

# Drug-related deaths in the UK

Alex Stevens

University of Kent

With thanks to Tim Millar, Claudia Wells and  
Annette Dale-Perera

## This talk

1. Causes of increased deaths
2. Effective responses
3. Conclusion: preventing preventable deaths.

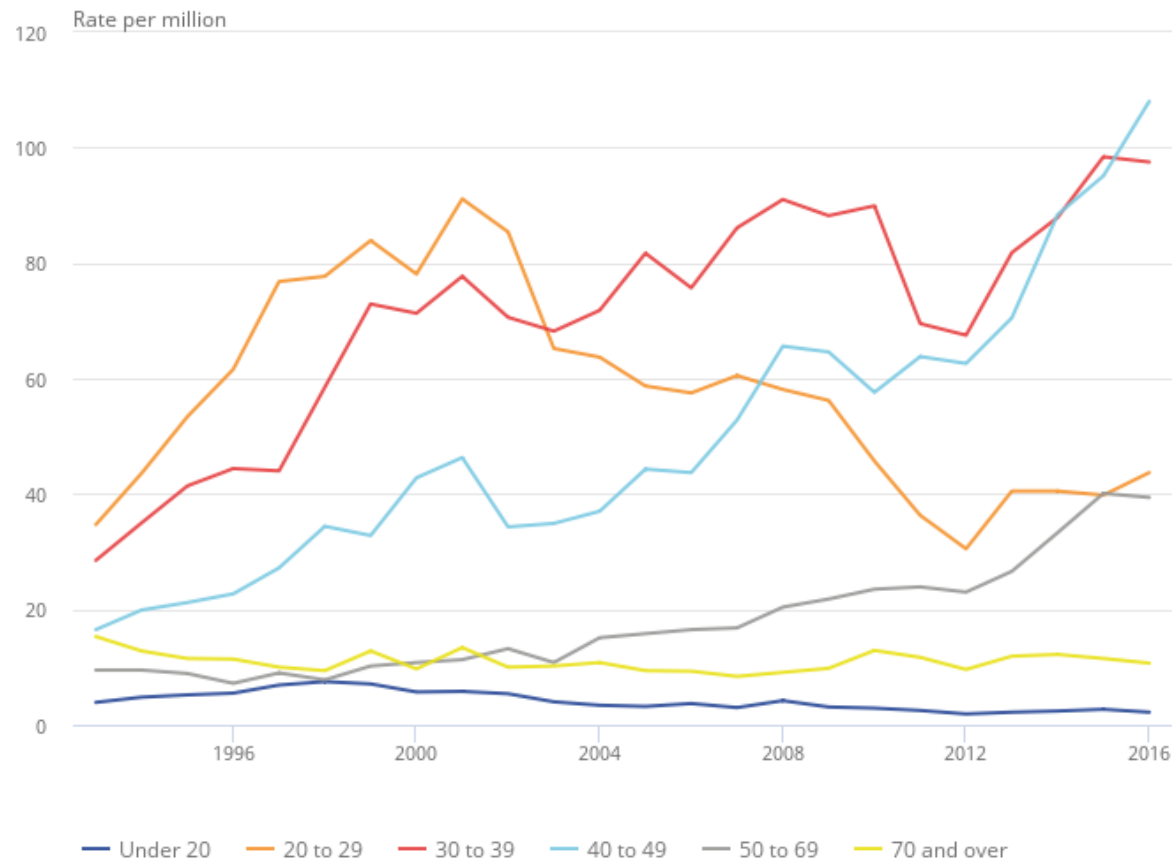
# Potential causes of recent increase

- Probable
  - An ageing cohort of prematurely ageing heroin users, with high vulnerability, chronic conditions and health risk behaviours.
    - The ageing ‘new heroin users’.
- Possible
  - Changes in the availability of heroin at street level.
  - Changes in the commissioning and provision of drug treatment.
  - Socio-economic changes, including increasing deprivation and cuts to support services in deprived areas.

