Public Health England

Protecting and improving the nation's health

Understanding and Preventing Drug-Related Deaths

Birmingham

19 April 2016

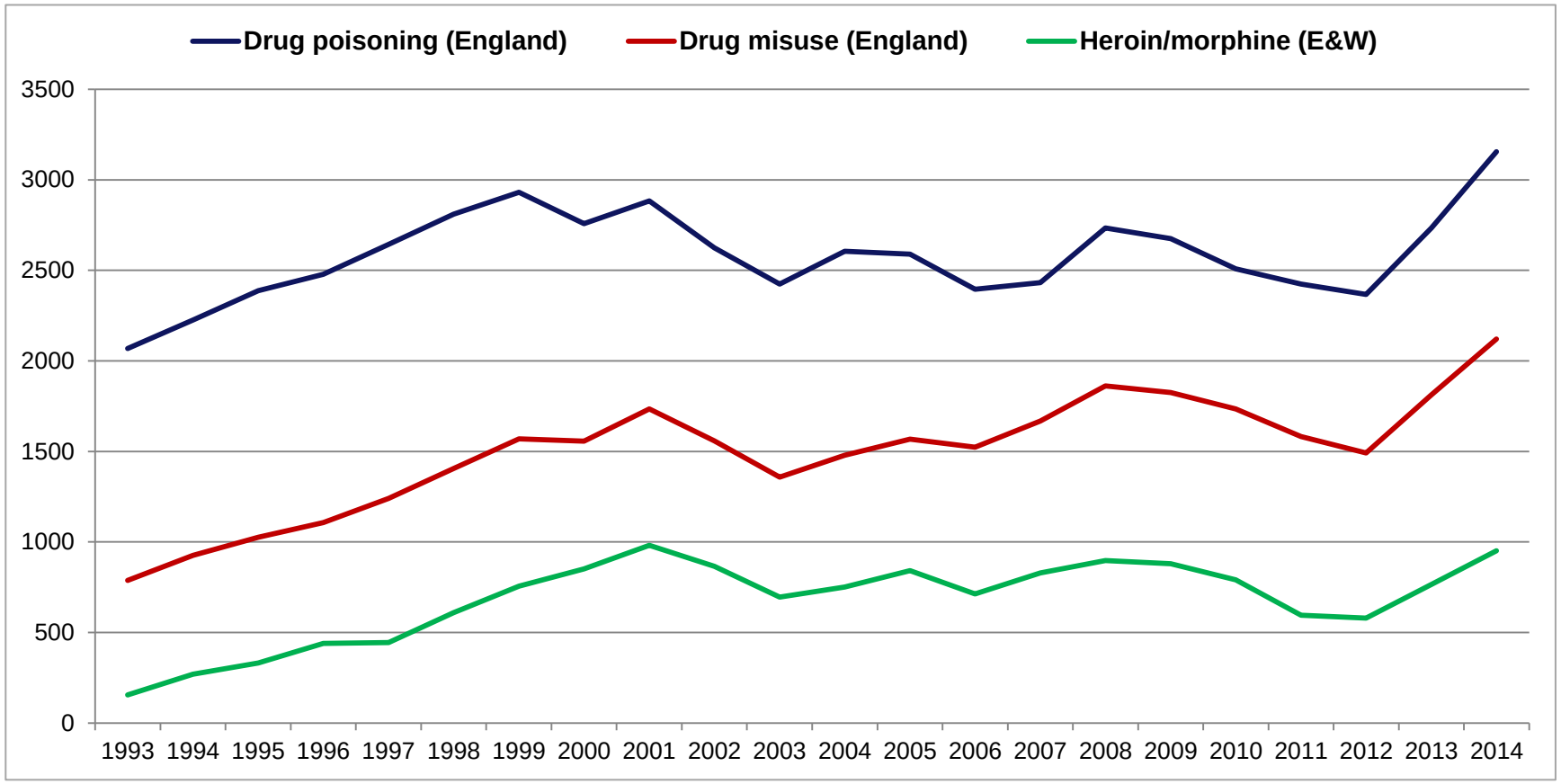
Drug-related deaths data and Public Health England's analysis

Martin White, Programme Manager, Evidence Application Team, Public Health England

