"Pilot sites trained the carers and relations of opiate misusers to respond to overdoses and use the antidote naloxone. This appears to have helped save lives..."

THE NTA OVERDOSE AND NALOXONE TRAINING PROGRAMME FOR FAMILIES AND CARERS

APPENDICES

NHS
National Treatment Agency
for Substance Misuse

APPENDIX 1
AIMS AND METHODOLOGY

Aims
1) To show the benefits of training carers to respond to overdoses, and to administer naloxone
2) To provide a set of practice recommendations for any local area wanting to run its own training programme

Methodology – programme
Research has shown that most overdoses are witnessed, and that the first people on the scene are often family members, partners and other carers[1]. A cross-section survey of families of drug users in England found that just under a quarter had dealt with a potentially fatal opiate overdose. It also revealed that 88% of family members want to learn how to respond to an overdose[2].

The programme did not focus on the efficacy of giving naloxone as a treatment intervention to drug users who have overdosed. The pilots aimed to demonstrate how training family members to respond to overdoses, including using naloxone, can be implemented locally.

The pilot scheme took its definition of families and carers from the NTA document *Supporting and Involving Carers: a Guide for Commissioners and Providers* (2008): "[A] family member is defined as any adult person who is significant in the life of the drug user, irrespective of his or her biological, social or legal status. A carer is defined as anyone who cares for or offers support on a regular and personal basis to an individual, whether or not he or she has formal carer responsibilities and status."

The NTA called for expressions of interest for its naloxone training programme in January 2009. It received 50 replies from a range of treatment providers, and family and carer organisations. From this group, 34 bidders were chosen via an initial sifting exercise by a panel made up of members of the NTA and DH. They were asked to prepare a business case, which the panel reviewed. From these business cases, 16 pilot sites were selected for their expertise and experience, and ability to train family members and carers. The sites covered urban and rural areas; one aimed to train ethnic minority groups, while three targeted families of users who had recently left inpatient detoxification or custody.

The NTA launched the naloxone training programme in June 2009. Sites were scheduled to begin training by September 2009, but most were delayed by a temporary shortage of naloxone caused by licensing issues with one pharmaceutical company and rationed supplies from another.

Eventually, 495 carers were trained to respond to an overdose, including phoning an ambulance, the recovery position, cardiopulmonary resuscitation (CPR) and giving naloxone. The carers at only one site were not also shown how to give naloxone, as the local medicines management committee held reservations that the project did not meet good clinical governance standards.

Methodology - evaluation
The evaluation had quantitative and qualitative components.

The quantitative elements comprised data from two questionnaires (A and B) devised by the National Addiction Centre, which the NTA adapted (see Appendices 3 and 4). Carers completed questionnaire A before training and again three months afterwards. The main aim was to see if they had witnessed further overdoses and had used naloxone. However, as there was low compliance with carers repeating questionnaire A, more useful information was captured during interviews with the pilot leads and the focus groups.

The following information was collected immediately before training, via questionnaire A (see Appendix 3):
- demographic information
- who the person cared for (eg sister, son)
- own injecting drug use history (if any)
- naloxone training history (if any)
- history of witnessing an overdose (if any).

Carers also completed questionnaire B (see Appendix 4) immediately before and immediately after training. The aim here was to measure impact of the training, and specifically, any change in the carers':
- ability to respond to an overdose and/or use naloxone
- willingness to intervene in an overdose situation
- concerns when dealing with an overdose.

The vast majority of carers and service users who attended a training session completed at least one questionnaire[3]. At one site's initial session, carers did not complete questionnaire A due to human error. Overall, 425 trainees completed at least one questionnaire. The data was entered into an SPSS database, and the results analysed by the NTA.

The qualitative elements of the evaluation consisted of site visits to all sites between May and September 2010, including semi-structured interviews with pilot leads and trainers, and focus groups with carers.

