Local Government Association

Preventing drug related deaths

Case studies

Acknowledgements

We are very grateful to the local authorities and organisations featured in this report.

Infographics courtesy of Public Health England

Disclaimer

Foreword

Drug-related deaths are rising and are a major concern to councils and our health partners. Deaths have increased sharply over the past five years and are now at their highest levels since records began.

The reasons for the jump are varied. When Public Health England (PHE) and the Local Government Association (LGA) investigated it last year they came to a number of conclusions.

One reason for the recent increase put forward by the expert group convened for the PHE/LGA investigation was the increased availability of heroin since 2012. This followed a period when the purity and availability was significantly reduced.

But they also identified a longer-term increase, mostly caused by the ageing cohort of heroin users, many of whom started to use heroin in the 1980s and 1990s. The cumulative impact of their drug use, it seems, has caught up with them and they are now experiencing physical and mental health conditions that make them more susceptible to overdoses. Other factors were mentioned too, including suicides and poly-drug and alcohol use.

So, what should be done? Commissioning good quality and effective drug treatment services is, of course, a prerequisite. But the rising number of deaths demands more. Working in partnership with social care, housing, mental health and prisons is important. So too is exploring how best to extend the availability of naloxone, a drug that can reverse the effects of an opiate overdose.

Engaging those not already in drug treatment is also essential. Latest estimates suggest there are about 200,000 getting help, but that still leaves another 100,000 who are not. We must reach out to them.

Any death related to the misuse of drugs is a tragedy and we know that reversing this worrying trend is not going to be easy. Public health budgets are being increasingly stretched. But there are plenty of examples of councils which are succeeding – and you can read about some of them in this publication.

Councillor Izzi Seccombe OBE
Chairman, LGA Community Wellbeing Board

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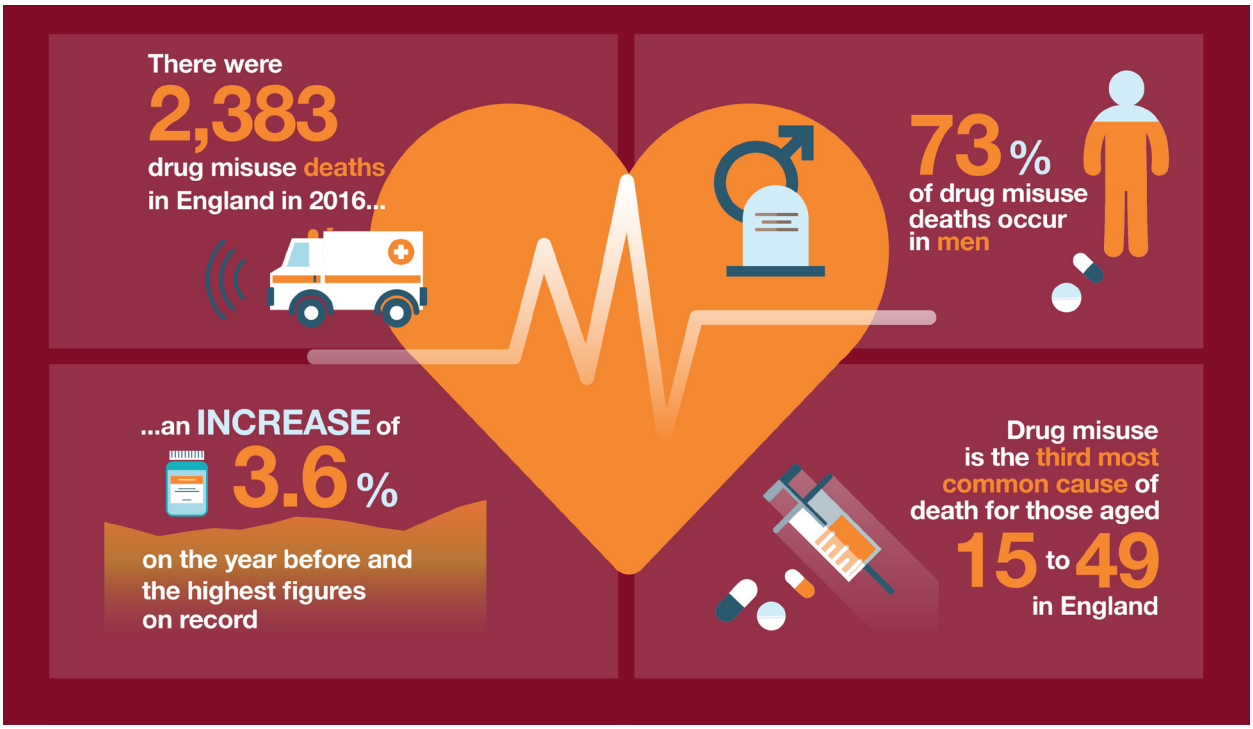
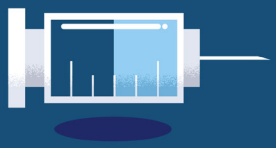
Key statistics



