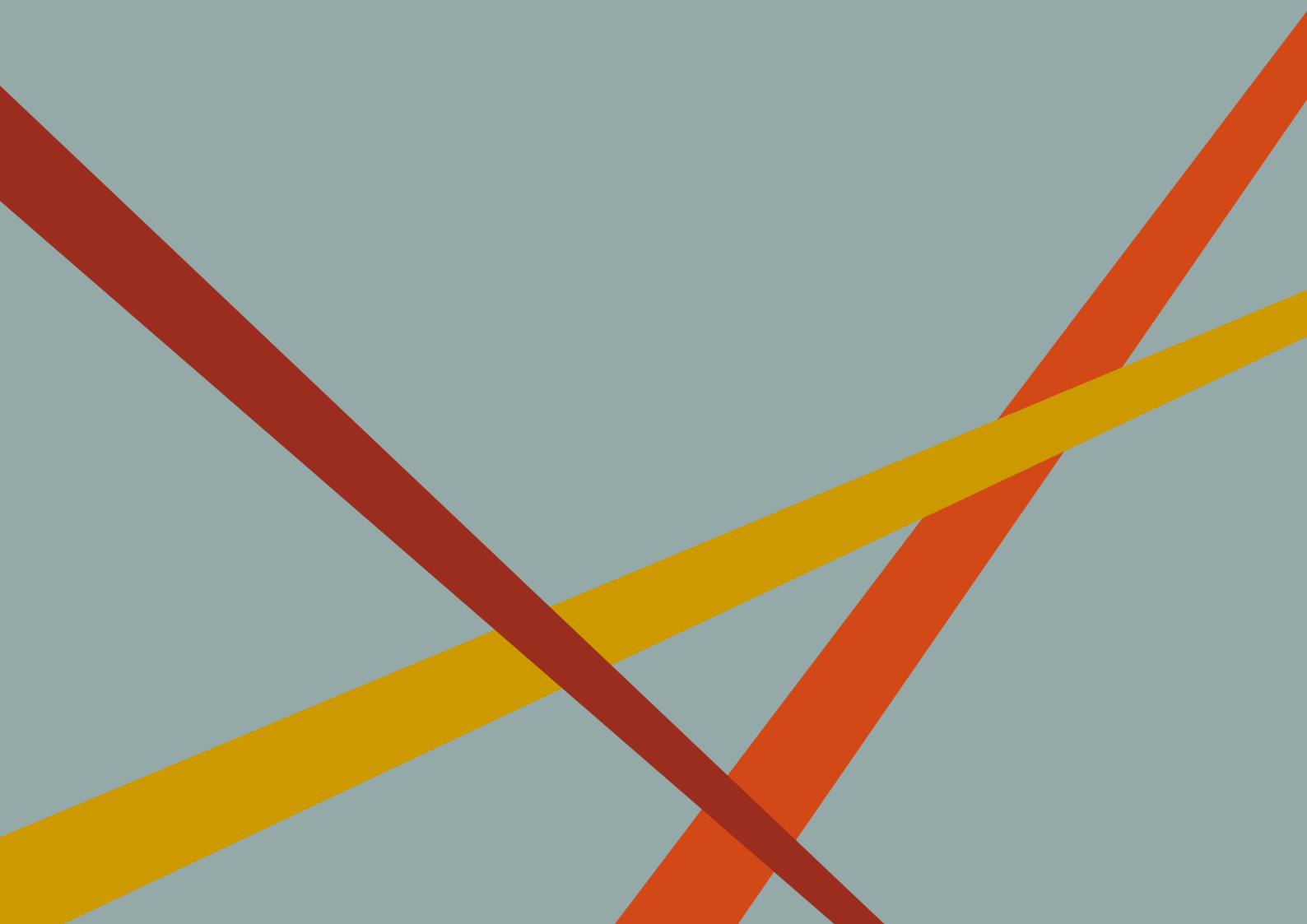




DrugScope

Drug-Related
Deaths Summit
2015



Key messages

- The availability of accurate, timely and easily accessible data is important in order to make the appropriate adjustments to policy and practice in order to reduce drug-related deaths.
- The majority of drug misuse deaths still involve opiates, in particular heroin and methadone.
- Being in contact with a treatment service would appear to be a significant protective factor for drug-related deaths.
- Services and practitioners should pay attention to the elevated risk for those in treatment who are regularly overdosing, are drinking excessively, live alone in temporary accommodation or are homeless, or as a result of smoking-related diseases have compromised respiratory systems.
- Policy makers and commissioners should think about providing timely and accurate alerts to drug users who are not in the treatment system - including drug users who don't use opiates.
- Commissioners and services should look at how they could supply naloxone more widely in the community to ensure those vulnerable to overdose (including not in treatment), their families, peers and carers are able to access the medicine.

