

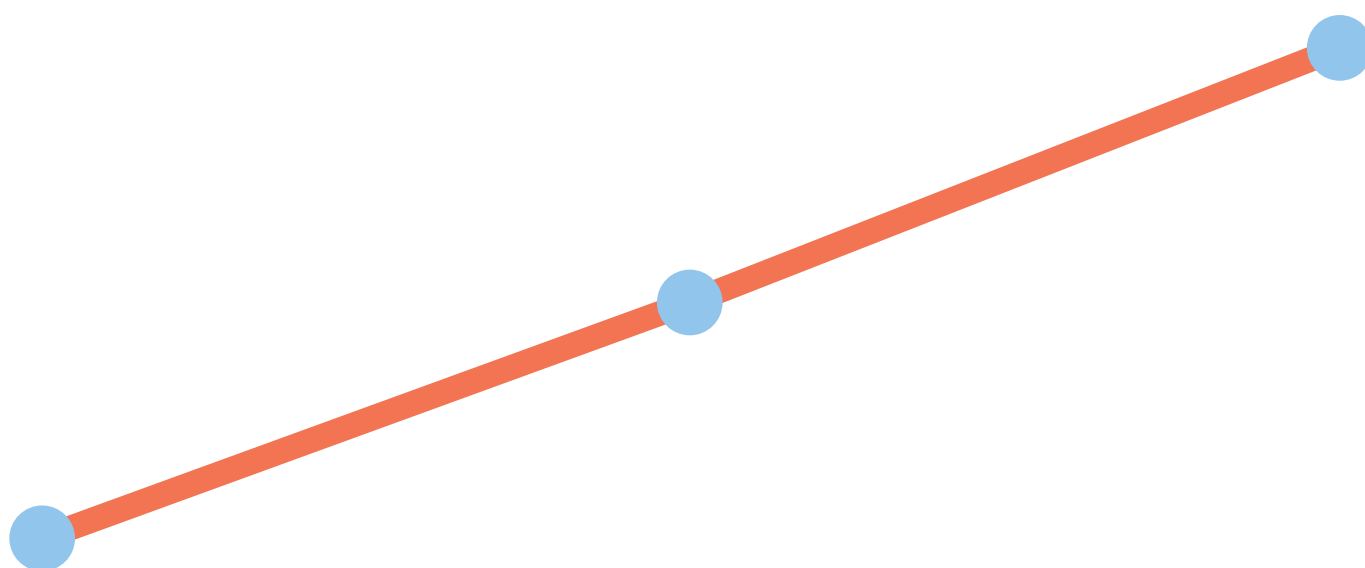
Drug-related deaths in England:



local authorities
and how they
are responding

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Executive Summary

Drug-related deaths (DRDs) are at their highest level since records began in 1993 with 3,756 DRDs in England and Wales last year, 53% of which related to opiate use. Almost a third of all deaths from overdose in 2016 in Europe happened in the UK. This constitutes a public health and humanitarian crisis which must be addressed urgently.

DRDs are now an indicator in the Public Health Outcomes Framework (PHOF) in England. The Harm Reduction Group wrote to the 40 local authorities with worse than benchmarked DRD rates, asking how they were responding to DRDs in their area. 35 local authorities responded.

Whilst most local authorities had discussed DRDs within relevant health-related committees, and in the context of commissioning new services, no local authority reported specifically making DRDs an agenda item at a full council meeting or meeting of Cabinet. There should be consideration of DRDs at the highest level within these local authorities to ensure appropriate political and strategic priority.

Naloxone is a cheap and highly effective medication used in response to an opioid overdose and can prevent death. However, coverage overall across England remains poor. Local authorities are making welcome efforts to improve provision. But confusion around use by police officers, probation services and prisoners on release, and some local failures to give access to naloxone for those not in treatment, need to be urgently addressed. Funding for naloxone should be increased, ideally via a national naloxone programme.

Maintaining people on Opioid Substitution Therapy (OST) is an immensely effective intervention to prevent DRDs. It is important to prescribe in line with clinical guidelines and avoid sub-optimal dosing – all local authorities need to audit their services to ensure this is happening. They must also ensure their service contracts do not incentivise inappropriate termination of treatment.

Many local authorities told us that both specific cuts to the Public Health Grant, and thus to funding for drugs services, as well as wider cuts to other important support services, are limiting what they can do in response to their high rates of DRDs. This clearly illustrates how adequate funding of the Public Health Grant is a matter of life or death. The Government must reverse recent cuts to public health funding, and instead provide sufficient resources to meet need, in line with its own ostensible commitment to prevention.

Innovation is essential in addressing DRDs. Many local authorities want to be able to consider introduction of Drug Consumption Rooms (DCRs) but the Government is refusing to allow this to happen. There is a wealth of evidence on the effectiveness of DCRs in reducing harms from problematic drug use, and no evidence they increase drug use where they are introduced. The Government should heed the evidence and allow DCRs to be introduced where they are considered to be needed locally.

Local authorities gave us many examples of good work being undertaken to address DRDs. We encourage all local authorities to review wider good practice, consider implementation as appropriate, and continue to share good practice with other local authorities.

Overview of Drug-Related Deaths

Drug-related deaths (DRDs) in the UK are at the highest levels since records began in 1993.ⁱ The statistics for DRDs in England and Wales in 2017 show that the rate has now increased six years in a row.ⁱⁱ There were 3,756 DRDs registered in England and Wales last year, 53% of which were related to opiate use.ⁱⁱⁱ We should not underestimate the scale of the issue; according to the most recent estimates, seven out of every thousand people in England use opiates.^{iv} The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that in 2015 almost a third of all deaths from drug overdoses in Europe happened in the UK.^v

With regards to people who inject drugs (PWIDs) living with HIV, recent PHE data found that the mortality rate amongst this population group compared to other population groups affected by HIV was significantly higher.^{vi} The mortality rate for gay and bisexual men and heterosexuals living with HIV stood at 3.08 per 1,000 and 3.15 per 1,000 respectively.^{vii} This rose to 14.21 per 1,000 amongst PWIDs living with HIV, demonstrating the impact that the acute harms associated with injecting drug use have upon this group.^{viii}

There has been much discussion on why the DRD rate has risen so dramatically. Public Health England (PHE) state that it seems to be a complex combination of an ageing group of people who have used opiates since the 80s (when a heroin epidemic first emerged) who are now more susceptible to ill health and overdose, and a rise in the purity of heroin following a 'drought' in 2010. Other factors such as increasing suicides, increasing deaths among women, improved reporting, an increase in polydrug and alcohol use, and an increase in the prescribing of some medicines (such as gabapentin and pregabalin) are also seen as partially responsible.^{ix}

The other factor, which is hard to track, but likely to have had a significant impact upon the rate of DRDs, is the significant cuts faced by drug treatment services over the last few years, coupled with the move over the last decade to an abstinence based 'recovery' model of drug treatment, rather than harm reduction. The Advisory Council on the Misuse of Drugs (ACMD) reported that "a loss of funding could lead to decreased treatment penetration and increased levels of blood-borne viruses, DRDs and drug-driven crime in communities" and that "despite the continuation of the ring-fenced Public Health Grant to local authorities until April 2019, reductions in local funding are the single biggest threat to drug misuse treatment recovery outcomes being achieved in local areas".

