

Outreaching Substance Misusers



A guide for all professionals working
within an outreach setting





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A guide for all professionals working within an outreach setting

Introduction

In 2007 the Norfolk Drug and Alcohol Partnership (N-DAP) Housing Group published guidance for providers of supported accommodation who house people using substances. Through the process of launching and training around that guide we were made aware that there was demand for a companion guide with a community focus. The aim of this new guide is to provide useful best practice information for people whose professional roles include visiting substance users in their own accommodation.

Context and Purpose

The Norfolk Drug and Alcohol Partnership recognises the need to support agencies in providing effective outreach to people in the community who misuse substances.

Legislation relating to the provision of outreach support to substance misusers can be complex.

Whereas a landlord's responsibilities in working with drug users falls under Section 8 of the Misuse of Drugs Act 1971, there is no similar piece of legislation directing the policies and guidelines for working in outreach settings.

This guide has been prepared for commissioners and providers of outreach services including:

- Floating support services
- Community mental health staff
- Probation officers
- Substance use services working in outreach settings
- Home support services
- District nurses

In using this guide it is important to be clear whether the responsibilities of the agency fall under the auspices of Section 8 of the Misuse of Drugs Act 1971 as 'concerned in the management' or as the provider of support to a tenancy.

For example a housing officer representing the landlord would be deemed 'concerned in the management' when visiting a substance misuser in their own tenancy, whereas a floating support worker linked to another agency may not.

Assessing where the responsibilities of each specific agency lie would form part of that agency's response to implementing this guide. As a general rule:

- Where the agency is 'concerned in the management' their responsibilities would be covered under the 'Spectrum of Possibility' guide.

- Outreach workers who are not directly concerned in the management should match their response in accordance with the guidelines contained within this document.

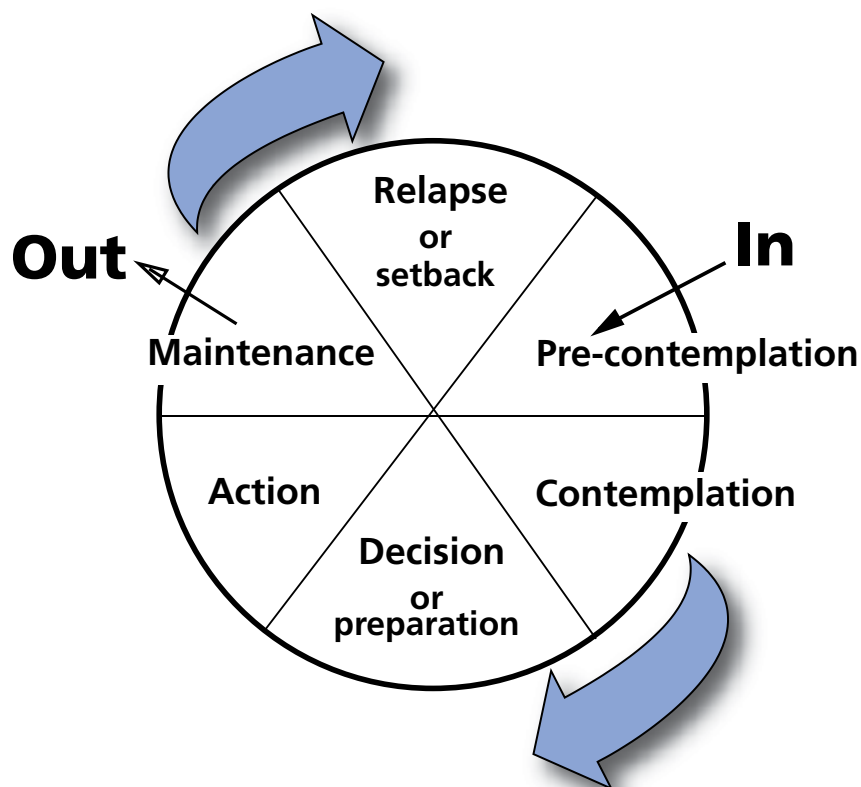
This document is aimed at a broad range of professionals involved in outreach support and would include tenancy support workers, homelessness/ substance use services, nursing/ social work staff etc.