Background

Registrations of drug misuse deaths reported by the Office for National Statistics (ONS) for 2013 in England increased by over 20%, with an even higher increase for heroin-related deaths. This reverses a trend of declining drug-related deaths over recent years and is a cause for concern among a wide range of stakeholders in the fields of drug and alcohol treatment, policy and research.

DrugScope, Public Health England (PHE) and the Local Government Association (LGA) convened a national summit on 23 January 2015 to explore the complex causes behind the rise in deaths and produce practical messages for key decision makers who can help prevent future drug-related deaths.

This note captures the main points in the discussion at the summit, which was structured with the intent of sharing the early findings from Public Health England's analysis of the ONS drug-related death data and data from the National Drug Treatment Monitoring System (NDTMS). It draws on the expertise and experience of experts from across the sector, including treatment providers, commissioners, the research community, and service users.

In addition to presentations from DrugScope and PHE, the agenda included structured discussion on the experience

of those present and posed questions on the role of drug purity, availability, poly drug use, other health vulnerabilities of drug users, changes in the philosophy guiding the treatment system, and other factors that might have led to the increase in deaths.

Drug-related deaths

The Deaths Related to Drug Poisoning in England and Wales, 2013 report showed the sharpest increase in drug-related deaths was attributed to heroin/morphine, up by 32% on the previous year. Over half of deaths attributed to drug poisoning included an opiate. In men aged 30 to 39, the proportion was much higher, with two in three involving an opiate.

The ONS reported there was a 21% rise in registrations of drug misuse deaths in England from 1,492 deaths in 2012 to 1,812 in 2013, the highest figure since 2009. The majority of the increases were in accidental overdoses and in men, although there were also more intentional overdose deaths (i.e. suicides).

Other drugs were also associated with increased numbers of registered deaths. Deaths where cocaine was mentioned rose by 22% between 2012 and 2013. Deaths from amphetamines were at the highest levels

since records began in 1993, as were deaths where New Psychoactive Substances (NPS) were mentioned.

The ONS reported increases in all regions but the largest increase in rates were in the South East (where the rise was statistically significant), West Midlands and North East (which also has the highest death rate) and the lowest increase was in the North West (though the regional death rate remains high).

In addition to confirming all of the above, PHE's subsequent analysis of the ONS statistics and NDTMS treatment data, which was able to look at year of death rather than year that death was registered, demonstrated:

- The majority of drug misuse deaths still involve opiates, in particular heroin and methadone;
- Notable recent increases in cocaine and amphetamine deaths;
- A marked increase in mentions of benzodiazepines among opiate deaths over recent years;
- General ageing profile among drug misuse deaths over recent years;

- General increasing trend in female drug misuse deaths, although still around a third of the number for males;
- General increasing trend in intentional overdoses;
- More than half of opiate deaths in 2012 were among those who had not been in treatment for at least five years.

PHE were unable to provide a full analysis of the data in time for the summit, but it was agreed that going forward there is a need to explore regional variation as well as poly drug deaths and the role of alcohol in drug related deaths.

What the summit identified

The attendees at the summit identified two distinct populations affected by drug-related deaths: broadly these could be described as opiate users and those who died after taking other illegal or illicit substances. The two groups were seen as having significantly different characteristics.

Opiate users

A key characteristic of opiate users who have died is the presence of multiple, entrenched and complex needs in addition to dependency. The additional needs discussed included a range of housing problems (including homelessness, living in temporary accommodation, poor housing conditions or living alone) and mental health needs.

It was also recognised that many opiate users had increased vulnerability to overdose because of using drugs (including alcohol) in combination with opiates. In particular, the summit identified the use of gabapentin and pregabalin as being a potential additional risk. In addition, the continued use of illicit drugs despite being prescribed an opioid substitution therapy, was considered to add to the risk of overdose.