- There were 3,744 drug poisoning deaths involving both legal and illegal drugs in England and Wales registered in 2016; this is 70 higher than 2015 (an increase of 2 per cent) and the highest number since comparable statistics began in 1993.
- Of these 3,744 deaths, 69 per cent (2,593) were drug misuse deaths.
- There has been an increase in the rate of deaths related to drug misuse in Wales from 58.3 deaths per 1 million population in 2015 to 66.9 per 1 million in 2016; deaths in England have remained comparable between 2015 and 2016.
- People aged 40 to 49 years had the highest rate of drug misuse deaths in 2016, overtaking those aged 30 to 39 years.
- Over half (54 per cent) of all deaths related to drug poisoning in 2016 involved an opiate (mainly heroin and/or morphine).
- The highest mortality rate from drug misuse was in the North East with 77.4 deaths per 1 million population, a 13 per cent increase from 2015; the lowest rate (29.1 deaths per 1 million population) was in the East Midlands.
- Analysis by PHE found that alcohol is mentioned in around a third of drug misuse deaths annually in England, and that heroin related deaths increasingly also involve other substances.

All drug poisoning deaths registered in England and Wales in 2016
3,744 (3,450 of which were in England)



Opiates (including heroin, methadone)

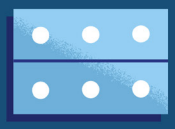
2,038

Benzodiazepines

406

Amphetamines

160



Anti-depressants (in combination)

460

Cocaine

371

1/3

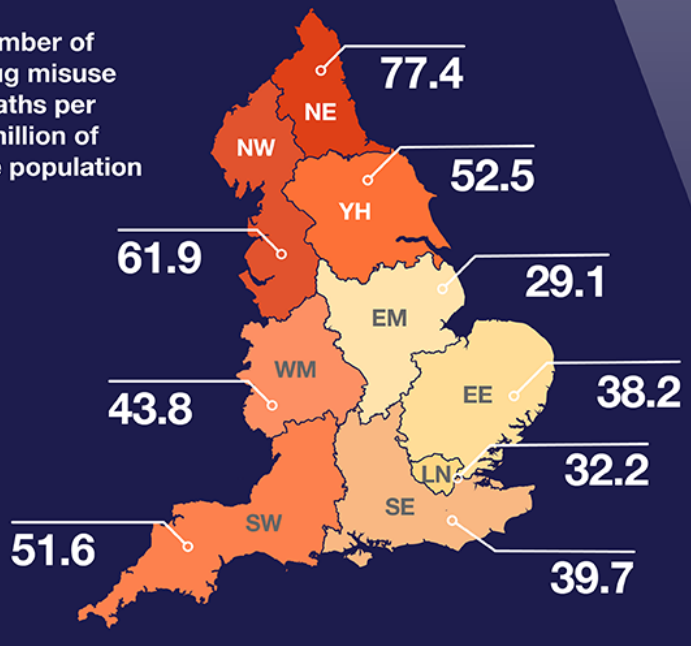
of drug misuse deaths involve alcohol

The Home Office estimated in 2010/11 that the cost of illicit drug use in the UK is £10.7bn per year. This figure includes:

- 8% health service use
- 10% enforcement
- 28% deaths linked to eight illicit substances*
- 54% drug-related crime

*amphetamines, cannabis, crack, ecstasy, heroin, LSD, 'magic mushrooms' and powder cocaine

Number of drug misuse deaths per 1 million of the population



North East (NE)
North West (NW)
Yorkshire and The Humber (YH)
South West (SW)
West Midlands (WM)
South East (SE)
East (EE)
London (LN)
East Midlands (EM)

Source: ONS statistics 2016

The policy picture

The Government's drug strategy in England 2017 sets out how the Government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes. The strategy targets four key themes:

- reducing demand
- restricting supply
- building recovery in communities
- global action.

This covers everything from education to tackling drug trafficking and supply. In terms of addressing drug-related deaths, it promotes the importance of empowering local authorities to deliver effective drug treatment programmes; from needle exchange and counselling to opiate detox programmes, including substitute prescribing of methadone and buprenorphine.

The strategy placed a particular emphasis on the importance of working in partnership with other partners from housing and social care to prisons to ensure the wider needs of people with drug problems are met.Local government is supported by PHE in its commissioning of drug treatment services. Among other activities, PHE coordinates a national intelligence network on drug health harms, which shares information between its members around the country and with directors of public health.

Questions on preventing drug related deaths

PHE have published the answers to a number of drug misuse deaths questions they received from professionals across the UK. You can access them at

https://publichealthmatters.blog.gov.uk/2017/03/15/health-matters-your-questions-on-preventing-drug-misuse-deaths/

In 2016 Legislation came into force to ban new psychoactive substances – 'legal highs' which contain one or more chemical substances which produce similar effects to cocaine, cannabis and ecstasy.

Rules governing naloxone were relaxed in 2015. It is a medicine which can temporarily reverse the effects of an overdose caused by opiates, such as heroin.

Now, drug treatment services can order naloxone so that people engaged or employed in their service can supply the treatment to others, such as carers, drug users and hostels, without a prescription.

This means naloxone can be administered in the case of a suspected opiate overdose to try to save a life.

New research conducted by the LGA found that 90 per cent of respondent local authorities currently made available take-home naloxone.

