Collective Voice

NHS Substance Misuse Provider Alliance

IMPROVING CLINICAL RESPONSES TO DRUG-RELATED DEATHS

A summary of best practice and innovations from drug treatment providers

August 2017

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With support from Public Health England

Preface

Improving clinical responses to drug-related deaths: a collaboration between Collective Voice and the NHS Substance Misuse Provider Alliance

For the last four years drug-related deaths in England and Wales have increased. They are now at the highest levels since records began in 1993. Scotland has also seen drug deaths increase dramatically in recent years. This is more individuals whose lives are cut short and denied the opportunity to realise a brighter future. More families blighted by the pain and bereavement that losing a loved one causes. Every effort has to be made by all stakeholders to do all they can to change these statistics, and this will involve action in all contexts in which drugs are used and among all drug users. However as providers of services to the most vulnerable sections of the population we have particular expertise in the delivery of effective evidence-based treatment and harm reduction services, which both Public Health England (PHE) and the Advisory Council on the Misuse of Drugs (ACMD) have identified as fundamental to addressing this crisis. The focus of this document is therefore to pool and share our expertise to maximise the treatment sector's contribution to minimise early and avoidable deaths, particularly among opiate users where risk is highest.

To this end Collective Voice and the NHS Substance Misuse Provider Alliance (NHS SMPA) have worked together, with PHE's support, to produce a set of recommendations for providers with the aim of ensuring that everything that can be done is done by service providers to help reverse this damaging trend. This demands a challenging balancing act, retaining a focus on the importance of harm reduction and safety while not undermining the opportunity and ambition for recovery of many people we work with. The document covers a number of subject areas, but detailed below are the key recommendations we believe providers and those commissioning services should commit to:

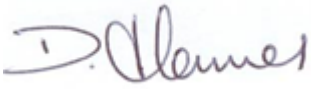
1. Drug treatment services should review their information systems to enable data relevant to risk of overdose to be captured and deployed to inform individual treatment plans.
2. Treatment plans should be consistent with the 2017 Clinical Guidelines and should be individually tailored to balance the protective benefits of OST with the opportunity to safely progress towards recovery. Providers and commissioners should guard against forced reductions or premature removal from treatment in a desire to achieve targets.
3. All providers should establish clear protocols for managing the risk of overdose and ensure their staff are competent to implement them. This should include ensuring naloxone is widely available.
4. Commissioners and service providers have a responsibility to maximise their contribution to addressing all the physical and mental health needs of service users, ensuring these are met either within their own services or by effective engagement with timely and appropriate access to primary care and specialist services in the NHS. This includes ensuring that more people are tested and treated for hepatitis C.

5. Commissioners and treatment systems need to increase local penetration rates to reduce deaths among those who are currently not engaged in treatment or in contact with harm reduction services. Fundamental to this is promoting and expanding access to needle and syringe programmes.

The constituent members, both voluntary sector and NHS providers, of Collective Voice and the NHS SMPA have contributed and shared their expertise with the aim of increasing best practice across all organisations. A subject as important as this demands openness and transparency to ensure every opportunity is taken by service providers to help save a life. As such the organisations we represent will take a lead in promoting these aims.

We thank the individuals and organisations who have contributed to this document and ask all those who commission or provide services to take the time to read it and apply the recommendations it makes and hopefully benefit from some of the innovative practice included.

Karen Biggs
Chair, Collective Voice



Danny Hames
Chair, NHS Substance Misuse Provider Alliance

Introduction

Following successive increases in drug-related deaths in England, in 2016 Public Health England (PHE) convened a national inquiry in partnership with the Local Government Association to investigate the causes of the rises and what could be done to prevent future premature deaths.

The subsequent report of the inquiry included recommendations for continued research and investigation to "explore with large drug treatment providers the feasibility of conducting further analysis of their significant data and resources". PHE and provider representatives agreed that the process should be led by Collective Voice and the NHS Substance Misuse Provider Alliance, supported by PHE, and go wider than sharing data analysis.

A working group (appendix 2) established five practice points for development:

Practice point	Aim
1. Identifying risk of drug-related death	To encourage and support the development and implementation of suitable systems able to routinely identify those most at risk of overdose and target resources accordingly
2. Delivering safe, recovery-orientated drug treatment	To clarify and summarise recent guidance, evidence reviews and other principles which can ensure good practice
3. Preventing overdose in people who use drugs	To delineate practice that can minimise the risk of drug misuse deaths
4. Meeting physical and mental health needs	To provide practice-orientated advice on specialist treatment pathways and reframe clinical practice with all service users to prioritise their physical mental health needs
5. Reducing the risk of drug-related death for people outside drug treatment	To identify opportunities to target and engage dependent users who are outside the treatment system, bringing them into treatment's protection where possible but otherwise protecting them if not

The practice points are covered in successive chapters, which include:

- a summary of what the relevant guidance says should be done in practice
- blocks and risks that can prevent implementing the guidance
- solutions and implementation principles
- practice examples to illustrate how others have overcome the barriers
- a list of references and resources, including the guidance from which the practice points are taken

1 Identifying risk of drug-related death

- There is clear evidence that some risk factors relating to overdose are likely to increase the risk of drug-related deaths. Identifying both acute and longer-term risks can inform continuing clinical management of people using services.
- Management information systems can be set up to routinely identify those most at risk of overdose and drug-related deaths and target resources accordingly.

