



# **Kent Drug and Alcohol Action Team**

**and**

# **Medway Community Safety Partnership**

# **Strategy For Reducing Drug Related Deaths (RDRD) – 2004**

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## **Acknowledgement**

This document was drafted by Neil Hunt on behalf of the Kent Drug & Alcohol Action Team and Medway Community Safety Partnership.

## Introduction – The National And Local Context

### Causes Of Drug Related Deaths<sup>1</sup>

Although opiate ‘overdose’<sup>2</sup> may be the first thing the term “drug-related death” (DRD) brings to mind there are numerous ways in which drug use can cause or contribute to premature death. The Advisory Council on the Misuse of Drugs (ACMD) distinguish ‘immediate deaths’ and deaths from ‘chronic illnesses’ (2000) and this broad distinction is also used by the National Treatment Agency (NTA) who discuss ‘immediate’ and ‘longer-term’ causes.

Other than opiate overdose, immediate causes can include:

- Acute effects of stimulants such as cocaine, amphetamine and ecstasy
- The effects of volatile substances
- Acute infection
- Accidental poisoning of children
- Road traffic accidents
- Drug-related violence

Longer term causes can include:

- Blood-borne viruses, notably HIV, Hepatitis B and Hepatitis C
- Complications of concomitant alcohol use
- Smoking-related disease
- Long-term infections and injuries that impair the cardio-vascular system

These lists are by no means exhaustive but they summarise the main causes that are commonly considered at present. It is important to note that ‘causation’ can also be understood in terms of immediate causes – such as the administration of a drug on a particular occasion – and more distal causes that in some way led to the drug use. For example, violent or sexual abuse, malnutrition associated with dietary neglect, poverty and a host of other situational and socio-economic factors. In-between these one might also include poor access to treatment and other forms of health and social care.

This strategy primarily focuses on the more immediate causes but in doing so it should be borne in mind that diverse activities such as enhancing social inclusion, community development, reducing waiting times and improving the accessibility and range of effective needs-led treatments locally may all contribute to the reduction of drug-related deaths.

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<sup>1</sup> Primary alcohol and tobacco related deaths are, of course, very numerous and can also properly be regarded as drug-related deaths. An annual toll of approximately 120,000 lives for tobacco and 28-33,000 for alcohol (ACMD (2000)). However, these are outside the scope of this strategy.

<sup>2</sup> Something of a problematic concept itself (Darke and Zador 1996).

## **How Many Drug-Related Deaths Are There?**

Information that can usefully inform a local strategy such as this has a number of limitations. Deaths are coded for the Office for National Statistics (ONS) using a range of ICD 10 codes. Causes are determined by doctors or coroners and entered by the Registrar of Births and Deaths prior to collation by the ONS. Variations arise in professional judgements about the 'cause' that is recorded. Shame about drug use sometimes means that a less stigmatising cause will be preferred by the family of the deceased. The hidden nature of much drug use will sometimes mean that drug use will neither be known or apparent and therefore is not considered. Deaths associated with drug-related violence or driving are not routinely included in aggregated statistics. Conversely, drug use may conceivably be attributed as the cause when other factors are, arguably, a more immediate cause e.g. hypertrophic cardiomyopathy.

With these limitations in mind, a national target was nevertheless set for reducing drug related deaths using definitions set by the European Monitoring Centre for Drugs and Drug Addiction – an EU body with an epidemiological function of supporting the development of comparable information across the EU. This identified a baseline of 1,568 deaths within England in 1999 and a target to reduce the annual rate of deaths by 20% by March 2004. The lagged nature of mortality data means that 2004 data will not be available until 2005/6.

### **Local Mortality Data**

An analysis of local mortality data for the years 2002/3 and 2003/4 has recently been undertaken by Rebecca Francis on behalf of the DAAT. Although similar limitations apply to these data as to the national information, these nevertheless provide a useful indication of the problems within the Kent and Medway areas (see overleaf).