Local government call to action

In early 2015, in response to the Office for National Statistics (ONS) annual report on drug-related deaths reporting a rise in deaths (ONS 2014), PHE convened a national summit with the LGA and DrugScope. The summit was to explore the complex causes behind the rise in deaths and produce practical messages for key decision makers who can help prevent future drug-related deaths.

What are the best ways to ensure what funding is well spent to reduce avoidable deaths?

- ensure complex needs are met – that means working in partnership with social care, the NHS and wider voluntary sector on everything from housing to physical health care
- intervene following non-fatal overdoses as these are people liable to go on to a fatal overdose
- use the National Institute for Health and Care Excellence (NICE) pathway for drug misuse which brings together a number of clinical guidelines alongside a quality standard which includes guidance on opioid detoxification and the management of opioid dependence
- find new ways to educate those not engaged in drug use
- maintain a balanced approach to risk and ambitions for recovery
- reflect on commissioning and clinical practice to avoid poor practice
- ensure people are being kept in drug treatment for as long as they are getting benefit from it
- share learning between services who have contact with those most at risk, especially homelessness and mental health services
- improve the way information is recorded and transferred between agencies so that it follows people between agencies
- support improved access for people who use drugs to broader physical and mental health care services
- support the provision of naloxone following the relaxation in the regulations (PHE has produced guidance on naloxone use for commissioners and providers)
- NICE has published guidance on providing needle and syringe programmes
- naloxone and overdose training also needs to be provided for drug service users, drug users not in treatment, family and friends, hostel residents and others.

"(A principle factor in the rise in drug related deaths is) an ageing cohort of 1980s and 1990s heroin users who are experiencing cumulative physical and mental health conditions that make them more susceptible to overdose."

The report of a national expert working group to investigate drug-related deaths in England 2015

Case studies

Newcastle City Council

Naloxone programme 'has saved lives'

- Newcastle has started handing out anti-overdose drug naloxone to people at risk and to staff at local accommodation and drug services.
- The drug has been used eight times in the first year of the scheme, potentially saving a life each time.
- A safer clubbing campaign has also been run as evidence suggests there is wider availability and stronger ecstasy on the market.

Newcastle is one of a number of areas that has started to make greater use of anti-overdose drug naloxone since a change in legislation in October 2015.

The relaxation in the rules prompted Newcastle City Council, which had been reviewing its procedures following a spike in deaths in 2013/14, to start rolling out a naloxone programme.

The local drug treatment provider, Northumberland Tyne and Wear NHS Trust (NTW), now supplies naloxone kits to people deemed at risk, at seven centres, about half the supported accommodation in the city.

These include people who have recently been released from prison and have low tolerance levels, have had a recent overdose or are struggling to engage with treatment services.

Clients are encouraged to bring their partner or friend and given training on how to administer it and then supplied with the kits. Over 450 have been handed out since the scheme was introduced last year.

The second part of the programme involves NTW supplying supported accommodation centres, drug services, and approved premises, such as bail hostels, for use in an emergency until help arrives.

This has been accompanied by half-day training workshops for staff, which have included basic life support and overdose training and advice on how to use naloxone. These have been delivered by staff from both NTW and the North East Ambulance Service.

Rachael Hope, Newcastle's community safety specialist in drugs, says: "We started looking at drug-related deaths following the spike in reports. We worked with coroners and the police to review 19 cases and realised that with many of them there were real opportunities to intervene to try and prevent deaths occurring.

"Quite often there are people there when someone overdoses, which is why extending the availability of naloxone in this way is important and in the cases where it has been used we believe it has saved lives."

Drug outreach clinics have also started to be run at accommodation centres and NTW is liaising with lung health clinics to help spot and treat the signs of respiratory problems such as COPD as well as hepatology in-reach clinics.

Meanwhile, work has begun to create closer links between social care and the drug and alcohol treatment service to break the cycle of drug use within families. About a third of the clients in drug and alcohol treatment in Newcastle have children living with them so a protocol has been developed to establish how they can work more effectively together and identify issues earlier. Staff training is also paramount, building on a train-the-trainer approach, which will see tier one staff, including social care, probation and hospital staff, trained in how to offer brief interventions in regards to both drug and alcohol use.

Work has also been done to create an early alerts system. This involves close liaison with the local needle exchange and user forums and cross-checking data from police to identify trends in drug use and availability of local markets.

"Part of it is keeping a track on the supply and purity of drugs," says Ms Hope. "That was one of the problems in 2013/14. There was a spike in purity and availability of heroin nationally.

"If we are aware of that we can respond. For example, this year we have found issues across the night-time economy and across student populations linked to substance use and we know from national data that there is an increase in ecstasy availability and purity so we are supporting a safer clubbing campaign with Gateshead to make sure people know the dangers of mixing or using substances."

The #dancenotchance campaign has been featured on social media and via posters put up in pubs and clubs. It stresses the importance of eating and staying hydrated during nights out and also gives people signs of what to look out for to spot if their friends are getting into difficulty.

There is also a video being produced which involves a house party scenario and explains the risks from drug, alcohol, burglary, fire and sexual consent/rape supported by local partners including the NHS, fire service and police.