1.1 What the relevant guidance says about this issue

- Identify risk factors that can help inform the risk management plan for an individual, at comprehensive assessment.
- Take particular notice of risk factors for overdose death that evidence suggests are clinically significant, including:
  - being male or in an older age group
  - not being in opioid substitution treatment (OST) but using heroin
  - entering treatment, especially during the first four weeks, or exiting treatment
  - reduced opioid tolerance, including individuals who have completed a planned detoxification or been released from a protected environment such as prison, rehab or hospital
  - use of central nervous system depressants, including benzodiazepines and alcohol, at the same time as opioids, especially heroin
  - a previous history of overdose, especially if recent
  - homelessness or living in a hostel or unstable accommodation
  - previous variable or poor engagement with treatment services.
- Assess for a wide range of other causes of death that are related to drug use, which include:
  - blood-borne viruses, and other infections
  - liver cancer and liver failure that follow chronic viral hepatitis
  - other liver disease (including with heavy alcohol use)
  - suicide
  - accidents, injuries and homicide
  - prolonged smoking, which leads to high risk of chronic lung disease (including COPD) and cardiovascular disease
  - respiratory and vascular complications of drug use
  - disease due to sustained heavy alcohol use
  - comorbid mental health problems associated with increased risk of comorbid physical health problems, and of suicide, and with antipsychotic and polydrug prescribing that carries an independent risk of premature death.

1.2 Blocks and risks that prevent implementation of the guidance

- Capturing data and analysing it to learn from previous drug-related deaths may be difficult where a service uses paper records.
- Inconsistent data collection can make sharing, analysis and learning more difficult.
- A time lag between deaths and receiving confirmation of cause of drug-related death, toxicology, and other important information, can delay opportunities to learn lessons.
- Accuracy in arriving at cause of death can be variable. For example, sometimes a coroner's report might include 'methadone toxicity' in an individual who was almost certainly likely to have developed tolerance to opioids.

1.3 Solutions and implementation principles

- Analysis of data to identify those at highest risk can be discussed and presented by practitioners and teams to improve learning and staff competence in prioritising risk.
- Electronic case management systems can record information for risk management plans to reduce drug-related deaths.
- Visible representations of outcomes, like the Outcome Star, or other outcome measures like the ADAPT, can help articulate and demonstrate an individual's risk profile.
- Risk profile, red flag and similar reports generated by electronic case management system can highlight individuals at higher risk in a patient cohort, based upon the presence of key data points.
- Clinical consensus groups can help construct reports and 'weight' individual risk factors.
- Data mining/analytics software, including text-mining, can be used to automatically spot trends in data.
- Data capture systems may need to be changed to support the identification of those most at risk.
- Treatment Outcomes Profile data could be used more frequently than just at recommended review periods to better gauge stability or 'use on-top', and highlight those requiring dose optimisation.
- Learning from analysis of previous incidents could be used to identify a 'high risk cohort' who staff then review and offer harm reduction interventions.
- Dynamic risk assessments can cause care plans to be adjusted according to new data, for example, a recent hospital admission or a significant life event.
- Data from commissioners and other providers for drug-related deaths of individuals not in structured drug treatment could be shared.
- More specific and detailed information could be recorded on drug-related deaths, for example, the circumstances of death.
- Routine sharing of best practice across services can facilitate learning and in-depth analysis of deaths over a number of years to better understand causal factors in a caseload, team or service.

Data sources and other information used by providers when identifying risk of drug-related death are included at appendix 1.

1.4 Practice examples

- cgl uses data in an electronic client management system to highlight, at a case-level, clinically significant factors that have been shown to confer a higher risk of overdose. This information is used to generate a report to support case segmentation and the application of focussed interventions to meet the needs that led to the increased risk. This approach does not seek to predict overdose, but instead be a tool to support the principles of good case management. It is relatively straightforward and could be explored by any service that collects clinical data as discrete data points.
- Inclusion collects all assessment, safeguarding and risk data electronically, and uses this to generate bespoke reports for core areas of risk. They also use third-party analytic plugins to interrogate large data-sets to aid learning and practice development. Future plans include the ambition to link historical and dynamic risk information with learning from incidents to help identify immediate and potential future risks.
- Addaction uses a purpose-built data tool to identify and score characteristics that indicate additional risk or complex needs. The tool attributes scores/weighting to risk-taking behaviours and is used to identify those most at risk within a service in real time as behaviour patterns change. The tool provides information to prompt the selection of specific elements of care pathways and individually-tailored approaches to care.
- The South London and Maudsley NHS Foundation Trust (SLAM) uses a data warehouse, called CRIS, which extracts data from its clinical records. This anonymised data can then be exported and subject to a range of searches including being able to interrogate text for particular words or phrases. The data set is also linked with other data sets including, mortality data and hospital usage data. This means that predictors of death from various causes can be analysed in detail enabling clinical services to identify clients who are vulnerable to early death.