# Age at drug-related death (England and Wales)

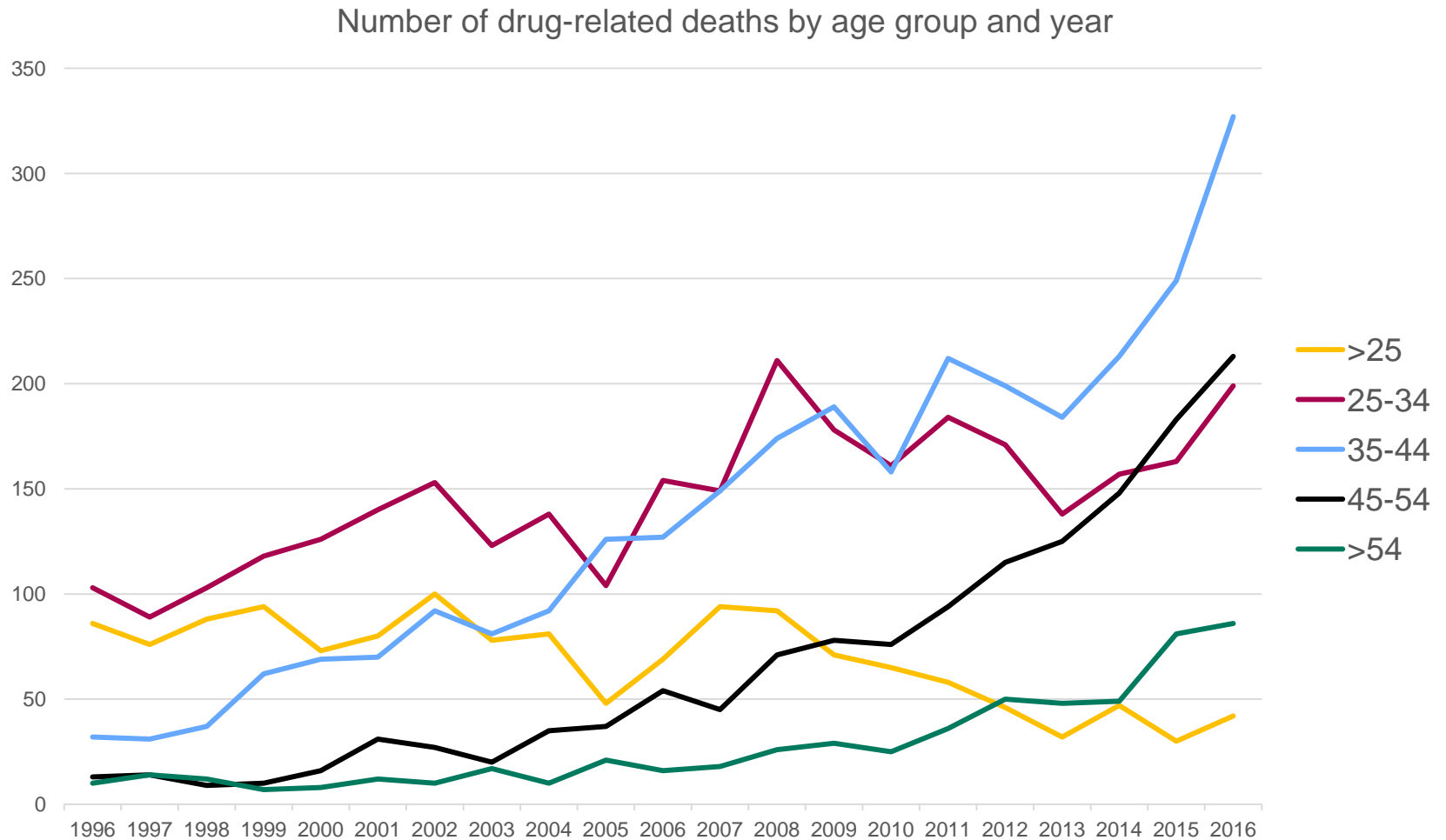
Figure 4: Age-specific mortality rates for deaths relating to drug misuse, deaths registered 1993 to 2016

