Public Health England

Protecting and improving the nation's health

Drug health harms – national intelligence

November 2015

Notes reflecting presentations and discussion from the eighth meeting of the National Intelligence Network on the health harms associated with drug use, held in London on 10 September 2015. These notes are for directors of public health, commissioners, service providers and needle and syringe programmes.

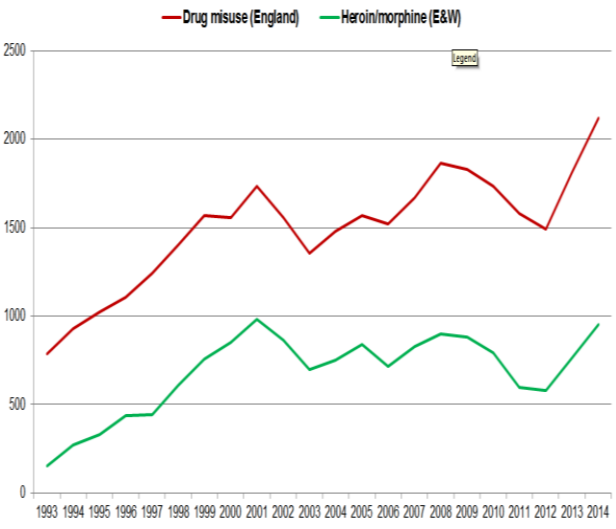
The National Intelligence Network on the health harms associated with drug use is convened by the alcohol, drug and tobacco division of Public Health England's (PHE) health and wellbeing directorate.

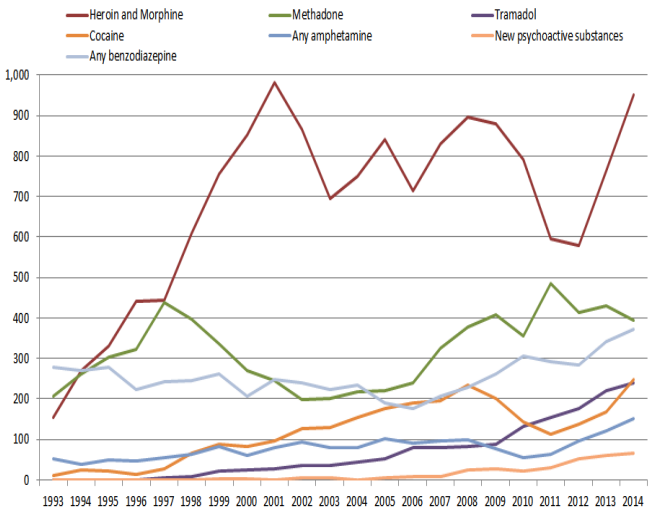
The network exchanges intelligence on blood-borne viruses, new and emerging trends in drug use, and drug-related deaths, and explores how to use this intelligence to improve practice.

Drug-related deaths

Martin White, Evidence Manager for Public Health England alcohol, drugs and tobacco presented the latest official statistics on drug-related deaths – current and future PHE responses to what the analysis is telling us were also discussed

Official statistics published in September reported that the number of drug-related deaths in England in 2014 was the highest on record. Deaths are rapidly increasing among long-term heroin users over 40 and deaths involving heroin increased by 64% from 2012.





Between 2013 and 2014, the number of deaths from drug misuse increased by 17% in England to 2,120 (an increase of 42% over two years). In addition to the rise in deaths involving heroin and morphine, deaths involving tramadol, codeine, fentanyl and buprenorphine also increased – while methadone deaths have dropped slightly. 2014 figures also showed a 46% increase in mentions of cocaine in drug-related deaths and a 26% increase in mentions of amphetamine. Deaths recorded as involving new psychoactive substances remain low in number by comparison (67) and largely involve GHB and mephedrone.

There were marked increases in deaths among the 40-49 and 50-69 age groups.

Statistics showed considerable regional variation, with some regions having large increases, but others seeing little change or slight falls. Drug-related death rates for each lower tier local authority are also published alongside this year's report.

Earlier this year PHE held a national summit on drug related deaths in collaboration with DrugScope and the Local Government Association.