1.5 References and resources

- Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
- Lyndon A, Audrey S, Wells C, Burnell E, Ingle S, Hill R, Hickman M & Henderson G (2017) Risk to heroin users of poly-drug use of pregabalin or gabapentin. Addiction 112(9): 1580-1589 http://onlinelibrary.wiley.com/doi/10.1111/add.13843/full
- Pierce et al (2016) Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. Addiction 111: 298-308 http://onlinelibrary.wiley.com/doi/10.1111/add.13193/abstract

- Pierce et al (2015) National record linkage study of mortality for a large cohort of opioid users ascertained by drug treatment or criminal justice sources in England, 2005–2009. Drug and Alcohol Dependence 146: 17-23 www.sciencedirect.com/science/article/pii/S0376871614018444
- Cornish et al (2010) Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database BMJ 341: c5475 www.bmj.com/content/341/bmj.c5475
- Sun et al (2017) Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. BMJ 356: j760 www.bmj.com/content/356/bmj.j760
- Merrall et al (2010) Meta-analysis of drug-related deaths soon after release from prison. Addiction 105: 1545-1554 http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.02990.x/full
- Kimber et al (2015) Mortality risk of opioid substitution therapy with methadone versus buprenorphine: a retrospective cohort study. The Lancet Psychiatry 2: 901-908 www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00366-1/fulltext

2 Delivering safe, recovery-orientated drug treatment

- Treatment interventions should be aligned to clinical guidelines and current guidance on delivering recovery-orientated practice in order to promote recovery and maintain patient safety.
- Equally, concern about drug-related deaths should not create a risk-averse clinical culture in which the legitimate ambition of recovery for service users is thwarted.

2.1 What the relevant guidance says about this issue

- Harm reduction and treatment interventions are needed for a broad range of drugs that are used and misused, and can lead to problems including dependence.
- Drug treatment systems should balance the protective benefits of opioid substitution treatment (OST) with the opportunity to progress towards further recovery support through regular review and development of individual treatment plans.
- Treatment must be supportive and aspirational, realistic and protective. The most effective interventions include 'phased and layered' interventions that reflect the different needs of people at different times, and treatment programmes that optimise medication according to evidence and guidance.
- Limiting the use or duration of substitute medication does not support people in their recovery, and can lead to increases in the spread of blood-borne viruses, drug-related deaths and crime. Pick-up arrangements should be appropriate to the individual.
- The dose of OST required will depend on biological, psychological and social factors and patients should not be 'under-dosed' if they continue to use illicit opiates.
- Knowledge, skills and attitudes that make up staff competence are crucial. A therapeutic relationship between staff and client should not appear adversarial or punitive – compromise is crucial to a lasting and meaningful engagement.
- Compromise may be required in negotiations about take-home doses for holidays or appointments fitting around work commitments.
- Contingency management can be effective in shaping behaviour.
- Clients who are excluded from treatment should be given clear advice on where to seek crisis support and routes back into treatment.

2.2 Blocks and risks that prevent implementing guidance

- Drug dependent and ex-dependent individuals who experience increasing morbidity and mortality risk require complex treatment.
- There may be limited patient engagement with prescribers, especially in primary care.
- Flexible prescribing regimes and pickups may be reduced where a risk-averse culture exists, and this culture may be brought about because of increasing drug-related deaths locally.
- There may be a lack of adequately skilled prescribers in specialist services.

- Commissioning arrangements may over-emphasise progress to abstinence.
- A limited treatment offer may be unattractive to patients, for example a treatment offer limited to medication that does not acknowledge the wider recovery resources that could be made available from the start of treatment.
- Local targets may put pressure on services to not readmit people who have left treatment.
- Retendering of services may increase the transfer of clients or turnover of staff which can directly impact continuity of treatment.
- Clinicians may resist considering naltrexone or 'retox' for those at high risk of overdose on prison release.
- Increasing resource constraints may inhibit the ability of services to consistently deliver evidence-based interventions.

2.3 Solutions and implementation principles

- Standard operating procedures or protocols for recovery-orientated prescribing can be used to increase access to community detoxification but retain a strong focus on harm reduction and the prevention of drug-related deaths.
- Local naloxone strategies should include provision to service users on OST.
- Treatment plans are more effective developed in partnership with service users (and where appropriate their family) following a comprehensive assessment. They should include rapid access to titration appointments and a clear induction plan.
- OST should be provided in combination with an individualised package of other interventions addressing all needs of the patient.
- OST should be given at an optimised dose. Patients should be given relevant information when being consulted about medication and OST should be reviewed regularly as part of an overall treatment plan.
- Clear standard operating procedures or protocols should be in place and 'owned' by all staff.
- Patients who decline to engage in therapeutic interventions can be offered low threshold programmes in combination with supervised dispensing. This must be regularly reviewed allowing further interventions to be offered where suitable.
- It may be best to include staff members from other teams in appointments with service users who have been temporarily or permanently excluded from services in other environments in the past.

2.4 Practice examples

- **Use on top:** Addaction's 'Breaking the Chains' programme focuses on opiate users who are still using. The programme includes psychosocial interventions, support to prepare for detoxification, an emphasis on behavioural change and significant peer support to achieve safe and effective progress towards recovery.