England and Wales



Source: Office for National Statistics

# Age at drug-related death (Scotland)

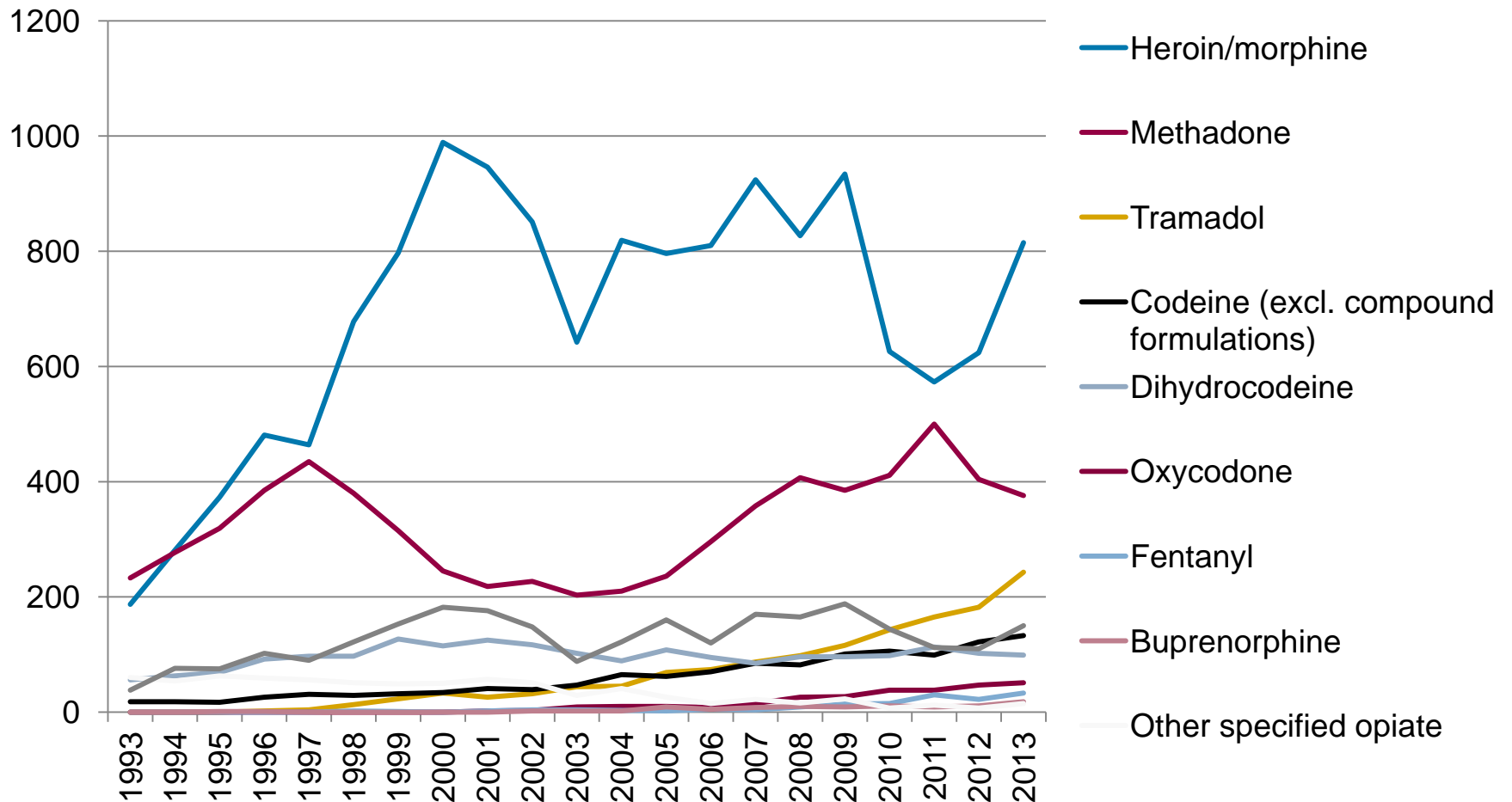


Source: National Records Scotland

# Changes in the availability of heroin

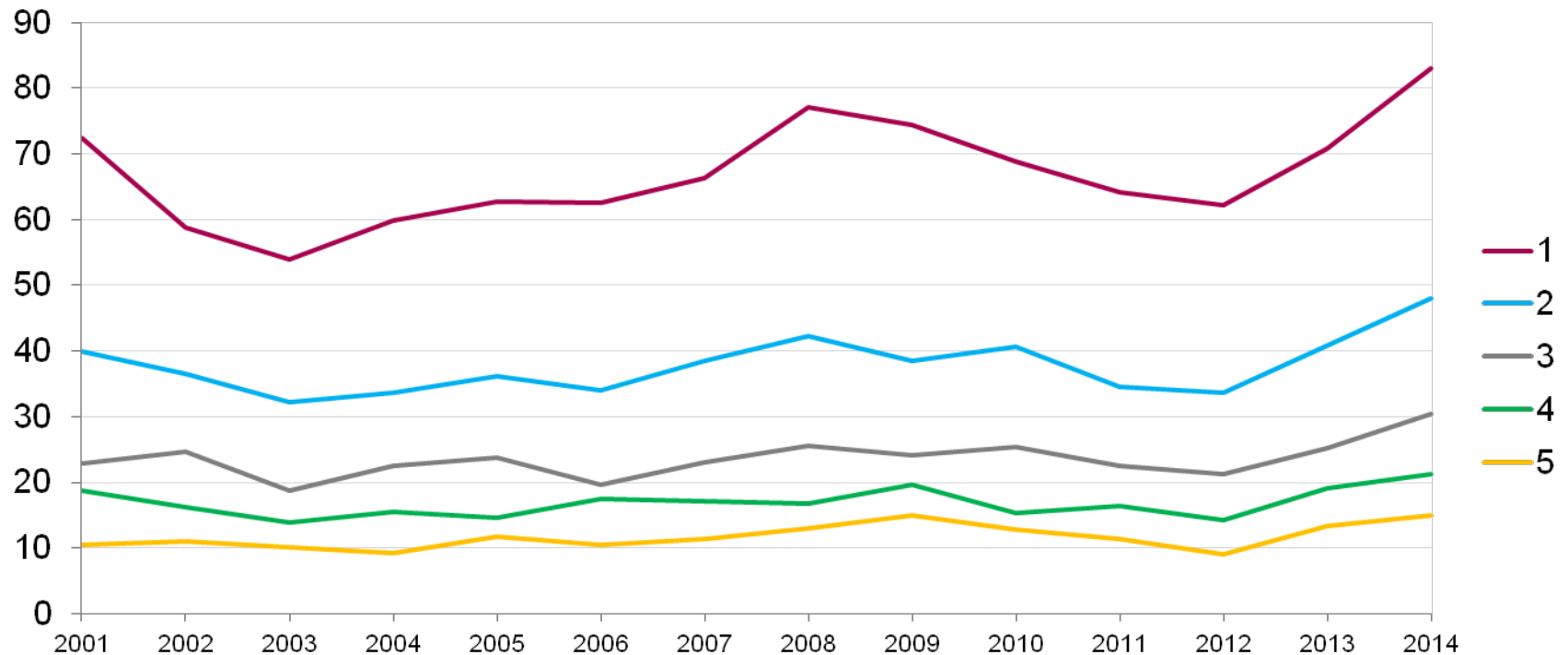
- In 2010-2012, a shortage of heroin was observed in many European countries.
  - Provisionally attributed to:
    - Poor weather and crop blight in Afghanistan.
    - Law enforcement on the 'Balkan' through Turkey.
- Purity of heroin seized at street level:
  - 2009: 46%
  - 2012: 17%
  - 2014: 36%