The transfer of the Pooled Treatment budget into the Public Health Grant in 2013 effectively removed the protection from drug treatment spend, resulting in widespread reductions in contract value for drug treatment estimated by Collective Voice to total around 30%.^x Since then, reductions in the Public Health Grant have continued to impact drug treatment services heavily. From 2014/15 to 2018/19, the Health Foundation report that there has been a 19% decrease in spend on adult drug and alcohol services.^{xi} There is predicted to be a 26% decrease in spend on drug and alcohol services by 2019/20. This is in excess of the overall reductions in the Public Health Grant and is not responsive to changing need. Overall, the Health Foundation predict that the total fall in public health spend per person between 2014/15 and 2019/20 is expected to reach 23.5%.

Figure 1.
Drug-related deaths (all poisonings) registered between 2012 and 2017, England and Wales

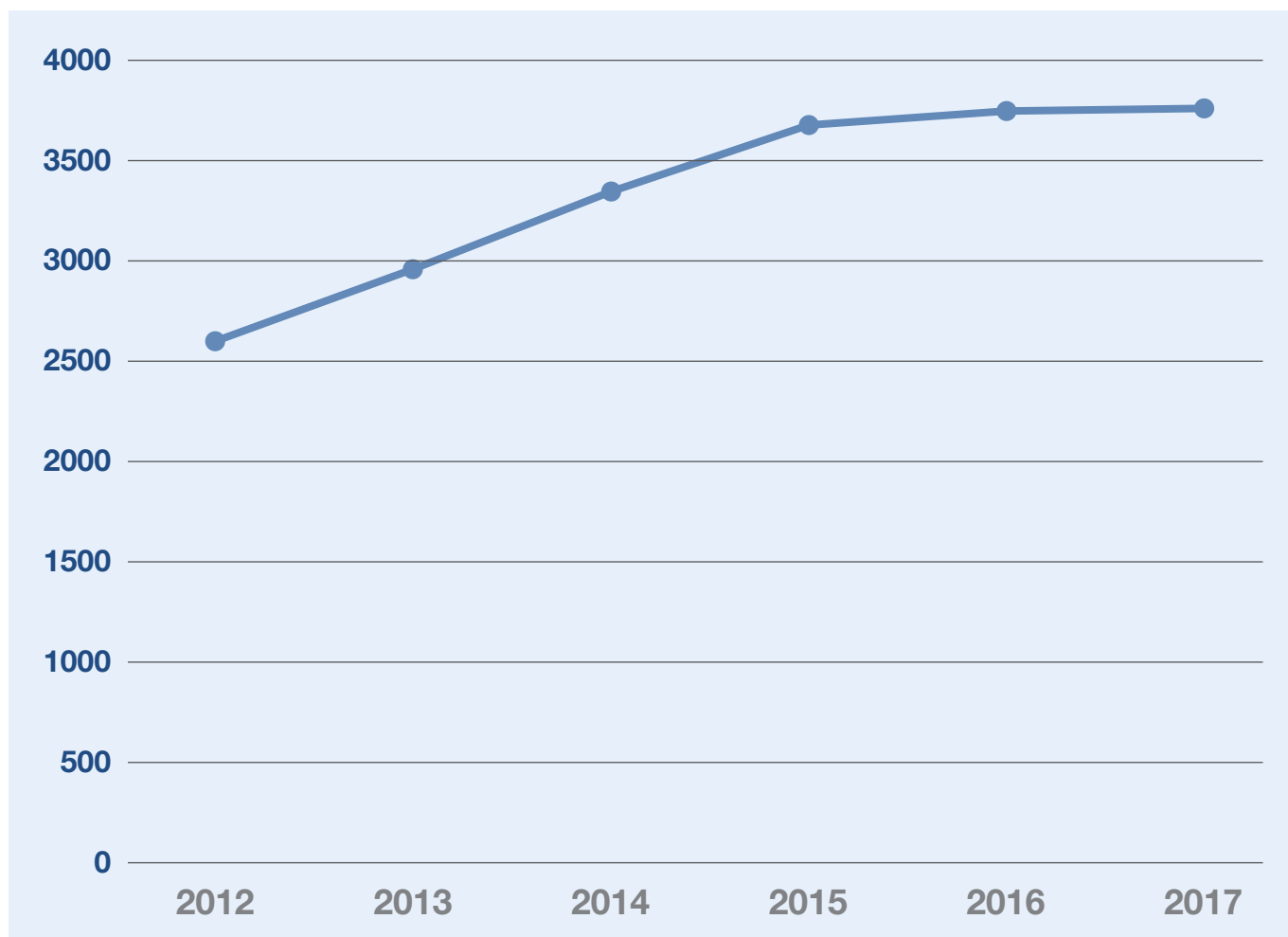
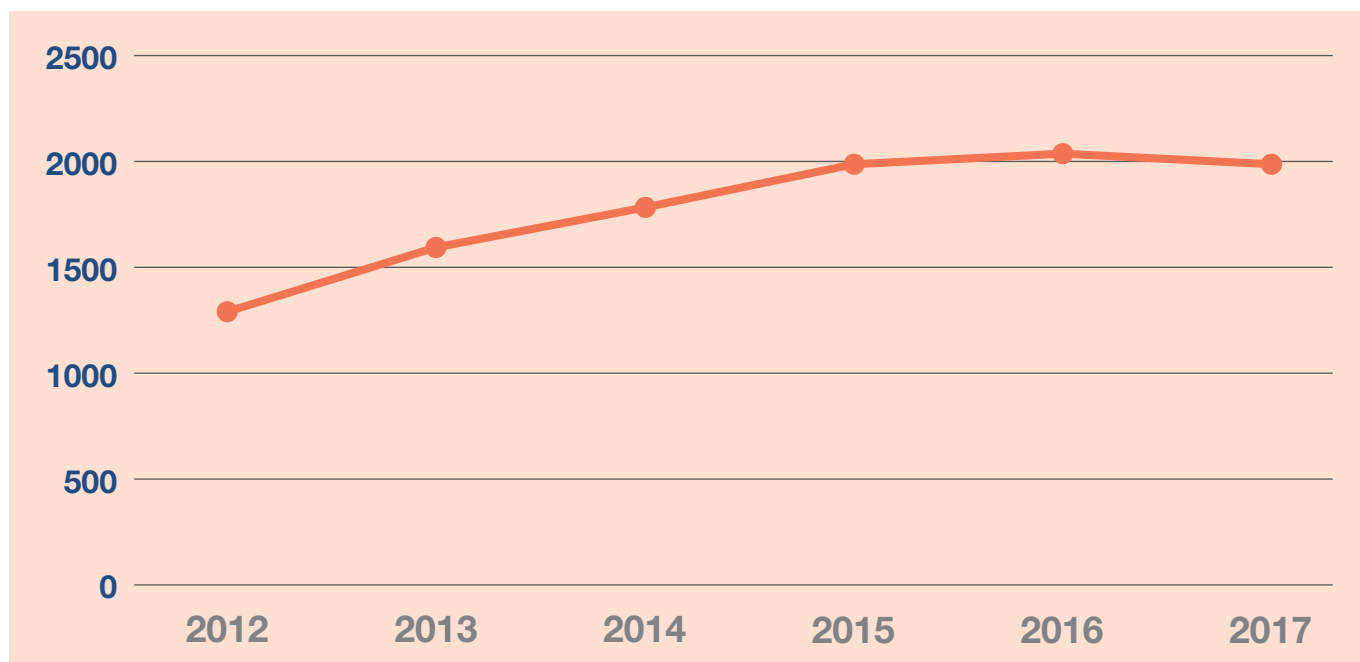


