



Public Health  
England

Protecting and improving the nation's health

# Drug alerts and local drug information systems

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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### **Main abbreviations used**

PIN	Professional information network
LDIS	Local drug information system

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# 1. Introduction

Media reports and other warnings regarding new and/or novel, potent, adulterated or contaminated drugs have increased over the last decade. However, these reports are often inaccurate, rarely confirmed by toxicology tests and may sometimes be counterproductive to public health messages intended to reduce drug-related harms and deaths.

An agreed local drug information system (LDIS) that uses consistent and efficient processes for sharing and assessing information, and issuing warnings where needed, can help ensure high-quality, effective information rapidly reaches the right people.

This document provides local authorities with information and advice to support them in assessing intelligence and issuing public health alerts on new and/or novel, potent, adulterated or contaminated drugs. It suggests systems and approaches that local areas may choose to adopt, adapt or use to inform their local systems.

Advice on developing such a system was requested by delegates at a north of England event run by Public Health England (PHE) and much of the content derives from their input.<sup>2</sup> It was developed for PHE by Michael Linnell, advised by a group including local authority and police representatives.

The LDIS model proposed in this document is intended to respond to immediate risk, to be a low-cost, low-maintenance and multidisciplinary system that uses existing local expertise and resources. It uses elements from established local systems in Salford,<sup>18</sup> Lancashire and Scotland.<sup>8</sup> It is separate but complementary to the protocol used by PHE centres and national teams to assess drugs intelligence and, where required, issue national briefings or alerts. The ambition is for an England-wide network of local systems that operate in a consistent and complementary way.

Although the primary aim of a drug alert is to inform people who use drugs of an immediate risk an equally important aim of an LDIS is to inform professionals. It is not envisaged that adopting the LDIS model will lead to an increase in public drug alerts and in all likelihood the systematic approach suggested will mean the majority of intelligence received will be used to inform front-line staff. The information sharing will increase staff knowledge, therefore local recording and intelligence will be improved enabling a more effective response. The systematic approach to information gathering used in the LDIS model also has the potential to assist with drug-related death reviews.

A summary of the evidence for drug alerts can be found in appendix 1.

## 2. A local drug information system model

A flow chart for the whole local drug information system described in the next few chapters is contained at appendix 2.

### 2.1 Existing local systems

Some local authority areas already have formal drug alert or early warning systems or there are informal systems, groups or networks that fulfil the drug alert function. The core elements of a local drug information system (LDIS) are similar regardless of local arrangements. The LDIS model proposed here is not intended to exclude additional elements of local systems that already work well and enhance the local response.

### 2.2 Governance

The LDIS model proposes joint ownership by a partnership of local services. Governance may sit within any existing relevant multidisciplinary group or network. The responsibility for establishing an LDIS would normally lie with local authority public health teams as part of the duties of the director of public health. However, it will be important to obtain support from senior managers in all organisations likely to contribute to the system (eg, police, treatment services, acute health trusts). An LDIS form template and criteria for grading alerts have been provided to enable a consistent approach and to assist in the production of a local alert protocol. An LDIS co-ordinator (2.4) takes responsibility for managing the alert process. The LDIS co-ordinator, assisted by an LDIS panel (2.5), is responsible for validating, grading and issuing alerts. It is suggested that public alerts are signed off by a responsible officer, usually the director of public health or a deputy covering unavailability.

### 2.3 Scope

The LDIS model is intended for dangerous, new and/or novel, potent, adulterated or contaminated substances regardless of their legal status. This would include all psychoactive or performance and image enhancing substances. This may overlap with Trading Standards in the case of alcohol and with the NHS National Patient Safety Alerting System (NPSAS) in cases where over-the-counter or prescribed medications are used for recreational purposes. For biological contamination issues such as anthrax or botulism, the mandated health protection process will apply as outlined at [www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report](http://www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report). In these cases the LDIS may also play a role in dissemination of any resulting alerts.

## 2.4 LDIS co-ordinator

A suitably experienced person should be designated to co-ordinate the LDIS. The local PHE centre needs to be informed of this person's details. LDIS co-ordinators, or in their absence a deputy nominated from the LDIS panel (see 2.5), will have responsibility for managing the local alerts process once the LDIS is established.

Some existing systems have nominated system managers from health service providers or built the requirement into service specifications, while others have bought in outside expertise or used existing staff resources. It may be appropriate and cost effective for an LDIS co-ordinator to cover several local areas depending on geography and local considerations. The role should not be time consuming as, once the system is set up, the co-ordinator is only needed when intelligence is being processed. Having a consistent system is not intended to increase the volume of alerts – in fact it may lead to a reduction in their number and in the work involved to confirm and produce them.

The coordinator will want to sign up to receive national briefings and alerts, including those from the Central Alerting System (see appendix 8).

## 2.5 LDIS panel

An LDIS panel of up to six people can assist the LDIS co-ordinator in the alerts process. The panel will benefit from being multidisciplinary and having a suitable level of expertise in relevant disciplines (medical, policing, pharmacology, drugs specialists, etc). Deputies from the LDIS panel can be nominated to cover the unavailability of the LDIS co-ordinator. If a professional such as an A&E consultant has been involved in dealing with an incident leading to a possible alert, he or she can usefully be asked to become part of the LDIS panel during the assessment of that incident.

## 2.6 Professional information network

A professional information network (PIN) is simply an interactive online network of local professionals who are likely to encounter new and/or novel, potent, adulterated or contaminated drugs and/or the people who use them. The purpose of this network is to share information, experience and knowledge that may inform any subsequent alerts or action by the LDIS.

A PIN can:

- feed in local information and send LDIS forms to the LDIS
- act as a checking mechanism, ie, monitoring whether a similar issue has been noted by PIN members
- cascade alerts to specific target audiences of professionals and service users

## Membership of the PIN

The core membership of a PIN could be formed by existing networks but should be open to all relevant professionals in the area. It may be appropriate to have representatives from the following services on the PIN but membership will differ from area to area:

- hospital emergency departments
- paramedics
- police
- drug services
- youth offending services or teams
- youth services
- children's services
- social services
- dual diagnosis services
- mental health services
- PHE centres
- health protection teams
- substance use commissioners
- community safety teams
- service user representatives
- schools and school counsellors
- trading standards
- housing agencies
- hostels
- homeless services
- forensic services
- prisons and children and young peoples estates
- communications teams
- police controlled drugs liaison officers
- liaison for coroner's office
- probation and community rehabilitation companies
- controlled drugs accountable officers
- research professionals
- police and crime commissioner's office
- pub and club watch

## Recruiting PIN members

Many of the professionals desired as members of a PIN may already be part of local networks or groups such as local strategic treatment governance groups, drug-related death groups, NPS response groups or controlled drugs local intelligence networks, etc. These networks can form the core of the PIN without too much adaptation. An LDIS launch event may also help recruit members and explain the operation of the LDIS to local professionals.

The PIN can be expanded as the LDIS develops. There is no limit to the size of the PIN and it is recommended that most organisations have at least two members. Specialist organisations such as drug treatment services may have more than this. Prospective members can be reassured that the PIN requires a minimal time commitment and is mutually beneficial to its members. Members are invited to join the PIN by the LDIS co-ordinator and must agree to its terms of reference.



## Terms of reference

PIN members should agree to its terms of reference. These should cover confidentiality, information sharing and data protection. An example of terms of reference for PIN members is provided (appendix 3).