These show a total of 40 deaths for 2002/3 (of which 6 were within Medway) and 42 deaths during 2003/4 (of which 3 were within Medway). Several deaths refer to drugs or poisons that are not regarded as intoxicants (e.g. paracetamol, salicylate or creosote). To give a more accurate indication of deaths by substance mentioned, data with mentions of commonly misused drugs have been extracted and categorised by drug below. Some deaths record multiple substances including alcohol and therefore these are not mutually exclusive. As these reveal, the main cause of drug related deaths locally involves opiates and that alcohol is also a common factor.

**PCT of Residence \* Underlying Cause of Death \* Year Recorded Crosstabulation**

Count		Underlying Cause of Death				Total
		Mental and behavioural disorders due to drug use	Accidental poisoning by drugs, medicaments, and biological substances	Intentional self poisoning by drugs, medicaments, and biological substances - undetermined intent	Other Classification	
Year Recorded						
2002/03	"Dartford, Gravesham and Swanley PCT"	1	2	5		8
	Ashford PCT	0	2	6		8
	Canterbury and Coastal PCT	0	2	2		4
	East Kent Coastal PCT	0	2	1		3
	Medway PCT	1	2	3		6
	Non-Resident	0	1	0		1
	Shepway PCT	0	1	4		5
	South West Kent PCT	0	2	1		3
	Swale PCT	0	1	1		2
	<b>Total</b>	<b>2</b>	<b>15</b>	<b>23</b>		<b>40</b>
2003/04	"Dartford, Gravesham and Swanley PCT"	1	2	3	0	6
	Canterbury and Coastal PCT	1	4	1	0	6
	East Kent Coastal PCT	6	0	2	1	9
	Maidstone & Malling PCT	0	0	1	0	1
	Medway PCT	1	1	0	1	3
	Shepway PCT	1	0	3	1	5
	South West Kent PCT	2	1	3	1	7
	Swale PCT	1	3	1	0	5
	<b>Total</b>	<b>13</b>	<b>11</b>	<b>14</b>	<b>4</b>	<b>42</b>

**Local drug-related deaths directly involving selected intoxicants**

	Cocaine	Heroin	Ecstasy	Amphetamine	Benzodiazepines <sup>3</sup>	All opiates <sup>4</sup>	Alcohol <sup>5</sup>
2002/3	1	2	2	2	1	15	8
2003/4	0	7	1	0	2	18	4

**Considerations For Local Target Setting**

The identified problems with the validity of data on drug-related deaths, the lagged nature of the data and the way that the smaller numbers of deaths that arise locally make local, annual rates highly sensitive to small variations. This means that although close scrutiny of local patterns is important, targets concerning local rates may not be the best way of monitoring progress within the strategy. Instead, this strategy focuses on process measures and milestones that will indicate whether progress is being made and services are being developed in line with best evidence.

<sup>3</sup> Diazepam, Temazepam and Zopiclone (not technically a benzodiazepine but an allied hypnotic)

<sup>4</sup> Heroin, Morphine, Methadone, Codeine, Dihydrocodeine and 'Opiate'. Note – where 'morphine' is detected this is often present as a metabolite of heroin.

<sup>5</sup> In only one case was alcohol an isolated cause of death.

## **Current Service Provision and Planned Developments Specifically Relating to the RDRD**

As has been noted, it is important to recognise the contribution that many general treatment services make towards RDRD. Enabling timely access to treatment for people experiencing drug-related problems makes an important contribution to this strategy. Additionally, there a number of other developments that are more immediately relevant to the this strategy such as the use of campaigns to distribute specialised information, programmes to train drug users in the prevention of overdose and to enhance their response to it, or the development of ambulance protocols that help clarify local processes for responding to overdose emergencies and reduce the concerns that drug users commonly have about involving emergency services with medical crises. Some of these initiatives have been picked up directly by service providers outside of any commissioning arrangements and are not currently explicitly contracted but it is unclear how consistently or extensively this is happening.