Analysis of service level data, carried out for the summit, suggested that the physical health problems of opiate

users were an important risk factor for overdose death. These included, but were not limited to, respiratory problems caused by smoking, liver problems such as hepatitis C and alcohol-related cirrhosis, and previous non-fatal overdoses. Attendees at the summit were also conscious that the average age of opiate users has been rising, and that this would be a factor in the vulnerability to overdose.

The drug treatment system in England engages about 60% of those estimated to be high risk drug users. This is acknowledged to be significantly higher than the treatment penetration rates achieved in other comparable countries. The early analysis matching the ONS and NDTMS data suggests that over half of those dying are not (and have not recently been) in treatment. Participants suggested that there is therefore a need to continue to focus on the level of engagement with high-risk drug takers. Being in contact with a treatment service would appear to be a significant protective factor for drug-related deaths.

Non-opioid users

The non-opiate deaths cover a broad class of drugs with very different actions, including 'traditional' stimulant drugs (cocaine), newer drugs like MDMA and PMA, and genuinely new NPS. Although NPS have mostly been

associated with young people and with oral use, there is some evidence of increasing injection and increased use by marginalised drug users who might have used opioids previously. This applies particularly to mephedrone in some areas.

The difference in actions between the drugs makes identifying commonalities between those dying more difficult.

The summit did however discuss the impact of increases in drug purity, particularly of MDMA, as well as the problems caused when users misunderstood, did not know or simply did not care what they were taking, for instance among people taking PMA believing it to be MDMA or those using an 'unknown white powder'.

Attendees acknowledged the increased number of deaths relating to drugs that are categorised as NPS, and how little was currently known about the toxicology of some of these drugs. It was commented that while current levels of deaths from these drugs were thankfully small that this may be partly as a result of relatively low levels of prevalence.

What the summit wanted

More data and better analysis

The availability of accurate, timely and easily accessible data was felt to be important in order to make the appropriate adjustments to policy and practice to reduce drug-related deaths.

A number of suggestions were made as to how PHE could try to analyse the data sets available to it. These included looking at the route of administration of fatal overdoses, the involvement of other drugs (including alcohol), the purity of drugs (especially heroin), and how many of those dying had recently left prison (and whether they had been in treatment in that environment).

In respect of issues of purity of drugs at a street level, it was felt that it was important for PHE to be able to see and use intelligence gathered by the National Crime Agency, particularly if that was available at regional level. It was recognised that this material might be operationally sensitive but being able to access it in a timely manner could contribute to a reduction in drug-related deaths.

It was felt that it would be important for any analysis to assess whether there were different risk factors for men and women, and whether age was a factor.

A number of attendees pointed to analysis of drug-related deaths from Australia, where the authorities had made the data sets used to analyse these deaths and other overlapping data sources available for wider scrutiny. It was felt that enabling independent academic investigation in this way had significantly helped improve understanding of the mechanisms and drivers of drug-related deaths.

The summit was conscious that the timing of coroners' reports can also affect the way that issues are understood and responded to. For example, the ONS report that over half of drug-related deaths registered in 2013 will have actually occurred in 2012 or even before that.

Consequently, it was felt that it would be advantageous if a group of specialists were to work with ONS and PHE to devise ways to improve the reporting of drug-related deaths. Options to explore included:

- Timing of reporting, e.g. reporting by year of deaths;
- Collecting additional information relating to how people died (the route of administration);
- Enabling more stable trend analyses, e.g. by presenting a three year rolling average; and

- Exploring how to make data more readily available for external analysis.

Other actions

The data presented to the summit confirms that drug treatment is protective for drug users, particularly opiate users. It is therefore imperative that policy makers, commissioners and service providers protect and improve treatment penetration rates. Treatment penetration to reduce drug-related deaths will have a positive impact on health inequalities.

Services and practitioners should pay attention to the elevated risk for those in treatment who are regularly overdosing, are drinking excessively, live alone in temporary accommodation or are homeless, or as a result of smoking-related diseases have compromised respiratory systems. They should encourage and support drug users to be tested for blood-borne viruses (particularly hepatitis C) and to engage in treatment for these should they need it. Practitioners should be conscious of the mental health needs of their service users and look at how they could contribute to wider strategies to reduce suicides. Drug users in treatment should be discouraged from 'use on top' of prescribed opioid substitution therapies, and the causes of this

should be considered and investigated, including whether dosages are adequate in the light of clinical guidelines.