# Trends in the type of opiate(s) involved in opiate-related deaths: 1993-2013: England and Wales



# Socio-economic deprivation

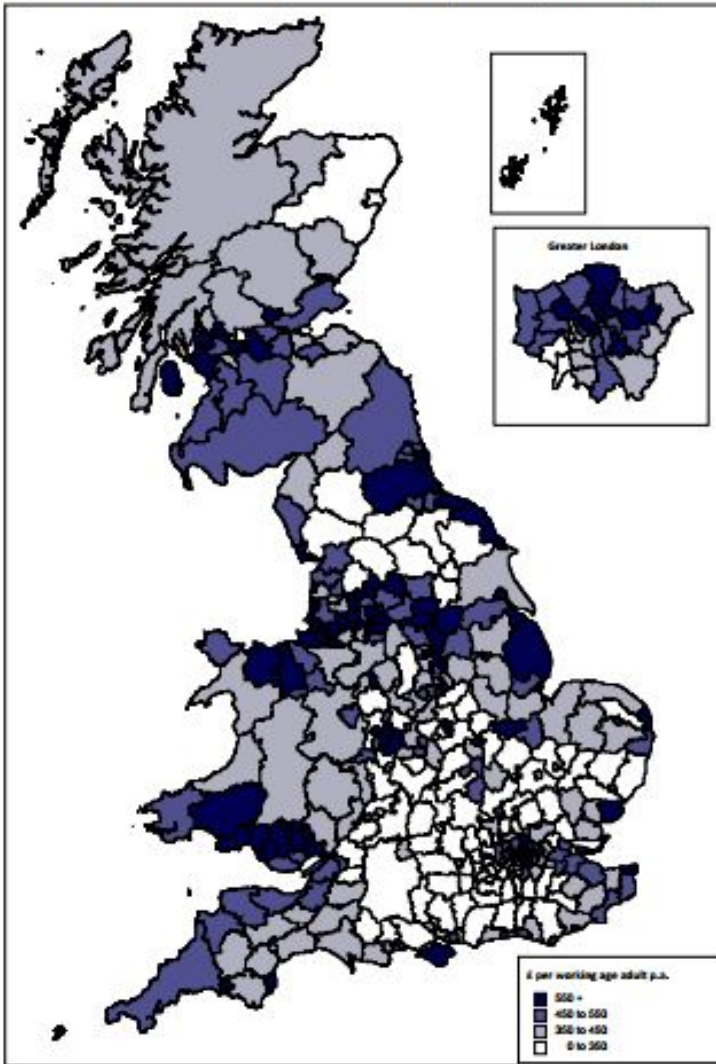
Age standardised mortality rates (drug misuse deaths per 1 million population) by lower super output areas sorted into quintiles of the Index of Multiple Deprivation (1 is the most deprived), 2001-2014.