## Confidentiality, information sharing and data protection

Information sent within the PIN should be anonymised so that patients or service users cannot be identified. The PIN should only be accessible to its members. Information from the PIN may be shared within services, but should not be in the public domain unless agreed upon by the LDIS co-ordinator.

## Technical set up of a PIN

A PIN is a way of passing information between relevant professionals. A number of easy-to-use and free online forums and messaging systems exist to simplify this process. An IT department will be able to help you get set up and assist with any technical issues.

## 2.7 Communication teams and media protocols

Relevant communications teams need to be familiar with the LDIS model and the role they may have as part of the PIN and LDIS panel. Ideally there should be a joint approach and shared protocols between communication teams from local authorities, health and the police. Local resilience forums or health resilience partnerships may be a good place for LDIS criteria to be discussed and processes agreed so in each local area there is a clear and concise way to disseminate alerts with communications leads identified.

Ideally any press response around new, potent, contaminated or adulterated drugs will be guided by the LDIS panel and use the same criteria for any statements or communications with the media or public as applied to the alert assessment process.

In consultation with the communications teams it is recommended that a spokesperson for alerts be nominated.

## 2.8 Alert dissemination protocols

An alert dissemination protocol agreed locally with the relevant communication teams may include:

- an email network list for professional alerts of a 'for information only' nature that includes existing cascade networks, eg, those held by NHS England, police and local authority public health
- a strategy for public alerts, which may include social media and local press contacts
- a strategy for targeted alerts to specific populations although dissemination plans will need to be created on a case-by-case basis

## 3. Information received

### 3.1 Type of information or alert received

<b>Type of information or alert received by the LDIS</b>	<b>Action by the LDIS co-ordinator</b>
<b>LDIS form or other information from a PIN member</b>	A completed LDIS form should be forwarded to the LDIS panel for assessment (see template, appendix 4). Ask the PIN member to complete a form if the information is in any other format.
<b>Local information from a non-PIN member</b>	The LDIS co-ordinator should ask for an LDIS form to be completed and, if appropriate, invite the person to join the PIN. The completed form should then be forwarded to the LDIS panel for assessment.
<b>Alert or information sent to LDIS from outside the area</b>	The alert or information should be forwarded to the LDIS panel for assessment.
<b>Alert from outside the area that has already been cascaded to local professionals</b>	The alert should be forwarded to the LDIS panel for assessment. If the alert is found to be inaccurate after the assessment process it may mean a response from the LDIS is needed.
<b>Alert concerning local issue that has already been cascaded to local professionals</b>	The original source should be traced and asked to complete an LDIS form. The alert should be forwarded to the LDIS panel for assessment. If the alert is found to be inaccurate after the assessment process it may mean a response from the LDIS is needed.
<b>Regional and national warnings, briefings and alerts</b>	Information affecting more than one local authority area may be issued as a PHE centre or 'regional' warning. Information affecting more than one region may be issued as a PHE national briefing. Formal, national alerts will usually come through the Central Alerting System (see appendix 8). The threshold for all these regional and national warnings, briefings and alerts is higher than is the case with local alerts. They should be cascaded as per protocol and/or as requested. The warning, briefing or alert should be sent to the LDIS panel to see if there are local issues or further actions required. A copy of the warning/briefing/alert and any relevant background information should be filed.

### 3.2 LDIS mailbox

A dedicated mailbox for receiving LDIS forms and drug alerts will make it easier to contact the LDIS. This mailbox should be regularly checked by the LDIS co-ordinator (eg, twice a day). The mailbox address should be publicised and available on directories and relevant contact information.

### 3.3 LDIS forms

A template for an LDIS form is provided in appendix 4. Forms should be made readily available in electronic format to all PIN members, relevant professional groups and services.

### 3.4 LDIS panel assessment

Local alerts or other information received via the mailbox or through other channels should be forwarded by the LDIS co-ordinator to the LDIS panel for assessment. The assessment should be completed as quickly as practicable and within 24 hours of the information being received on a normal working day. The panel may need to meet by teleconference for an acute or serious incident, and should have an out-of-hours process agreed for urgent incidents. The LDIS co-ordinator should ensure that any supplementary information or evidence is available to the LDIS panel before assessment begins (see 4.1).

### 3.5 Local media reports

A local news item may have been published or a journalist may have contacted communications teams asking for a response. The information or story should be sent to the LDIS coordinator and LDIS panel for evaluation in the same way as any other alert or information received.

If little is known but the media are reporting the story, a holding statement may be considered while an assessment is underway or until more is known. Examples of holding statements are provided (appendix 5). If the media report is found to be inaccurate after the assessment process or toxicology is confirmed it may mean a response from the LDIS is needed. Speculation on drugs, adulterations or contaminations should not be made without forensic evidence (see 4.2).

If, after consultation with the communications team, it is felt that the media coverage is exaggerated or counterproductive and that further media coverage may exacerbate the issue, the best option may be to offer no official response.

## 4. Validating information

### 4.1 Validation checklist

The LDIS co-ordinator is responsible for providing all available information to the LDIS panel. It may also be appropriate for the LDIS co-ordinator to validate the information. For example, check:

- **the original source:** check with the specific services involved or trace the source of the original alert; ensure the LDIS form is completed and ask for additional information if available
- **for similar reports:** post on the PIN; contact neighbouring LDIS co-ordinators; look online for similar reports or alerts; search online user groups/forums for relevant experiences
- **that the information is accurate:** check information is plausible, makes sense and sounds credible; look for online briefings, relevant data or risk assessments; contact an expert or someone with knowledge of the issue; check available drug identification databases
- **forensic information:** is forensic information available; is any forensic testing underway and is any more likely to be known; if appropriate, find out if drug analysis/testing is feasible

### 4.2 Forensic analysis

Ideally, when a local alert is being considered forensic evidence will be available to confirm the identity of a drug or its contaminants. However, in reality this is often not the case. Local forensic evidence is usually only available where death or serious harm has occurred. In some cases there are no samples or forensic means of identification. In some cases press or social media speculation on a drug involved in an incident may occur without forensic results being known. In these cases a holding statement highlighting this may be considered (appendix 5).

Protocols are already in place for the police to collect drugs confiscated by professionals, eg, from in-patient psychiatric units. In most cases these drugs are destroyed without being analysed. Police forces either have contracts with commercial forensic service providers or have their own in-force laboratories which they use to identify drugs, whether controlled or not. Although it is an ideal rather than an expectation of the LDIS model, discussions could be entered into with local police forces and forensic service providers to investigate the possibility of testing substances when they cause concern locally. The funding to perform the analysis would need to be agreed between the police, forensic service provider and the local authority.

### 4.3 Identifying drugs

In the absence of forensic analysis there may be physical descriptions of a drug and its effects or even photographs available. These can be used to assist in identification by online or commercially available drug identification programmes (appendix 8). Online databases (appendix 8) can be useful. Local police will have various types of field test equipment available which may assist in giving an indication of the drug(s) involved. However, although these resources are useful in identifying drugs that are in circulation, if there is no forensic evidence available for an incident that prompts an LDIS panel investigation, this should be made clear in any alert or communication.

FEWS<sup>4</sup> is designed to alert the UK government to drugs coming into the country and will be sharing more of its results. However, FEWS is unlikely to be able to provide the level of local detail required to enable it to function as a harm reduction resource. Other European countries have their own testing programmes (appendix 8). WEDINOS, the Welsh early warning system, publishes online results of samples sent in from anyone living in Wales.<sup>9</sup>

## 5. Assessing information

### 5.1 Grading criteria

The following **five criteria** should be used to grade information by the LDIS.