- **Pregnant service users:** Inclusion Thurrock provides a 'one stop shop' approach for pregnant service users to help them with the appointment burden and streamline medication and specialist midwife input. They have clinics running concurrently, which can test, assess and treat for hep C treatment, provide antenatal scans on site and review prescription and adjust prescriptions. Any changes are then communicated to all agencies including hepatology, primary care and gynaecology.
- **Rural communities:** Addaction service users and family members in rural communities can access assessment and some interventions by telephone, video-conference (including mobile and app-based), face-to-face in community and partner locations, and at main service sites. The approach increases flexibility in appointment times, enables increased opportunity to undertake multi-agency support and makes much more effective use of staff time. It also supports access to multi-lingual recovery workers and volunteers, harnessing the skills across organisation's workforce.
- **Cardiac monitoring:** Inclusion services provide ECG testing for all patients on more than 100ml of methadone every six months to monitor that the QT interval is not prolonged. GPs are updated with the results and where the QT is elongated (over 430msec in males and over 450msec in females) a dose reduction is considered with the service user by the GP and prescriber.
- **Improving access for veterans:** Addaction's 'Right Turn' veteran-specific recovery programme incorporates peer support from other veterans. The veteran-specific project element motivates initial engagement and continued attendance by veterans.
- **Facilitated Access to Mutual Aid:** Addaction teams actively facilitate access to mutual aid in local areas and provide additional mutual aid support through Addaction's MAP programmes. MAP groups are tailored by peers and supported to develop and grow by service staff. They provide peer support during and after treatment. MAP programmes respond to geographical gaps in local provision and to specific needs (such as women, veterans).

2.5 References and resources

- Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
- National Treatment Agency for Substance Misuse (2012) Medications in recovery: re-orientating drug dependence treatment www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf
- Advisory Council on the Misuse of Drugs (2015) How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? London: Home Office www.gov.uk/government/publications/how-can-opioid-substitution-therapy-be-optimised-to-maximise-recovery-outcomes-for-service-users

3 Preventing overdose in people who use drugs

- Overdose can often happen in high risk situations for high risk individuals at particularly high risk points in time, but many overdoses can be prevented and the danger of drug-related death reduced.
- By ensuring appropriate practices are in place, along with the policies or protocols to support them, commissioners and providers of services for people at risk can prevent overdoses and subsequent fatalities.

3.1 What the relevant guidance says about this issue

- Needle and syringe programmes, including in community pharmacies, are important for identifying individuals at risk of overdose and providing information and advice to reduce that risk.
- Providers should ensure that staff in treatment services have provided service users with information and advice on the risk of overdose and the steps they could take to reduce that risk.
- Staff in drug treatment services should have a good understanding, which informs their practice in reducing overdose risk, of:
  - high-risk practices, e.g. injecting, polysubstance use, alcohol use
  - high-risk groups, e.g. users who have previously overdosed, older users, users with certain comorbid health problems
  - high-risk stages, e.g. the initial weeks of titration on to opioid substitution treatment, or the weeks following exit from treatment drug-free.
- Systematic assessment of the risk of overdose for every user attending structured drug treatment should take place and include a discussion with them about the ways in which they can reduce risks.
- A range of treatment options should be available, including:
  - rapid assessment and treatment engagement for those at high risk, including rapid access to OST
  - local access to supervised consumption of opioid substitution treatment
  - support for alcohol dependence and alcohol detoxification
  - support for safer injecting practices and to stop injecting
  - information and advice.
- People leaving structured treatment should have aftercare plans that include ongoing recovery check-ups, and processes should be in place for rapid re-entry to treatment and re-stabilisation if needed.
- Service users should be made aware of the available pathways back into treatment if they need to re-enter at any time.
- Local areas should provide overdose awareness education for prisoners.

- Service users should be transferred between local prison(s) and community-based treatment services on release.
- Released prisoners should have seamless continuity of substitute prescribing, including rapid access to community prescribing and other services.
- Service users should be made aware about their loss of tolerance after detoxification and exit from residential rehabilitation programmes or inpatient treatment, which increases the risk of overdose and death.
- Service users should be given information on support networks and helped to engage with them, after they have detoxified or left residential rehabilitation programmes or inpatient treatment.
- Treatment services should provide recovery check-ups (via regular phone calls or other means) for people who have left structured treatment.
- Treatment services should work with other health and social care and criminal justice services used by drug users to identify those at risk, and to develop effective care pathways.

3.2 Blocks and risks that prevent implementing guidance

- Some overdoses which lead to death do not take place at the point of high risk in a transition but rather there are points in time where risk is compounded by unexpected 'life events' (such as a personal bereavement).
- Service users may know that tolerance (on transition) is an issue but not recognise precisely when that high level of risk exists.
- Lack of the dose optimisation that is crucial in opioid substitution treatment. To minimise episodes of craving, the effective opioid dose may be higher than the one the service user describes feeling 'OK' on.
- Service users released from prison without notice and without being given naloxone.
- Lack of an adequate range of specialist, outreach and pharmacy-based needle and syringe programmes.
- Pharmacological and psychosocial support not being optimised for service users who have not been able to benefit from treatment.
- Care not being informed by service users' experience of trauma.

3.3 Solutions and implementation principles

The response to overdose risk will depend on how urgent the need for intervention is.