As part of the development of this strategy lead practitioners in local services<sup>6</sup> were contacted to try to identify existing activities of this sort. This was not in any way a comprehensive survey, but nevertheless it is evident that some recently distributed materials for RDRD from the NTA appear to have been obtained by services directly and are already in use to some - rather uncertain - extent.

Beyond this, one local targeted programme has been identified - a structured training programme, based on guidance from the Department of Health, for overdose prevention and management provided by KCA to drug users and their significant others. The programme uses manikins to explain the use of CPR techniques under the instruction of qualified personnel and distributes targeted information and face shields to prevent infection during CPR. During the past year the programme has been delivered in six services and as part of all KCA day programmes. This programme is not currently commissioned within local DAAT contracts.

### ***Action 1***

***Two immediate priorities within our strategy are therefore:***

- a) to clarify the extent of the existing use of specialised resources (available at no direct cost by the NTA) and the way that they are incorporated within care pathways – with a view towards developing clearer local standards and commissioning and ensuring that they are used effectively by March 2005; and,***
- b) to review local provision of overdose prevention and management training to drug users, their carers/significant others and relevant***

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<sup>6</sup> West Kent Health and Social Care NHS trust, KCA, Kenward Trust, The Cyrenian's User Involvement project and Addaction's stimulant service in Medway.

***professionals by March 2005, and ensure that these are commissioned to produce full coverage across the DAAT area and undertaken in line with best evidence to maximise their effectiveness (Department of Health 2002).***

## **Strategic Objectives**

NTA commissioning guidance for RDRD discusses several areas for consideration when developing local work:

- Planning and commissioning
- Monitoring and review
- Consistent communication about acute risks from drugs

With reference to service specifications, it suggests several groups of items for consideration:

- Items for inclusion across all tiers
- Tier 1 – Non-substance misuse specific services
- Tier 2 – Open access drug and alcohol services
- Tier 3 – Structured community-based services
- Tier 4 – Residential services.

Beyond this, detailed guidance on minimum service specifications for each treatment modality<sup>7</sup> (some of which will be of direct relevance to this strategy) is being issued by the NTA. This is not yet fully available but, in the longer term, will be a key point of reference when developing the local RDRD strategy.

## **Action 2**

***By March 2005 the DAAT will:***

- 1 review published NTA minimum service specifications for each modality with regard to this strategy;***
- 2 incorporate them with suitable performance indicators – as appropriate - into local service specifications for 2005/6; and,***
- 3 identify any implications for services that cannot be immediately commissioned or provided.***

***As part of this activity attention will be paid to:***

- a) implications for Care Co-ordination;***

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<sup>7</sup> Information, advice and support services, Needle exchange and harm reduction, Care planned counselling, Day programmes, Community prescribing, In-patient drug (and alcohol) misuse treatment, Residential Rehabilitation

- b) through-care for people most at risk (including those recently released from prison); and,**
- c) arrangements for people discharged from treatment to ensure that discharge is not likely to increase risk to the individual.**

### **Action 3**

**As an ongoing activity, the DAAT will monitor the availability of newly published or updated minimum service specifications for each treatment modality that are relevant to this strategy in order to align local commissioning with national guidance at the earliest opportunity.**

Based on the structure of the NTA commissioning guidance for RDRD, the following sections have been adapted and developed from a preliminary review of its content to identify additional priorities for development during the year 2004/5 and in the longer term.

### **Monitoring and Review**

Co-ordination of the local RDRD strategy – RDRD will be an ongoing and evolving aspect of the national strategy and continuous function of DAATs rather than a one-off activity. It is recommended that an identified person has lead responsibility for the strategy and that this may require a sub-group of the DAAT.

### **Action 4**

**By March 2005 we will identify a lead person who will co-ordinate the local RDRD strategy.**

### **Action 5**

**By March 2005 we will agree whether the local RDRD lead should be supported by a sub-group of the DAAT and how non-substance misuse specific services can best be involved. If required, the DAAT will constitute a sub-group from across relevant disciplines and organisations to further develop the local strategy and support its future implementation.**

Liaison with local Coroners – It is recommended that Coroners are centrally involved with the RDRD strategy and appropriately involved in the DAAT and relevant sub-groups. The DAAT covers an area that includes a number of coroners' offices.