The qualitative element of the evaluation consisted of interviews with pilot leads and trainers, and focus groups with carers from each site[4]. The interviews and focus groups looked at these areas:
- why carers decided to take part in the training
- carers' views of the training, including when they first heard about it, during the training, and after training, in terms of relevance, accessibility, and impact
- carers' confidence before and after training in responding to an overdose and using naloxone
- why pilot sites decided to take part
- the pilot sites' experience of setting up the training
- the pilot sites' experience of delivering the training
- future plans around providing naloxone in local areas and recommendations from pilot sites for other services.

(See Appendices 5 and 6 for the specific questions.)

[1,2]Strang, John, Manning, Victoria, Mayet, Soraya, Titherington, Emily, Offor, Liz, Semmler, Claudia and Williams, Anna (2008). Family carers and the prevention of heroin overdose deaths…. Drugs: education, prevention and policy, 15:2, 211-218 [3]As well as this, in Birmingham, one questionnaire per pair – a service user and a carer – was completed (32 questionnaires and 72 people in all). [4]Apart from Lancashire and Herefordshire. At one site, health/other commitments prevented carers from attending; at the other, carers failed to arrive.

APPENDIX 2

GUIDANCE NOTES FOR NALOXONE SUPPLY

- Naloxone is a prescription-only medicine in England, although it may be used by anyone for the purpose of saving life in an emergency
- It can be prescribed directly to a patient, or given via a PGD or PSD
- Prescribers should only prescribe and supply naloxone to a known patient with a medical condition that requires the medication, and with the patient's informed consent
- This means naloxone cannot currently be prescribed (or supplied using a PGD/PSD) to a carer on behalf of a drug user, and cannot be given to a carer without the drug user's informed consent.
- There were therefore three requirements that sites needed to fulfil to supply the drug:

1. The naloxone should be prescribed for a specific patient (or supplied by PGD/PSD) to an opiate user only

2. This prescription should therefore be provided only with the opiate user's informed consent

3. The opiate user needs to give written or verbal consent if a carer is to collect the naloxone on his or her behalf.

Sites took slightly different approaches to supplying naloxone, using combinations of written and verbal consent. Four common approaches included:

Sites took slightly different approaches to supplying naloxone, using combinations of written and verbal consent. Four common approaches included:

Scenario one

1. The opiate user hears about training from his treatment service

2. The user tells his carer about the training, and the carer agrees to be trained

3. The user contacts a prescribing doctor or non-medical prescriber (NMP), and gives written or verbal consent for a) a naloxone prescription to be written in his name, and b) for his carer to pick it up on his behalf, when the carer completes the training

4. The carer attends training, completes it, and picks up the naloxone on the training day from an NMP or prescribing doctor

5. The carer keeps the naloxone supply on behalf of the user, in case he overdoses.

Scenario two

1. An opiate user, who also cares for someone is recruited for training and attends with the person she cares for – who is also an opiate user (i.e. they are mutual carers – for example a husband and wife)

2. Both attend and complete the training. A prescribing doctor or a NMP is also present

3. The NMP or doctor writes two naloxone prescriptions and gives out two naloxone supplies on the spot

4. Each mutual carer holds onto a naloxone supply in case the other overdoses.

Scenario three

1. The opiate user AND his carer are recruited for training – it is irrelevant whether the opiate user or the carer is recruited first

2. Both attend and complete the training. A prescribing doctor or NMP is present

3. The NMP or doctor writes a naloxone prescription in the opiate user's name, and obtains verbal or written permission to give it to the carer on the spot

4. The carer keeps the naloxone supply on behalf of the user, in case he overdoses.

Scenario Four

1. The carer of an opiate user is recruited directly for training

2. The carer discusses the training with the user

3. The user contacts a prescribing doctor or NMP, and gives written or verbal informed consent for a) a naloxone prescription to be written in his name, and b) for his carer to pick it up on his behalf when the carer completes the training