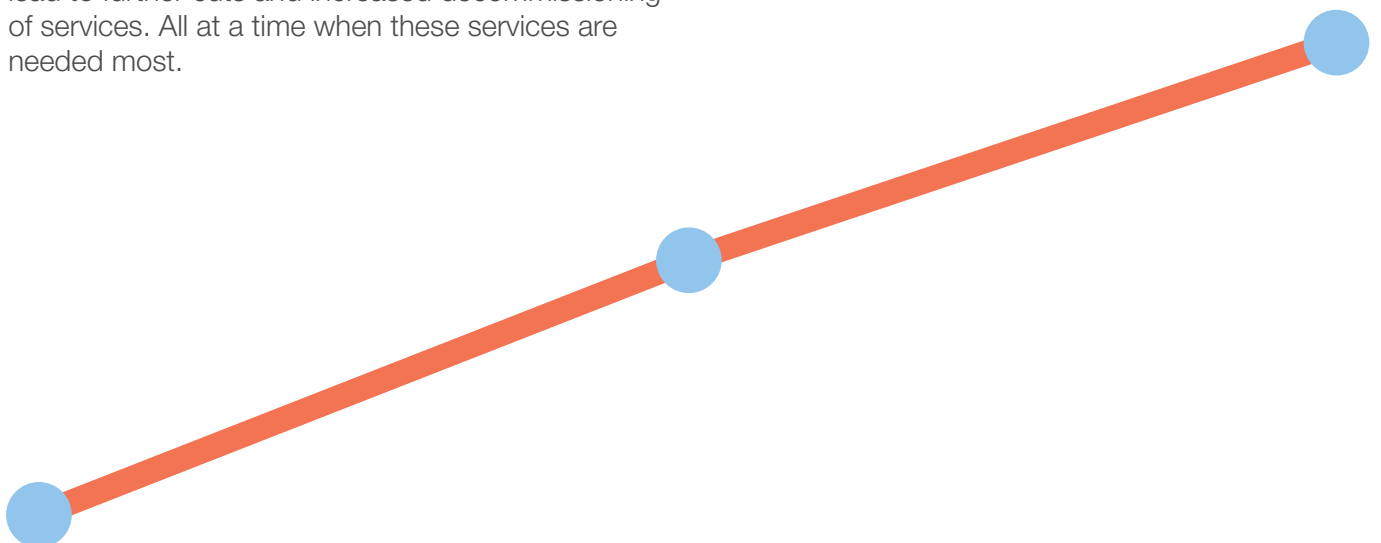
Figure 2.
Deaths related to Heroin and/or Morphine registered between 2012 and 2017, England and Wales



Local Authority responsibility

The Health and Social Care Act 2012 made local authorities responsible for public health.^{xii} This includes commissioning drug treatment and harm reduction services. This move was not uncontroversial – drug services are primarily clinical services that some argued would be best commissioned directly by the body most deemed to understand clinical issues – the NHS. It has been noted that the move has led to a fragmentation of care, with ACMD reporting on “an increasing disconnection between drug misuse treatment and other health structures, resulting in fragmentation of drug treatment pathways (particularly for those with more complex needs)”.^{xiii} And increased competitive tendering for contracts to provide drug services has eroded co-operation between providers (both statutory and voluntary sector) and led to a lack of stability and consistency in provision.

Local authorities fund drug treatment services through the Public Health Grant awarded by central Government, which has been ring-fenced (though subject to drastic cuts as previously explained). This ring-fenced budget is due to end in 2020, meaning uncertainty over future funding for drug treatment services. Uncertainty is further compounded by local authorities not currently being mandated in law to provide drug treatment services (unlike sexual health services, which are mandated). This could lead to further cuts and increased decommissioning of services. All at a time when these services are needed most.



What we did

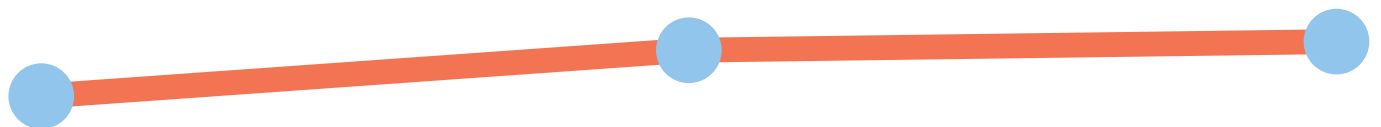
NAT (National AIDS Trust) are part of the English Harm Reduction Group, a coalition of organisations committed to the principles of harm reduction who campaign for improved drug policy on this basis in the UK. In order to ensure that local authorities were held to account on their efforts to reduce DRDs in their area, we secured a change to the Public Health Outcomes Framework (PHOF) to ensure that it included an indicator on DRDs. The only previous indicator had been the successful completion of treatment – which has been criticised for incentivising providers to move people off Opioid Substitution Therapy (OST) and through drug treatment too quickly. This has been a particular concern given the evidence that being in drug treatment is one of the most protective factors in preventing DRDs.