"We have a large student population and our enforcement officers and police were finding themselves increasingly being called out due to noise issues to houses where large parties were taking place.

"They have identified a lot of risky behaviour so the campaign will focus on this and try to make sure people are aware of the dangers to try to encourage more responsible behaviour," says Ms Hope.

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Southampton City Council

A drug warning system

- In Southampton, regular warnings are sent out to known drug users to alert them about possible dangers.
- The system is coordinated by the council and involves the local service user group as well as other partners including the police and NHS.
- It is credited with playing a part in saving lives following a spike in overdoses in 2014.

Southampton has a centralised warning system to alert people who use drugs about the substances that are in circulation.

The system was set up in 2011 after being run informally for several years.

The city council's public health team provides the funding to help with the communications, which are handled by MORPH, a local service user advocacy service.

The system is coordinated by Colin McAllister, service development officer at the drug action team, which is part of Southampton's joint council and clinical commissioning groups integrated commissioning unit.

Mr McAllister and MORPH work with a variety of partners, including the local hospital trust, ambulance service, substance misuse team and police.

Information is fed into Mr McAllister and MORPH and then with the help of partners they investigate the reports and decide whether a warning needs to be issued.

The partners meet every few months at a drug deaths forum meeting, but they also communicate regularly in between these when the need arises.

"It is a two-way process," says Mr McAllister. "We share the information and help to corroborate it. The police are the ones who provide the most regular information, but everyone plays their part.

"What it means is that rather than everyone putting out information and warnings which can contradict each other we do it in a coordinated way.

I think that helps to build up trust with people who use drugs. If you start saying things and they turn out not to be true people will just not listen.

So if we hear there is high-strength heroin around and we think it's true we will issue a warning."

But Mr McAllister says it is important to think carefully about the language that is used. "There is no point saying, for example, there's a strong batch on the market because that could make it attractive. So we say there is a variety of strengths available so – we hope – the user thinks carefully when they use it, perhaps trying a little bit to start with," he adds.

Evaluating the impact of schemes such as this is difficult. But there is some evidence to suggest it has made a difference. In 2014 there was a rise in non-fatal overdoses or near misses. Police testing showed there was a wide variety in the strength of heroin on the streets – from 20 per cent to 70 per cent purity.

Mr McAllister says: “That was a significant variation and so we issued a warning explaining what had happened. The number of near misses dropped. We can’t say it was because of the warning that we put out, but we like to think it at least helped.”

Key elements of the programme:

- The warnings that go out are distributed as posters via email.
- Partners in hostels, the local emergency department and across universities and colleges print them out.
- Social media is also used to reach out to students. The regularity of warnings varies.
- It is not always the strength of the drugs that prompts warnings. When spice and other synthetic cannabinoids were banned last year, an alert was issued explaining how there was evidence users could develop physical addictions to the so-called “legal highs” and as a result of the ban the substances could become harder to get hold of.

It went on to set out the sort of symptoms that could be experienced, such as cravings, sweating, nausea, tremors and increased heart rate and urged people to seek medical help if needed. Posters also provide information, such as about symptoms of legal high physical addictions.

Si Parry, who runs MORPH with his colleague Sue Tutton, says: “We try to make sure people are informed. That is all you can do really. Give people the information and hope they keep themselves safe.

“You really have to think about the group you reach out to. For example, we share information with other service user groups and say we hear about a batch of ecstasy in Kent that is really strong we might think about issuing a warning.

“People will travel a long way for a rave and are likely to buy their ecstasy there as they don’t want to get caught by the police carrying it. So it is possible someone in Southampton might need to know about that Kent batch and we could issue a warning.

“But we would be unlikely to do that with heroin. Heroin users tend to source their drugs locally to where they live. It all needs careful consideration.”

You can get fed a lot of different bits of information, but you can’t always take it on face value If one of us hears something we share it with the other partners to try to get to the bottom of it.”

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Barnsley Metropolitan Borough Council

Naloxone scheme that's here to stay

- Barnsley launched a naloxone pilot in 2015.
- More than 50 drug treatment staff have since been trained to hand out the anti-overdose drug.
- Local homeless centres also stock the drug.
- The council is pleased with the success of the scheme and it has now made it a permanent part of the provider's contract.

Just two years ago Barnsley did not use naloxone, a drug used to treat opioid overdoses, except in medical settings such as hospitals.

But today it is a completely different situation.

The change has been brought about after a relaxation of the regulations, which meant anyone employed by drug services can supply it and it can be used by anyone by injection to save a life.

The extended use of naloxone started in 2015 as a pilot led by Barnsley Council's communities team with the three drug treatment providers – Phoenix Future, Addaction and South West Yorkshire Partnership NHS Foundation Trust – which run the Be Recovery service.

Project lead Garreth Robinson says: "In the past it could only be prescribed by medical professionals, but by increasing the availability of the drug we can save lives.

While overdoses may occur on treatment premises, the reality is that most occur away from the healthcare setting, mainly in homes, among the homeless or in public places.

"The time delay before the arrival of emergency services contributes to the high mortality rates. But as most overdoses are witnessed, this provides opportunities for life-saving interventions before the arrival of emergency services."