1. Local relevance
2. Anecdotal evidence
3. Source of evidence
4. Forensic evidence
5. Confirmation of harm

Each criteria question should be considered (5.2). It may help to use a grading matrix (appendix 6). A single criterion may be enough in itself to warrant an alert. The initial decision should then be considered against the efficacy questions (5.3). It may help to use an efficacy matrix (appendix 6). A final decision should then be made (5.4). The grading matrix is designed to assist the decision making process. However, a value judgement will still need to be made based on the evidence available. The decision of the LDIS panel should be recorded and copies kept in an appropriate file.

### 5.2 Grading criteria questions

Criteria question	Do not consider an alert	Consider an alert if other evidence exists	Consider an alert
<p><b>1. Is the report locally relevant?</b></p> <p>Is the problem confined to another geographical area?</p> <p><i>A batch of contaminated heroin in a distant area or a pattern of drug use that is unknown locally may not be relevant to your area, whereas potent MDMA pills that have appeared in a number of different areas or a dangerous NPS sold on the internet may be relevant.</i></p>	<p><b>Do not consider an alert</b> unless the report is relevant locally.</p>	<p>If the report is not relevant locally it may still be considered, for example, if there have been multiple deaths or serious harm confirmed to be linked to the substance in other areas and it is causing concern locally.</p>	<p><b>Consider an alert if the report is locally relevant.</b></p>

<b>Criteria question</b>	<b>Do not consider an alert</b>	<b>Consider an alert if other evidence exists</b>	<b>Consider an alert</b>
<p><b>2. Is evidence purely anecdotal?</b></p> <p>For example, the report comes directly or indirectly from drug users about effects, potency or content of a drug.</p> <p><i>Anecdotal reports about drug effects are subjective as drugs affect different people in different ways and can only be described in relation to personal drug experience.</i></p> <p><i>Is the information plausible? For example, if an anecdotal report states ecstasy pills contain heroin, how likely is this and how could this be known without forensic information?</i></p>	<p><b>Do not consider an alert</b> if the report is purely anecdotal and no further evidence or reports support it.</p>	<p>Consider an alert if anecdotal evidence is supported by secondary sources, including other criteria such as confirmed harm or forensic evidence.</p>	<p><b>Consider an alert</b> if the evidence is anecdotal but strong and supported by multiple anecdotal reports.</p>
<p><b>3. Are reports from a reliable source?</b></p> <p>For example, a hospital or the police report a number of suspected drug-related incidents occurring on the same evening.</p>	<p><b>Do not consider an alert</b> if the information available is from an unknown or unreliable source and no further evidence or reports support it.</p>	<p>Consider an alert if the report is vague but from a reliable source and supported by evidence from other criteria.</p> <p><i>For example, a hospital report of suspected drug related incidents where the drug(s) involved are unknown.</i></p>	<p><b>Consider an alert</b> if the information is from a reliable source and is specific enough to provide useful information.</p>
<p><b>4. Has the drug, potency or contamination been confirmed via forensics/toxicology?</b></p>	<p><b>Do not consider an alert</b> if forensic evidence is unavailable and there is no other compelling evidence.</p> <p><i>Speculation on drug content, adulterations or contaminations should not be made without forensic evidence.</i></p>	<p>If forensic evidence is unavailable, only consider an alert in exceptional circumstances or where compelling evidence from other criteria exist.</p> <p><i>It is desirable in all cases to have forensic evidence, though this is not always possible. If for instance a number of people had died from taking a pill and there was compelling evidence as to its appearance, an alert might be considered.</i></p>	<p><b>Consider an alert</b> if there is forensic evidence of particularly dangerous, high potency, adulterated or contaminated drugs.</p>



<b>Criteria question</b>	<b>Do not consider an alert</b>	<b>Consider an alert if other evidence exists</b>	<b>Consider an alert</b>
<p><b>5. Has there been confirmation of harm or death?</b></p> <p><i>Are the consequences minor or is there an immediate risk of death or serious harm; how many people are involved and how many is this likely to affect; which populations are at risk and are vulnerable groups involved; if people are still in hospital is any more information likely to be known?</i></p>	<p><b>Do not consider an alert</b> if the health consequences are minor.</p>	<p>Consider an alert without confirmation of harm occurring if serious potential harm or death is likely and supported by other evidence.</p> <p>Consider if serious potential harm or death is likely or large numbers of people or vulnerable groups could be at risk.</p>	<p><b>Consider an alert</b> if there has been confirmation of serious harm or death.</p>

A grading matrix (appendix 6) may assist in the decision making process

### 5.3 Efficacy questions

The initial decision prompted by the answers to the criteria questions should then be considered against the efficacy questions.

<b>Efficacy question</b>	<b>Do not consider an alert</b>	<b>Consider if other evidence exists</b>	<b>Consider an alert</b>
<p><b>Information in the public domain?</b></p> <p><i>Is the press or social media reporting the story and is it prompting concerns?</i></p> <p><i>Is the story being reported in an inaccurate or unhelpful way?</i></p>	<p><b>Do not consider an alert</b> if the information is not in the public domain or is being reported responsibly and would not otherwise warrant an alert.</p> <p><i>If an alert would broadcast an issue further that was seen as a one-off event.</i></p>	<p>Inaccurate media reports may increase the likelihood of issuing an alert.</p> <p><i>Response to inaccurate reporting may be needed.</i></p>	<p><b>Consider an alert</b> if other criteria are met and media reports are causing concern locally.</p> <p><i>An alert is warranted and social media or press reports are inaccurate or unhelpful.</i></p>

<b>Efficacy question</b>	<b>Do not consider an alert</b>	<b>Consider if other evidence exists</b>	<b>Consider an alert</b>
<p><b>Will an alert enable avoidance or risk reduction?</b></p> <p><i>Can the drug be identified and is there something specific to say about the risks of the drug, potency, mixtures, method of use, infections, adulterations or settings that will enable the harm to be reduced or the drug avoided?</i></p>	<p><b>Do not consider an alert</b> unless the available information is specific enough to enable the risk to be reduced or avoided.</p> <p><i>For instance, the drug is unknown and the risks or harm reduction options cannot be explained.</i></p>	<p>An alert is warranted by other criteria and generic harm reduction advice is applicable.</p> <p><i>For instance, the drug is unknown but serious harm or death had occurred and generic harm reduction advice would reduce risk.</i></p>	<p><b>Consider an alert</b> if it enables the drug to be avoided or the risk reduced.</p> <p><i>For instance, the drug can be identified and there are alternatives or harm reduction options.</i></p>
<p><b>Will an alert be counterproductive?</b></p> <p>Will it encourage the use of a dangerous new and/or novel drug or alert to an extra potent source?</p> <p><i>For instance, a warning of potent heroin may cause users to seek it out and increase the incidence of overdose.</i></p>	<p><b>Do not alert</b> if thought to be counterproductive.</p> <p><i>In most cases do not alert about potent heroin. However, there may be circumstances when an alert is justified: for instance there have been a number of deaths or the purity is exceptionally high.</i></p>	<p>There is a serious risk and realistic harm-reduction advice is available.</p> <p><i>For instance, high potency ecstasy pills may be sought out without the risks being understood. Simple risk-reduction, such as breaking a pill in half, may be effective.</i></p>	<p><b>Consider an alert</b> if it is unlikely to be counterproductive or the risks of the drug involved outweigh any potential risk from issuing an alert.</p>

An efficacy matrix (appendix 6) may assist in the decision making process.