PHE produced a trend analysis which showed around two-thirds of drug-related deaths were of people not currently or recently in treatment. The analysis also showed a clear pattern of movement away from 'heroin only' deaths to polysubstance deaths. This analysis will be updated using the latest data and published in December 2015. PHE is also planning analysis of other datasets from prisons, hospital admissions and mental healthcare.

PHE will publish further targeted briefings promoting evidence-based prevention and treatment responses, to supplement those already available, including one on preventing drug-related deaths.

PHE will continue to support the wider availability and use of naloxone, following the legislative change in October 2015, including dissemination of local case studies, protocols and guidance (see section below, 'Naloxone legislative change').

Network members went on to discuss some possible causes of and solutions to the increase in drug-related deaths in England

Some members felt that an increase in heroin purity was unlikely to be one of the main drivers in the increase of heroin deaths since the data indicates little significant change in purity. Commissioning practice and service delivery for the age group 40-49 was thought to be influential by some network members, with this age group among the least amenable to routine opioid substitution therapy treatment and therefore most susceptible to using illicit heroin on top of their prescription. Analysis to date has not been able to identify any evidence that changes in practice were having an effect.

Early analysis suggests that a large proportion of drug-related deaths are in people not being reached by treatment. Some members felt this was due to frequent and widespread changes in contract providers and the difficulties of transferring care when contracts

change. Continuity of care can be a significant challenge in this population. More analysis would be needed to substantiate this.

Some network members proposed that there were unlikely to be one or two overriding causes behind the increase in drug-related deaths – it was more likely that there were multiple causes of relatively small influence but large cumulative effect. Other members warned against looking for a national fix and where possible data should be analysed locally and practice influenced at 'street-level'.

Chronic diseases, including heart and lung diseases (such as COPD), were recognised as having a big impact on drug-related deaths – for example, about four in five drug-related deaths from the Norwich and Suffolk Foundation Trust area are reported to have chronic physical health problems.

[This topic will be feature again at the next meeting of the National Intelligence Network. Local areas and providers were asked to contribute to the discussion and share service/local level examples of responding to the rise in drug-related deaths]

Heidi Douglas, Specialty Registrar in Public Health, presented an audit of drug-related death processes carried out for the North East Public Health England Centre

In England, the North East had the highest mortality rate from drug misuse in 2013 with 52.0 deaths per million (England's rate 33.9 deaths per million population). An audit was carried out of the confidential inquiry process to review drug-related deaths across 12 local authority areas. Confidential inquiries gather and analyse information about the causes and circumstances of drug-related deaths.

The results of the audit showed that areas had different processes in place from an active drug-related death review process, to a log of deaths, to no recording at all.

Some areas had a dedicated coordinator, but it was acknowledged that there were significant resource pressures since the reconfiguration of former structures – organisational memory loss was felt strongly in many areas.

Two of the six areas had review processes with a governance structure with a direct line of accountability to the Director of Public Health. The other four areas reported to Health and Wellbeing boards.

The audit found that good practice relied on the commissioner having a good relationship with their local coroner and the engagement of local police both in terms of reporting a death and in the review process. Areas where alcohol related deaths and suicides and accidental deaths were incorporated into the review process added to the richness of data, while regularly reviewing processes and supporting documentation to reflect current practice was also important.

Confidential inquiries and drug-related deaths processes could be improved by having a broader public health focus (eg, many older heroin users have respiratory problems from smoking) and a good relationship with coroners is essential.

Changes in data availability have prohibited some local review systems and there is great variation area-by-area. Some findings from reviews would be reported by commissioners whereas other clinical commissioning groups' statutory arrangements prohibited access.

Naloxone legislative change

Steve Taylor introduced a discussion on the change in legislation (now implemented) which means naloxone can be more widely provided in the community

On 1 October 2015, new legislation came into force that enables naloxone (which reverses the effects of opiate overdose) to be supplied to individuals by drug services without prescription.

Naloxone can be supplied without prescription by a drug treatment service commissioned by a local authority or the NHS to any individual needing access to naloxone for saving a life in an emergency, including:

- someone who is using or has previously used opiates (illicit or prescribed) and is at potential risk of overdose
- a carer, family member or friend liable to be on hand in case of overdose
- a named individual in a hostel (or other facility where drug users gather and might be at risk of overdose), which could be a manager or other staff

A slide pack has been made available to summarise the new situation (post-October 2015) and builds on PHE's February 2015 advice on 'Take-home naloxone for opioid overdose in people who use drugs', which still stands.