For the purpose of the guide, a definition of someone who has problems with drugs/ alcohol is taken as:

'Any person who experiences or causes social, psychological, physical or legal problems relating to their self-administration of drugs and/or alcohol'

The Cycle Of Change

The Cycle of Change model, developed by Prochaska and DiClemente, takes into account the fact that people with drug/ alcohol problems go through specific stages of change. These stages must be understood in order for support to be appropriate. People do not always go through these stages smoothly and can shift rapidly from one to another. Many people go through them several times.



If someone has not thought about changing, the support emphasis has to be around harm reduction and perhaps building trust. Interventions are likely to be brief and focussed on practical tasks such as finding/ maintaining housing rather than interventions around substance misuse.

Contemplators –Those ambivalent about change

Work for someone contemplating change focuses on weighing up the pros and cons of changing. Workers will promote choices and possibilities without suggesting plans.

In Decision – Those preparing to change

Work will focus on establishing goals, remaining realistic and identifying pitfalls.

In Action - Those making a change

Work is varied during this stage. Clear advice can be offered, referrals made and progress monitored. Workers remain positive and encouraging.

In Maintenance – Those having made a change

In this stage, work is focused on relapse prevention and establishing wider support networks. Feedback about achievement is important.

In Relapse – Those who have had a setback

In relapse there must be a rapid response and reaffirming support/ achievements. Workers remain positive and assess whether the person can return to maintenance rapidly or whether they are going through the cycle again.

The right intervention at the right stage is crucial. If someone is in 'pre-contemplation', trying to make plans to change behaviour is a waste of time and can ultimately be detrimental. If someone in 'decision stage' is not given options they could easily fall back into 'contemplation stage'.

Prochaska J, DiClemente CC. The transtheoretical approach: crossing traditional boundaries of therapy. Homewood Illinois: Dow Jones-Irwin, 1984

Responding to substance users within an outreach setting

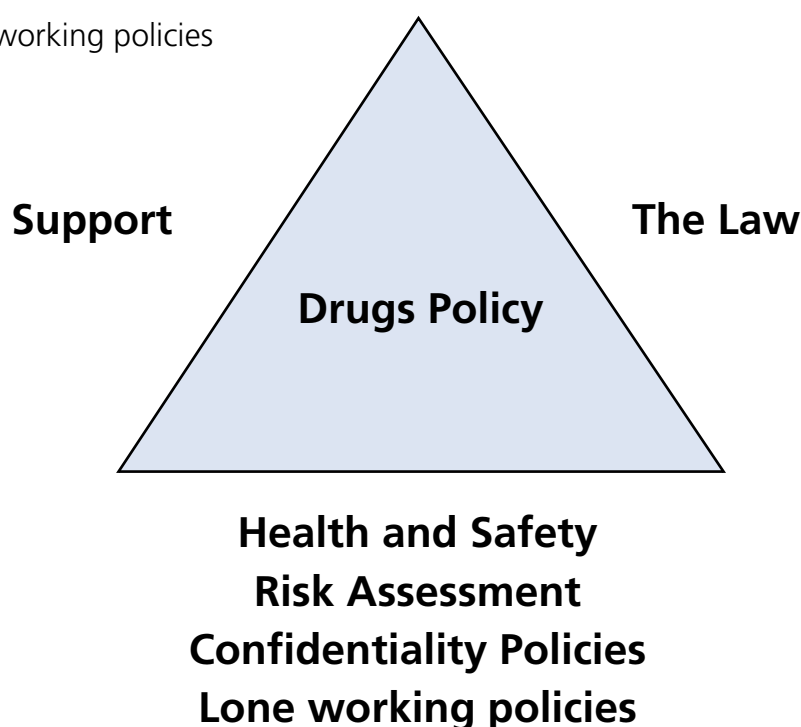
Introduction

Essentially the role of an outreach worker is dependent on the maintenance of engagement with an individual. For the relationship to develop positively it is necessary to build trust with a client and this would be severely compromised if there was an expectation that outreach workers were required to notify landlords/ police etc. as routine where there was evidence of substance misuse-related activity.

Where Section 8 of the Misuse of Drugs Act 1971 details the legal responsibilities of landlords in responding to drug use on site, outreach services are not similarly covered.