4. The carer attends the training and completes it

5. The carer then receives the naloxone supply on behalf of the user, from an NMP or prescribing doctor

6. The carer keeps the naloxone supply on behalf of the user, in case he overdoses.

APPENDIX 3

QUESTIONNAIRE A: PRE-TRAINING EXPERIENCE QUESTIONNAIRE

About you	
Please answer the following questions thinking about your experience of overdose and naloxone. This should only take 5-10 minutes, and when you've finished, please can you return your questionnaire to one of the trainers. All your responses will be kept confidential and anonymous, and only aggregated data will be reported. We do need you to give us your name, gender and date of birth so that we can link your answers to the questionnaires you filled out when you had your training. However, this will not be used to identify you or your answers after the questionnaires have been linked.	
1. Your name (or initials if you prefer)	
2. Your gender	
3. Your date of birth	
4. Have you ever been advised/trained about how to deal with an opioid overdose?	
5. Are you a drug user yourself?	
6. Do you use or have you ever used any injectable drugs?	
7. Have you got a naloxone supply?	

About your friend/family member
8. What is their relationship to you? (e.g. son, husband, granddaughter, friend, etc.) If you have more than one family member with a drug problem (opiates) choose the one you've got most contact with.
9. How many times a week do you see him/her?
10. Which is their main drug of misuse?
11. How long have you known about his/her drug problem?
12. Are they: (please tick all that apply) [ ] Currently in contact with a community drug service [ ] Receiving substitution treatment (e.g. Methadone) [ ] Currently in in-patient treatment [ ] Currently in residential rehabilitation [ ] Not receiving any treatment/support [ ] In recovery from past opiate abuse
13. Has your friend/family member ever used heroin/opiates in your presence?
14. Have they ever been advised/trained about how to deal with an opioid overdose?
15. Have they got a naloxone supply?
16. Do you know where it is?

Witnessing an overdose		
17.	Has your relative/friend ever experienced an overdose from use of heroin or another opiate?	
18.	If yes, how many times have they overdosed?	
19.	How many overdoses are you aware they have had in the last six months?	
20.	Have you personally ever witnessed someone having an overdose?	
21.	How many times have you witnessed an overdose?	
22.	When was the last one?	
23.	Did the person survive the overdose?	
24.	Was naloxone used?	
25.	Who gave them the naloxone?	
26.	If your relative/friend survived, in your opinion, did the naloxone save their life?	
27.	Have you ever experienced an overdose yourself?	
28.	How many times has this ever occurred,	
29.	How many times have you experienced an overdose in the last six months?	
30.	When was the last one?	
31.	Was naloxone used?	
32.	Who gave you the naloxone?	
33.	In your opinion, did the naloxone save your life?	

Keep in touch

Would you like to keep in touch with our family members' network? [ ] Yes [ ] No

ADDRESS

Flat/House Number	
Street name	
Town/City	
County	
Postcode	

PHONE NUMBER

Home	
Mobile	
Alternative phone	

APPENDIX 4

QUESTIONNAIRE B: PRE-TRAINING QUESTIONNAIRE

Please answer the following questions thinking about your knowledge of overdose and naloxone and your attitudes towards overdose and naloxone. This should only take 10-15 minutes, and when you've finished, please can you return your questionnaire to one of the trainers.

All your responses will be kept confidential and anonymous, and only aggregated data will be reported.

We do need you to give us your name and date of birth so that we can link your answers to another questionnaire which we'd like you to fill in after the training. However, this will not be used to identify you or your answers after the questionnaires have been linked as this front sheet will be detached.

My name (or initials if you prefer): ……

My date of birth: ……...

Gender (please tick): **Female** ☐ **Male** ☐

To help with your answers, please bear the following definitions in mind:

Overdose refers to any of the following symptoms occurring in conjunction with heroin use (or the use of other opioids such as methadone, morphine or codeine): difficulty breathing, turning blue, losing consciousness, being unable to be roused, collapsing.