# Redistribution away from people in poverty

Figure 1: Overall financial loss arising from welfare reform by 2014/15<sup>23</sup>, by local authority



- Welfare cut per working age adult p.a.:

**Blackpool -£910**

**Westminster -£820**

**Knowsley -£800**

**Liverpool - £700**

**S. Oxfordshire -£260**

**Cambridge -£250**

**City of London -£180**

# Cuts in drug treatment funding (England)

- Past:

- 30 – 40% cuts in community drug treatment 2008-09 to 2016-17.
- Survey of local commissioners:
  - Half of commissioners said local substance misuse service are underfunded by 2016.

- Futures:

- Local public health grant ringfence removed from 2017/18
- Evidence of predicted cuts of 60% to substance misuse treatment funding in some areas.

# Changes in commissioning

- Local authorities deal with cuts by re-procuring
  - High flux in treatment services
    - E.g. three year commissioning cycles
- Damage to performance at the area level
  - Perception that initial dips in service quality take months to recover...
  - ... just in time for the next commissioning round.
- Damage to the continuity of individual treatment
  - E.g. arbitrary changes in prescribing and supervision of consumption.

# Changes in treatment

- Recovery, not harm reduction?
- Pressure on services to produce “drug-free exits”
- Denigration/disavowal of maintenance in OST:
  - “We only do reduction ‘scripts’”.

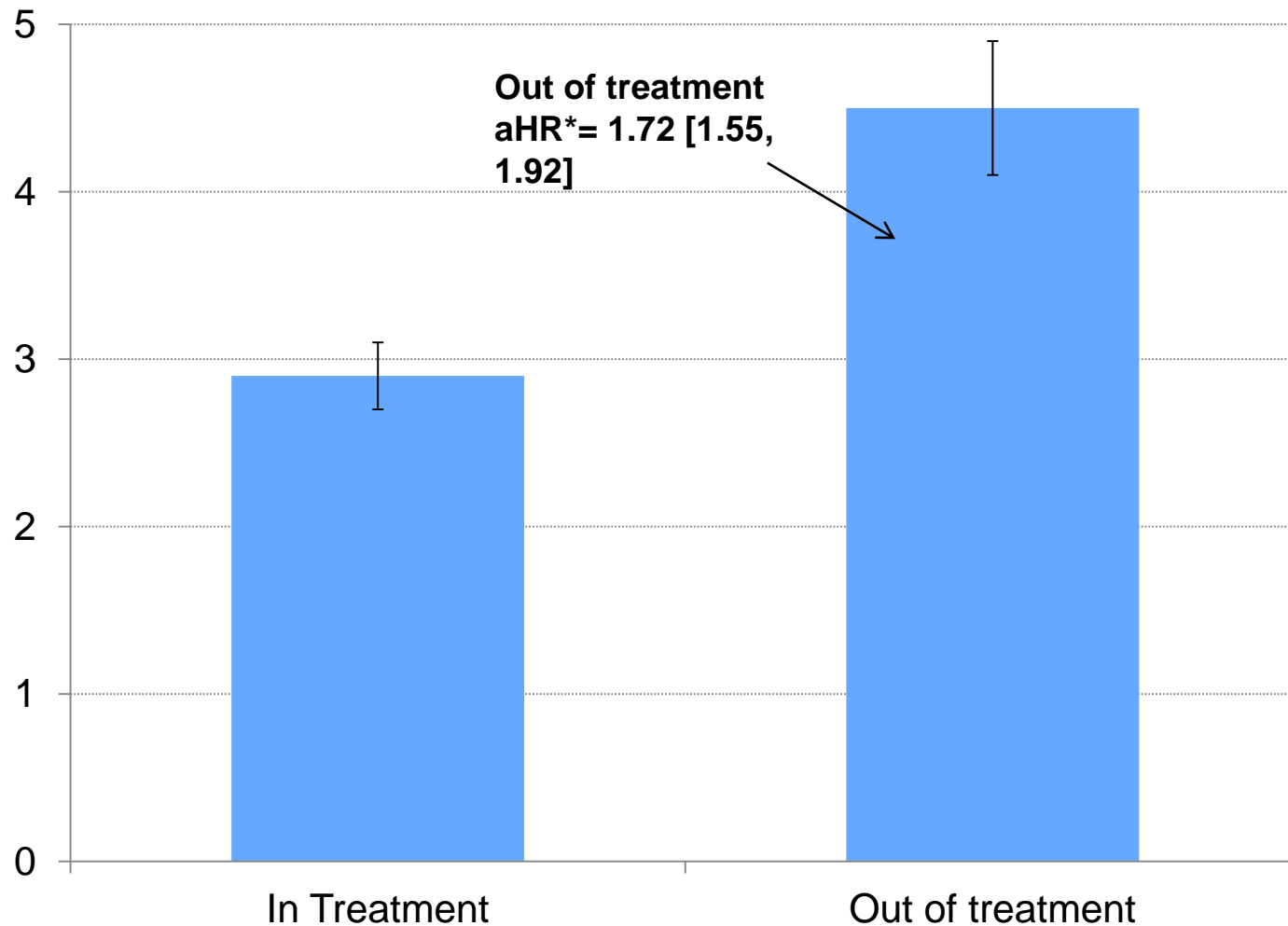
# Effective responses

- Opioid substitution treatment (OST)
  - Optimal dosage
  - Optimal duration
- Naloxone
  - Practitioners
  - Peers and potential 'bystanders'
  - Intra-nasal and over-the-counter?
  - Carried by police?
- Heroin assisted treatment (HAT)
- Medically supervised drug consumption rooms (DCR/SIF)