In the absence of any clear legal obligations under the Misuse of Drugs Act 1971 regarding outreach, professionals working within an outreach setting need to be mindful of an array of other policies that will impact on how they respond to drug use, including:

- Health and Safety
- Confidentiality
- Risk assessment
- Lone working policies

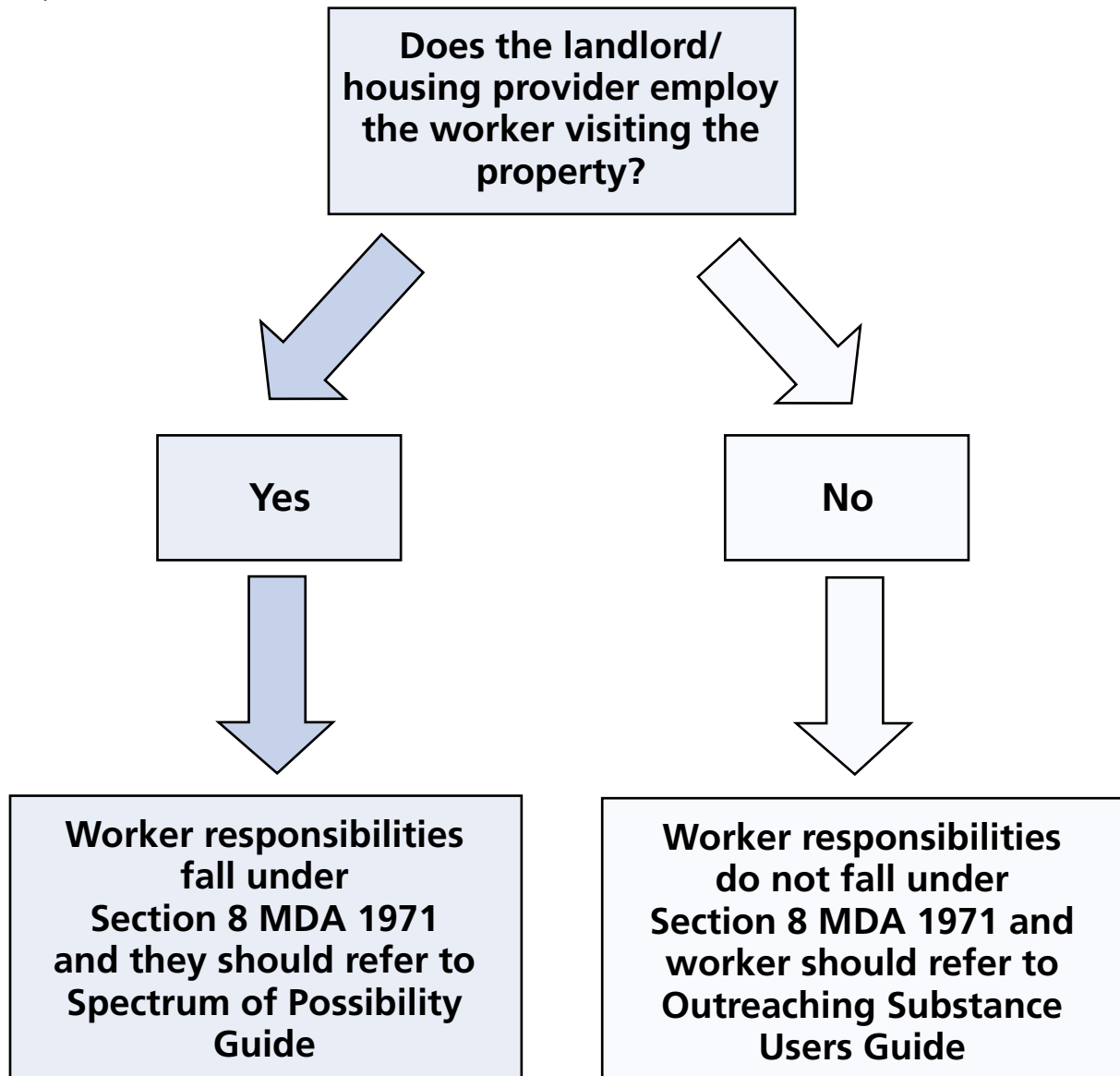


In assessing any response to evidence of drug use/ supply from an outreach perspective, agencies will need to consider how closely linked their role is to the management of that premises.

Which guide?

Introduction

In responding to the housing needs of drug users from an outreach perspective it is essential to be clear which of the two Norfolk Drug and Alcohol Partnership Guides is required.