Naloxone is the 'heroin antidote', commonly used by ambulance services to reverse the effects of an overdose and bring the person back into consciousness.

Part 1: Knowledge Scale

✓	**1. Which of the following factors increase the risk of a heroin overdose? (tick all that apply)**
	Taking larger than usual doses of heroin
	Switching from smoking to injecting heroin
	Using heroin with other substances, such as alcohol or sleeping pills
	Increase in heroin purity
	Using heroin again after not having used for a while
	Using heroin when no one else is present
	A long history of heroin use
	Using heroin again soon after release from prison
	Using heroin again after a detox treatment

✓	**2. Which of the following are indicators of an opiate overdose? (tick all that apply)**
	Having blood-shot eyes
	Slow/shallow breathing
	Lips, hands or feet turning blue
	Loss of consciousness
	Unresponsive
	Fitting
	Deep snoring
	Very small pupils
	Agitated behaviour
	Rapid heartbeat

✓	**3. Which of the following should be done when managing a heroin overdose? (tick all that apply)**
	Call an ambulance
	Stay with the person until an ambulance arrives
	Inject the person with salt solution or milk
	Mouth to mouth resuscitation
	Give stimulants (e.g. cocaine or black coffee)
	Place the person in the recovery position (on their side with mouth clear)
	Give Naloxone (opioid antidote)
	Put the person in a bath of cold water
	Check for breathing
	Check for blocked airways (nose and mouth)
	Put the person in bed to sleep it off

✓	**4. What is naloxone used for?**
	To reverse the effects of an opiate overdose (e.g. heroin, methadone)
	To reverse the effects of an amphetamine overdose
	To reverse the effects of a cocaine overdose
	To reverse the effects of any overdose
	Don't know

✓	**5. How can naloxone be administered? (tick all that apply)**
	Into a muscle (intramuscular)
	Into a vein (intravenous)
	Under the skin (subcutaneous)
	Swallowing – liquid
	Swallowing – tablet
	Don't know

✓	6. Where is the most recommended place for a non-expert?
	Outside of thighs or upper arms
	Any vein
	Heart
	By mouth
	Don't know

✓	7. How long does it take for naloxone to start having effect?
	2-5 minutes
	5-10 minutes
	10-20 minutes
	20-40 minutes
	Don't know

✓	8. How long do the effects of naloxone last for?
	Less than 20 minutes
	About one hour
	1 to 6 hours
	6 to 12 hours
	Don't know

Please mark "true", "false" or "don't know"	True	False	Don't know
9. If the first dose of naloxone has no effect a second dose can be given			
10. There is no need to call for an ambulance if I know how to manage an overdose			
11. Someone can overdose again even after having received naloxone			
12. The effect of naloxone is shorter than the effect of heroin and methadone			
13. After recovering from an opiate overdose, the person must not take any heroin, but it is ok for them to drink alcohol or take sleeping tablets			
14. Naloxone can provoke withdrawal symptoms			

Part 2: Attitude Scale

Please can you tell us how much you agree or disagree with the following statements.

	Completely Disagree	Disagree	Unsure	Agree	Completely Agree
15. I already have enough information about how to manage an overdose					
16. I am already able to inject naloxone into someone who has overdosed					
17. I would be able to check that someone who had an overdose was breathing properly					
18. If I had to assist someone who is overdosing, I would be concerned of virus contaminations (such as HIV or hepatitis)					
19. I would be afraid of giving naloxone in case the person became aggressive afterwards					
20. I am going to keep a naloxone supply with me at all times					
21. If someone overdoses, I want to be able to help them					
22. I would be afraid of doing something wrong in an overdose situation					
23. I would be reluctant to use naloxone for fear of precipitating withdrawal symptoms					
24. Everyone at risk of witnessing an overdose should be given a naloxone supply					
25. I couldn't just watch someone overdose, I would have to do something to help					
26. Someone who has overdosed should only be treated by a doctor or a paramedic					
27. If someone overdoses, I would call an ambulance but I wouldn't be willing to do anything else					
28. I am going to need more training before I would feel confident to help someone who had overdosed					
29. I would be able to perform mouth to mouth resuscitation to someone who had overdosed					