## 5.4 LDIS panel final decision

The panel's decision should be recorded (appendix 6).

## 6. Outputs

### 6.1 Types of action or alert

The LDIS may decide to take a number of different actions. Any form of alert or information sent to professionals should be shared with PHE local centres. If an alert affects more than one local authority area, PHE may issue a regional or national alert.

<b>Alert not warranted</b>	<p>The evidence may not warrant an alert but may still contain useful information and may be worthwhile posting on the PIN or using in other ways.</p> <p>If an alert has already been cascaded and is inaccurate it may be appropriate for the LDIS co-ordinator to inform the originator of the local alerts protocol and ask them to join the PIN. In some cases it may be necessary to issue a clarification.</p>
<b>For information only</b>	<p>Information intended for professionals only should be marked '<b>For information only</b>'.</p> <p>Sending briefings to PIN members and other professionals keeps them informed and may enable a more effective response. A number of reliable evidence-based briefings are available online (see appendix 8).</p>
<b>Targeted alert</b> to specific populations	<p>Targeted alerts directly or indirectly to specific populations of drug users either by setting (eg, prisons, in-patient psychiatric units) or by user populations (eg, steroid and image enhancing drug users).</p> <p>Targeted alerts may require a bespoke dissemination strategy.</p>
<b>Information or alert sent to neighbouring LDIS</b>	<p>If a local alert or information received by one LDIS may affect neighbouring geographically areas, other local LDISs may be sent the information or alert to assess whether it is relevant to their locality.</p>
<b>Biological contamination</b>	<p>For biological contamination issues, such as anthrax or botulism, inform PHE following the process outlined at <a href="http://www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report">www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report</a></p>
<b>Public alert</b>	<p>Public alerts should be sent via communications teams in line with locally agreed protocols. Public alerts reach the widest audience and will be cascaded through social media and personal networks. A public alert may warrant a specific press briefing. Inform the local PHE centre of public alerts. Public alerts should be signed off by a responsible officer (see 2.2).</p>

### 6.2 Alert content

A simple local template for alerts should be prepared in advance. It will contain standard elements like those shown in the example in appendix 7.

## 6.3 Evaluating the impact of your LDIS and alerts

It can be difficult to assess whether drug alerts reduce adverse incidents and often the work to do so would require substantial additional resources. The following potential measures are just some ways of evaluating the LDIS and alerts – each area will have to decide the extent to which it wants to evaluate the operation of and outcomes from its LDIS:

- yearly review of numbers of PIN members, new members, and member organisations
- numbers of organisations making active use of the LDIS (information/alerts submitted to LDIS mailbox or active participation in LDIS panel and PIN discussions)
- number of alerts/information submitted and responded to via LDIS panel.
- number of public facing messages and professional briefings raised
- short annual online survey circulated via the PIN to assess member views of the usefulness of the LDIS and recommended improvements
- front-line staff's knowledge of harms from new psychoactive substances or other drugs and their confidence in dealing with them (could be assessed using PIN for dissemination of a survey, through targeted focus groups or simply through feedback in operational and strategic groups)
- where a professional or public facing alert has been issued whether there are subsequently any incidents reported via the PIN in relation to that harm or substances
- for public or targeted information/alerts, follow-up surveys could be completed in relevant services or on the street to see whether information conveyed in the alert has been seen and absorbed by the target audience and also where applicable whether they have changed their behaviour as a result. This will obviously be a more resource-intensive option and may not be achievable for all areas

## References

1. Public Health England. Alerts and warning systems. [www.nta.nhs.uk/healthcare-alerts.aspx](http://www.nta.nhs.uk/healthcare-alerts.aspx) (accessed June 2015).
2. Public Health England. Local Early Warning Systems for Drug Related Incidents Conference. 10<sup>th</sup> July 2014, York. [www.phe-events.org.uk/hpa/frontend/reg/thome.csp?pageID=143991&eventID](http://www.phe-events.org.uk/hpa/frontend/reg/thome.csp?pageID=143991&eventID) (accessed June 2015).
3. Home Office. Annual Report on the Home Office Forensic Early Warning System (FEWS). [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98031/fews.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98031/fews.pdf) (accessed June 2015).
4. UK Focal Point on Drugs. Report 2014. [www.nta.nhs.uk/uploads/uk-focal-point-report-2014.pdf](http://www.nta.nhs.uk/uploads/uk-focal-point-report-2014.pdf) (accessed June 2015).
5. EMCDDA. Early-warning system on new psychoactive substances - operating guidelines. [www.emcdda.europa.eu/html.cfm/index52448EN.html](http://www.emcdda.europa.eu/html.cfm/index52448EN.html) (accessed June 2015).
6. Agar M. The Story of Crack. Towards a Theory of Illicit Drug Trends. *Addiction Research & Theory* 2003; Vol. 11(No. 1).
7. Seddon T. Drugs, Crime and Social Exclusion: Social Context and Social Theory in British Drugs–Crime Research. *British Journal of Criminology* 2006; 46 (4).
8. North Ayrshire Alcohol and Drug partnership. Drug Trend Monitoring Group (DTMG). [www.naadp.com/adp-info/adp-subgroups/drug-trend-monitoring-group.aspx](http://www.naadp.com/adp-info/adp-subgroups/drug-trend-monitoring-group.aspx) (accessed June 2015).
9. WEDINOS. Welsh Emerging Drugs and Identification of Novel Substances Project. [www.wedinos.org](http://www.wedinos.org) (accessed June 2015).
10. Mounteney J and Leirvåg S. Providing an earlier warning of emerging drug trends: the føre var system. *Drugs: education, prevention, and policy* 2004; 11(6).
11. Korf DJ and Nabben T. 'Antenna: a multi-method approach to assessing new drug trends'. G Greenwood and K Robertson (ed). *Understanding and responding to drugs use: the role of qualitative research*, Scientific monograph series no 4 ed. Lisbon: EMCDDA; 2000. pp. 73-82.
12. Mounteney J, Stooze M, and Haugland S. Monitoring emerging drug trends: Psychometrics and validity in earlier warning systems. *Addiction Research & Theory* 2011; 19(1).
13. Fielden S and Marsh C. It's time for Canadian community early warning systems for illicit drug overdoses. *Harm Reduction Journal* 2007; 4(10). [www.harmreductionjournal.com/content/4/1/10](http://www.harmreductionjournal.com/content/4/1/10) (accessed June 2015).
14. Topp L, Breen C, Kaye S and Darke S. Adapting the Illicit Drug Reporting System (IDRS) to examine the feasibility of monitoring trends in the markets for 'party drugs'. *Drug and Alcohol Dependence* 2007; Volume 73 (Issue 2).
15. Mounteney J, Fry C, McKeganey N and Haugland S. Challenges of Reliability and Validity in the Identification and Monitoring of Emerging Drug Trends. *Substance Use & Misuse* 2010; 45(1-2).
16. Van de Mheen H, Coumans M, Barendregt C and Van der Poel A. A drug monitoring system: Keeping a finger on the pulse by triangulation of qualitative and quantitative methods. *Addiction Research & Theory* 2006; 15(5).
17. Griffiths P, Vingoe L, Hunt N, Mounteney J and Hartnol R. Drug Information Systems, Early Warning, and New Drug Trends: Can Drug Monitoring Systems Become More Sensitive to Emerging Trends in Drug Consumption? *Substance Use and Misuse* 2000; 35(68).
18. Linnell M. Local Drug Early Warning System: A working model for a low cost, local drug early warning system (LDEWS) developed in Salford with regional & England wide network expansion proposal. [www.nta.nhs.uk/uploads/salfordewsmodelever10.pdf](http://www.nta.nhs.uk/uploads/salfordewsmodelever10.pdf) (accessed June 2015).