This drug policy guidance does not replace the requirement for agencies to develop their own policies that meet their particular needs; rather this document should be used as a discussion tool for developing those policies. Whilst this guide makes suggestions about appropriate responses, it should not be seen as a definitive guide.

This Guidance is for outreach projects, for example community mental health/ substance use services, home carer services and voluntary sector outreach teams. For supported accommodation projects, please refer to the 'Spectrum of Possibility' guide.

Developing an outreach policy for working with people who use substances

A policy should be developed in consultation. This could be with staff, service users, police and other stakeholders. This approach helps to ensure the policy is usable and legal. Support to do this may be required (the Norfolk Drug and Alcohol Action Team (DAAT) can help facilitate this).

Purpose

The purpose of having an outreach policy is to ensure that clients receive effective and consistent support. In addition, the service provider has a duty to ensure the health and safety of clients, volunteers and staff members and has an obligation to follow good practice and work within the law. Working within an outreach setting can present complex and challenging legal and ethical dilemmas. Having an outreach policy enables organisations to establish a balance between health and safety, confidentiality, risk management and legal obligations.

An outreach policy needs to acknowledge the ethical dimension inherent in this type of work. An outreach or visiting worker is seeing somebody in the client's own home. The home is a personal space, which embodies the privacy and the life choices of the individual living in it. An effective policy needs to strike a balance between respect for that individual's lifestyle and the safety of the worker who is visiting.

Using the policy

Organisations should ensure that staff members adhere to the outreach policy and guidelines for services that visit people in their own homes. Training and supervision need to be made available to ensure that staff members are clear about all aspects of the policy and guidelines.

Alongside specific training on policy, staff should receive appropriate levels of training on drugs/ alcohol to enable them to work with this client group effectively.

This could include induction, in-house training, outsourced specialist training (this can be sourced through Norfolk DAAT) as well as regular supervision. Locum/ agency/ temporary/ volunteer staff will need an appropriate level of understanding of, and access to, the policy.

What Drugs?

Under the Misuse of Drugs Act 1971 controlled drugs include those that are illegal unless prescribed, such as benzodiazepines and methadone, alongside substances such as heroin, cannabis and crack cocaine. Consideration should be given to legal substances including alcohol and tobacco. There is also an increasing number of 'legal highs', which are not covered under existing legislation and which can be purchased freely from 'head shops'. These would include products such as 'snow blow', 'Neuro Blast' and other herbal preparations. Organisations need to be mindful that such

products can enter classification at a later date, so it is essential to monitor ongoing changes in drugs legislation.

With regards to outreach work, consideration should be given to the effects of particular substances on the individual from the perspective of health & safety and risk management.

For a comprehensive list of substances and classifications under the Misuse of Drugs Act 1971, please visit Kevin Flemen's website, www.ixion.demon.co.uk and follow the link through the Drugs Fact section to the **'DRUG CLASS AND SCHEDULE checker'**

The premises

As detailed previously in this document, organisations will be required to establish their relationship to the tenancy in clarifying an appropriate response.

Where outreach workers/ home visiting staff are operating from an office base and receive client visits to the office on occasion, the office site would fall under the legal responsibilities of Section 8 of the Misuse of Drugs Act 1971. In such instances where there was evidence of drug use or supply taking place the organisation would need to make a response along the lines of the 'Spectrum of Possibility' guide.

Staff Conduct

Outreach services should consider developing their policies to cover their workforce. These should include standards of behaviour and responding to suspicions of drug use amongst workers. Central to the development of effective outreach work is the ethos underpinning the service and the policy should reflect a philosophy of equal opportunities and diversity.

The policy should highlight the organisations aim to support staff members experiencing difficulties in relation to drugs/ alcohol, however this must be carefully balanced with the need to provide an effective service to an often vulnerable client group.

The policy should ensure that staff conduct should include an avoidance of stigmatising language such as 'alcoholic' or 'junkie' and recognition that each individual has the capacity to make positive changes in their lives.

Drugs Policy Guidance

Guidance 1. Sharing of information

Any passing on of information by professionals to a Housing Provider/ Police relating to the substance use activities of a tenant, would constitute a breach of confidentiality unless the client was fully aware and in agreement that such action was taking place.

Professionals should consider taking such action only where it would ordinarily be necessary to breach confidentiality, i.e. serious risk related issues, child safety etc., and not as a matter of routine. Clients should be made aware of the organisations confidentiality policy and instances where staff may be required to pass on information.