The Public Health Outcome that local authorities are assessed against is “the rate of drug misuse deaths per million population over a three-year period”.^{xiv} Drug misuse death includes death from accidental poisonings, intentional self-poisoning by drugs, poisoning by drugs with an undetermined intent, an assault by drugs, and death from mental and behavioural disorders due to drug use.^{xv}

The first set of data on DRDs for the PHOF was for the three-year period of 2014-2016 and was published in August last year.^{xvi} We identified 40 local authorities that had higher than benchmarked rates of DRDs.^{xvii} We wanted to establish whether these 40 local authorities had concrete plans to reduce DRDs in their area.

A letter was sent from the English Harm Reduction to all 40 local authorities (specifically to the Director of Public Health in each one) in May 2018 to ask what plans were in place to ensure that they were securing improvements against the DRDs PHOF indicator.^{xviii} Our letter focused on a number of issues, including:

- Asking local authorities whether any formal consideration of DRDs had taken place at full council meetings or other relevant committees since April 2016;
- Asking local authorities whether they have plans to commission an increase in the provision of naloxone (with research showing only 12% coverage currently across England)^{xix};
- Asking local authorities whether providers are providing OST in line with ‘Drug misuse and dependence: UK guidelines of clinical management, 2017’ (as research indicates sub-optimal dosing as an issue in the UK)^{xx};
- Asking what other initiatives the local authorities were implementing and what further reflections they had on support they needed to help reduce deaths.



Responses we received

We received responses from 35 out of 40 local authorities.^{xxi} The responses were wide ranging, but overall showed a substantial amount of responsiveness by local authorities to the issue of tackling DRDs, which highlighted the importance of having this indicator as part of the PHOF – prompting areas into action. Below we summarise our findings in more detail, broken into the key themes that arose from the responses. These are:

1. **Consideration of DRDs at council and committee meetings**
2. **Naloxone provision**
3. **Opioid Substitution Therapy**
4. **Public Health Funding**
5. **Heroin Assisted Treatment/Drug Consumption Rooms**

We then have a section entitled ‘Good Practice’ List – this details various initiatives that local authorities are implementing which other local authorities might be interested in.

We then summarise our recommendations for local authorities, PHE, NHS England, the UK Government and the Crown Prosecution Service to take forward.

1. Consideration of DRDs at council and committee meetings

In none of the 35 local authorities had DRDs been mentioned at Full Council meetings. This is disappointing given the seriousness of the issue and the wider link to the clinical and financial position of drug treatment services, rates of deprivation and homelessness, and the need for collaboration across the whole health and social care system.

While no local authorities reported that DRDs were an item in and of itself at Cabinet meetings, a few local authorities (for example Medway and Wigan) did mention that reports on the recent re-tendering of treatment services had been produced for councillors at Cabinet level.

Many local authorities reported DRDs being discussed at various other committees, including Scrutiny Committees, committees responsible for health, and Health and Wellbeing Boards.

We recommend that all local authorities with higher than benchmarked rates of DRDs formally consider DRDs as an agenda item at Council or Cabinet level. We also recommend that all local authorities with higher than benchmarked rates of DRDs ensure that their Health and Wellbeing Boards and other health focused committees are engaged on the issue of DRDs.

2. Naloxone Provision

Naloxone is a life-saving medication that counteracts the effects of opioids, such as heroin, and is administered in cases of a suspected opioid-related overdose to prevent death. Naloxone is included in the World Health Organisation’s list of essential medicines.^{xxii} The following bodies have recommended that take-home naloxone is made widely available to people likely to witness an opioid overdose: the Department of Health and Social Care^{xxiii}, PHE^{xxiv}, the ACMD^{xxv}, the World Health Organisation^{xxvi}, and the EMCDDA.^{xxvii} The medication is cheap and has no potential for misuse, so it is vitally important that local authorities ensure that take-home naloxone is supplied in a variety of settings to people likely to witness an overdose. This can include drug treatment services, needle and syringe programmes, community pharmacies, police officers in custody suites, as well as hostels and homeless shelters, and can include supply to someone at risk of an opioid overdose and their friends and family.^{xxviii}

In a recent Freedom of Information (FOI) request conducted by Release local authorities in England were asked about the coverage of their take-home naloxone provision. Release found that while 138 out of 151 local authorities were providing naloxone, nationally only 12 naloxone kits were given out for every 100 people using opiates (equivalent to 12% coverage) in 2016/17.^{xxix} In our letter to local authorities we called on those areas with inadequate

coverage to urgently increase the amount provided and improve access to take-home naloxone.

The case for naloxone's potential to support a reduction in deaths was made powerfully by a number of local authorities in their responses, including Blackpool which commented that 'since April 2017, 16 clients have self-reported that their lives were saved through the use of naloxone'. A number of areas committed to increasing their naloxone provision giving encouraging data on improved distribution. It was also encouraging to see many areas carefully considering in which settings to distribute naloxone, with many referring to hostels, emergency workers, and street workers.

However, a number of policy issues were identified in the responses. Southampton, for example, stated that "we are exploring options for the local police to offer naloxone, although this is hindered by guidance nationally for the police force". We followed up with Southampton to ask them more about the issues they had been facing. The Director of Public Health stated that they had anecdotally been told that police forces were being informed that it was unsafe for officers to carry naloxone, so many forces are reluctant to implement naloxone initiatives. We are aware that some areas across England do have police officers carrying naloxone, but we are aware of others where there is reluctance from police forces, so there seems to be an inconsistent approach across England. **We recommend that PHE work with the National Police Chiefs' Council to address the issue of police officers carrying naloxone as a matter of urgency, issuing a statement to police forces that it is safe for police officers to carry naloxone.**

Similarly, Newcastle said that "in terms of support needed for this agenda, it may be useful for the English Harm Reduction Group to work with the National Probation Service to understand and address their reservations about having Naloxone stored for use on their Approved Premises". We are aware that the National Probation Service does not currently make take-home naloxone available to people under their supervision and this is being reviewed. **We recommend that PHE work with the National Probation Service to address any concerns they have about supplying and storing naloxone, and, once addressed, a communication should be sent to all probation services on the outcomes of this work.**