30. Family and friends of drug users should be prepared to deal with an overdosed					
31. I would be able to perform chest compressions to someone who had overdosed					
32. I would be concerned about calling emergency services in case the police came					
33. If I tried to help someone who had overdosed, I might accidentally hurt them					
34. If I witnessed an overdose, I would call in an ambulance straight away					
35. I would feel safer if I knew there was naloxone around					
36. I would be afraid of suffering a needle stick injury if I had to give someone a naloxone injection					
37. If I saw an overdose, I would panic and would not be able to help					
38. If someone overdoses, I would know what to do to help them					
39. I would be able to place someone who had overdosed in the recovery position					
40. I would stay with the overdose victim until help arrives					
41. I would prefer not to help someone who had overdosed, because I'd feel responsible if they died					
42. I know very little about how to help someone who has overdosed					
43. Needles frighten me and I wouldn't be able to give someone an injection of naloxone					
44. I would be able to deal effectively with an overdose					
45. If I saw an overdose I would feel nervous but I would still take the necessary actions					
46. I will do whatever is necessary to save someone's life in an overdose situation					

Thanks for filling in this questionnaire. Please now hand it back to one of the trainers.

APPENDIX 5

QUESTIONS FOR CARERS AND INTERVIEWERS' NOTES

1. Introduction

- Introduce yourself and colleagues, including role at NTA and involvement in the naloxone carers' programme
- Confirm that everyone has taken part in the naloxone and overdose training, and also that the programme is commonly known as the 'naloxone pilot'
- Provide overview of interview: before naloxone training, after naloxone training, and overall impressions. We're here specifically to find out how you view the naloxone training, not about any other aspect of your relative or loved one's or friend's treatment. So please don't feel that you have to tell us things if you're uncomfortable about doing so
- Explain that we need their consent and have a form (hand it round) that we would like them to fill in. They can do this now or at the end as they prefer. They can also use any name and the forms will not be seen by anyone outside the NTA
- Explain confidentiality and anonymity. Again, we want to find out what you think but we don't want you to be worried about what you say. So everything you say will be confidential – and anything you say will be anonymous so that no-one can trace a comment back to you. This also means that you shouldn't repeat outside anything you hear today – what is said in this room stays in this room
- Explain taping to ensure an accurate record of their comments and enable full analysis later. No-one outside the NTA will hear the tapes. Gain consent to record and start tape
- Ask them to introduce themselves: whatever they feel like telling us, maybe who the person is that they care for (eg son, wife, close friend, partner) how long this person has been in treatment, when they did the naloxone training.

2. Before the programme

BRAINSTORM: What did you think when you were first approached or heard about the naloxone and overdose training?

- What were your first impressions when you were first told about the naloxone training in a bit more detail? In terms of:
  - Understanding: did you know what naloxone was? Seem intimidating in any way: the needle? Anxiety?
  - What did the person you care for think of the training initially?
  - Relevance: high or low? Not for me/my family member/loved one?
  - Training: seem too long/short? Difficult or easy to get to? At a convenient time?
- What made you decide to take part?

3. The training

- What did you think about the training?
  - Was the training easy to get to and at a convenient time? Was it too long/short or about right?
  - Was the person you care for also given training?
  - Were the trainers able to answer all your questions about naloxone and overdose?
  - Relevance: felt training to be useful for you and your family member?
  - Anything else?
- Impact of the training
  - Compared to before having the training, did you feel more confident or less confident in identifying an overdose?
  - Impact: what has been the impact on you and your family member now that you have been trained?
  - Attitude: if you were faced with an overdose situation today, would you know what to do?
  - Can you tell me three things which mean someone has had an overdose?
  - What concerns do you still have about giving naloxone, or identifying an overdose if any?
  - Anything else?