Clearly, there will be times when outreach staff members are required to cooperate with the police and there will be a legal obligation to do so.

Norfolk Drug and Alcohol Partnership fosters positive relationships with the police and work collaboratively on a wide range of projects. In developing an outreach drugs policy, organisations are advised to link in with N-DAP Drug Availability Liaison Officer, Richard Price, tel: **01953 424018** or email: **priceR@norfolk.pnn.police.uk**

If there are known behavioural risks associated with a client's substance use, there is a potential need to pass on information. This would have to be judged on the severity and the likelihood of an incident taking place and based upon the knowledge of each individual client.

Case example:

Stephen's use of crack cocaine and cannabis has had a detrimental effect on his mental health in the past. When unwell, Stephen presents as a significant risk to staff members and the risk assessment advises against lone worker visits. Staff working with Stephen would be required to advise other professionals against lone worker visits if there was evidence of increased risk.

Clearly the amount of detail in the sharing of information should be assessed carefully. In the above example, the issue is more about the effects and associated behaviour, rather than the substance use per se, and it may be that it is more appropriate to advise colleagues that joint visits are essential due to risk, rather than going into the specifics of the client's substance use.

Guidance 2. Environment

When providing outreach support, consideration should be given to the environment visited by staff. This will largely fall under the remit of health and safety and risk assessment / management and include the well being of both staff and clients. Specific risk issues would include risk from sharps, particularly where drug use is chaotic and sharps may be lying about. Staff providing support to maintain a tenancy, assist with moves or other domestic tasks should pay particular attention to such risks and ensure that they use suitable protective clothing. Where the assessment or other

evidence/knowledge suggests that the residential premises being visited is being used for injecting, visiting staff should check with the occupant about the possible risk of sharps lying about.

In environments where active intravenous drug use takes place, staff should be mindful of the possibility of discarded sharps on seating etc.

Clients should be encouraged to access sharp bins, tongs etc., for the safe storage and disposal of needles and other hazardous items.

Organisations developing outreach policies should consider the availability of information and training resources to prevent the spread of infections and the management of needle stick injuries.

A suggested procedure for needle stick injury (KFx 2006)

- Remove needle and retain it somewhere safe
- Squeeze the injury to encourage bleeding for a few minutes, and place under cold running water (do not suck the injury site)
- Wash and clean the site with iodine or cold running water if iodine is not available
- Dry and apply a plaster or other dressing
- Those not vaccinated against Hepatitis B should report to a local A&E department for vaccination within 48hrs
- A senior worker should be informed and an entry made into the accident book
- Support and counselling should be made available to the injured person
- Assessment for prophylaxis treatment should be made rapidly (where a protocol with hospital/ health centre exists)

Organisations should consider offering vaccinations to staff against infectious diseases, for example Hepatitis, in accordance with their health and safety policy.

Guidance 3. Witnessing substance use

Under the Misuse of Drugs Act, 1971, there is no suggestion that an outreach worker would be committing an offence whilst remaining at the property if a service user is using non-prescribed controlled substances in their own tenancy.

Whilst the law makes it possible for a worker to remain in the presence of a service user who is actively using non-prescribed controlled substances, organisations would need to consider the rationale for why a professional would need to remain in the presence of someone using.

For the majority of professionals providing outreach support it would be inappropriate and unprofessional to remain in the presence of someone who was using. The issue is therefore one of organisational policy rather than legislation. Setting clear professional boundaries around the therapeutic relationship is an essential aspect of providing support to people who use substances.

It could be argued that nursing staff might provide useful harm reduction work within the context of some aspects of supervised consumption, however this remains a grey area and strict protocols involving the police would need to be developed and closely adhered to. Provision of supervised consumption rooms is currently unlawful in the UK and therefore staff remaining present whilst a client is actively using is arguably verging on similarly unclear territory.

Good practice dictates that for the vast majority of instances, a visiting worker should not remain present whilst someone is actively using in their presence. Organisations are advised to set clear boundaries in relation to this. Good practice is to discontinue a visit where an individual is actively using, arranging a more appropriate time to return when the service users can commit to not using. This helps to establish a clear, professional relationship between worker and service user.

Staff members visiting should be aware that whilst cannabis is amongst the more commonly used substances, it remains a controlled substance, and therefore they should encourage the service user to discontinue their use for the duration of the visit, or else arrange an alternative appointment.