19. Davoli M, Simon R and Griffiths P. Current and future perspectives on harm reduction in the European Union. Tim Rhodes and Dagmar Hedrich (ed). *Harm reduction: evidence, impacts and challenges*, EMCDDA Monographs 10 ed. Lisbon: EMCDDA; 2010. pp. 437.
20. Clift E, et al. Information, Education and Communication lessons from the past; perspectives for the future, WHO/RHR/01.22 ed. Geneva: World Health Organization, Department of Reproductive Health and Research; 2001.
21. Bandura A. Social Learning Theory (Relabelled social cognitive theory). Englewood Cliffs, NJ: Prentice Hall; 1977.
22. Macdonald G. Communication Theory and Health Promotion . Bunton R, Macdonald G (eds). *Health Promotion: Disciplines and Diversity*, 2 ed. London: Routledge; 1992. pp. 197.
23. McGuire W. Communication - Persuasion Models for Drug Education. In Goodstadt M (ed). *Research on Methods and Programmes of Drug Education*. Toronto: Addiction Research Foundation of Ontario; 1974. pp. 1-26.
24. Derzon J and Lipsey M. A meta-analysis of the effectiveness of mass-communication for changing substance-use knowledge, attitudes, and behavior. In Crano, W, Burgoon, M (eds). *Mass media and drug prevention: Classic and contemporary theories and research*. Mahwah, NJ: Lawrence Earlbaum Associates; 2002. pp. 231-258.
25. Midford R, Ramsden R, Lester L. et al. Alcohol prevention and school students: findings from an Australian 2-year trial of integrated harm minimization school drug education. *Journal of Drug Education: Substance Abuse Research and Prevention* 2015; 0(0): 1-24.
26. Fletcher A, Calafat A, Pirona A and Olszewski D. Young people, recreational drug use and harm reduction. In Rhodes T and Hedrich D (ed). *Harm reduction: evidence, impacts and challenges*, EMCDDA Monographs 10 ed. Lisbon: EMCDDA; 2010. pp. 357-376.
27. Whittingham J, Ruitter R, Bolier L, Lemmers L, Van Hasselt N and Kok G. Avoiding counterproductive results: an experimental pretest of a harm reduction intervention on attitude toward party drugs among users and nonusers. *Substance Use & Misuse* 2009; 44(4).
28. Van Dongen A, Otte R and Schoenmakers A. Local Pass: Literature review, Workstream 3: Interventions. Drug Prevention and Information Programme of the European Union. 2014
29. ECDC and EMCDDA guidance. Prevention and control of infectious diseases among people who inject drugs. EMCDDA/ECDC, Stockholm 2011
30. Moffat B, Jenkins E and Johnson J. Weeding out the information: an ethnographic approach to exploring how young people make sense of the evidence on cannabis. *Harm Reduction Journal* 2013; 10(34). [www.harmreductionjournal.com/content/10/1/34](http://www.harmreductionjournal.com/content/10/1/34) (accessed June 2015).
31. Callon C, Charles G, Alexander R, Small W and Kerr T. 'On the same level': facilitators' experiences running a drug user-led safer injecting education campaign. *Harm Reduction Journal* 2013; 10(4). [www.harmreductionjournal.com/content/10/1/4](http://www.harmreductionjournal.com/content/10/1/4) (accessed June 2015).
32. Móró L. Harm reduction of novel psychoactive substance use. In Potter G, Wouters M & Fountain J (eds). *Change and Continuity: researching evolving drug landscapes in Europe*. Lengerich: Pabst Science Publishers; 2014. pp. 36-50.
33. Sorensen J, London J, Tusel D, Wolfe R and Washburn A. Mass media as drug users' key information source on overdoses. *American Journal of Public Health* 1992; 82(9).
34. Boyer E, Lapen P, Macalino G and Hibberd P. Dissemination of Psychoactive Substance Information by Innovative Drug Users. *CyberPsychology & Behavior* 2007; 10(1).
35. Van Hout M and Hearne E. "Word of Mouse": Indigenous Harm Reduction and Online Consumerism of the Synthetic Compound Methoxphenidine. *Journal of Psychoactive Drugs* 2015; 47(1).
36. Soussan C and Kjellgren A. Harm reduction and knowledge exchange - a qualitative analysis of drug-related Internet discussion forums. *Harm Reduction Journal* 2014; 11(25). [www.harmreductionjournal.com/content/11/1/25](http://www.harmreductionjournal.com/content/11/1/25) (accessed June 2015).
37. Walsh C. Drugs, the Internet and change. *Journal of Psychoactive Drugs* 2011; 43(1).

38. Hungerbuehler I, Buecheli A and Schaub M. Drug Checking: A prevention measure for a heterogeneous group with high consumption frequency and polydrug use - evaluation of Zurich's drug checking services. *Harm Reduction Journal* 2011; 8(16).  
[www.harmreductionjournal.com/content/8/1/16](http://www.harmreductionjournal.com/content/8/1/16) (accessed June 2015).
39. Benschop A, Rabes M and Korf DJ. Pill Testing-Ecstasy & Prävention. Eine wissenschaftliche Evaluationsstudie in drei Europäischen Städten. Amsterdam: Rosenberg Publisher; 2003.
40. Winstock A, Wolff K and Ramsey J. Ecstasy pill testing: harm minimization gone too far?. *Addiction* 2001; 96(8).
41. Allott K and Redman J. Patterns of use and harm reduction practices of ecstasy users in Australia. *Drug Alcohol Dependence* 2006; 28(82(2)).
42. Tom Gardner. Is this really a wise use of taxpayers' money?'. *Daily Mail*.  
[www.dailymail.co.uk/news/article-2549474/Is-really-wise-use-taxpayers-money-New-publicly-funded-drug-testing-service-used-addicts-test-quality-stash.html](http://www.dailymail.co.uk/news/article-2549474/Is-really-wise-use-taxpayers-money-New-publicly-funded-drug-testing-service-used-addicts-test-quality-stash.html) (accessed June 2015).
43. Harris M, Forseth K and Rhodes T. "It's Russian roulette": Adulteration, adverse effects and drug use transitions during the 2010/2011 United Kingdom heroin shortage. *International Journal of Drug Policy* 2015; 26(1).
44. Darke S, Hall W, Weatherburn D & Lind B. Fluctuations in heroin purity and the incidence of fatal heroin overdose in South Western Sydney, 1993-1995, Technical Report No. 58 ed. New South Wales, Australia: National Drug and Alcohol Research Centre University of New South Wales; 1998.
45. Freeman R and French J. What is the addicts' grapevine when there's 'bad dope'? An investigation in New Jersey. *Public Health Rep* 1995; 110(5).
46. Kerr T, Will W, Hyshka E, Maher L and Shannon K. 'It's more about the heroin': injection drug users' response to an overdose warning campaign in a Canadian setting. *Addiction* 2013; 108(7).
47. Miller P. Safe using messages may not be enough to promote behaviour change amongst injecting drug users who are ambivalent or indifferent towards death. *Harm Reduction Journal* 2009; 6(18). [www.harmreductionjournal.com/content/6/1/18](http://www.harmreductionjournal.com/content/6/1/18) (accessed June 2015).