- All staff should be trained to recognise a medical emergency that requires someone to be immediately referred to A&E.
- A broad range of harm reduction interventions needs to be offered in a range of settings to a range of people, including:
  - opioid and non-opioid overdose prevention advice

    - widespread provision of naloxone, including to prisoners on release
    - safer injecting advice at multiple points in the treatment system.
- An active re-engagement plan should be agreed in case the service user drops out.
- Introduce a medication management plan, which might include daily supervised consumption, or medication reconciliation with the help of the GP.
- Services should have protocols to ensure people get support at a time of crisis, for example when they have been bereaved.
- Services should have protocols with other organisations locally that can provide support to people if they leave treatment early.
- Care plans in prison drug treatment services should include early preparation for release, especially for short-term prisoners.
- Staff should be trained in trauma, and aware of trauma-informed services for high risk groups.

3.4 Practice examples

- **Prisoners' naloxone:** Inclusion, with Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham prison, has developed a pathway where prisoners at risk of drug overdose are trained in the administration of naloxone and its importance and given naloxone at the same time they are given their phone and keys on release.
- **First aid training:** Addaction delivers first aid training, including what to do in the event of an overdose, that enables participants to teach their peers everyday first aid.
- **Multi-lingual harm reduction information** is available across Addaction services.
- **Post-rehab support:** Phoenix Futures developed a discharge from residential rehab protocol that includes advice and interventions to reduce harm and risk. This includes making naloxone available for early discharge and completions, as well as measures like recovery check-ups for a year after discharge that support people to sustain their recovery.

3.5 References and resources

- NICE (2014) Needle and syringe programmes. Public health guideline 52 www.nice.org.uk/guidance/ph52
- Public Health England (2014) Turning evidence into practice: Preventing drug-related deaths www.nta.nhs.uk/uploads/teip-drd-2014.pdf
- Public Health England (2016) Understanding and preventing drug-related deaths www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf
- Advisory Council on the Misuse of Drugs (2016) Reducing opioid-related deaths in the UK www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk

4 Meeting physical and mental health needs

- Long-term illness associated with drug use can cause death and cumulative poor physical and mental health also makes people more susceptible to overdose. Responding to these associated risks from drug use requires action from specialist drug and alcohol providers and other services in the health and social care system.

4.1 What the relevant guidance says about this issue

- Services should identify the healthcare needs of drug users in treatment through a general health assessment and decide if more specialist urgent care is required – and then liaise with the appropriate primary or secondary care services.
- Drug services should be aware of the high risks associated with smoking. Staff should be competent to deliver smoking cessation and/or ensure pathways to access these interventions are available.
- Services should be aware of the effects of alcohol on health and on possible mortality and treatment interventions for alcohol should be offered where a need is identified.
- Drug treatment staff should have suitable competencies around mental health and similarly mental health staff should be able to identify the need for interventions and the appropriate pathways for substance misuse.
- A concurrent model of service delivery is most effective for the provision of mental health and substance misuse services.
- Drug service staff should be capable of recognising mental health crisis in their client including suicidality and psychosis.

4.2 Blocks and risks that prevent implementing guidance

- People who use drugs are among the most in need in society but may face difficulties in accessing healthcare: primary and secondary. The negative consequences for drug users if they cannot access healthcare services are long-term and incremental.
- Barriers to access can be particularly difficult to overcome for people who use drugs who also experience homelessness, have mental health issues or come into contact with the criminal justice system.
- Challenges are at their sharpest where people are easily dissuaded or do not have the personal skills or resources to navigate complex systems.
- People may have a fear of diagnosis, or have experienced a previous negative experience in a healthcare setting, or feel the burden of stigma often associated with drug misuse.

4.3 Solutions and implementation principles

- Local authorities, commissioners and drug treatment and healthcare providers need to work together to create systems and pathways that enable the most challenged and challenging individuals to access services.

- Physical and mental health training should feature more prominently within recognised drug treatment sector staff competency frameworks.
- Multi-agency working protocols should be implemented so that good practice is not dependent only on good relationships between individuals.
- There is a need for direct service user facing information about mental and physical health risks to help people make better decisions about their own health and signpost relevant services.
- Local areas should consider developing a system which flags individuals known to carry high or multiple risks (also see chapter 1).
- Agencies need to ensure the competence of their workforce to screen for physical and mental health vulnerability, and the workforce should be equipped to recognise high-risk conditions.
- All services can contribute towards the reduction in deaths and services should provide links to physical and mental health facing interventions.
- Services should address their own culture and protocols on health and wellbeing, particularly around smoking cessation, which could help promote interventions among service users.
- Engagement with substance misuse services should not preclude use of mental health services and vice-versa.
- Services should link with specialist service provision (for example respiratory, or hepatology services) within or near the treatment services wherever possible to make this provision more accessible.
- Local agency involvement in strategic planning is essential for pathways between services to be effective.
- Establish links between treatment services and NHS Health Checks and working with hospitals.
- Establish electrocardiogram (ECG) tests based on dose of substitute medicine and risk.