Some £10,000 was set aside to fund the programme, which paid for 500 kits from Martindale Pharma who also provided the training.

All Be Recovery staff in contact with service users have received training in the prevention and management of opioid overdoes, cardio-pulmonary resuscitation, basic life support and naloxone administration. Refresher courses have been held subsequently.

They can now supply it to services users, family members, carers, hostels and supported housing sites.

Before giving "take home" naloxone Be Recovery staff must ensure that the service user has been instructed and trained in how to inject the drug as well as on the prevention and management of overdoses.

Mr Robinson says: "The training is not time-consuming. It takes five to 10 minutes and covers the importance of ensuring personal safety, reminds them to call an ambulance, to place the victim in the recovery position and to inject naloxone into the thigh or upper arm muscle."

Each time it is supplied it must be recorded using the official administration record, which notes who it was supplied to, the batch number, the expiry date and the name of the person supplying the kit.

If it is a replacement kit, details are taken using the administration feedback form. This records valuable information about the use of the naloxone kit and the situation in which it was used.

So has the pilot been a success? Mr Robinson says so.

"In the first 18 months through to the end of March 2017, naloxone was administered to 12 people, potentially saving a life each time.

"I think that has convinced everyone of the importance of this change. For example, we had one housing group which was a little reluctant to stock naloxone. But they were encouraged to and have used it twice. They now see why it is so important. In fact, we had to find an extra £1,000 to buy another 65 kits to see us through to the end of March – they had all been handed out."

But perhaps the ultimate indication of the success of the pilot is that the extended use is now a permanent fixture in Barnsley's approach to drug-related deaths.

On 1 April a new provider took control of the drug treatment services and it was written into their contract that they would need to supply and provide the training for the extended naloxone use going forward. "It is here to stay," adds Mr Robinson.

My experience

Anne Pickerill, a support assistant at one of the local hostels which stocks naloxone, found a man collapsed in his room and it soon became apparent he had overdosed on heroin. After speaking to ambulance staff, the decision was taken to give him naloxone.

"I was shaking so my colleague loaded the syringe up for me and I stuck the needle into the top of the customer's leg through his trousers. It was a very scary experience, but one I feel better for doing – my actions actually saved a man's life. I feel that anyone who works in a hostel should be trained to administer and have access to naloxone. It is a vital part of our kit to be used as and when required."

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Doncaster Metropolitan Borough Council

Meeting the wider needs of the homeless

- The local drug and alcohol treatment service has launched a 'long reach' project to engage homeless drug and alcohol users.
- It is based on a housing first model, which then sees wider support wrapped around while they receive help for their addiction problems.
- It has only just launched but so far over 50 people have been helped.

Aspire Doncaster provides the full range of drug and alcohol services to the 2,000 people in the town with substance misuse problems.

The service is delivered by a partnership between Rotherham, Doncaster and South Humber NHS Foundation Trust and the Alcohol and Drug Service, a charity.

In recent months it has been delivering a new 'housing first' approach to the borough's homeless people by getting workers to go out on the streets to take services to them.

The scheme – known locally as the Long Reach Project – was launched in December 2016 and involves working closely with local services and agencies to support vulnerable people identified as homeless or at risk of being homeless who are experiencing problems with drug or alcohol addiction.

Helen Owen, the team leader who oversees the Long Reach team, said: "There are a range of obstacles which can make it difficult for homeless people to access services.

"Their priority is usually somewhere safe to sleep for the night so, unsurprisingly, at times they may put this before attending appointments with support services.

"We use a variety of approaches to help. This could be out-of-hours appointments, visiting people at food providers or using street walks to actively seek out people."

The project works to provide safe accommodation for people and then connects them with other services. An assessment identifies support needs, which are then wrapped around the person and their accommodation.

The project is a real coming together of various local organisations and services. Aspire's 'single point of access' team works side-by-side with social care, accommodation providers, mental health and Doncaster Metropolitan Borough Council.

It is still very early days, but already the project has engaged with over 50 people since its launch.

Once in accommodation, the project works to ensure that the support is in place to ensure people do not gravitate back to the streets. This may include learning skills such as paying bills or abiding by rules in tenancy agreements or hostels.

Aspire's service manager Stuart Green said: "There are people with some very complex problems in the project. It's not just drugs or alcohol. They may have mental health problems or learning disabilities too. So it is important that comprehensive and coordinated support is in place utilising the whole range of available services.

"The temptation is to think you have to redevelop the service. But when we looked closely we found that there were the services people needed out there, they were just not connected to them…or if they were the services weren't working in a coordinated way. That is why I prefer the term 'long reach' to outreach – it's about connecting people with existing services in the best way possible."

Stuart Green, Aspire's service manager

As part of Aspire's work with the homeless, the service has launched a naloxone scheme, which has seen support staff and needle exchange staff given training so they can hand out naloxone kits to hostel staff, users, friends and family.

Aspire is also planning to develop the way it works with people released from prison. "There are three prisons in the Doncaster area and when people are released," says Mr Green, "Aspire picks up their treatment to ensure there is no gap in their prescription, for instance. However, not everyone turns up after being released and they can become disengaged from support. This often results in reoffending and a return to prison.