# Appendix 1. Drug alerts – evidence for effectiveness

**Information and behaviour change:** a drug alert is a way of cascading information in the hope of reducing risk. The information, education, communication (IEC) approach,<sup>20</sup> based on social cognitive theory and with information at its core,<sup>21</sup> is designed to influence target groups. Although information – in this case about drug risks – is only part of the complex process of behavioural change, it is an essential starting point. For information to be acted upon, the recipient of a message must believe that the risk involved is serious, that they are susceptible to that risk, and that they are able to moderate their behaviour to avoid or reduce it.

**Mass media and harm reduction:** the main communication channel used in disseminating public drug alerts is mass media. Interpersonal communication is more effective in changing behaviour<sup>22,23</sup> but doesn't reach such a wide audience. Mass media campaigns that aim to reduce or prevent drug use are often counterproductive, particularly those featuring resistance skills.<sup>24</sup> What little evaluation there has been of harm reduction mass media campaigns does not always show positive results – they can prevent harm but may arouse interest and encourage use.<sup>25,26,27</sup>

**Targeted information:** messages should be credible, accurate and tailored to specific target groups. They should be gender and culturally specific, use terminology that the users can understand, be comprehensive, easy accessible and provided at every possible opportunity.<sup>28,29</sup> Involving drug users in the creation of public health messages that target peers has been shown to be effective.<sup>30,31</sup> It has been argued, in the context of new psychoactive substances, that users should be viewed as consumers of a product and drug alerts as consumer safety information that may empower them to promote responsible use and develop their own 'smart' drug user subcultures.<sup>32</sup>

**Communicating with target groups of drug users:** research in the 1990s suggested that users learn about drug warnings through television and print media, from healthcare staff, and "on the street".<sup>33</sup> Although the internet now dominates communication channels, some target groups of drug users do not have regular access to it. There is therefore still a place for alerts pinned to a noticeboard and for face-to-face interventions.

There is evidence that young people use social networks to promote and warn about new and/or novel drugs.<sup>34,35</sup> Evidence is generally positive about the way new and/or novel, potent or adulterated drug information is used by online user groups.<sup>36</sup> Online drug information from drug-using communities is routinely used by professionals wanting to find out about new drugs.



**Drug checking:** drug checking is the process of testing a user's drug with the purpose of avoiding harm to that individual and enabling warnings to other potential users. Although this is not a part of the local alert process, learning from this area may be relevant when considering drug alerts that inform of drug contents.

Evidence suggests drug checking does not lead to increased or dangerous use<sup>37,38</sup> and may even result in restricted consumption among ecstasy users.<sup>39</sup> However, it has been argued that the commercially available self-tests are not effective or reliable and may give a false sense of security. Only tests of a forensic standard are accurate enough to be relied upon and even then they do not guarantee safety or protect the consumer against individual responses to substances.<sup>40</sup>

**Pill warnings:** evidence indicates that ecstasy users are aware of the potential for harm associated with ecstasy use and attempt to minimise it by employing strategies to reduce that harm.<sup>41</sup> Messages about adulterated pills, such as those containing PMA and PMMA, are fairly unambiguous: the 'bad' pill is to be avoided, as it is more dangerous than the 'good' or desired pill. However, messages become more complex when, for instance, the danger involves pills containing high doses of MDMA. Although potent pills can kill just as adulterated ones can, they are also likely to be sought out because they are potent. Harm reduction messages about, for example, breaking potent pills in half, may be appropriate but they involve a more morally ambiguous narrative for public bodies and are more likely to come under scrutiny from the media.<sup>42</sup>

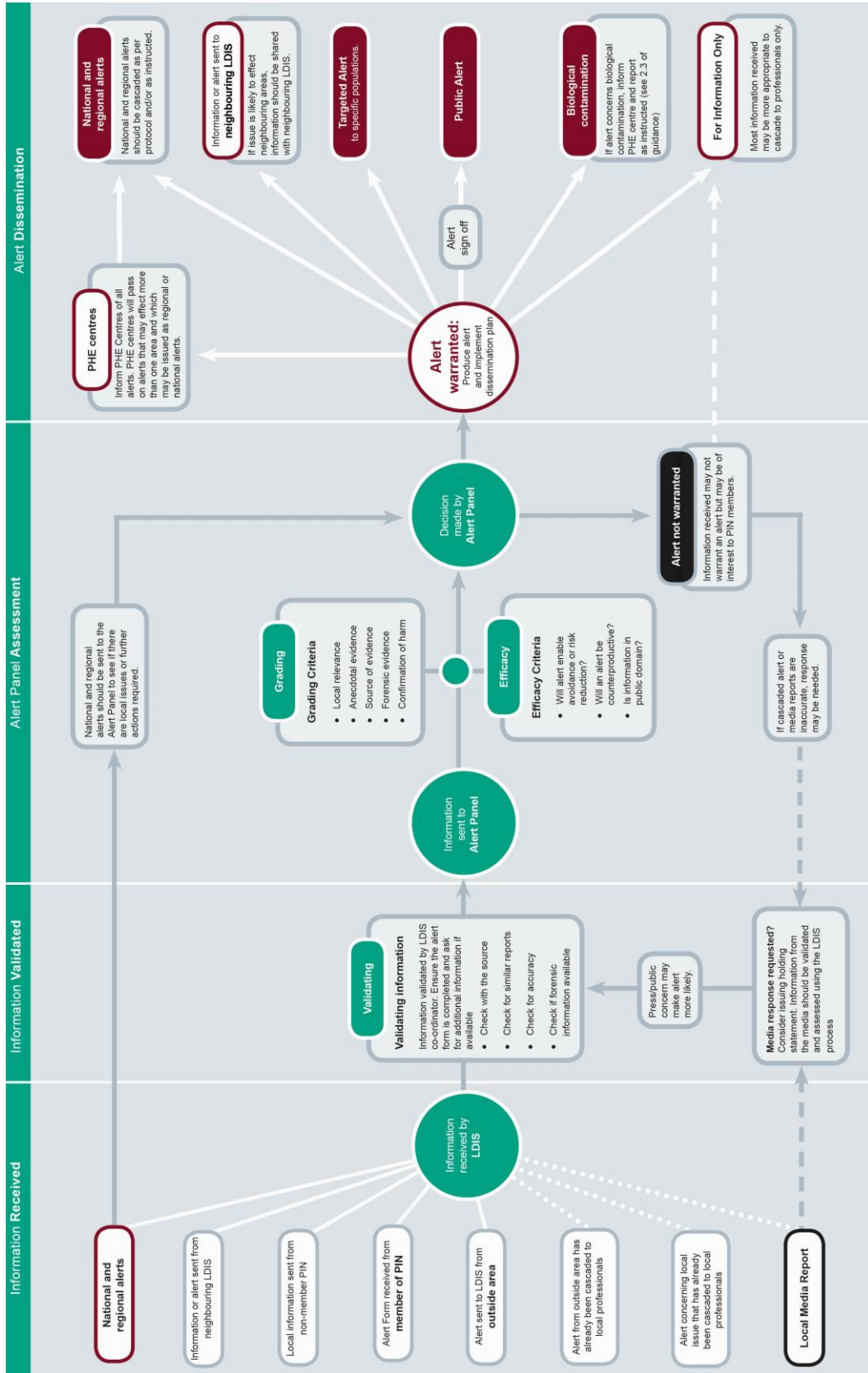
**Heroin purity:** the question of alerting heroin users to 'strong' batches of heroin is complex. During the UK heroin drought of 2010 the purity of heroin fell considerably. On the face of it, overdose was less likely when lower purity heroin was on the streets. The risk would come from lowered tolerance once higher purity heroin inevitably returned. However, evidence suggests people continued to use heroin during the drought but also increased the amount and range of substances used simultaneously with heroin. The heroin shortages may have increased as well as reduced harm.<sup>43</sup>

Although purity is a factor in heroin overdose, evidence suggests that purity is only moderately correlated with overdose deaths.<sup>44</sup> Other factors such as loss of tolerance, drug combinations, age, depression and having recently overdosed are more reliable predictors of overdose risk.