Organisations will need to consider the training needs of their staff in relation to working with substance users, including provision of training around the effects of substances, the impact on mental health, health and safety, and risk management.

Guidance 4. Evidence of Production/ Supply - General

As stated in the **Context and Purpose** section of this document, professionals need to assess their relationship to the housing provider in responding to issues around production and supply. If professionals are directly linked to the housing provider, for example a tenancy support officer employed by the landlord, then their responsibilities would fall under Section 8 of the Misuse of Drugs Act 1971. In such cases, staff should refer to the 'Spectrum of Possibility' guide.

Where an outreach worker is not directly concerned in the management of the property and discovers that production and/or supply is taking place at a client's tenancy, the staff member would need to assess the scale, extent and the impact that it is likely to have on others.

Staff would need to consider their risk assessment/management, health and safety and confidentiality policies in making a response.

Clearly there is a spectrum of production and supply from a client offering prescription benzodiazepines to a visiting friend, through to larger scale production and supply of crack cocaine. It would be disproportionate to provide the same response to all scenarios.

For specific advice relating to larger scale production and supply, please refer to **Guidance 6** of this document.

In all cases of production and supply, it is essential that staff keep a clear record of any response made and the follow up action undertaken. Whilst staff may not be directly concerned in the management of the property under Section 8 of the Misuse of Drugs Act 1971, it is good practice to remind clients of their responsibilities as a tenant and that any production or supply of controlled substances could ultimately lead to eviction for a breach of the tenancy conditions and prosecution.

Case example:

Simon has been supported by your service for a number of years. More recently the level of dealing taking place from his tenancy has increased significantly and there has been a significant rise in associated nuisance from the property with increased neighbour complaints. From your contact with Simon, it is evident that he has a number of people staying with him and dealing from the flat.

Realistically, there is a considerable likelihood that other agencies would be aware about the issues surrounding Simon's tenancy. On the grounds of health and safety it is necessary to advise other professionals who would be likely to visit Simon that there are associated risk issues with the property. Other agencies would, therefore, be in the position to develop their own risk management plans in respect of their contact with Simon.

Whilst the police are likely to be aware of the situation, it would legally fall to the housing provider to notify them in accordance with Section 8 of the Misuse of Drugs Act.

Guidance 5. Storage/ handling of controlled substances

There may be occasions within an outreach setting whereby staff members are asked to take possession of a controlled substance, for example methadone, benzodiazepines etc.

Clearly there are occasions when this falls under the remit of a service users support package, for example, a period of support where a member of staff is collecting a service user's methadone from the pharmacy on their behalf. On such occasions staff need to be aware that they are coming into possession of a substance that is controlled by law and that they should make every reasonable effort to pass the substance on to the rightful owner as soon as possible. It is good practice to ensure that such plans are documented clearly.

Other occasions may occur, for example where a service user asks a member of staff to look after prescribed medication, particularly where a service user may be vulnerable to exploitation.

As a general rule, staff members should only take a controlled substance into their possession in order to pass it on to the rightful owner within a reasonable timescale.

Therefore, holding on to a service user's prescribed, controlled medication could be construed as unlawful.

Exceptions to this may fall under nursing guidelines and therefore it is essential that nursing professionals who are working within an outreach setting are clear as to the relevant clinical guidelines governing their practice.

In the event that staff are required to hold on to a controlled substance for longer than intended, (for example a service user does not respond when the worker visits to drop off their medication), then safe, locked, storage will need to be provided and a clear record should be made. Staff would be required to return the substance to either the client or the pharmacy at the earliest opportunity. Storing a controlled substance without any clear timescale for returning it to the person to whom it is prescribed, or the pharmacy from which it was dispensed, would constitute a breach of the law.

Case example:

Maggie is a vulnerable lady with a history of mental illness and substance use who lives by herself in the community. Over the years, Maggie has been the victim of exploitation by some of her neighbours and Adult Protection has been involved intermittently. Recently Maggie has described people knocking on her door asking her for money and pestering her for her prescription benzodiazepines.

Maggie asks if it would be possible for staff to look after her medication at the outreach team's office.

As benzodiazepines are classified as a controlled drug under the Misuse Of Drugs Act 1971, a staff member would be breaking the law by taking Maggie's medication into their possession, particularly in the absence of any clear timescale within which they would be returned to the person for whom they are prescribed.