Data sources on drug-related deaths

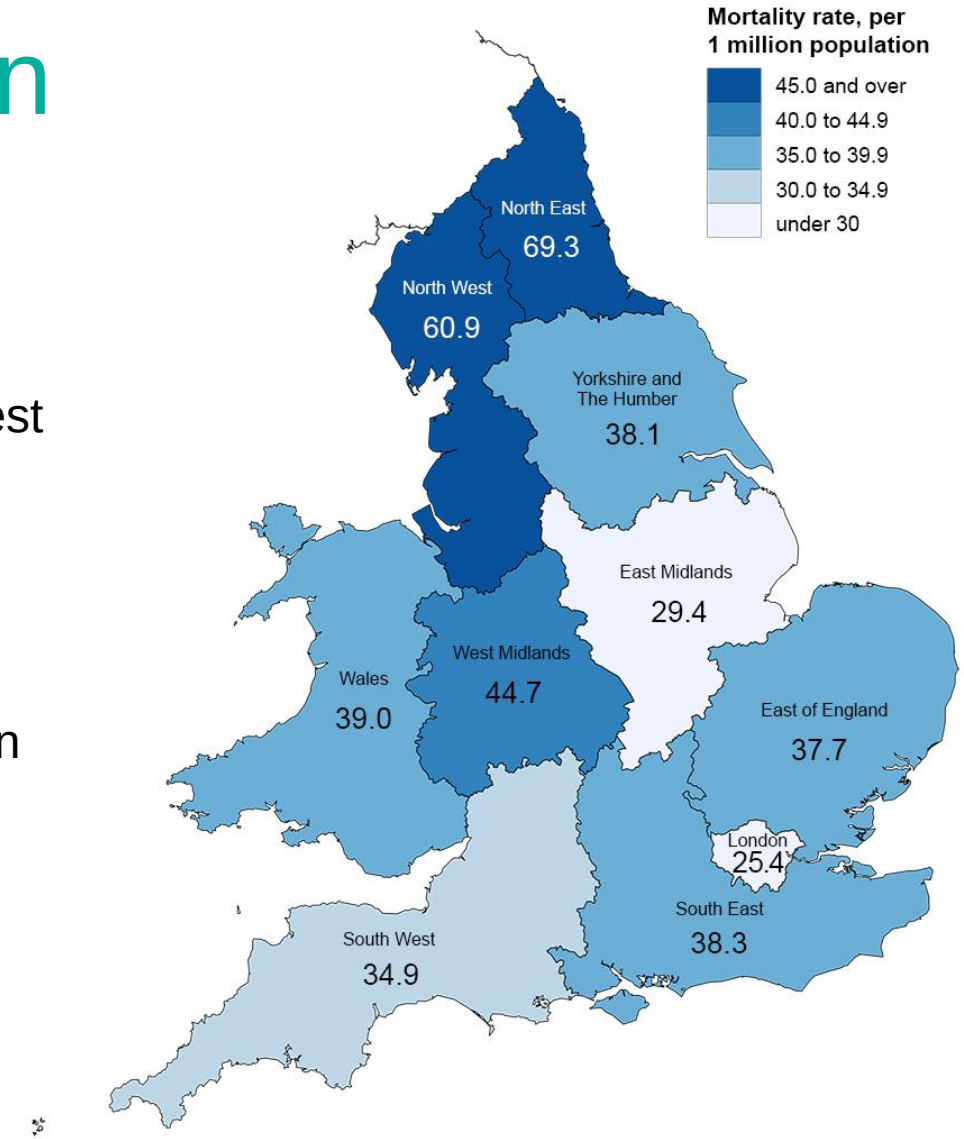
- ONS publish annual national statistics on registrations of drug-related deaths in England and Wales. Latest bulletin is at http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2015-09-03
- PHE receive row-level data from ONS and have published more detailed analyses focusing on deaths from drug misuse in England and cross-referencing with treatment data. The most recent trend publication can be found at http://www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf
- The National Programme on Substance Abuse Deaths (NPSAD) is a special registry to which the majority of coroners in England report and can be found at http://www.sgul.ac.uk/research/population-health/our-projects/national-programme-on-substance-abuse-deaths