There is also convincing evidence that alerts to high-purity heroin designed to reduce the risk of overdose may be of limited effectiveness and even exacerbate overdose risk.<sup>45,46</sup> Evidence suggests heroin injectors view the arrival of potent heroin on the local scene as a positive development and actively seek it out.<sup>44</sup> The need for a hit overrides all other considerations and there may be indifference to death.<sup>47</sup>

There may well be occasions that would justify heroin potency alerts, such as when the potency of heroin has led to multiple deaths. Messages need to be considered in light of highlighting other predictors of overdose risk and be specific in promoting alternative strategies.

# Appendix 2. LDIS drug alert flowchart



## Appendix 3. Example PIN terms of reference

### **[Your LDIS] local drug information system Professional information network (PIN) terms of reference**

**Background:** [your LDIS] professional information network (PIN) is a multidisciplinary online network for professionals in the [your area]. The ethos of the network is one of co-operation. The [your LDIS] PIN was established in [year] and is governed/owned by [relevant details].

**Aim:** the group enables better information sharing between local professionals and enhances local recording of, and therefore intelligence and responses to, new and/or novel, potent, adulterated or contaminated drugs.

**Membership:** the network is open to any professionals working within [your area]. Colleagues with relevant knowledge or experience should be encouraged to join the PIN. You may nominate relevant colleagues for membership by emailing the LDIS co-ordinator.

**Confidentiality:** information sent within the PIN should be anonymised so that patients or service users cannot be identified. The network should only be accessible to PIN members.

**Information requests:** queries, clarification and requests for information may be posted on the PIN. Information requests and any subsequent answers or comments should be marked as 'For Information Only'.

**LDIS forms:** any information or concerns over incidents that you have should be sent to the LDIS mailbox. They should be recorded on the LDIS form provided. Forms are available from the LDIS co-ordinator or at [details]. Relevant managers should be informed and service protocols should be followed.

**Information sharing:** as a member of the PIN you will be expected to disseminate information and alerts as requested by the LDIS co-ordinator. The mechanisms for doing so should be discussed with colleagues within your organisation.

- information provided to PIN members and marked 'For information only' may be shared within services, but should not be in the public domain unless agreed by the LDIS co-ordinator
- alerts may be targeted to specific groups and should not be cascaded outside the groups specified
- public alerts may be cascaded as instructed or within the area, but should not be cascaded outside the area unless specified by the LDIS co-ordinator

**Contact details:**

The LDIS co-ordinator is [name, contact details]

The email address of the PIN is [details]

The public email address for the alert mailbox is [details]

## Appendix 4. LDIS form

Please complete as much of the form as possible and return to [insert LDIS mailbox]

<b>Your contact details:</b> if appropriate role and service		
<b>Location where incident occurred:</b> geographical area and location if known (ie, home, street, nightclub, hostel, hospital)		
<b>Name of drug:</b> if known, indicate if brand name on packet, street name, chemical name etc.		
<b>Route of administration:</b> how was the drug taken? (Tick if known)		
Smoked <input type="checkbox"/>	Swallowed <input type="checkbox"/>	Sniffed <input type="checkbox"/> Injected <input type="checkbox"/>
	(If injected) IV <input type="checkbox"/> IM <input type="checkbox"/> Skin pop <input type="checkbox"/>	Other <input type="checkbox"/> (please specify)
<b>Effect of drug:</b> the effect of drug as described to you		
<b>How was this effect different from what expected?</b> (eg, lasted longer, was more potent)		
<b>Polydrug use?</b> Was the drug used with any other drugs or alcohol?		
No <input type="checkbox"/>	Yes <input type="checkbox"/>	Unknown <input type="checkbox"/> If yes, please list others
<b>Dosage:</b> how much was taken; if more than one type of drug please list amount for each		
<b>Cost:</b> please specify if price is for weight, per bag, pill etc.	<b>Appearance of drug:</b> (ie, white powder, pill) If available, please attach photograph (next to coin for scale)	
<b>Concern:</b> please indicate concern (ie, adverse effect, altered behaviour, violence, overdose)		
<b>Did the incident involve a hospital admission?</b>		
No <input type="checkbox"/>	Yes <input type="checkbox"/>	Unknown <input type="checkbox"/> If known please specify which hospital, when this occurred, whether still ongoing?
<b>Did the incident result in death or other serious harm?</b> (Give details if known)		
<b>Where was the drug purchased?</b> (Please tick if known)		
Internet <input type="checkbox"/>	Shop <input type="checkbox"/>	Dealer <input type="checkbox"/> Friend <input type="checkbox"/> Other (describe)
<b>Has this issue or concern been raised by other service users?</b> (How many times?)		
No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, roughly how many times
<b>If known, please indicate drug experience of person concerned</b>		
Experienced drug user <input type="checkbox"/>	Recreational drug user <input type="checkbox"/>	Naive drug user <input type="checkbox"/> Other relevant background information, ie, vulnerable adult, young person (age)
<b>Any other information</b>		

Thank you for your co-operation

This form is also available as a Word template to download and adapt at [www.nta.nhs.uk](http://www.nta.nhs.uk)

## Appendix 5. Examples of media holding statements

### Substance X

There has been a death of a young person locally, and it is being speculated that substance X is responsible, but there is no toxicology.

**Holding statement:** *“Any loss of a young life is a tragedy.*

*“Until the cause of death is officially confirmed we are unable to comment on any possible involvement of drugs.”*

### Potent heroin

Potent heroin of 60% purity has been confirmed by toxicology in a recent police operation. Despite the LDIS deciding not to alert, the police have issued a warning.

**Holding statement:** *“Any death from drug use is a tragedy.*

*“Drug users and their friends and families need to be aware that the strength of heroin is only one of a number of factors that can lead to an overdose. People can become less tolerant to heroin after a period of abstinence, and using the drug at the same time as other depressant drugs, including alcohol, all contribute to the risk. Age, depression and having recently experienced another overdose can also increase the risk.”*

**Promoting services:** *“Heroin addiction is a chronic relapsing condition and can take many years and several attempts at treatment to overcome. But we should never write people off – with the right support and treatment, they can and do recover. There are good services and support is available for anybody who wants to overcome addiction.”*

**Harm reduction advice:** *“After a period of abstinence people can become less tolerant to heroin. A much smaller amount should be used than in the past. Use a test dose with any new batches, don’t use depressants like alcohol and diazepam at the same time as heroin, and don’t use alone. If somebody overdoses on heroin, it rarely leads to instant death. An ambulance should be called immediately and any available naloxone used.”*

## 'Rogue' pills

On the first day of a three-day music festival, paramedics treat several young people after they took a pink pill sold as ecstasy. Rumors are circulating and the press is reporting that these pink pills are 'contaminated' with PMMA.