Further information can be found in an open letter from Professor John Strang, which summarises preliminary advice from the working group of the clinical guidelines, while FAQs have also been published on GOV.UK.

New psychoactive substances (NPS)

Dr Owen Bowden-Jones (Addiction Psychiatrist, Imperial College London) presented on the health harms of NPS

The number of NPS reported in Europe in recent years has increased significantly. This is especially true for NPS containing synthetic cathinones and synthetic cannabinoids.

There are distinct populations using NPS and club drugs: traditional heroin users moving to mephedrone injecting; clubbers and students taking NPS in nightclub settings; men who have sex with men (MSM) using NPS in a sexual context; and prison populations (largely synthetic cannabinoids).

Clinical responses need to adapt to the new drugs appearing and the new populations using them. Clinical staff sometimes have a poor knowledge of changing patterns of drug use and they need to develop 'technical' knowledge (what are the drugs, how do they

work), 'cultural' knowledge (who is using, how are they using), 'clinical' knowledge (how to clinical manage acute/chronic presentation) and 'service' knowledge (when and where to refer).

NEPTUNE was developed to raise standards in clinical management of 'club drugs' including NPS across the health system, by undertaking a comprehensive review of treatment research literature for NPS and club drugs, leading to the development of evidence-based clinical guidance. Additional LGBT guidance will be released shortly.

NEPTUNE II is currently being worked on to maximise the impact of NEPTUNE by disseminating guidance at a national level, in ways that are convenient to clinicians. This will involve developing e-learning modules for different clinical settings, and developing care bundles and other tools. NEPTUNE II will also review and support development of national clinical data collection tools to facilitate recording of new drugs and improve assessment of needs among populations at risk of club drug harms. The project will be evaluated by the College Centre for Quality Improvement.

Clinical guidance for NPS dates rapidly because of the changing patterns of use and substances available. There is a lack of toxicology available for many NPS and the effects of poly-substance use are unpredictable. Longer term harms from NPS use are unknown and NPS users need to be engaged by existing drug treatment services where possible.

DrugWatch update

Harry Shapiro updated the network on intelligence reports being made to the DrugWatch network – an informal online Professional Information Network (PIN)

DrugWatch colleagues shared recent reports of pills on the market in Scotland containing alpha-PVP (a synthetic stimulant linked to severe adverse effects) but being sold as MDMA (ecstasy). This had led to a number of hospitalisations and some users being sectioned under the Mental Health Act.

There have also been an increasing number of reports of incidents in prisons involving e-cigarettes where refill contents have contained synthetic cannabinoids.

PHE update

Pete Burkinshaw, Steve Taylor, Vivian Hope and Koye Balogun updated the network on activity from the Alcohol, Drugs and Tobacco Division and the National Infections Service at PHE

A survey of providers and commissioners of needle and syringe programmes is taking place to help demonstrate the value of investment in interventions that reduce drug-related health harms. Data collected can help PHE map the provision and activity of NSP across England and gauge how recommendations from NICE guidance PH52 are being adhered to. The survey also gives an opportunity to look at the extent of the provision of naloxone in local areas and through needle and syringe programmes as new legislation comes into force.

The new Hepatitis C in the UK report makes a series of UK public health recommendations including that commissioners of blood-borne virus prevention services for people who inject drugs "need to sustain or expand, as appropriate, the current broad range of provision (including opioid substitution treatment and needle and syringe programmes) to minimise transmission of hepatitis C, including among people who inject new psychoactive substances or image and performance-enhancing drugs."

PHE has published three briefings as part of the 'Turning Evidence into Practice' series:

- improving hepatitis C pathways from drugs services to hepatitis treatment
- preventing the transmission of blood-borne viruses among people who inject drugs
- commissioning and providing services for people who use image and performance enhancing drugs (IPEDs).

Data tables of the Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in People Who Inject Drugs have been published and will form a significant part of the next Shooting Up report on people who inject drugs in the UK.