The summit believed that making naloxone more widely available in the community in line with the guidelines developed by the World Health Organisation, and as recommended by the Advisory Council for the Misuse of Drugs, would help save lives. The summit was presented with evidence that some local areas in England are already making strides with this but that it is far from universal. The introduction of new regulations by the Medicine and Healthcare products Regulatory Agency (MHRA), which should come into force in October 2015, will make it easier to supply naloxone to those vulnerable to opioid overdose, as well as those likely to be present during an overdose, such as family members and carers.

Service providers should share good practice on approaches and interventions that are effective in reducing drug-related deaths. The summit heard that services that stay in touch with people who have completed treatment have found that this can be protective in terms of preventing relapse and therefore the risk of overdose.

Commissioners and drug and alcohol services should work with others to protect drug users not in treatment.

In particular it was acknowledged that those with multiple and complex needs are often known to other services – for example, health services, homelessness services or the criminal justice system - where they could and should be assessed for risk of overdose. The Care Quality Commission should use the inspection regime for general practice and acute health services to find out if the health needs of drug users (as a group living in vulnerable circumstances) are being met.

Policy makers and commissioners may also want to think about providing timely and accurate alerts to drug users who are not in the treatment system - including drug users who don't use opiates. Policy makers may want to assess the evidence for other interventions - such as pill testing - to see if they could make a contribution to reducing drug-related deaths.

Commissioners and services should look at how they could supply naloxone more widely in the community to ensure those not in drug treatment but vulnerable to overdose, their families, peers and carers are able to access the medicine.

Attendees at the summit

- Cllr Sophie Linden – Deputy Mayor, London Borough of Hackney (Chair)
- David Biddle – Chief Executive, CRI
- Dr Owen Bowden-Jones – Consultant Psychiatrist, Central and North West London NHS Foundation Trust
- Simon Bray – Commander, Metropolitan Police
- Andrew Brown – Director of Policy, Influence and Engagement, DrugScope
- Andy Brown – Head of Substance Misuse, Brent Council
- Pete Burkinshaw – Commissioning & Clinical Practice Development Lead, Alcohol, Drugs and Tobacco, PHE
- Annette Dale-Perera – Co-chair, ACMD Recovery Committee
- Kirsty Douse – Head of Legal Services, Release
- Paul Duffy – Health Improvement Manager (Alcohol and Drugs), PHE
- Chloe Dunnet – Head of Drugs, D&A Unit, Home Office
- Rachael Hope – Community Safety Specialist (Drugs), Newcastle City Council
- John Jolly – Chief Executive, Blenheim CDP/Chair, Naloxone Action Group England

- Dr Jack Leach – Consultant GP, Royal College of General Practitioners
- Dr John Marsden – Clinical Research Psychologist, King's College London
- Liz McCoy – Drug Service Manager, Pennine Care NHS Foundation Health Trust
- John McCracken – Drugs Programme Manager, Department of Health
- Danny Morris – Drug trainer/consultant, 2gether NHS Foundation Trust
- Mark Norris – Senior Adviser, LGA
- Rosanna O'Connor – Director, Alcohol, Drugs and Tobacco, PHE
- Paul Ogden – Senior Adviser, LGA
- Margaret Orange – Treatment Effectiveness & Governance Manager (Addictions), Northumberland Tyne & Wear NHS Foundation Trust
- Dr Mark Prunty – Senior Medical Officer for Drug and Alcohol Policy, Department of Health
- Dr Marcus Roberts – Chief Executive, DrugScope
- Dr George Ryan – GP/Senior Clinical Adviser, PHE Criminal Justice
- Ben Seale – Public Health Commissioning Manager, Sunderland City Council
- Professor John Strang – Head of the Addictions Department, King's College London

- Steve Taylor – Programme Manager, Alcohol, Drugs and Tobacco, PHE
- Martin White – Programme Manager, Alcohol, Drugs and Tobacco, PHE
- Rob Wolstenholme – Programme Officer, Alcohol, Drugs and Tobacco, PHE

About DrugScope

DrugScope is the national membership organisation for the drug and alcohol field and is the UK's leading independent centre of expertise on drugs and drug use.

We represent more than 300 member organisations involved in drug and alcohol treatment, supporting recovery, young people's services, drug education, prison and offender services, as well as related services such as mental health and homelessness.

DrugScope is a registered charity (number 255030).

Contact

DrugScope
Asra House
1 Long Lane
London
SE1 4PG

www.drugscope.org.uk
info@drugscope.org.uk
020 7234 9730