# Opiate substitution treatment

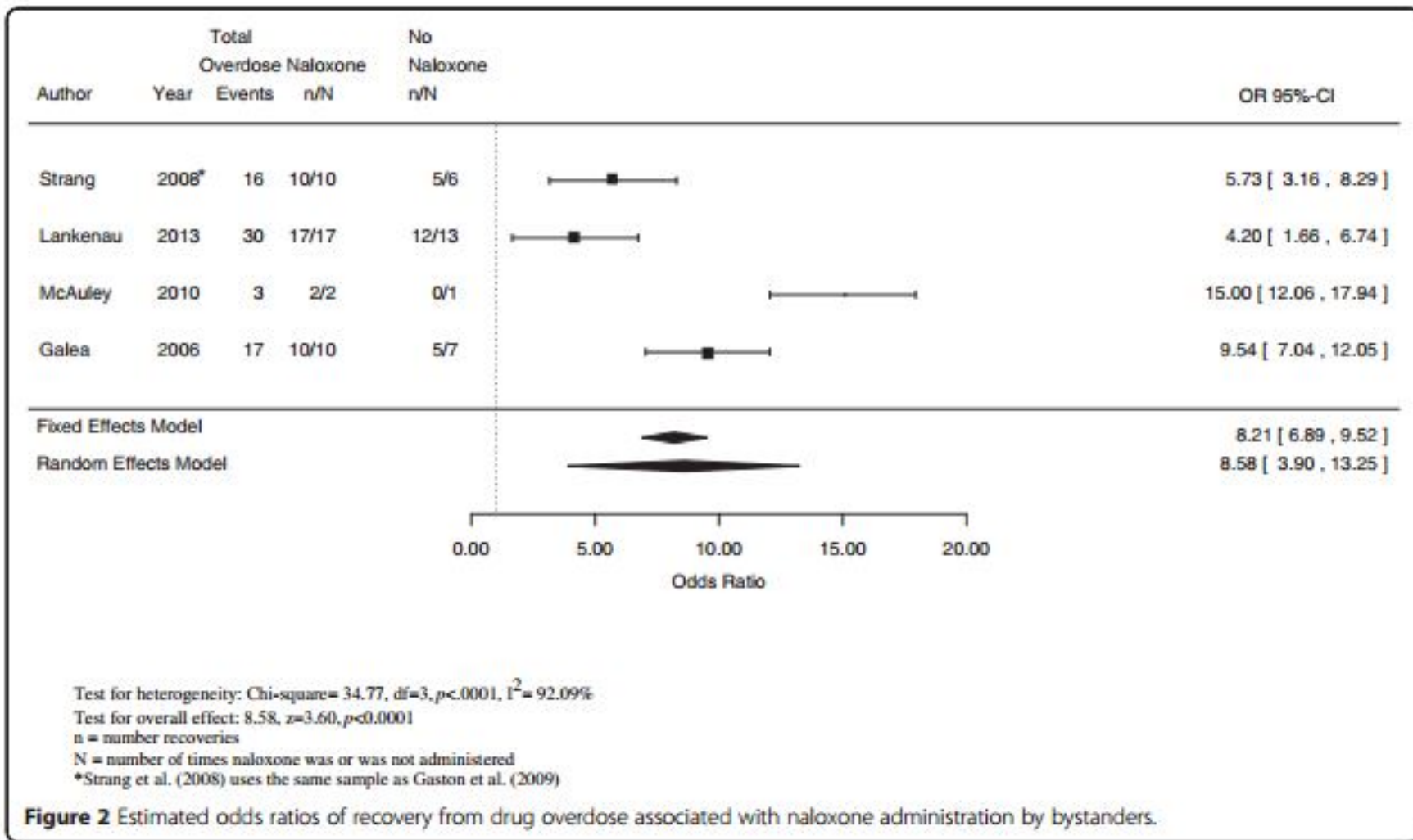
- Findings of systematic reviews:
  - Increased engagement and retention of problematic drug users in health services.
  - Reductions in HIV and other infections.
  - Reduction in criminal offending.
- Observational studies show reductions in deaths. E.g:
  - Introduction of OST in Barcelona associated with an increase of *21 years* in the life expectancy of heroin users (Brugal et al 2005).
  - Threefold increase in OST in Sweden, 2000-2006, associated with a *reduction in opiate deaths* of 20-30% (Romelsjö et al 2010)