In relation to prisons, Bournemouth, Poole & Dorset currently distribute naloxone through their prisons and to prisoners upon release. Leeds and Wigan both mentioned working with their prisons to initiate plans to deliver naloxone to prisoners upon release. However, the wider challenge of coordinating care in prisons, and particularly on release from prisons, was mentioned by Camden & Islington, Kent, Newcastle and Wigan. Kent stated, "we would like to see NHS England give greater priority to this issue particularly given they commission the prison health pathway". Blenheim CDP in a recent report commented on the failure of the prison system to consistently supply naloxone to prisoners upon release despite clear recommendations from the Government and PHE.^{xxx} This issue is particularly important given the high mortality rates of opiate dependent prisoners in the immediate post-release period,^{xxxi, xxxii} compounded by the high dropout rates in community treatment services amongst those with experience of incarceration.^{xxxiii} **We recommend that NHS England support prisons to ensure that they are providing take-home naloxone to all prisoners identified as at risk of opioid overdose upon release.**

Some local authorities restricted access to take-home naloxone to only those in treatment (Sheffield, Reading). Given the fact that most deaths are happening to people not currently in structured treatment this is worrying. Both gave the reason of the lack of funding to extend the service, with Sheffield stating that "any expansion of the service would be at the expense of other drug treatment and recovery services". It is appalling that cuts to drug treatment has been so severe as to prevent local authorities from supplying a life-saving drug to all those at high risk of overdose and death. **No local authorities should restrict take-home naloxone provision to those in treatment and all local authorities should assess whether their current naloxone provision ensures access to all who need it.**

To ensure that there is consistency of approach across local areas, regular monitoring and reporting of naloxone provision, and a level of resource that equates to need, we recommend that the UK Government explore the implementation of a national programme similar to that in Scotland.

Regardless of whether there is a national programme, funding for naloxone via the Public Health Grant must be increased. This would allow

local authorities to commission services that provide naloxone in line with need, reach people in and out of treatment, ensure access via a variety of settings (including prisons and probation services), and allow for peer education initiatives to enable those groups who are harder to reach to have better access to naloxone.

3. Opioid Substitution Therapy (OST)

We asked local authorities whether their providers were supplying OST in line with ‘Drug misuse and dependence: UK guidelines on clinical management, 2017’.^{xxxiv} This is the most recent guidance on drug misuse management at national level (badged by the health departments of all four UK nations). Sub-optimal dosing has been stated as an issue in the UK, and current guidance seeks to clarify what optimal dosing looks like. Sub-optimal dosing often leads to people in treatment using heroin and other opiates on top of their OST, increasing the risk of overdose and treatment failure.

Nearly all the local authorities stated that their providers are abiding by current guidelines. What this means in practice though remains somewhat unclear. A few local authorities (Bournemouth, Poole & Dorset, Bristol, Sefton) have carried out audits of OST provision. **We would recommend that all local authorities audit their OST provision to ensure that clinical prescribing is actually in line with clinical guidelines and is not resulting in worsened health outcomes and deaths.**

We have historically voiced concern that the move to a more abstinence-based model of drug treatment has meant that people have been moved off OST too quickly. UK clinical guidance states quite clearly that for some people recovery will mean lifelong OST.^{xxxv} However, local authorities are not incentivised to keep people in structured treatment, rather they are measured against an indicator that rewards completion of OST. It is worrying that some local authorities such as Stoke-on Trent state that they are working to achieve “a greater focus on visible recovery, encouraging people whenever possible and safe to consider full recovery or abstinence from drugs and alcohol”. We hope that this does not mean moving clients off OST before they are ready to. Bristol encouragingly stressed that they have no time limits and Cumbria stated that they have rebalanced their model of recovery to one that has greater flexibility around longer-term

substitute prescribing. **We recommend that all local authorities ensure that their drug service contracts do not reward providers financially for ‘successful completion’ against the PHOF indicator.**

PHE have in the past noted that there is no evidence that the PHOF indicator on successful completions is resulting in increased deaths. It is not so clear, however, whether the indicator is bringing about any health benefits for service users. **We recommend that PHE publish evidence of the impact of the treatment completion PHOF indicator on service improvement and better health outcomes for service users. In the absence of such evidence the indicator should be removed from the PHOF.**

Finally, the ACMD stated in their report on reducing opiate-related deaths that “the most important recommendation in this report is that government ensures that investment in OST of optimal dosage and duration is, at least, maintained”.^{xxxvi} Many local authorities raised issues around funding, but Bournemouth, Poole & Dorset raised concerns specifically on OST, stating that maintaining funding for OST is dependent on the continuation of the Public Health Grant. **The UK Government should ensure that funding is maintained and increased for key initiatives that are known to reduce DRDs such as OST.**

We are concerned about recent reports of the huge increase in costs of Buprenorphine as a result of the generic drug maker, Subutex, who has stopped producing it. This price rise could lead to increased deaths amongst people on OST, particularly if they are moved over to methadone, which could lead to disengagement from treatment. **We recommend that the UK Government work to reduce the price of Buprenorphine.**

4. Public Health Grant/Funding for Drug Treatment Services

As aforementioned, funding for drug treatment (and public health more widely) has been drastically reduced over the last few years (see Figure 3 for more detail). One of the key themes running through a large number of the responses was the great pressure that had come with the decrease of funding. Local authorities stated how this was impacting upon efforts to maintain the quality of the services as well as expand key initiatives needed to

RESPONSES WE RECEIVED

reduce DRDs. For example, Bournemouth, Poole & Dorset stated that “it is particularly challenging that these funding pressures are being placed on local authority public health services at a time when the need for coordinated and effective health and social care for opiate users is increasing”.