For additional information on storage of controlled substances, the document 'On Storage' (Kfx) is a very useful reference www.ixion.demon.co.uk.

Guidance 6. Intoxication / Anti Social Behaviour

Staff should refer to their service guidelines and policies in responding to incidents of aggressive or abusive behaviour. Training should be made available and staff should be prepared to contact the police if behaviour becomes serious.

Working with someone whilst they are under the influence of substances is an issue for organisations to consider from the perspective of good practice, health and safety and risk management. Negotiating suitable times to meet up with a client is part of the ongoing development of a therapeutic relationship. Again, this should form part of the ongoing assessment by the worker.

Equally, a visiting worker may arrive for an appointment with an individual to find they have visitors who are intoxicated and/or who may be using controlled substances on the premises. An outreach substance policy should address how the worker should respond

to substance use, intoxication and any threats to personal safety by visitors in the course of a planned visit.

On a subsequent visit, a worker could take the opportunity to raise with the individual any risks to their tenancy that arise through allowing visitors to use on the premises, and negotiate times to visit when the client is less likely to have other visitors.

Alongside the visiting clients who use controlled substances, organisations will need to consider responding to clients who regularly use legal substances including alcohol, legal highs and tobacco. Whilst good practice dictates that staff should not be present whilst a client is intoxicated organisations will need to consider where there may be exceptions to this rule, for example, a client requires medical assistance. Organisations will also need to consider their response to clients who smoke whilst a visit from a member of their staff is taking place.

Where a client is intoxicated and is planning to take charge of a vehicle, staff are required to advise the client that they would be breaking the law by driving whilst under the influence of substances. In the event that the client insists on driving, then staff are required to contact the police. Clients should be made aware that this is organisational policy. There may be occasions where it is not clear that someone is intoxicated and staff can only be expected to use reasonable judgement in such instances.

Guidance 7. Larger scale production and supply

There may be instances where staff are visiting clients who are either involved in larger scale production and supply, or else are vulnerable to exploitation in such circumstances, for example their tenancy has been taken over by dealers.

In such instances, a multi agency approach is required, involving housing departments, police and any other agencies involved in the care and support of the client. Through a multi agency approach, the vulnerability of the client can be ascertained and the most appropriate course of action followed.

Kensington & Chelsea have developed a document entitled 'Protocols for Disrupting Class A drug production, use or supply',

www.rbkc.gov.uk/yourcouncil/communitysafety/cs_asbo_protocols_low2.pdf

This guide offers definitions for vulnerable and non-vulnerable tenants and an appropriate multi-agency response, allowing for the vulnerable tenant to receive temporary accommodation and treatment.

Whilst Norfolk does not currently have a protocol of this nature in operation, the principles of Kensington and Chelsea's protocol offer a useful guide for when professionals are considering an effective strategy in managing incidents of larger scale production and supply.

With regards to providing outreach support to a client living in such circumstances, staff are advised to consider Health and Safety and Risk Assessment/ Management procedures and take necessary precautions.

Case example:

Bridie has been a client of your service for over a year. She has a diagnosis of schizophrenia and uses heroin on and off to manage her symptoms. Bridie experiences difficulty in engaging with services and often feels isolated from the community. Over the last six months, Bridie has started to use crack cocaine and this has resulted in a deterioration of her mental health. Recently, there have been numerous complaints from neighbours about people visiting her flat and there are reports that she has a number of people staying with her. The housing officer has been contacted by the police advising that there is supply of Class A substances taking place from the premises.

As an agency offering tenancy support to Bridie and assistance with her ongoing mental health problems it is important to advocate for her potential vulnerability in this scenario and call for a multi agency meeting to ascertain an appropriate way forward to enable Bridie to receive treatment and alternative accommodation to prevent her becoming homeless.

Resources

Ethos

In developing drugs policies it is important to be clear on the ethos underpinning the role of your organisation in meeting the needs of substance users.

As detailed previously, the Cycle of Change Model serves as an excellent tool for gauging the approach of staff members in matching the needs of the individual service user. In addition, the model carries the recognition that each stage of change is a 'normal' part of the process, including relapse. Inherent in the model is the message of hope, that relapse does not need to be viewed as failure, rather it is part of the learning experience that can be used to avoid future relapse.