4.4 Practice examples

- **Physical health:** Derbyshire Healthcare NHS Foundation Trust set up a physical health risk alert system with enhanced nursing interventions, called 'Red Flag'. This involves the identification of common risks among service users; training and education of frontline staff; a red flag facility installed on the clinical IT system; assessment and review processes which include identified risks; and nurse-led second opinions and intensive management integrated into specialist addictions interventions.
- **Hepatitis C testing and treatment:** Pennine Care NHS Foundation Trust boosted attendance for hepatitis C treatment by hosting on-site specialist hepatitis C screening and treatment for injecting drug users. Pennine Acute Trust's infectious diseases consultant provides a portable fibroscanner together with specialist staff for Pennine Care's treatment services. New protocol hepatitis C treatment is provided by the

consultant directly on-site, including all necessary assessments, testing, scanning, treatment initiation and follow-up.

- **Lung health:** A lung health clinic has been set up in Lambeth Community Drug and Alcohol Team. Smoking cessation and respiratory care was brought to drug service users in an environment where patients felt comfortable, with the aim of improving their quality of life, reducing drug related deaths and reducing the use of acute hospital settings.
- **Suicide prevention:** Addaction has a national lead who oversees training in suicide prevention, including ensuring that staff feel able to talk comfortably and confidently about suicide with people who access their services. The lead champions treatment and support options, and improved access to them, by listening to service users, facilitating access to partner agency services, continually evolving services and using outreach, creative promotion and marketing to reach more people at higher risk of suicide. Data and case studies are used to support reflective discussions and learning across teams.
- **Mental health:** Futures in Mind service in Essex offers inclusive support for people with substance/alcohol misuse and mental ill health by providing befriending, mentoring and training opportunities.

4.5 References and resources

- Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
- Public Health England (2017) Health Matters – Preventing drug-related deaths: lung health clinic case study www.gov.uk/government/case-studies/a-lung-health-clinic-in-an-addictions-service
- PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

5 Reducing the risk of drug-related death for people outside drug treatment

- Approximately half of those who died of an opiate misuse related death had not been in treatment since at least the start of 2007.
- Drug treatment is protective, reducing the risk of overdose or suicide and other drug related health harms. Therefore an important strategy to reduce the number of drug related deaths is to support more people to enter treatment. Increasing the proportion of drug users in treatment (the treatment penetration or access rate) has long been an important focus for treatment providers.
- This chapter briefly sets out the main guidance that exists to support treatment services increasing the proportion of drug users who access treatment and explores how the guidance can be implemented effectively in local areas.
- Arguably, it would be ideal if everyone using drugs problematically accessed specialist help, but the reality is that there will always be people who won't access treatment. This population may be at the greatest risk but there are still interventions that can reduce their risk of overdose and these are also outlined in this section.

5.1 What the relevant guidance says about this issue

- The extent of drug treatment penetration should be fully identified and services designed to be safe, attractive and accessible to all potential service users, e.g. women, LGBT individuals, men who have sex with men, parents of young children, young adults, people with co-existing mental health conditions, and NPS and club drug users.
- Treatment should be easily accessible and attractive, with access improved through, for example, outreach, needle and syringe programmes, and accessible opening times.
- NSPs should help people to stop using drugs by providing access to drug treatment, e.g. opioid substitution treatment.
- Services should consider the extent to which their services, and the way in which they are delivered, are accessible to all people who use drugs, how they address people's vulnerabilities and whether they are culturally sensitive.
- Where there are known drug use issues in specific ethnic or cultural groups, efforts should be made to consult with relevant community groups and agencies to establish a culturally relevant service offer.
- Depending on local circumstances, particular consideration may need to be given to service users from black and minority ethnic groups, LGBT groups, traveller communities and club drug users.
- Consideration should be given to sensitively and flexibly engaging with people who may be particularly vulnerable. This may include sex workers, young adults, and people with mental health problems.

- Services may wish to consider adaptations to treatment induction processes such as women-only sessions, parent and child-friendly spaces, in-reach to non-drug-specialist services or providing booked appointments and drop-in sessions.

5.2 Solutions and implementation principles

People in treatment can give valuable insight into how people can be better supported. Service users in focus groups across the country suggested how people dependent on drugs could be better supported and their input has been included in and informed the recommendations that follow.

5.2.1 Ease of access to treatment and support

- All agencies likely to come into contact with people using drugs problematically should be aware of the treatment services available in their area and the referral pathways. Many people approach their GPs for help in the first instance but other non-specialist agencies including ambulance and fire services can provide useful help at times of crisis.
- Treatment providers should ensure staff who are the first point of contact for a service have the right skills and approach to deal with enquiries in a reassuring and engaging manner.
- Treatment providers and commissioners should ensure that waiting times are kept to a minimum for all treatment options
- Approaches should be targeted for 'at risk groups', i.e. outreach and engagement workers for rough sleepers or harm reduction awareness initiatives for targeted groups.
- With the right support, families can play a vital role in helping people to engage in treatment.
- Outreach workers should have good and up-to-date knowledge and information on the range of different treatment options.
- Services should work with all community groups or specialist services who work with targeted populations, including those with mental health issues, LGBT groups, the homeless, young adults, sex workers and those experiencing domestic violence and abuse. Partnership working should aim to ensure there are supported referral mechanisms, good understanding of each other's services, and partnership approaches to increase referral rates, such as drop-in sessions in community services.
- Commissioners may find it difficult to resource efforts to identify and engage currently excluded populations as their treatment systems come under increasing financial stress.
- Stigma can be a real barrier to people accessing treatment. More informative media programmes and coverage on substance misuse, and how people can support those who use drugs in their communities, could help break down stigma and fear.
- Employers should be made aware of how they can support employees with drug use and dependence issues and signpost them for help.