**Holding statement:** *“Without forensic tests we cannot speculate about the contents of these pills.”*

**Holding statement 2:** *“Over the past few years PMA and PMMA sold as ecstasy pills have been responsible for a number of deaths. In numerous cases pills have been found to contain high doses of MDMA, which can be equally dangerous. Without forensic tests it is impossible to know what is in a pill.”*

**Harm reduction advice:** *“PMMA takes longer to take effect than MDMA. There is a danger that users will take more in the belief the pills are weak. Potent pills containing high doses of MDMA are now commonly found and these can be equally dangerous as PMMA. When taking any unknown drug it is safer to take a half and wait at least an hour.*

*“If anyone is in trouble call an ambulance or a paramedic straight away.”*

## Appendix 6. Grading and efficacy matrices

### Grading of information received

Grading criteria	Weak evidence Do not consider an alert	Medium evidence Only consider if supported by multiple criteria	Strong evidence Consider alert	Exceptional circumstance
1. Local relevance	Not locally relevant	Maybe relevant	Locally relevant	Exceptional circumstances
Tick one box				
2. Anecdotal report	Anecdotal without support	Anecdotal supported by multiple reports	Anecdotal supported by multiple sources and other criteria	Exceptional circumstances
Tick one box				
3. Source of evidence	Unreliable or unknown source, no other evidence	Unreliable but multiple sources or supported by other evidence	Reliable source and specific enough to be of use	Exceptional circumstances
Tick one box				
4. Forensic evidence	No forensic evidence	No forensic evidence but other compelling evidence	Forensic evidence	Exceptional circumstances
Tick one box				
5. Confirmed harm	No confirmed harm	Potential serious harm or death	Serious harm or death confirmed	Exceptional circumstances
Tick one box				
	Boxes ticked in this column are a good indication that alert <b>is not</b> warranted	Boxes ticked in this column are neutral and should be supported by other strong evidence to warrant an alert	Boxes ticked in this column are a good indication that alert <b>is</b> warranted	Exceptional circumstances for one criteria, may make alert more likely or even justify an alert by itself
Result of grading matrix (no. of ticks)				
Initial LDIS panel decision	<input type="checkbox"/> Do not alert <input type="checkbox"/> Undecided <input type="checkbox"/> Alert or other actions considered			

## Efficacy of alert

<b>Efficacy questions</b>	<b>Do not consider alert</b>	<b>Efficacy neutral</b>	<b>Alert more likely</b>	<b>Exceptional circumstance</b>
Information in public domain	Alert unwarranted and press reporting not causing concern	Alert unwarranted but press reports causing concern	Alert considered and press reports causing public concern	Alert more likely because of intense media and public attention
Tick one box				
Will alert enable avoidance or risk reduction?	Alert not specific enough to enable avoidance or risk reduction	Alert not specific but generic harm reduction advice applicable	Alert enables drug avoidance or harm reduction response	Alert not specific but other exceptional concerns override
Tick one box				
Will alert be counterproductive?	Alert likely to be counterproductive	Alert maybe counterproductive but harm reduction message suitable	Alert unlikely to be counterproductive	Alert warranted despite risk of being counterproductive
Tick one box				

Use the answers to the efficacy questions to review the initial LDIS panel decision and arrive at a final decision recorded below.

## Panel decision

<b>Final decision</b>	
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This form is also available as a Word template to download and adapt at [www.nta.nhs.uk](http://www.nta.nhs.uk)



## Appendix 7. Local alert template

Alert should be dated and have a version number in case you need to update it.

Your LDIS logo and details

# DRUG ALERT

## **DANGEROUS SUBSTANCE ABOUT** **Brief warning about dangerous substance**

*Provide details about what has happened.  
Give example if for instance a local person is in hospital or dead.  
State clearly if it has been tested and what it is.*

### **Explain what the consequences of taking this dangerous substance are**

*Describe what it looks like or how it can be identified.*

Add photograph of the dangerous substance  
if you have one

**Explain what can be done to avoid this dangerous substance**

**Give specific harm reduction advice**

**Explain what should be done if dangerous substance has been taken**

**Say where to go for help and give contact details.**

A footnote should say where the alert should be displayed and by what date it should be taken down.

The impact of an alert is lessened the longer it is displayed.

If the issue is still a concern after the specified date an update can be issued.

## Appendix 8. Useful information sources

### National alerts

Central Alerting System: sends safety alerts to the NHS and independent health and social care providers registered with the Care Quality Commission (CQC) and signed up to receive alerts. To sign up, email [safetyalerts@dh.gsi.gov.uk](mailto:safetyalerts@dh.gsi.gov.uk) with:

- full name of organisation
- business of organisation (eg, school/charity/care home etc)
- first name
- last name
- job title
- full postal address
- email address
- telephone number

<https://www.cas.dh.gov.uk>

### Official websites and resources

Advisory Council on the Misuse of Drugs: detailed technical drug reports and information on new legislation

[www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs](http://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs)

EMCDDA: operates the European early warning system and the website has both detailed technical reports and information in user-friendly formats

[www.emcdda.europa.eu](http://www.emcdda.europa.eu)

Forensic Early Warning System (FEWS)

[www.gov.uk/government/publications/forensic-early-warning-system-fews-annual-report](http://www.gov.uk/government/publications/forensic-early-warning-system-fews-annual-report)

UK Focal Point on drugs

[www.nta.nhs.uk/focalpoint.aspx](http://www.nta.nhs.uk/focalpoint.aspx)

NHS Choice medicines A-Z: NHS online resources with information on over-the-counter and prescribed medicines

[www.nhs.uk/medicine-guides/pages/default.aspx](http://www.nhs.uk/medicine-guides/pages/default.aspx)

## Popular websites and resources

Wikipedia: information on a wide range of drugs. However, it may be inaccurate or outdated so, where possible, references should be checked at the original source  
[en.wikipedia.org/wiki/Category:Psychoactive\\_drugs](https://en.wikipedia.org/wiki/Category:Psychoactive_drugs)

Erowid: a comprehensive drug information website  
[www.erowid.org](http://www.erowid.org)

DrugScience: formerly the Independent Scientific Committee on Drugs  
[www.drugscience.org.uk](http://www.drugscience.org.uk)

DS Daily: a free email newsletter with policy, research and media coverage  
[www.dsdaily.org.uk](http://www.dsdaily.org.uk)

The Drugs Wheel: useful for the current legal status of a range of psychoactive substances. Also contains professional briefings produced by Drugwatch.  
[www.thedrugswheel.com](http://www.thedrugswheel.com)

Online user forums: contain user experiences and often have some of the most comprehensive briefings on new drugs. However, information in forums should not be relied upon on their own without checking with other sources.  
[www.drugs-forum.com](http://www.drugs-forum.com)  
[www.bluelight.org](http://www.bluelight.org)

## Drug analysis and identification

WEDINOS: Welsh early warning system publishes online drug analysis  
[www.wedinos.org](http://www.wedinos.org)

DIMS: Dutch testing system, publishes results and information (needs translation)  
[www.drugs-test.nl](http://www.drugs-test.nl)

Pill reports: provides pill reports  
[www.pillreports.net/index.php?page=region\\_home&region=2](http://www.pillreports.net/index.php?page=region_home&region=2)

TICTAC: commercially available drug identification database  
[www.tictac.org.uk](http://www.tictac.org.uk)

## NPS clinical information

Project Neptune: information and clinical guidance on NPS  
[www.neptune-clinical-guidance.co.uk](http://www.neptune-clinical-guidance.co.uk)