"So what we are trying to do is to start working more proactively, meeting up with them before release and starting to engage people in planning what will happen on their release."

Aspire has also worked hard to change attitudes, challenge stigma and celebrate the value of recovery from drug and alcohol addiction. A key part of this has been the Recovery Games, which is in its fourth year and acts as a celebration for those who have been through recovery.

The games feature a Gladiator-style inflatable assault course, along with water and climbing challenges where teams of approximately 10 take part in trials throughout the day with a final obstacle race to decide the winning team.

Mr Green says: "It is a great fun day out for everyone and there are fun activities for families, children and friends.

"Feeling part of the community in which they live is an important part of someone's ability to sustain recovery and to thrive, as it is ultimately the community that keeps people well."

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Westminster, Hammersmith and Fulham and Kensington and Chelsea

Helping club drug users

- A specialist club drug clinic is run in central London with funding from three local authorities.
- The clinic helps 50 clients at a time, offering a combination of detox, counselling and peer mentoring.
- Seven in 10 of those who start treatment end up achieving their aims.

Research shows drug use among young adults who go clubbing is much higher than the general population. But most drug services do not tailor their support to these groups.

However in central London the Club Drug Clinic has been set up with funding from the London boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster to do just that.

The service includes specialist addiction doctors and psychologists, nurses, counsellors and peer mentors with lived experiences.

The team accepts referrals from anyone. Clinic founder Dr Owen Bowden-Jones says: "Most traditional services focus on alcohol, heroin and cocaine and so people with problems related to club drugs tend not to engage with those services.

"Half of people we see have jobs and they often come from more affluent and socially networked backgrounds. It is a very different client group. But the risks to harm are still there."

The clinic offers a wide range of help including:

- assessment of problems and planning in how to improve the situation
- medically-assisted withdrawal from substances or detoxification
- talking treatments led by psychologists, counsellors and peer mentors
- onsite sexual health screening and support
- liaison and referral for mental health and physical problems, such as HIV and kidney difficulties.

"A lot of the work is one-to-one," says Dr Bowden-Jones. "We used to do more group work but we find people prefer the privacy and intensity of the one-to-one support. However, we do offer mindfulness, Alcoholics Anonymous and Narcotics Anonymous groups, which are popular.

"We have also started providing some psychosexual counselling for our clients who are using drugs for sex."

There are three treatment pathways, varying in length from a short three-session series focusing on brief interventions to a 12-week and six-month structured programme.

The service – which is provided by the Central London and North West London NHS Trust – has also started working more closely with local sexual health services.

For the last year it has been running a drop-in clinic at two local sexual health centres. It means people coming in for sexual health treatment can also see the drug service if they want.

It is only run once a week, but has proved to be incredibly popular. “It is a way of reaching out and engaging people who might not necessarily come to our service,” says Dr Bowden-Jones.

“That is important for any drug service. You need to make sure you are being proactive. We get referrals from all over – HIV services, the voluntary sector and the NHS as well as self-referrals.“

It certainly seems to be working. The service can take a maximum of 50 clients on at any one time – and the places are almost always full. About a third are heterosexuals, often students or young professional people, while the rest are from the lesbian, gay, bisexual and transgender communities.

Since it started in 2010 the clinic has helped several thousand patients. Just over 70 per cent of those who enter treatment achieve their goals, whether that is to stop using drugs or just controlling their drug use.

The clinic has also been at the forefront of innovation. It is running a trial looking at how best to help those who are dependent on drug GHB/GBL. In particular it is looking at which mediations are most useful to prescribe when people try to stop using GHB/GBL.

And, more recently, it has teamed up with the Health Foundation to offer training to improve clinical practice when it comes to club drugs and psychoactive substances.

The online training programme – called Project Neptune – will be launched later this year after a successful pilot.

There are three courses. An introduction version aimed at any health professional, one for those working in emergency departments and another specifically tailored to those work in drugs and sexual health services and primary care.

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North Yorkshire County Council and York City Council

Learning from drug deaths

- Every drug-related death is reviewed in North Yorkshire and York to see if lessons can be learned.
- The expert group meets every six months to discuss cases.
- Recommendations are then made for local partners, including the drug treatment service and NHS.

North Yorkshire County Council have set up a system to review every drug-related death along with those that involve people receiving treatment for alcohol dependence.

The region's Drug and Alcohol-related Deaths Advisory Group was set up in 2011.

It meets every six months and makes recommendations to local services about what may have been done differently. It aims:

- to establish whether there are lessons to be learned about the way local agencies and professionals work together
- to produce recommendations for improvement for local providers
- to monitor demographics of suspected deaths to inform local needs assessments and future commissioning decisions.

The advisory group has a 20-strong panel, chaired by a North Yorkshire public health consultant.

It includes representatives from the local treatment provider, NY Horizons, police and the ambulance service along with clinical and mental health representatives. Staff from the coroner's office and prison service also attend in a consultant member capacity, while professionals involved in individual cases can be called on to help take lessons learned back in to their organisations.

Following meetings any recommendations are cascaded to partners, while an annual report is produced for the North Yorkshire Drug and Alcohol Partnership Group and Safer York Partnership Board. A thematic review bringing together wider lessons is also being carried out. That is due to be published later this year.