4. Overall impressions

- Do you think the training has been useful for you? In the short-term? Long-term? Why and how? What were the positive aspects? What were the negative aspects?
- How have you felt since completing the training?
- How much of the training can you remember? Would you feel confident in helping someone in an overdose situation now? In six months time? Would refresher training be useful?
- Do you think carers for opiate misusers all over England should be given the chance to have similar training? Why?
- Finally, what would you change about the training? How could it be made to attract more carers? Do you think it should be offered to other people?
- Anything else?

5. Wrapping up

- If you have anything else you want to tell us, perhaps away from the group, you can put comments in writing and send them to us in confidence using one of these FREEPOST envelopes
- Thanks for your time and contributions.

APPENDIX 6

QUESTIONS FOR PILOT LEADS AND TRAINERS, AND INTERVIEWERS' NOTES

1. Introduction

- Introduce yourself and colleagues, including role at NTA and involvement in the NTA naloxone carers' project
- Provide overview of interview: project preparation, staffing, carers, the programme itself, overall experience
- Explain taping to ensure an accurate record of their comments and enable analysis later if required. No-one outside the NTA will hear the tapes. Gain consent to record and start tape
- Ask them to introduce themselves: their role in the service and involvement in the naloxone carers' project. IF they provided training themselves, ask relevant questions below*.

2. Before the pilot

- Why did you (or your service) decide to take part in the pilot?
- What did you think about providing naloxone and overdose awareness training to carers before starting this project? Why?
- What approval or support, if any, did you have to get to run the project (senior management, Trust, commissioners, partnership, Medicines Management Committee, clinical governance, local carer group etc)?
- Apart from documentation that was required by the NTA, did you develop any other paperwork and management systems to run the pilot?
  – How useful have these been? Any changes you've had to make or anything you would do differently in the future?
- Did you develop any site-specific processes for setting up and running naloxone training?
  – Have these been useful or not?
- Were your staff competent in delivering training before the pilot, or was training them part of the pilot itself?
- Anything else you want to say about the preparation for your programme?

3. Carers and training

- How did the selection criteria defined by the NTA impact on the types/numbers of people trained?
- Did the uptake of the training (ie those who attended/ completed training) compare to your expectations?
- Now you have more experience of providing naloxone and overdose training, would you have different selection criteria? Why?
- Would you do anything differently to promote the pilot?
- Did carers have any concerns around the use of naloxone itself? Did they feel confident in administering it after their training?
- How did you perceive confidence levels in providing overdose response and naloxone before and after the training sessions?
- Did you identify any other training needs which arose as a result of running the training sessions? Did different groups of people appear to need different types of training?
- What issues came up for discussion in the training? Eg police presence when dialling 999, giving naloxone to someone other than the script recipient
- Have any carers given naloxone to anyone since the training? Ask for details and if they can write a brief account of events at later date. Ask if people involved would be willing to be spoken to by the NTA about the event
- Anything else you want to say about the carers who took part in the pilot?

4. Resources

- What effects did running the pilot have on your service? In terms of:
  – Finances? Was the pilot cost-effective in your view?
  – Staff awareness of overdose and harm reduction?
- How did the service deal with these effects?
- What resources did you need to set up and run the project, and did you provide additional resources on top of the NTA funding?
  – Financial resources
  – Staff resources (both those involved with the pilot and those not involved)
- How did you ensure that your staff had the knowledge and skills to run a naloxone and overdose training programme?
- How did staff respond to the pilot once it began?
  – Did this change over time? How?
- How much time did staff spend on running the pilot? (we're just looking for some average impressions of how demanding it is)
- Were there any unforeseen consequences of the programme on staff – in terms of workload, morale etc?
- Were there any delays in getting naloxone supplies, and how did this impact on the running of the project?
- Anything else you want to say about staffing and resources during your pilot?