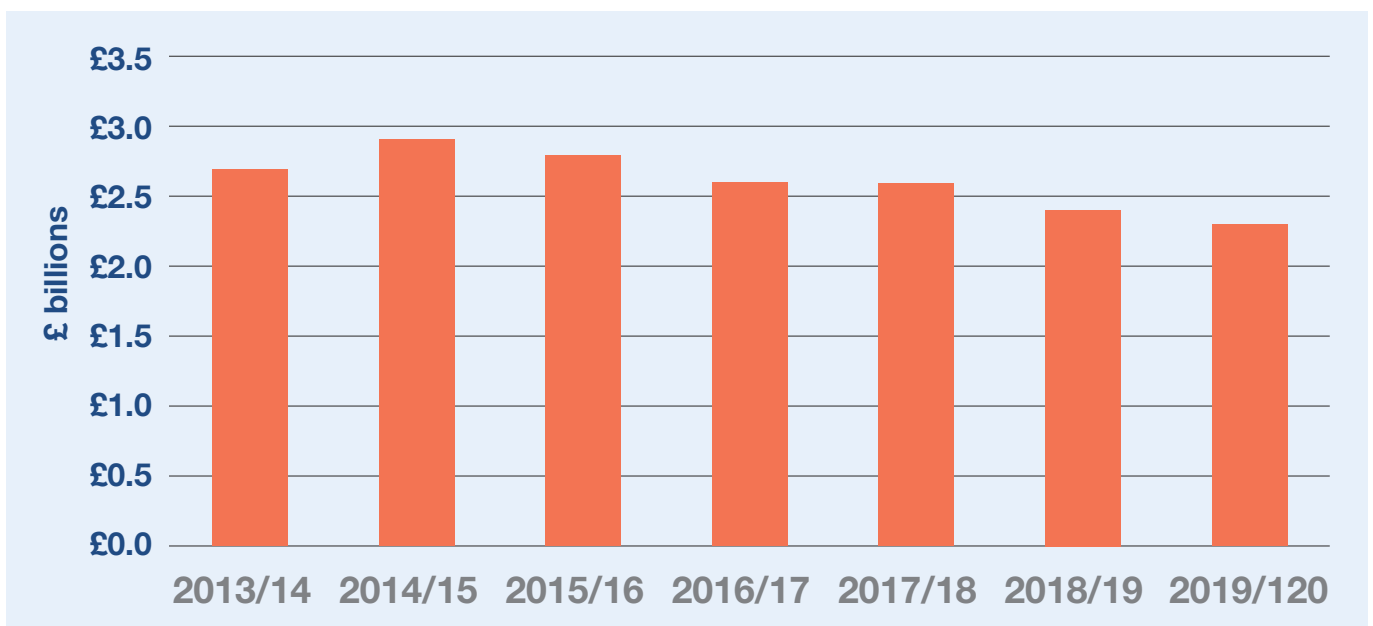
A number of local authorities mentioned the Public Health Grant specifically and how maintaining quality of services requires maintaining this grant. Any further cuts to this grant risks further impacting upon the quality of drug treatment services. Such risks to the quality of drug treatment services are exacerbated by the uncertainties around the future of public health funding. Drugs services are funded from the ring-fenced Public Health Grant distributed to local authorities. The Government plans, from 2020, to end the central Public Health Grant, with the proposal that instead local authorities fund their public health work from business rates retention. There could well be severe repercussions on levels of funding available for public health more generally and drugs services in particular, especially in areas of significant need where business rates revenues may be relatively low.

Plymouth mentioned the cumulative effect of austerity and its particular impact upon people who use drugs problematically, resulting in people

having less support systems to seek help from. An integrated approach to tackling DRDs is needed, focusing care around the holistic needs of patients. This means quality access to a wide range of support such as homeless and housing support, initiatives to support people into work, access to adult social care, as well as accessible and effective drug treatment services is needed. This requires not just drug treatment services to be well funded, but the wider services needed to help people and protect them from vulnerability to death. Other local authorities that mentioned issues around funding were Portsmouth, Sefton, Sheffield, and Southampton. As an example of the extremity of the cuts it should be noted that Sefton mentioned how they had suffered a 51% reduction in budget for drug treatment services between 2014 and 2016.

It is imperative that, as a minimum, cuts to drug treatment services over the last few years are reversed. We further call on the UK Government to ensure that funding for harm reduction services aligns with need. We also strongly recommend that the Public Health Grant to local authorities is maintained and that local authorities are mandated in law to provide drug treatment services (which would protect against complete decommissioning).

Figure 3. Annual Public Health Grant net expenditure between 2013/14 and 2019/20 in real terms (2018/19 prices)



(Source: Health Foundation’s analysis of published data).^{xxxvii}

5. Heroin Assisted Treatment/Drug Consumption Rooms

We also asked local authorities what further reflections they had on measures needed to reduce DRDs. Several areas mentioned Heroin Assisted Treatment (HAT) – prescribing medical-grade heroin, diamorphine, to patients who do not respond to first line OST medications, such as methadone and buprenorphine.^{xxxviii} HAT is an evidence-based harm reduction intervention, which has been shown to be cost-effective^{xxxix}, and is supported by NICE Guidelines, the ACMD, and the British Medical Association.^{xl} Bristol and Sefton are conducting feasibility studies and Newcastle is reviewing literature on HAT. Uptake of HAT is low across England, mainly due to the costs involved in setting a service up. ACMD recommended that central funding becomes available for HAT, which would support local areas to implement it.^{xli} **In order for uptake of HAT in local areas to increase, we would encourage the UK Government to take up the ACMD’s recommendation of central funding to be provided to support HAT for patients for whom other forms of OST have not been effective.** To date, the UK Government have only provided funding for a pilot programme of HAT. **We also recommend that local authorities explore commissioning HAT as an option for service users that do not respond to OST.**

A number of areas also mentioned Drug Consumption Rooms (DCRs). DCRs are legally sanctioned facilities where people can use illicit drugs obtained themselves, under the medical supervision of trained staff. These facilities aim to reduce transmission of blood-borne viruses through unhygienic injecting, prevent drug-related overdose deaths and link PWIDs with drug treatment services and other health and social services.^{xlii} There are at least 78 DCRs operating in Switzerland, Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark, Greece and France, as well as additional facilities in Canada and Australia.^{xliii} Bournemouth, Poole & Dorset, for example, stated that one national policy level issue that “if addressed would potentially make the task a little easier at local authority level” was “a clearer position and serious consideration of the evidence around drug consumption rooms”. Newcastle is currently reviewing the evidence around DCRs, Sefton and Bristol are conducting feasibility studies on DCRs, and Southampton detailed in a report how DCRs would help reduce drug-related litter in the area. This shows the wide

support from local authorities to have the option to seriously consider DCRs in their area. However, despite evidence of the effectiveness of DCRs, the UK Government has blocked the creation of a DCR anywhere in the UK.

For provision for DCRs to be made in law, this would require a change in legislation (Misuse of Drugs Act 1971). This would ensure implementation and use of a DCR are exempt from prosecution. **We call on the UK Government to amend the Misuse of Drugs Act 1971 so that local areas can open DCRs where there is need without fearing falling foul of the law.**^{xliv}

However, the Misuse of Drugs Act 1971 does not make DCRs unlawful in and of themselves, but rather it is the crimes that would take place within a DCR that could lead to potential prosecution. In advance of any change in the law, a DCR could be implemented in a local area if there was guarantee from local police forces that they would not prosecute those delivering or using the service for crimes under the Misuse of Drugs Act 1971. This could also be achieved if the UK Government stated that they would not expect police forces across the UK to prosecute those involved in setting up a DCR (a similar approach to that taken on festival drug testing). **We call on the UK Government in the short term to take the same approach as they recently announced with festival drug testing, by sending a message that local Police & Crime Commissioners and health bodies can develop their own positions on DCRs without direction from Westminster.**