### **Action 6**

**By March 2005 we will have identified all local coroners from across the area and initiated discussion about how they can best have ongoing involvement in the RDRD strategy**

### **Action 7**

***By June 2005 will have put in place explicit arrangements for involving coroners' effectively within the RDRD strategy.***

Reviewing local drug-related deaths – It is recommended that local systems are in place for reviewing DRDs. These should include maintaining an overview of any patterns within local DRDs and learning from new cases in order to establish areas where future service delivery can be improved.

Arrangements are already in place to summarise official statistics on local DRDs. The plans to better involve coroners will enhance our capacity to interpret available statistics and its limitations and, may also lead to improvements in data quality. At present no systematic arrangements are in place to identify and review local DRDs as they occur. Closer involvement of coroners should facilitate this.

### **Action 8**

***As part of the explicit arrangements for involving coroners by June 2005, we will agree systems for the early identification of local DRDs and develop and implement a protocol to enable learning from these to inform future service delivery.***

Information systems and reporting – to an extent, aggregated local data is already collected and analysed. We need to review the quality of the available data and any refinements that are needed to its analysis in order to disseminate it and inform local stakeholders effectively about the extent and nature of DRDs.

### **Action 9**

***By March 2005 we will have agreed and implemented arrangements for an initial distribution of existing local information for 2002/3 and 2003/4 to priority local stakeholders (to include treatment providers, ambulance services and community safety partnerships).***

### **Action 10**

***By March 2006 we will have consulted key stakeholders on how to improve the way that these data are shared, identified any additional stakeholders to whom they should be routinely provided (such as key personnel in casualty departments) and have explicit arrangements for future distribution of data on DRDs.***

## **Consistent Communication About Acute Risks From Drugs**

Timely warnings about dangerous impurities and contaminants (e.g. occurrences of clostridium in heroin, ecstasy pills containing PMA which have been the subject of alerts from the European Monitoring Centre on Drugs and

Drug Addiction and, local reports of heroin containing Rohypnol) or unusually high purity drugs that are in circulation can result in clusters of deaths. The number of such alerts has increased markedly in recent years. Because of the risk of poorly co-ordinated responses and erroneous or unsubstantiated alerts being issued it is now recommended that an identified person should have responsibility for verifying and co-ordinating local responses, which require clearly communicated, credible, consistent information as well as measures to remove information from circulation when it is no longer current.

### **Action 11**

***By March 2005 we will have identified a local lead person with responsibility for managing alerts and have informed all key stakeholders of their role and how and when they should be contacted with regard to alerts.***

### **Items For Inclusion Across All Tiers**

All tiers are required to have service specifications that address:

- individual risk assessment in line with Models of Care
- provision of basic life-saving information in the event of an overdose (recovery position, dialling 999)
- provision of basic advice and information on preventing short and long term risks of death
- provision of injecting equipment where appropriate
- services that attract and reflect the needs of special groups (stimulant users, women drug users, black and minority ethnic populations and young drug users).

These activities will all be addressed through **Actions 1, 2, 3 and 12** of this strategy.

### **Tier 1 – Non-Substance Misuse Specific Services**

Non-substance misuse specific services are important partners within an effective local strategy. Each of the following services has an identified role within NTA commissioning guidance:

- Local ambulance services, police and control room staff, with whom local ambulance protocols for dealing with overdose incidents should be developed
- Primary health care providers and Primary Care Trusts
- Accident and emergency departments
- Local authorities (regarding collection and disposal of used injecting equipment)
- Police custody staff
- Mental health services.

As part of its consideration of **Action 5** the DAAT will take a view on how best to involve non-substance misuse specific services within this strategy.

Evidence suggests that ambulance protocols can increase the timely and appropriate use of emergency services by drug users. Our immediate priority is to develop local ambulance protocols for dealing with overdose incidents and communicate these to relevant stakeholders (especially local drug users) so that they are aware of the response that can be expected when calling emergency services.