- Information (posters, flyers) should be visible in all GP surgeries, chemists, community and drop-in centres and other services used by people who use drugs and alcohol.
- Volunteers and peer supporters can promote the message that treatment is protective.
- Support for people struggling with their mental health and issues like stress, debt and bills should be visible, to encourage people to access help and drug treatment.
- People on substitution therapy can be supported and incentivised to promote its benefits to their peers who are not in treatment.
- Use social media to promote the benefits of treatment.
- Service users can provide a vital insight into how services can be made more accessible and responsive, and services should engage with them to enhance their practice.

5.2.2 Tailoring services and approaches

- It the responsibility of local commissioner to understand their local populations, particularly which populations are not accessing treatment. They should then support and collaborate with providers to ensure treatment reaches these populations.
- One of the potential unintended consequences of whole treatment system design, which may use one provider, has been the loss of a plurality of treatment providers offering a range of services. Commissioners and providers should ensure that services are flexible and tailor their services to specific needs or populations to compensate for this possible loss of plurality.
- Naloxone can be provided in emergency departments and in hostels, as well as in drug treatment services, to drug treatment service users.
- Particular attention should be paid to how accessible services are to people in rural areas.
- Effective joint working between treatment providers and other agencies can ensure services are accessible for specific groups, e.g. LGBT organisations or agencies that support women involved in sex work.
- In an area where the conditions appear to be right for a drug consumption room all local partners, including criminal justice, would need to be involved in considering and enabling a proposal to develop one.

5.2.3 Addressing needs, including complex needs

- Many people find it difficult to access treatment because they experience a number of complex or multiple needs. Commissioners and local authorities should ensure that there is effective partnership working to actively support people into treatment who have mental health issues, are homeless or experiencing domestic violence and abuse.
- Consideration should also be given to how best to support people with no recourse to public funds.

- Commissioners should consider specific approaches to address high levels of new psychoactive substance misuse in some at risk groups, i.e. those involved with the criminal justice system and rough sleepers.
- Peer mentor and volunteer roles can improve reach into local communities, and appropriate support and training should be provided.
- Many people do not access treatment because they have childcare responsibilities. Commissioners and providers should ensure there are clear pathways to support parents to access treatment, as well as implementing service adaptations which make it easier for them to do so.

5.2.4 Reducing risk among those not in treatment

While a focus for providers and commissioners of substance misuse services must be to increase the reach of treatment to a wider 'at risk group', a partnership approach across a range of health and social care services could ensure the risk of people dying out of treatment is reduced.

- People who do not necessarily want to stop using drugs may find it difficult to access healthcare services. Pathways should be developed to support access to healthcare for people not engaged in treatment, from services such as needle and syringe programmes and information and advice services.
- Harm reduction, including information and advice services, for some people may be enough and should not always be seen only as a gateway to structured treatment.
- Mobile needle exchanges and targeted outreach into specific rural areas can support access for people in rural areas.
- Families of people using drugs should receive appropriate harm reduction advice, including access to naloxone training and kits, as well as support for their own wellbeing.
- Information should be available for the public on when and how people should intervene when a person is under the influence or needs medical intervention. General information on the nature of dependency should also be available.
- Naloxone should be easily available through hostels, emergency departments, and primary care.

5.3 Practice examples

- **'Virtual' support:** Addaction Webchat enables individuals who are not in contact with services, are concerned others (friends, family members, partners) or are accessing services but want additional help to get advice and support to manage often complex issues. Expert advisors address barriers and facilitate access to local services (across multiple service providers) and, where this has not been possible, provide harm reduction advice and information.
- **Making services more welcoming:** An independent review of its services led Addaction to have more volunteers and peers in service waiting areas to support

engagement of new service users, and to a premises re-design plan across the organisation that will include more open reception areas without glass screens.

- **Engagement through hospital:** Addaction Wigan and Leigh's Active Case Management (ACM) scheme includes a proactive approach to engaging with individuals who are presenting to hospital with alcohol or drug related issues. The partnership with Royal Albert Edward Infirmary hospital includes information sharing agreements to enable rapid re-engagement or an increase in support for current service users, and rapid engagement of new individuals into drug and alcohol services.
- **Engagement through mutual aid:** Addaction Wigan and Leigh embed mutual aid groups in community drop-ins and areas of highest deprivation. The drop-ins include a local foodbank, Citizens Advice and benefits advice. Addaction's mutual aid programme (MAP) is open to all local residents, not just current service users, so that effective support, including harm reduction advice and information, is available. This approach has supported new people into treatment and is part of an aim to reduce stigma and ensure that visible recovery is embedded across community venues.
- **Specialist residential services:** Phoenix Futures has specialist residential services to support people who find it difficult to access generic residential treatment. Phoenix Futures National Specialist Family Service accommodates parents and their children and provides intensive support to people to address their substance misuse and develop their parenting approaches. Grace House uses a trauma-informed approach to support women with multiple needs.
- **Supporting people outside traditional treatment:** Phoenix Futures piloted a model to deliver support and interventions to people who wouldn't access mainstream drug services, especially for NPS use. B-Chilled outreach services use community health champion volunteers to provide early targeted interventions in the night-time economy, raising attention and awareness to the risks associated with recreational drugs and alcohol use, before problematic behaviour occurs. B-Chilled also provides education and training to staff working in organisations that come into contact with people using substances.