North Yorkshire County Council health improvement officer Greg Hayward, who is a member of the advisory group, says: "We discuss each case in detail with members expected to contribute their own knowledge, looking at what happened and why.

"I would not say every death is preventable, but certainly there are often lessons to be learnt. Like the rest of the country, we have seen a rise in drug-related deaths in recent years so it is essential we establish what has happened and how things could have been done differently.

"The advisory group meetings are useful for the local drug treatment service, of course, but they also internally review deaths prior to these meetings. So they are perhaps most useful for primary and secondary care as well as other agencies."

The review process only covers deaths of individuals who are aged 18 years or above and have died where the underlying cause is poisoning including alcohol, drug abuse or drug dependence. Also included are deaths from prescribed medication and accidental deaths and suicides where the individual is accessing local drug and alcohol treatment services.

The work is currently led by a public health team who are notified by the police, coroner's office or treatment service of any deaths known to them. The officer then produces a report which is discussed at the next advisory group meeting.

It means at each meeting there are normally about 12 cases discussed.

The most recent annual report, from 2015, is a perfect illustration of the benefits the process brings.

It covered 37 deaths. Some 21 cases where drug misuse was either implicated or a factor in the death, and six of these were deaths of those who were also problem drinkers. The remaining 16 were cases where alcohol was the only substance misused. Examples of the type of recommendations that have been made by the board include repromoting the 999 overdose protocol, which makes it clear under which circumstances police will attend ambulance drug overdose call-outs to help address the reluctance of some people to report these, and an increased focus on the management of physical health issues and long-term conditions in substance misuse service users.

The latter involved steps to improve communication between GPs and NY Horizons.

An independent GP representative was appointed to the board to help advise over the management of long-term conditions and aid communications with local doctors.

Meanwhile, NY Horizons also now record all services users known to them with long-term conditions and this is monitored regularly.

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Brighton & Hove City Council

Helping patients at A&E

- Specialist nurses are stationed at Brighton & Hove's main A&E unit to help patients who attend with drug-related problems.
- They advise doctors and nurses about the immediate care that needs to be provided and to engage drug users with wider community treatment options.
- They also prescribe naloxone kits to patients who are prone to or have presented with an opiate overdose.

Brighton & Hove City Council's substance misuse service has three nurses who work in the area's main A&E department.

The team, employed by the local provider Pavilions, provides support to patients who arrive at the Royal Sussex County Hospital with both alcohol and drug problems.

The nurses work from 9am to 5pm Monday to Friday and on an average day will see about 10 patients with drug-related issues. This can involve anything from accidents caused by drug misuse or alcohol problems to overdoses, substance misuse withdrawals and a wide range of acute and chronic physical and mental health conditions. The department consistently has between five to 10 opiate overdose presentations every month.

Dispensing of naloxone provides an opportunity to offer advice around the recognition, treatment and prevention of accidental opiate overdose. But the service, which was launched in 2011, goes much further than that, as Jo Bisp, one of the three substance misuse nurses explains.

"We work as specialist nurses within the multi-disciplinary team alongside doctors, nurses and other health and social care staff seeing patients in both A&E and the acute medical assessment unit.

"We see a variety of drug misuse presentations and the types of substances that people use. This can range from intravenous heroin misuse, over-the-counter medications, cocaine, ketamine and a whole host of other novel psychoactive substances.

"When a patient comes in the staff will refer to the Pavilions team and we will see them at the earliest opportunity. Electronic referrals can also be made out of hours.

"We also offer prescribing advice to the medical team where appropriate and advice on general management issues.

"A big part of our work is liaising with community services, both locally and out of area, for patients who are already in treatment. This ensures on going, safe prescribing for the patient while they are in hospital.

"But we are also there to engage the individual in drug treatment. If they are already in treatment we liaise with their care co ordinator who may visit them on the ward if they are admitted.

"If they are not in treatment we can discuss the treatment and recovery options available and signpost them to services. Booked appointments can also be made."

Pavilions offers a range of different treatments from chemsex support, prescribing and detox to peer mentoring, group work and midfulness programmes.

“There are often a range of complex issues at play which involve us working closely with other services – mental health, the homeless and social care teams,” says Ms Bisp.

“There may be issues of neglect or long-term physical health problems that need addressing. There is an ageing cohort of drug users who frequently present. The system works really well. We have a close relationship with the staff in the hospital but also the services in the community – that is important so you don’t miss the opportunity to help people who are in and out of hospital.”

Liz Tucker, the council’s public health practitioner who oversees the drug work, agrees.

“The nurses often know the patients coming in – it is the nature of drug addiction that people will lapse and can end up in and out of hospital. An overdose or accident that requires a hospital visit can often be an opportunity to re-engage people with treatment or unlock a wider issue. That is why having the nurses at the A&E is an essential part of our work.”

But she says the scheme also benefits the wider A&E team. One thing that marks Brighton & Hove out from other A&E substance misuse services is that the nurses also provide training and advice to junior doctors so they can support even when the team is not there.