### **Action 12**

***By August 2005 we will have agreed a local ambulance protocol with relevant partners for responding to overdose incidents and produce and disseminate local information about the protocol to local stakeholders including drug users, their families and carers. In doing so we will refer to nationally identified models of good practice such as Nottingham DAT.***

### **Tier 2 – Open Access Drug and Alcohol Services**

Open access drug and alcohol services (Tier 2) should provide attractive accessible services that can help drug users move towards a less risky lifestyle. NTA commissioning guidance states that Tier 2 service specifications should include the following items:

1. Risk assessments in line with Models of care (NTA 2002).
2. Training courses for drug users and their friends and families on avoiding overdose and dealing appropriately with overdose situations. See, Preventing overdose: guidance for drug action teams on providing resuscitation training for drug users (Department of Health 2002).
3. Information and advice to injectors aimed at reducing initiation to injecting and on alternatives to injecting.
4. Information on the risks of injecting drug use, and discussion of safer alternatives, to those at risk of progressing to injecting.
5. Easy access to information and advice on the risks of injecting drug use, and on how injectors can limit risks. Such information is provided in a variety of forms that are credible, easily understood and culturally appropriate.
6. Provision of basic health checks for clients of needle exchanges (opportunities for this may be limited via pharmacy needle exchange).

7. Provision of a full range of sterile injecting equipment via needle exchanges, including appropriate 'paraphernalia' to injectors. This service is widely and easily available to injecting drug users, and is provided in ways, and at times, that best suit their needs. The needs of stimulant injectors are likely to be different to those of opiate injectors. In particular, those injecting cocaine are likely to require greater amounts of equipment.
8. Provision of injecting equipment via a number of types of outlets. Sole reliance on pharmacy needle exchange means that opportunities for engagement, health promotion, education and referral of injecting drug users to other treatment services will be missed.
9. Disposal facilities for used injecting equipment that are widely and easily available to injectors in ways that best suit their needs alongside regular information campaigns to encourage responsible disposal of used injecting equipment.
10. Good links with environmental health departments for disposal of used injecting equipment found in the community, and a strategy for working with the community around such incidents.
11. Regular information campaigns on specific areas including overdose, hepatitis B vaccination and initiation into injecting.
12. Easy access to hepatitis B vaccination, using the most effective protocol(s), and all opportunities to vaccinate service users and complete the full course of vaccinations should be utilised.
13. Access to hepatitis C and HIV testing, which should be provided alongside skilled pre- and post-test counselling.
14. Clear pathways of referral to hepatitis, HIV and liver specialists.
15. The opportunity to address alcohol problems within the service and refer to specialists where necessary.
16. The opportunity to address nicotine dependence, including referral to specialist smoking cessation workers where necessary."

### **Action 13**

***We will review the commissioning of Tier 2 services by March 2005 in order to pursue an achievable, long-term programme of aligning service provisions with all 16 requirements above. Within these we have two immediate priorities that we will address in detail within contracts for 2005/6:***

- a) **Because training courses for drug users, their friends and families in line with Department of Health (2002) guidance has already been initiated spontaneously by services in part of Kent we will ensure that these are commissioned equitably and in line with Department of Health guidance across the entire Kent and Medway area.**
- b) **Delivering on many of the items requires that injecting drug users having access to specialist staff through low threshold services – notably specialist needle exchange services other than pharmacy exchange (see item 8). Consequently, within contracts for 2005/6 we will ensure that open access services are commissioned equitably to provide specialist needle exchange coverage across the entire Kent and Medway area<sup>8</sup>.**

### **Tier 3 – Structured Community-Based Services**

A substantial emphasis within the NTA's commissioning guidance for structured community-based services is on prescribing services:

Effective, evidence-based, drug treatment should be provided. A central plank of this should be well-managed methadone prescribing for those who are opiate dependent. Methadone prescribing services should have an emphasis on providing evidence-based doses of methadone, and on engaging and retaining drug users who are at high-risk in treatment. Methadone treatment is not without risk and it requires careful management to ensure that the risks of treatment are minimised. Particular care should be taken in the first weeks of methadone treatment, when the risk of overdose is highest.

