicit warnings about the risks of overdose and that referral and care pathways into substitute prescribing are available	PCT & Adult Social Services Lead Commissioner for substance misuse to include in the development and monitoring of new specifications for Tier 4 services

<b>Strategic Objective 7</b> <b>Harm reduction in custody/Integrated Drug Treatment System</b>	
<b>Why are we doing this?</b>	Promotion of harm reduction in custody settings will help to lead to better outcomes from the treatment given to those service users in custody.
<b>How will we do this?</b>	Through working in partnership to ensure an effective Integrated Drug Treatment System operates in HMP Wayland and HMP Norwich and by the continued provision of an effective Drug Interventions Programme.
<b>What do we hope to achieve?</b>	The promotion of harm reduction interventions and a reduction in drug related deaths and substance misuse related suicides and overdoses in all custody settings.
<b>Who will this affect?</b>	Substance misusers who are in custody and those working with them.

<b>Key Action</b>	<b>Framework for delivery and timetable</b>
7.1 Ensure the promotion of harm reduction to substance misusers in custody, their carers, families and friends is undertaken in line with this strategy	Include as part of HRGG work plan First meeting September 2008
7.2 Consider the workforce development needs of those staff working in custody settings, including the prevention and management of overdose in custody (both police and prisons)	Include as part of HRGG work plan First meeting September 2008
7.3 Provide rapid access to substitute prescribing for HMP released prisoners	Appropriate N-DAP groups to support/monitor Drug Interventions Programme, treatment agencies and IDTS sites Ongoing
7.4 Ensure the effective sharing of information between prison healthcare, CARATS, Drug Interventions Programme and treatment agencies as appropriate to allow for effective treatment of those in and leaving custody	Ongoing

# Appendix 1

**Injecting behaviour:** the Health Protection Agency (HPA) report, Shooting Up: Infections among injecting drug users in the United Kingdom 2005, An update: October 2006<sup>6</sup> describes the high levels (48%) of sharing injecting equipment amongst current injecting drug users (IDUs) with mixing containers such as spoons being the most commonly shared items. In 2005, more than a quarter of IDUs reported direct needle/syringe sharing during the previous month. An increase in sharing injecting equipment has been reported from 1997 to 2003: in 2003, 33% of an anonymous sample reported that they had shared injecting equipment in the previous four weeks. Recent research (Rhodes T et al<sup>7</sup>) into drug injecting trends amongst those using heroin and crack/cocaine indicate a growing risk of bloodborne virus transmission, infections and venous damage.

**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, 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 provides 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.

The NTA second Annual Service User Satisfaction Survey (2006)<sup>8</sup> reported that 1 in 5 IDUs requested hepatitis B vaccination but did not receive it; just under 30% did not receive a general healthcare assessment; and over a third reported not receiving the overdose prevention training they felt they needed. It is vital therefore that the provision of and the opportunities to vaccinate all IDUs, be taken as appropriate and that courses are completed which means 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 - commissioners may want to discuss with their PCT Directors of Public Health the agreed locality position on vaccination provision and recommended immunisation schedules.

**Hepatitis C:** hepatitis C is the most significant infection affecting IDUs with 42% of IDUs having been infected. There is marked regional variation with a prevalence of 20% in the North East to prevalence's of 55% and 58% in London and North West respectively. The prevalence of hepatitis C infection amongst current IDUs increased from 39% in 1998 to 44% in 2005 (with approximately half being unaware of their infection). Injecting crack cocaine has an association with a higher prevalence of hepatitis C infection (67% versus 44%) and evidence shows the use and injecting of crack-cocaine is becoming more common<sup>9</sup>. 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 disease<sup>10</sup>.

---

<sup>6</sup> Health Protection Agency, 2006 Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006, London, HPA: [http://www.hpa.org.uk/infections/topics\\_az/injectingdrugusers/shooting\\_up.htm](http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm)

<sup>7</sup> Rhodes T et al (2006) Visual assessment of injecting drug use: a pilot study, London: NTA: [http://www.nta.nhs.uk/publications/documents/nta\\_visual\\_assessments\\_injecting\\_drug\\_use\\_2006\\_rb13.pdf](http://www.nta.nhs.uk/publications/documents/nta_visual_assessments_injecting_drug_use_2006_rb13.pdf)