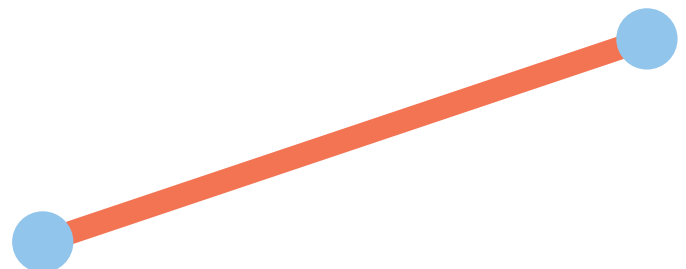
Local authorities that wish to explore implementation of a DCR should liaise directly with their local police forces to initiate conversations on how one would be managed from a legal perspective in their area. These conversations would be aided if, at a national level, the Crown Prosecution Service amended their legal guidance on drug offences to bring DCRs in line with needle exchange services which already recommends that police forces do not prosecute those accessing sterile injecting equipment.^{xlv} **We recommend that the CPS amend their guidance to state that it is not in the public interest to bring prosecutions for possession of controlled substances where a person is accessing a DCR.**

List of good and innovative practice

As an additional section to this briefing, we wanted to highlight some of the innovative and interesting practices that local authorities highlighted in their responses. **Local authorities should review the good practice contained within this report and consider as appropriate implications for their own services.** We hope that this may be useful to other local authorities, who may take inspiration from some of the initiatives:

- Many local authorities have implemented early warning systems/drug alerts to inform stakeholders if issues around the purity of drugs, or drugs adulterated with other substances, arise and to identify when a spike in deaths is linked to a particular type or batch of drugs. They often work by providing information to all key stakeholders in the area. Some local authorities have implemented systems that operate across local authority boundaries.
- Some local authorities monitor and audit all DRDs to identify missed opportunities to support people who have died. Cornwall hold an annual DRDs conference to disseminate new research, best practice, and themes that have emerged from recent deaths. Plymouth's audits have allowed them to identify as factors the increase in availability and purity of heroin in their area, and the overlap between DRDs, alcohol use and suicide. Serious Incident Reviews in Blackpool and Stoke-on-Trent mean that providers and commissioners can come together to discuss cases and identify themes.
- Some local authorities have a specific post for a DRD coordinator (usually multi-agency). For example, in Middlesbrough they are jointly funding a Preventing Drug-Related Deaths Co-ordinator with Stockton and Redcar & Cleveland. This means that there is complete oversight from one staff member who can identify gaps in the approach taken (e.g. they currently have no early warning system, but the co-ordinator is in the process of setting one up).
- Local drugs strategies have been used to ensure strategic action is being taken on DRDs. Kent, North Tyneside, Sheffield and Southampton have all developed local drug strategies that cover a defined period. This process has allowed them to comprehensively understand what actions need to be taken to reduce deaths.
- There was in many local authorities a particular focus on respiratory ill-health and other co-morbidities, which have been linked to the increase in DRDs. Blackpool have identified that a number of the deaths occur in those with Chronic Obstructive Pulmonary Disease (COPD), end stage liver disease and heart failure. They therefore ensure to commission a service which has good referral mechanisms into physical healthcare. Sefton are offering people with COPD on OST the option to switch to buprenorphine (from methadone) – which is known to have less of a depressant effect on the respiratory system. Similarly, Wirral routinely screens all service users for COPD (they have around 50% produce a positive test). Sefton are also providing hepatitis C treatment to people in the community as part of their clinical and healthcare support package.
- There were some mentions of service user involvement in the designing of services (Camden and Islington, Liverpool, Newcastle, Stoke-On-Trent), however, we were surprised there were not more references. Camden and Islington stated that they are “committed to designing and delivering coproduced services, where the voices of clients are heard and acted on”. In Camden they have a service user forum which meets regularly with commissioners. Newcastle has a funded Service User Involvement Officer to coordinate user and carer activity. **We would encourage more local authorities to ensure that service users are meaningfully involved in discussions of service design.** This would include sufficient resource committed to this area (which could include, for example, a dedicated worker on involvement, budget, remuneration, training, discussion forums) and proactive efforts to engage with groups under-represented in involvement such as people not ‘in recovery’,

- women, BME people, LGBT+ people, young people, and those with dual diagnosis. Service users should be included at every stage of the commissioning process for drug services (e.g. needs assessment, awarding of contracts, performance management) and not just the designing of services.
- Cornwall have a focused programme to tackle deaths in supported accommodation after analysing data that suggested the highest number of deaths were happening to those in support accommodation – with residents not disclosing problematic drug use because of low tolerance for people who use drugs by accommodation providers. They introduced a ‘Substance Misuse in Premises’ protocol, supported by a workforce development programme. Specialist substance misuse workers now work from supported accommodation and naloxone has been introduced in this setting (with 40 overdoses reversed).
 - Gateshead and Newcastle both mentioned work with needle exchange services. Gateshead monitor their needle exchange activity and ensure there is increased access to these services (both fixed and mobile) to not only support harm reduction efforts but to integrate service users into treatment. Newcastle are looking to expand their needle exchange services.
 - Medway commission intensive support to those identified as high risk. They have a programme called ‘Intuitive Thinking Skills’ which is used to provide staff with additional capabilities to support those who have become ‘stuck in treatment’ and are likely to be using illicit opioids on top of their OST.
 - Mental health services were mentioned by many local authorities. In Cornwall, concomitant mental health conditions (i.e. dual diagnosis) are seen as highly prevalent in DRDs, with many people falling between services and not receiving adequate care. Issues around joint care led to the local coroner issuing a Rule 28, often used when similar deaths are likely (meaning that a report is sent to organisations who are in a position to take action to prevent similar deaths). Kent has worked to improve upon the mental wellbeing of people who use drugs through what they call ‘trauma informed care’. Sheffield has worked to identify risk factors for suicide to identify people early and more them into care.
 - Durham, Gateshead and Wirral had all engaged primary care on DRDs. Durham has commissioned dedicated support to GP surgeries on prescribing pain management in people who use drugs. Gateshead and Wirral similarly have looked at the issue of pain medication prescribing by GPs, and Gateshead have presented information on trends of deaths to GPs to increase their awareness.
 - Many local authorities mentioned conducting outreach to those not in treatment (Cornwall, Cumbria, Durham, Hartlepool, Plymouth, Sheffield, Wigan, Wirral). This is particularly important given the high number of deaths happening to those not in treatment and the protective factor that structured drug treatment can have. Sheffield has commissioned an open access drug treatment service that allows people to walk in and be seen the same day for an assessment and to be started on OST shortly afterwards if appropriate (this has significantly increased their treatment penetration rates). Wirral have a re-engagement outreach service for patients that drop out of treatment. **Local authorities should seek to improve the accessibility of drug treatment services – given the high rate of deaths amongst those not currently engaged in structured treatment.**



Conclusion & Recommendations

We were encouraged by the responses from local authorities, who all seem to have considered the high rate of DRDs in their area. Many also have concrete plans in action to attempt to reduce the rate of deaths. Below we summarise our recommendations for local authorities, PHE, NHS England, the UK Government, and the Crown Prosecution Service, which, if implemented, would support efforts to reduce DRDs.