Four indicators for optimal oral methadone treatment are:

1. Methadone dosage following assessment – needs to be in line with Drug misuse and dependence: guidelines on clinical management (Department of Health 2002) and sufficient to make 'topping up' unlikely.
2. Supervised consumption and monitoring for a minimum initial period in line with the Department of Health clinical guidelines and Reducing Drug-Related Deaths (ACMD 2000).
3. Good relationships with service users.
4. Access to psycho-social interventions.

All clients of services providing take-home opiate substitution treatment and particularly those with young children, should receive:

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<sup>8</sup> This is all the more importance in the light of the newly published Hepatitis C Action Plan for England (Department of Health 2004:14)

- advice on the dangers of drugs to young children
- advice on the safe storage of drugs
- their drugs in containers with child-resistant caps; and
- where possible, the provision of lockable safes or containers in which to store their drugs.”

A local audit of client satisfaction with dose completed for Kent DAAT as part of its contract monitoring requirements has identified difficulty distinguishing clients whose methadone treatment is part of a planned detoxification from those whose treatment is better regarded as opioid maintenance (Senbanjo and Hunt 2004)<sup>9</sup>. This limitation to local clinical information systems seriously impedes even the most basic monitoring of whether dosage is in line with the clinical guidelines.

#### **Action 14**

***Within contracts for 2005/6 we will require clinical information systems to distinguish more clearly those clients whose treatment is best characterised as ‘care-planned community detoxification’ from those whose treatment is better regarded as ‘care-planned opioid maintenance’. This is essential for us to be able to audit whether methadone and other substitution treatment services are being delivered optimally.***

#### **Action 15**

***Within the ‘prescribing audit’ element of the contract monitoring requirements for 2005/6 we will require treatment services to audit prescribing treatment with reference to the four indicators of optimal oral methadone treatment specified and the four bulleted points (above) relating to take-home opiate substitution treatment.***

With regard to Tier 3 service specifications more generally the NTA commissioning guidance states:

Tier 3 service specifications should also include the following items:

1. Adequate provision for stimulant users. Many existing tier 3 drug treatment services are seen as opiate-based and are often seen as particularly unresponsive to the needs of cocaine users and are therefore not approached for help. The needs of different geographical areas vary, but adequate provision of services may require the setting up of stimulant-specific services alongside existing services. For more information see *Research into practice No. 1b commissioning cocaine/crack dependence* (NTA 2002).

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<sup>9</sup> KCA Prescribing Audit, Senbanjo R and Hunt N. June 2004

2. Waiting times for drug treatment that are within, or better than, those indicated in the NTA guidelines and targets (see, *Making the system work, guidance on managing and reducing waiting times for specialist drug treatment services in England*, NTA 2002).
3. All clients receiving structured treatment should have individual care plans that address the risks of drug-related harm to themselves and others.
4. Drug treatment services have a shared and coherent strategy with mental health services on the management of people with mental ill health (including low level anxiety and depression) and substance use co-morbidity.
5. Resourcing, co-ordination and inter-agency collaboration across all parts of the criminal justice system/drug treatment system, to best ensure that offenders moving through the system (via Arrest referral schemes, Drug Treatment and Testing Orders and prison-based drug treatment) through to release and afterwards receive timely and appropriate treatment. This will make best use of access to offenders to achieve maximum treatment gains.
6. Arrest referral schemes engage offenders at risk and provide appropriate harm reduction interventions, referral for treatment and the provision of low threshold treatment interventions (*Models of care* – tier 2) including the development of an initial care plan, case management and motivational engagement. It is inevitable that there will sometimes be delays in access to specialist tier 3 services and it is essential that, during this period, work is undertaken to develop and sustain offenders, motivation and prepare them for specialist treatment.
7. Drug treatment services in prison establishments have:
  - release procedures that include realistic discussion of the dangers of returning quickly to former levels of drug misuse, particularly that of overdose;
  - meaningful arrangements for aftercare following release – there is currently some ad hoc, but no comprehensive, aftercare provision for drug misusers returning to the community from custody – (many are very vulnerable, particularly those serving sentences of less than 12 months as they are not subject to statutory supervision); and,
  - mechanisms for rapid referral into substitute-prescribing programmes where appropriate.