A recent Health Protection report on acute hepatitis B in England covers low incidence of hepatitis B among people who inject drugs while self-reported uptake of vaccination is relatively high.

PHE has also recently published a report on HIV: New Diagnoses, Treatment and Care in the UK 2015. Although a low and stable number of people acquired HIV through shared use of injecting drug equipment in 2014 (around 2%, or 131 people), new infections among men who have sex with men continue to rise.

An updated version of the "orange book" (Drug misuse and dependence: UK guidelines on clinical management), is due to be published early in 2016. A working group has been convened and sub-groups are working on topics including opioid substitution treatment, psychosocial interventions, blood-borne infections and naloxone (focussing on dosing, products and provision). External experts are providing evidence reviews on topics such as smoking, image and performance enhancing drugs and new psychoactive substances. Service user and carer representative groups have also been established to support individual representatives sitting on the main working group.

PHE has published a summary briefing of the UNODC prevention standards which gives examples of relevant UK guidelines, programmes and interventions in England.

The co-existing substance misuse and mental health issues (CESMMHI) expert reference group (ERG) is part of a large work programme on mental health crisis care. National data is published on Fingertips. The ERG will refresh the 2002 Department of Health guidelines on dual diagnosis and is scheduled to publish in March 2016 to coincide with NHS England's publication on crisis care.

PHE published an interim report on Turning Point pilots on smoking cessation within their drug and alcohol treatment services.

In July, PHE issued an alert relating to a "recent increase in harm from synthetic cannabis use". This was primarily in response to the hospitalisation of young people in North Wales, Lancashire and Cheshire who had used AB-CHMINICA, and MMB-CHMINACA (also

known as MDMB-CHMICA). Deaths from use of these drugs had been reported in Germany and Sweden.

Finally, PHE has been commissioned to "review the evidence on what can be expected of the drug treatment and recovery system and provide advice to Government to inform future policy" and this work will develop over the coming months.

Future topics

The network discussed priorities for future meetings including:

- Service user advocacy services
- Cannabis
- New drugs for hepatitis C treatment – and access to them
- Commissioning of addiction services

Full presentations from past meetings are at: www.nta.nhs.uk/who-healthcare-drd-bbv.aspx

The next network meeting will take place on Wednesday 2 December at Coin Street Neighbourhood Centre, 108 Stamford Street, London SE1 9NH

Attendees

- Koye Balogun, Health Protection, PHE
- Brandie Bolt, Brighton Oasis Project
- Owen Bowden-Jones, Central and North West London NHS Foundation Trust
- Andy Brown, Brent Council
- Emma Burke, PHE London
- Pete Burkinshaw, Health and Wellbeing, PHE
- Katelyn Cullen, Health Protection, PHE
- Brian Dalton, Blenheim CDP
- Heidi Douglas, PHE North East
- Paul Duffy, PHE North West
- Adrian Edwards, The Harbour Centre (Plymouth)
- Denise Grimes, Norwich and Suffolk NHS Foundation Trust
- Anna Hemmings, Lifeline
- Rachael Hope, Newcastle City Council
- Viv Hope, Health Protection, PHE
- Andrew Kilkerr, CRI
- Ian Joustra, Rotherham, Doncaster and South Humber NHS Foundation Trust
- Mike Kelleher, SLaM & Health and Wellbeing, PHE
- Liz McCoy, Pennine Care NHS Foundation Trust
- Jim McVeigh, Liverpool John Moores' University/Centre for Public Health
- Fortune Ncube, Health Protection, PHE
- Rosanna O'Connor, Health and Wellbeing, PHE
- Margaret Orange, Northumberland, Tyne & Wear NHS Foundation Trust
- Si Parry, MORPH
- Andrew Preston, Exchange Supplies
- John Ramsey, St George's Hospital/TICTAC Communications

- Harry Shapiro, DS Daily
- Steve Taylor, Health and Wellbeing, PHE
- Caroline Townsend, North Yorkshire County Council
- Daniel Vincent, National Aids Trust
- April Wareham
- Martin White, Health and Wellbeing, PHE
- Nicky Wilsenham, Phoenix Futures/Foundation 66
- Rob Wolstenholme, Health and Wellbeing, PHE

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