<sup>8</sup> 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](http://www.nta.nhs.uk/publications/documents/nta_2006_survey_of_user_satisfaction_in_england.pdf)

<sup>9</sup> Health Protection Agency, 2006 Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006, London, HPA: [http://www.hpa.org.uk/infections/topics\\_az/injectingdrugusers/shooting\\_up.htm](http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm)

<sup>10</sup> Health Protection Agency, 2006 Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006, London, HPA: [http://www.hpa.org.uk/infections/topics\\_az/injectingdrugusers/shooting\\_up.htm](http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm)

**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 in 65 (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.

**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.

**Drug related overdose deaths:** evidence suggests that the recent downward trend in drug related deaths has unfortunately reversed in recent years and has begun to rise<sup>11</sup>.

**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 cocaine<sup>12</sup>. 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. The full Health Protection Agency (HPA) report, Shooting Up (HPA 2006), is available to download at:  
[http://www.hpa.org.uk/infections/topics\\_az/injectingdrugusers/shooting\\_up.htm](http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm)

---

<sup>11</sup> Office of National Statistics, 2006, Health Statistics Quarterly, Vol 29 Spring 2006, p7

<sup>12</sup> Health Protection Agency, 2006 Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006, London, HPA:  
[http://www.hpa.org.uk/infections/topics\\_az/injectingdrugusers/shooting\\_up.htm](http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm)

## Glossary

**DH.** Department of Health.

**Harm Reduction Governance Group (HRGG).** The N-DAP group which oversee the implementation of the Harm Reduction Strategy and ensure effective progress against the strategic objectives and key actions.

**Modality.** A method of treatment, for example, a prescription.

**Models of Care for treatment of adult drug misusers.** Introduced by the NTA in 2002, and updated in 2006, this set out the national framework for commissioning the treatment of adult drug misusers in England, describing best practice in drug treatment provision. The key aspects are: four-tiered model of commissioning; local screening and assessment systems; care planning and coordination of care; and integrated care pathways.

**N-DAP.** Norfolk Drug and Alcohol Partnership. One of the biggest partnerships in Norfolk, N-DAP brings together a wide range of agencies from the public, voluntary, community and private sectors with specific interests in criminal justice, drug and alcohol treatment, health, community safety, regeneration and the needs of young people in order to achieve one overarching aim - to reduce the harm caused by the misuse of drugs and alcohol in Norfolk.

**NTA.** National Treatment Agency for Substance Misuse. Created in 2001 as a special health authority to improve the availability, capacity and effectiveness of drug misuse treatment in England.

**Shared Care.** Joint management of an individual's treatment care plan as a partnership between GPs and specialist services.

**Substance Misuse Treatment Tiers.** There are four tiers of substance misuse treatment, as defined in the Models of Care for treatment of adult drug misusers:

**Tier 4a** Residential substance misuse specific services.

**Tier 4b** Highly specialist non-substance misuse specific services, for example, specialist liver disease units or specialist psychiatric units.

**Tier 3** Structured community-based specialist drug misuse services, for example, community-based detoxification services or community-based prescribing stabilisation and maintenance prescribing.

**Tier 2** Open access drug misuse services, for example, motivational interviewing/brief interventions or needle exchange (pharmacy/service/outreach).

**Tier 1** Non-substance misuse specific services, for example, personal/general medical services (primary care).

**Treatment.** The NTA define treatment in Models of Care for the treatment of adult drug misusers as: 'a range of interventions that are intended to remedy an identified drug-related problem or condition relating to a person's physical, psychological or social (including legal) wellbeing.'

If you would like this booklet in large print, audio, Braille, alternative format or in a different language please contact the DAAT on 01603 677577 and they will do their best to help.



**TACKLING  
DRUGS  
CHANGING  
LIVES**

**This logo represents all the partner agencies of N-DAP:**

Norfolk Constabulary, Norfolk's 7 Crime & Disorder Reduction Partnerships (CDRPs), Norfolk County Council, Norfolk Health, HM Prisons (Norwich & Wayland), Norfolk Probation Area, Norfolk's 8 Local Strategic Partnerships (LSPs), Norfolk Youth Offending Team, Connexions, Norfolk Healthy Schools, Norfolk's District/City/Borough Councils, Norfolk drug & alcohol treatment providers, National Treatment Agency, Government Office for the East of England (Crime & Drugs Team).

**Published by Norfolk Drug and Alcohol Partnership, July 2008**