8. To prevent diversion of prescribed drugs, measures such as supervised consumption are in place where appropriate, for a minimum initial period, in line with *Drug misuse and dependence: guidelines on clinical management* (Department of Health 2002).
9. Measures are in place to limit the prescribing of benzodiazepines and specific protocols are developed on the prescribing of benzodiazepines within prescribing services including shared care schemes.
10. Services are available for safe benzodiazepine detoxification, including as an in-patient where necessary, because of the possible adverse effects of detoxification, including seizures.
11. Opportunities to address issues relating to alcohol use among drug users are utilized effectively and workers have the necessary skills to do this. All alcohol use to be discussed.
12. Blood testing for hepatitis and HIV status is actively promoted and easily available to those who perceive themselves to be at risk.
13. Hepatitis B vaccination using the most effective protocol(s) is widely promoted, easily available and all opportunities are utilised to vaccinate current injectors, those at risk of becoming injectors and their close household contacts. Hepatitis B infection is a co-factor for progression of hepatitis C disease. Reduction in the incidence of hepatitis B should reduce the numbers of people with hepatitis C progressing to serious liver disease. All drug action teams have arrangements in place to ensure provision of hepatitis B immunization programmes for injecting drug users (Hepatitis C Strategy for England, Department of Health, 2002)."

#### **Action 16**

***We will review the commissioning of Tier 3 services by March 2005 in order to pursue an achievable, long-term programme of aligning service provisions with all 13 requirements above. Within these we have three immediate priorities that we will address in detail within contracts for 2005/6:***

- a) **ensuring that release procedures from prison, aftercare arrangements and facilities for rapid referral into substitute prescribing programmes are available in line with item 7 above due to evidence of the disproportionate risk of overdose in the post-release period**

- b) ensuring that testing for hepatitis and HIV testing is easily available and systematically promoted within local care pathways across Tier 2, 3 and 4 services and that there are corresponding systems for monitoring its promotion and uptake (item 12)<sup>10</sup>
- c) Ensuring that hepatitis B immunisation is easily available and systematically promoted within local care pathways across Tier 2, 3 and 4 services and that there are corresponding systems for monitoring its promotion and uptake (item 13).

#### **Tier 4 – Residential Detoxification and Rehabilitation Services**

Although people who are referred to residential detoxification and rehabilitation programmes are often attempting to become drug free, the evidence is clear that many people do not achieve this. Consequently, it is important to include provisions for the large number of people who lapse in their use of one or more drugs. Commissioning guidance recommends that programmes include the following elements:

- Programmes for drug users that tackle excessive alcohol misuse
- Hepatitis B vaccination programmes
  
- Discharge procedures that include realistic discussion of the dangers of returning quickly to former levels of drug use
  
- Overdose training that focuses on the causes of overdose, signs and symptoms of overdose and on how to respond effectively to an overdose incident
  
- Robust and meaningful arrangements for aftercare
  
- Mechanisms for rapid referral into substitute-prescribing programmes
  
- Specialist hepatitis and HIV treatment available to all those who require it.

#### **Action 17**

***We will review our commissioning of Tier 4 services by March 2004 in order to pursue an achievable, long-term programme of aligning service provisions with all of the requirements for residential detoxification and rehabilitation services.***

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<sup>10</sup> This is all the more importance in the light of the newly published Hepatitis C Action Plan for England (Department of Health 2004:11)

***Summary of References, Key Documents and Resources that Inform and Support this Strategy***

Commissioning services to reduce drug-related deaths. National Treatment Agency. 2004. Resource pack for Commissioners. Briefing 11.2.

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