5.4 References and resources

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- Making Every Adult Matter (MEAM) approach to designing and delivering better coordinated services for people with multiple needs www.meam.org.uk
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- White M, Burton R, Darke S, Eastwood B, Knight J, Millar T, Musto V & Marsden J (2015) Fatal opioid poisoning: a counterfactual model to estimate the preventive effect of

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- Public Heath England (2016a) Trends in drug misuse deaths in England, 1999-2014 www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf
- Public Heath England (2016b) Adults – drugs JSNA support pack 2017-18: commissioning prompts - Planning for drug prevention, treatment and recovery in adults www.nta.nhs.uk/uploads/jsna-support-pack-prompts-adult-drug-2017-final.pdf
- Public Heath England (2016c) 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

Appendix 1. Sources of information for assessing risk of drug-related death

As part of the information gathering in chapter 1, drug treatment providers were surveyed to find what data sources and other information were used when identifying risk of drug-related death. These included:

- Treatment Outcomes Profile (TOP)
- National Drug Treatment Monitoring System (NDTMS)
- Validated scales, such as:
  - Generalised Anxiety Disorder assessment (GAD-7)
  - Patient Health Questionnaire on depression (PHQ-9)
  - Learning Disability Screening Questionnaire (LDSQ)
  - Alcohol Use Disorders Identifications Test (AUDIT)
  - Severity of Alcohol Dependence Questionnaire (SADQ)
  - Malnutrition Universal Screening Tool (MUST)
- Output reports delivered by risk management tools in case management systems
- Case notes
- Investigations like urinalysis and blood test results
- Prescribing information
- Care plans, risk management plans and joint care plans
- Discharge summaries with diagnostic and prognostic detail (e.g. Child-Pugh score for liver disease)
- Collateral information from other service users, friends and carers
- Learning from other drug-related deaths through incident reports, local intelligence from police, toxicology reports, coroners/cause of death reports
- Screening, including health screening data, nature and severity of drug use, intravenous use of heroin and risky injecting practices and previous overdose
- Blood-borne virus status and engagement with immunisation and/or treatment as appropriate
- COPD assessment tool (CAT), MRC breathlessness scale
- Chronic and acute illnesses (mental and physical)
- Smoking status
- Self-care
- Mobility and activity levels
- Oral health

Appendix 2. Contributors

A working group was convened in January 2017 and met five times until July 2017. The following were members of the working group and many contributed directly to this document:

- Karen Biggs, Collective Voice (Chair)
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Public Health England staff supported the working group and helped develop the briefing:

- Pete Burkinshaw, Public Health England
- Steve Taylor, Public Health England
- Martin White, Public Health England
- Rob Wolstenholme, Public Health England

Focus groups of service users from the following services supported the development of chapter 5:

- Phoenix Futures residential services in Sheffield and Wirral
- Pennine Care NHS Foundation Trust
- Futures in Mind Essex (a Phoenix Futures and Mind service)

Collective Voice

The Collective Voice project will ensure that the voice of the drug and alcohol treatment sector and those who use our services are adequately heard. We have shared ambitions to make a real difference to the communities we work with by delivering effective recovery focussed services.

Our aim is to consult broadly with organisations from across the sector, in order to best represent the interests of those who use our services. We want to establish how the drug and alcohol treatment sector can help the government achieve its ambitions whilst at the same time supporting the needs of those who use our services.

Our intentions are to:

- Effectively engage with the new government to establish how the drug and alcohol treatment sector can help the government achieve its ambition.
- Identify the most effective structures and mechanisms to enable the entire drug and alcohol treatment sector to represent the interests of its service users to relevant stakeholders.
- Create alliances across other relevant sectors such as mental health, criminal justice, housing, to identify issues of shared concern.
- Develop a business plan and funding proposal to take forward this work.

www.collectivevoice.org.uk

NHS Substance Misuse Provider Alliance

The NHS Substance Misuse Provider Alliance started in 2016 as a group of peers from NHS organisations throughout England who provide drug and alcohol treatment services. We came together with a joint belief that as a group we will be more effective in positively contributing to the drug and alcohol treatment sector.

The Alliance includes eleven NHS trusts from across England working with service users, carers and other organisations to contribute positively to the ongoing development of the substance misuse field.

Our aim is to ensure that our historical knowledge, along with the innovative practices we have employed, is not lost to the treatment field, through:

- Contributing our expertise and resources to the government's and sector's drug and alcohol policy development.
- Contributing to the development of academic research with the aim of positively contributing to developments in the sector.
- Ensuring that the voice of service users and carers who use our services are represented.
- Working collaboratively with other organisations and stakeholders across and connected to the drug and alcohol treatment sector.

www.nhs-substance-misuse-provider-alliance.org.uk