## Treated Opiate User Cohort: Crude Mortality Rate per 1,000 person-years: In vs. out of treatment (n=151,983)



\* *adjusted for demographic and behavioural covariates*

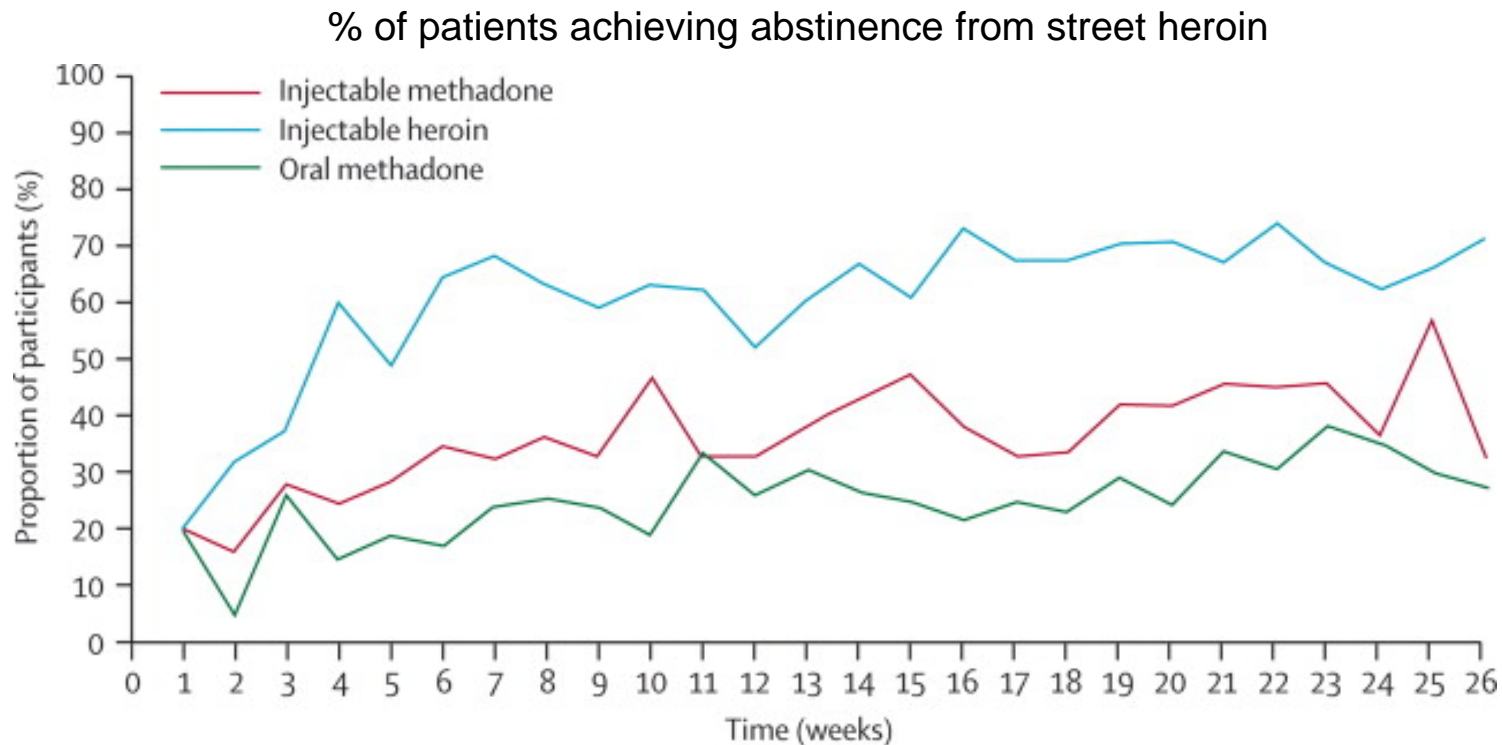
# No naloxone: 8 times higher odds of death from OD