The doctors can dispense naloxone when appropriate and every drug-related attendance – along with alcohol-related ones – is recorded in the system. This allows nurses to follow up patients if they are still in hospital or, for drug overdose patients, send them a follow-up letter.

Ms Tucker says: “Junior doctors have regulator rotations so when new ones join the nurses provide information as part of their induction. It is really just raising awareness about what the latest practice is. The aim is to provide a service to people arriving with drug admissions 24/7. It means we can make the most of the service and – hopefully – save lives.”

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Lancashire County Council

Investing in quality treatment

- Lancashire County Council has been modernising its drug treatment programme over recent years
- Instead of having scores of different contracts, services are now provided across three footprints with a focus on sustainable recovery
- It is having impressive results with data showing performance is well above the national average

Having a good treatment service that achieves high quality outcomes is a core part of keeping drug-related deaths to a minimum. Lancashire County Council has achieved just that by maintaining a constant eye on how to improve the services it commissions.

The council's substance misuse treatment system – one of the biggest in the country – has been through an on-going modernisation and development programme since 2008.

Previously services were split between scores of contracts, but now the county uses a prime provider model to commission services and target resources across three core footprints – North, East and Central Lancashire. This approach led to greater quality and more efficient use of resources.

There is a significant focus on sustainable recovery beyond the treatment system with the aim of addressing the wider needs of service users and their families. The services provide psychosocial and healthcare interventions, including healthcare assessment, vaccinating and testing, wound care and onward referral to specialist services and there are specialist treatment packages for those with specific needs, such as people with a dual diagnosis, long-term condition or who are pregnant.

There is support post exit, or for those who do not require structured treatment, through the form of brief interventions, recovery and aftercare packages, including online courses.

The impact of the approach is clear to see. Latest performance data shows 10.5 per cent of individuals engaged in treatment are successfully completing it and not returning for treatment for six months, well above the national average of 6.6 per cent.

Access to treatment has also been speeded up. Some 100 per cent of individuals start treatment within three weeks compared to 86 per cent six years ago.

Public health director Dr Sakthi Karunanithi says: "Considering the high levels of deprivation we have, I think our performance is holding up pretty well and we are proud of that. But like many areas of the country drug-related deaths have increased. However, we hope that by providing high quality services we have been able to keep them to a minimum. But we do have some real challenges – as all drug treatment commissioners and service providers have.

"The drug-related deaths we are seeing are quite different to what they used to be. We have an ageing cohort of drug users who have a range of long-term conditions – COPD and liver disease for example – and are smoking and drinking and likely to have poor diets. Generally their health is poor already and they are becoming more susceptible to overdose - it is quite a different challenge."

One option being explored is to end the practice of discharging some clients. Dr Karunanithi says: "The problems with some clients that are discharged is that they are at risk of using again due to poor social capital and support outside of treatment and there is a significant risk of OD because of the state of their health.

"So we are giving consideration to only discharging them where there is a clear post treatment plan in place with facilitated access to other partners such as primary care, mutual aid or even not discharging at all. We may have to accept that. It won't look good on our successful treatment completions data but it may be the best way to look after these groups."

Another key aspect is linking broader public health services with primary care, social care and other key services. Targeting substance misuse services with stop smoking support is one example of this. Strategic steps have also been taken to keep Lancashire's services up-to-date.

Lancashire has historically commissioned a number of confidential inquiries into drug-related deaths that have been shared with partners to inform practice.

But more recently treatment providers have been developing their own review processes and the specialist social workers have started multi-agency reviews of those deaths during or following rehab placements.

Lancashire has also joined with colleagues from Blackburn with Darwen and Blackpool councils to develop a pan-Lancashire multiagency preventable harms group to debate and share best practice. It is also overseeing the establishment of a new drug alert system.

Finally, in recognition that drug-related deaths overlap with the suicide prevention agenda, they will form part of the forthcoming suicide prevention action plan.

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Further information

Understanding and preventing drug-related deaths (Public Health England, 2016)

www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf

Drug misuse deaths by local authority

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority

PHE: Trends in drug misuse deaths

www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf

Deaths related to drug poisoning in England and Wales: 2016 registrations

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations

Understanding and preventing drug -related deaths: The report of a national expert working group to investigate drug-related deaths in England

www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf

Reducing opiod-related deaths in the UK (Advisory Council on the Misuse of Drugs)

www.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf

The Drug Treatment Outcomes Research study

http://tna.europarchive.org/20100413151426/rds.homeoffice.gov.uk/rds/pdfs09/horr25c.pdf

PHE guidance on changes to naloxone regulations

www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdosefeb2015rev.pdf

PHE: Drug misuse treatment in England evidence review of outcomes

www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdoseaug2017.pdf

Turning evidence into practice (PHE guidance)

www.nta.nhs.uk/uploads/teip-drd-2014.pdf

NICE pathway for drug misuse

https://pathways.nice.org.uk/pathways/drug-misuse-management-in-over-16s

NICE needle and syringe programmes overview pathway

https://pathways.nice.org.uk/pathways/needle-and-syringe-programmes

ADPH position statement on naloxone

www.adph.org.uk/2015/12/adph-position-statement-on-naloxone/

DrugWise

www.drugwise.org.uk/

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