Alongside the Cycle Of Change Model, organisations developing their own substance use policies may wish to consider the principles of harm reduction/ minimisation as described by Patt Denning.

Harm Reduction

Basic Principles

- There is a spectrum of drug use from non-problematic to extremely problematic with a continuum of harms as well
- Harm Reduction does not debate the view that drug use is pathological – in other words that drug users are psychologically different from others.

Treatment

- Harm-Reduction is about accepting the person at the stage they are at
- Focus on reducing the harm caused by drug use not the drug use per se
- Clients can establish their own goals – they are not set by the professional and do not necessarily have to be abstinence based. Safer drug use is an option
- Harm Reduction recognises the right of the individual
- Harm Reduction recognises the cultural, religious and ethnic differences
- Harm Reduction can incorporate advice and interventions from staff
- Harm Reduction is research based
- Harm Reduction recognises that there may be other issues in a person's life, which they view as more urgent and problematic than their drug use.

Practicing Harm Reduction Psychotherapy An Alternative Approach to Addiction,
Patt Denning, The Guildford Press, 2000

The provision of stable and appropriate housing is in itself a cornerstone in the reduction of harm. Effective housing is likely to promote positive and successful engagement of people who use substances problematically with treatment providers. The harm reduction approach is particularly well suited to workers who are not substance misuse specialists but who offer visiting support to people who use substances. Non-clinical interventions, which include healthy eating, basic nutrition, encouragement to address basic health issues, budgeting, goal setting and encouragement to use needle exchange, alongside support to engage in alternative lifestyles, such as sport, can all form part of a harm reduction approach.

Potential Reading resources

Carlo DiClemente and Carl W Scott: "Stages of Change: Interactions with Treatment Compliance and Involvement" (1994) at

[http://www.nida.nih.gov/pdf/monographs/monograph165/131-156 DiClemente.Pdf](http://www.nida.nih.gov/pdf/monographs/monograph165/131-156%20DiClemente.Pdf)

J.O. Prochaska and C.C. DiClemente: "Toward a comprehensive model of change" in W. Miller and N. Heather (Editors): "Treating Addictive behaviours: processes of change" (1986)

D.L. Thombs; "Introduction to Addictive Behaviours" (1999); Guilford Press

Training

As described previously in this document staff working with substance users should be provided with appropriate levels of training including,

- Risk assessment/ risk management
- Lone working
- Health and safety, (including information regarding infectious diseases such as hepatitis, and needlestick injuries)

This should be accompanied by more specific training to include,

- Basic drug awareness
- Responding to overdose
- Motivational Interviewing
- Harm reduction/ harm minimisation

Information about courses is available through the Drug and Alcohol Action Team training department:

Telephone: 01603 677577

Email: michael.hutchinson.dat@norfolk.gov.uk

Relevant Legislation:

The Misuse of Drugs Act (1971)

The Misuse of Drugs Regulations (1985)

The Intoxicating Substances (Supply) Act (1985)

The Medicines Act (1968)

The Crime and Disorder Act (1998)

The Anti Social Behaviour Act (2003)

The Drugs Act (2005)

The Care Standards Act (200)

Human Rights Act (2010)

Useful websites:

The following websites are popular with professionals in the substance use field or offer examples of harm reduction approaches to working with drug users.

Kfx: www.ixion.demon.co.uk - KFx seeks to balance a large amount of common sense with up-to-date harm reduction and drug policy information

DanceSafe: www.dancesafe.org - An American based harm reduction organisation promoting health and safety within the rave and nightclub community

The International Harm Reduction Association: www.ihra.net

Release: www.release.org.uk

Alcohol Concern: www.alcoholconcern.org.uk

UK Harm Reduction Alliance www.ukhra.org

N-DAP – Norfolk Drug and Alcohol Partnership - www.nordat.org.uk

National Treatment Agency – www.nta.nhs.uk

Some of the above websites offer examples of approaches to working with drug users, however they do not necessarily reflect the approaches adopted in the UK or advocated by the N-DAP. They are included in this document for illustrative purposes only.



If you would like this booklet in large print, audio, Braille, alternative format or in a different language, please contact the DAAT on 01603 677561 who will do their best to help.



This document was written for the Norfolk Drug and Alcohol Partnership by Ben Curran, of Julian Housing Support, with support and advice from the Partnership's Housing Strategy Group.

Thanks Ben.

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www.nordat.org

**TACKLING
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