Source: Giglio et al (2015) in *Injury Epidemiology*, 2:10



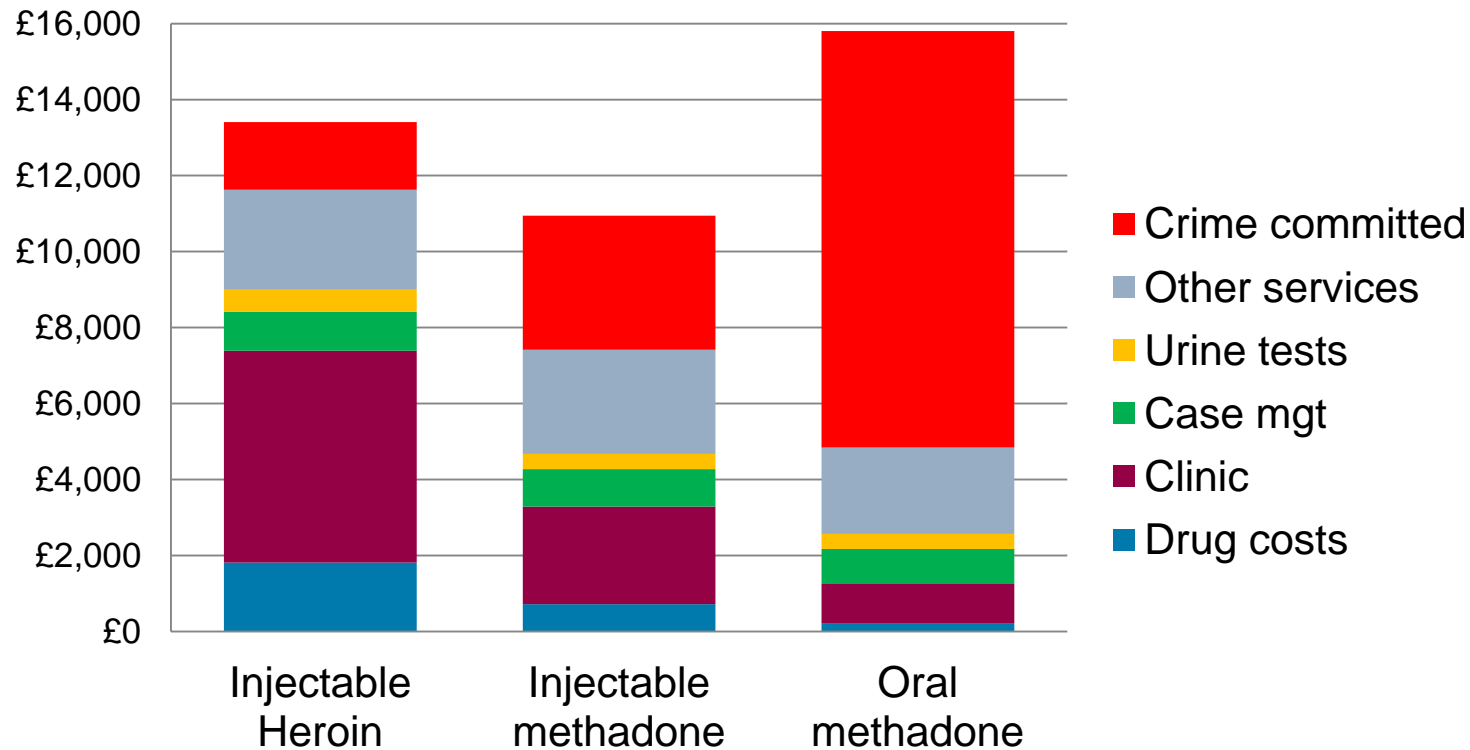
# Heroin Assisted Treatment *versus* optimised oral methadone



Source: Strang et al (2010) *The Lancet*, 375(9729):1885-1895

# Comparing costs

## Cost of service for 26 weeks



Source: Byford et al (2013) *British Journal of Psychiatry*, 203: 342-349

# Medically supervised drug consumption rooms

- Clinics where people can use drugs (purchased elsewhere) under medical supervision.
- Evidence from Vancouver and Sydney:
  - Reductions in overdoses
  - Reductions in injecting risk behaviours
  - Reduced BBV transmission
  - Reductions in drug-related litter
  - No evidence of increases in crime or drug use
  - Reductions in ambulance call-outs and deaths *in the immediate vicinity*
    - Potier et al. 2014

# New dangers to the same people

- Synthetic opioids
- E.g. fentanyl, carfentanil
- More powerful and kill more quickly than heroin.
- The solutions?
- THE SAME AS FOR HEROIN, BUT MORE SO.

# UK Government response to ACMD report

- On poverty
  - Welfare changes are increasing poverty
- On OST:
  - Continued cuts in funding
- On naloxone:
  - No new national initiatives.
- On heroin-assisted treatment
  - Will not fund nationally
- On supervised drug consumption rooms
  - “The Government has no plans to introduce drug consumption rooms. It is for local areas in the UK to consider, with those responsible for law enforcement, how best to deliver services to meet their local population needs.”

# Preventing overdose deaths in the UK

- We have good evidence for how to reduce these deaths.
- It is clear that the UK government will not take the necessary actions.
- Will Scotland lead the way?

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