Recommendations for local authorities:

- All local authorities with higher than benchmarked rates of DRDs should formally consider DRDs as an agenda item at Council or Cabinet level.
- All local authorities with higher than benchmarked rates of DRDs should ensure that their Health and Wellbeing Boards and other health focused committees are engaged on the issue of DRDs.
- No local authorities should restrict take-home naloxone provision to those in treatment and all local authorities should assess whether their current naloxone provision ensures access to all who need it.
- All local authorities should audit their OST provision to ensure that clinical prescribing is actually in line with clinical guidelines and is not resulting in worsened health outcomes and deaths.
- All local authorities should ensure that their drug service contracts do not reward providers financially for 'successful completion' against the PHOF indicator.
- Local authorities should explore commissioning HAT as an option for service users that do not respond to OST.
- Local authorities that wish to explore implementation of a DCR should liaise directly with their local police forces to initiate conversations on how one would be managed from a legal perspective in their area.

- Local authorities should review the good practice contained within this report and consider as appropriate implications for their own services.
- Local authorities should ensure that service users are meaningfully involved in discussions of service design.
- Local authorities should seek to improve the accessibility of drug treatment – given the high rate of deaths amongst those not currently engaged in structured treatment.

Recommendations for Public Health England:

- PHE should work with the National Police Chiefs' Council to address the issue of police officers carrying naloxone as a matter of urgency, issuing a statement to police forces that it is safe for police officers to carry naloxone.
- PHE should work with the National Probation Service to address any concerns they have about supplying and storing naloxone, and, once addressed, a communication should be sent to all probation services on the outcomes of this work.
- PHE should publish evidence of the impact of the treatment completion PHOF indicator on service improvement and better health outcomes for service users. In the absence of such evidence the indicator should be removed from the PHOF.

Recommendations for NHS England:

- NHS England should support prisons to ensure that they are providing take-home naloxone to all prisoners identified as at risk of opioid overdose upon release.

Recommendations for the UK Government:

- To ensure that there is consistency of approach across local areas, regular monitoring and reporting of naloxone provision, and a level of resource that equates to need, we recommend that the UK Government explore the implementation of a national programme similar to that in Scotland. Regardless of whether there is a national programme, funding for naloxone via the Public Health Grant must be increased.
 - The UK Government should ensure that funding is maintained for key initiatives that are known to reduce DRDs such as OST.
 - The UK Government should work to reduce the price of Buprenorphine.
 - As a minimum, cuts to drug treatment services over the last few years should be reversed. The UK Government should ensure that funding for harm reduction services aligns with need.
 - The Public Health Grant to local authorities should be maintained.
 - Local authorities should be mandated in law to provide drug treatment services (which would protect against complete decommissioning).
- The UK Government should take up the ACMD's recommendation of central funding to be provided to support HAT for patients for whom other forms of OST have not been effective.
 - The UK Government should amend the Misuse of Drugs Act 1971 so that DCRs can be opened in areas where there is need without fear of falling foul of the law.
 - In the short-term the UK Government should take the same approach on DCRs as they recently took with festival drug testing, by sending a message that local Police & Crime Commissioners and Health Authorities can develop their own positions on DCRs without direction from Westminster.

Recommendations for the Crown Prosecution Service:

- CPS should amend their guidance to state that it is not in the public interest to bring prosecutions for possession of controlled substances where a person has been accessing a DCR.

Note on 2015-2017 data (PHOF)

We note that more recent data has now been published on the PHOF that shows deaths from drug misuse covering the period of 2015-2017. There are now 42 local authorities with higher than benchmarked rates of DRDs. Birmingham, Cornwall, Kent, Medway, Sefton and South Tyneside are no longer worse than the benchmark. East Sussex, Hackney, Isle of Wight, Kingston Upon Hull, North East Lancashire, Redcar and Cleveland, Rotherham and Wakefield do now have worse than benchmarked rates.

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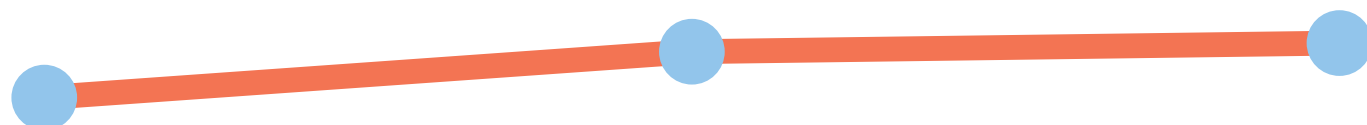
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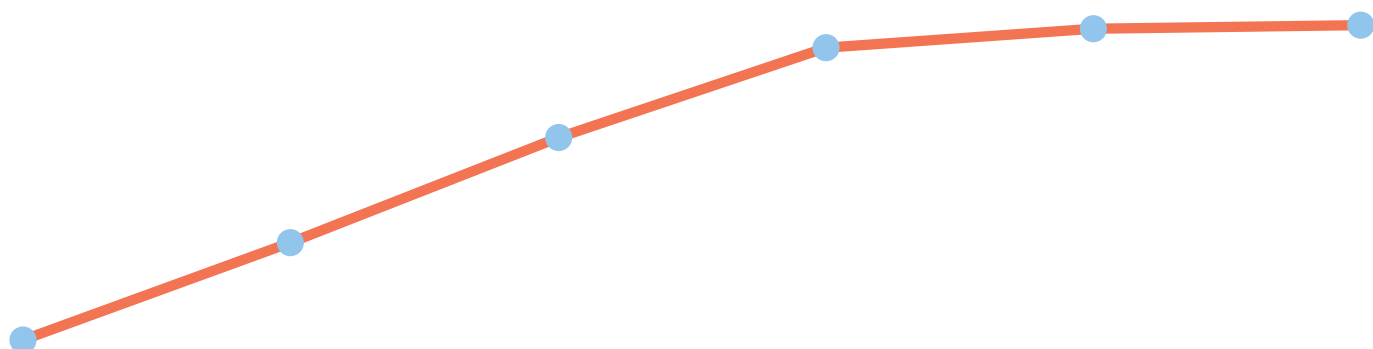
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