5. Overall experience

- Now that you have experience of providing naloxone and overdose training to carers, what do you think about it?
- Do you plan to incorporate this training into your 'standard' service? Why/why not? Any obstacles?
- Overall, what, if anything, worked better than you expected? Why and how?
- And what went worse than you expected? Why and how?
- What would you do differently now that you have experience of providing naloxone training?
- What would you recommend that commissioners, managers, staff would need in order to introduce naloxone/overdose training in their services? What is most important
  – Role of service user and carer groups – how important is this?
  – Information (protocols, written information for users and carers etc.)
  – Resources (staffing and financial, clinical leads)
  – Training for staff
- Anything else you want to add?

6. Wrapping up

- Thank you
- If we have other questions, is it OK for us to come back to you? And, of course, you can do the same.
- On the carers focus group: you understand it's just them and us – they may feel constrained if staff are in the room
- What have you called your pilot – just so we know that carers will understand if we use the words, "naloxone training".

APPENDIX 7

LIST OF PILOT SITES

Region	Partnership	Pilot site
London	Ealing Camden	Central and North West London (CNWL) NHS Foundation Trust Carers Service & Max Glatt Inpatient Detoxification Unit – Ealing
London	Lambeth	National Addiction Centre (South London and Maudsley NHS Foundation Trust)
North East	Newcastle	Newcastle PROPs
North East and London	Durham Lambeth	Durham (Tees, Esk and Wear Valleys NHS Trust) & Lambeth CDAT-Lorraine Hewitt House (SLAM)
North West	Bolton	Bolton Drug and Alcohol Strategy and Commissioning Team & Bolton Drug Service (GMW NHS Foundation Trust)
North West	Lancashire	Drugline Lancashire
North West	Wigan	Wigan & Leigh Substance Misuse Services
South East	Southampton	Hampshire Partnership NHS Trust Substance Misuse Services (Southampton City DAAT)
South East	Kent	KCA (UK), Kent
South East	Kent	KCA (UK) and CRI, Kent Drug and Alcohol Team (DAAT)
South West	Plymouth	Harbour drug and alcohol service, Plymouth DAAT
West Midlands	Birmingham	Birmingham and Solihull Mental Health Foundation Trust
West Midlands	Herefordshire	DASH, Hereford
West Midlands	Shropshire	Shropshire Service Users Network (SUN)
Yorkshire & Humber	Bradford	Bradford and Airedale Substance Misuse Service in partnership with The Bridge Project
Yorkshire & Humber	Sheffield	Relatives of Drug Abusers (RODA) and Primary Care Addiction Service Sheffield (Sheffield PCT)

APPENDIX 8

USEFUL LINKS, ACKNOWLEDGEMENTS AND FURTHER READING

Useful links

- ADFAM – the national umbrella organisation working to improve the quality of life for families affected by drug and alcohol use.
  www.adfam.org.uk

- The Harbour Project – a Bolton-based voluntary support group for parents, families and friends who are affected by someone's drug and alcohol misuse.
  www.boltondrugsinfo.co.uk/FamiliesFriends/HarbourProject.aspx

- Harm Reduction Works – these campaign materials are designed to inform and change the conversations that occur between drug workers and drug users, and between drug users themselves, in order to change the decisions drug users make, and reduce the risks they take.
  www.harmreductionworks.org.uk

- Newcastle PROPS (Positive Response to Overcoming Problems of Substance misuse) – Newcastle/Tyneside-based organisation which supports family members coping with a loved one's drug or alcohol misuse.
  www.newcastleprops.org.uk/index.htm

- RODA (Relatives of Drug Abusers) – Sheffield-based family and carer organisation, whose aim is to meet the needs of families and friends whose lives are affected by a loved one's substance misuse.
  www.roda.org.uk

- SPODA – SPODA has been providing services to families and carers who live within the county of Derbyshire since 1998.
  www.spoda.org.uk/Home.aspx

The NTA is not responsible for the content of external websites.

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Further reading

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