Headline figures from recent ONS report

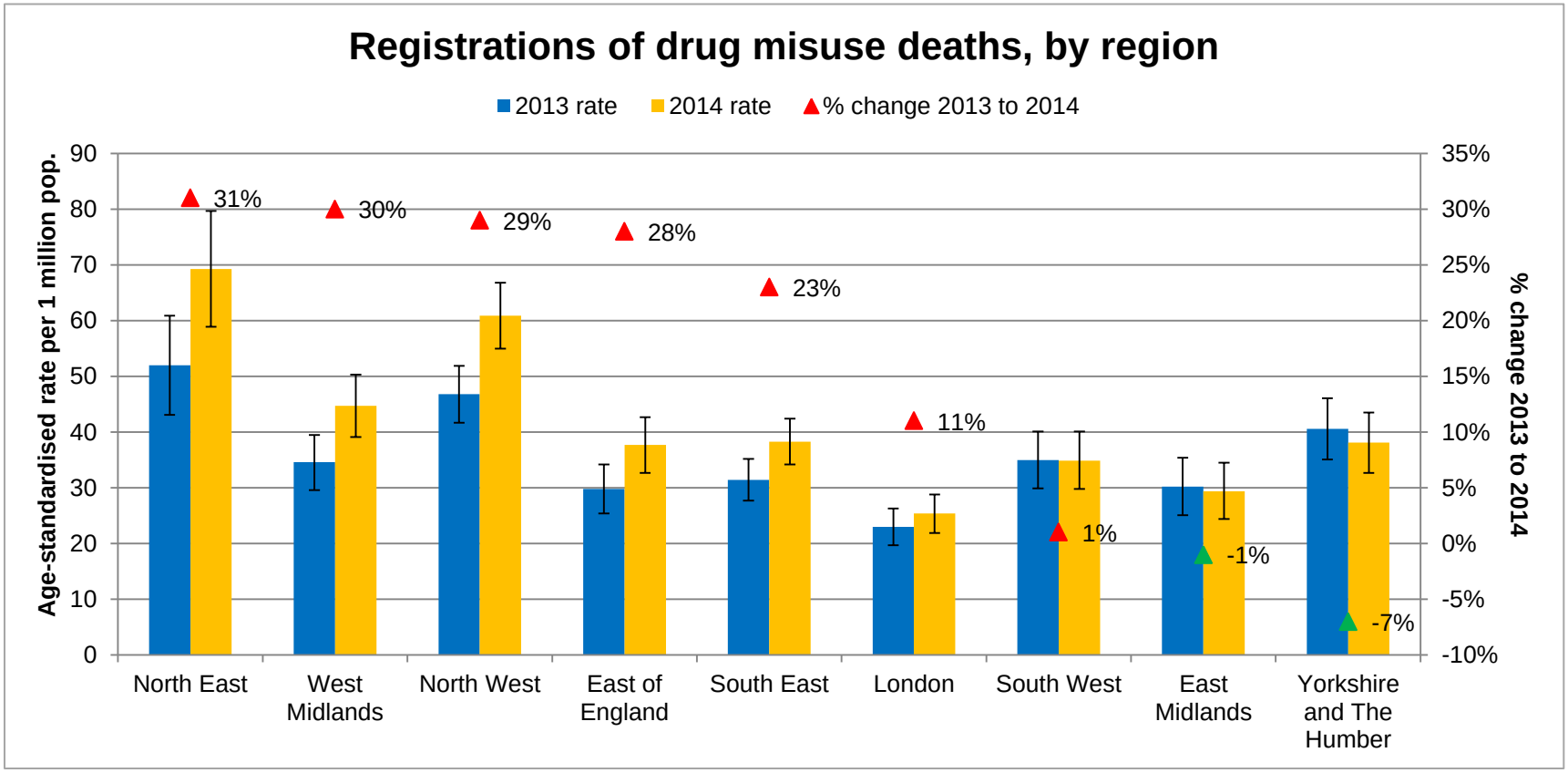


Regional variation

- ONS statistics report that North East and North West have highest rates among the nine regions in England
- Both regions have significantly higher rates than the other seven regions in England
- London has the lowest rate nationally, having fallen significantly over the time ONS have been reporting



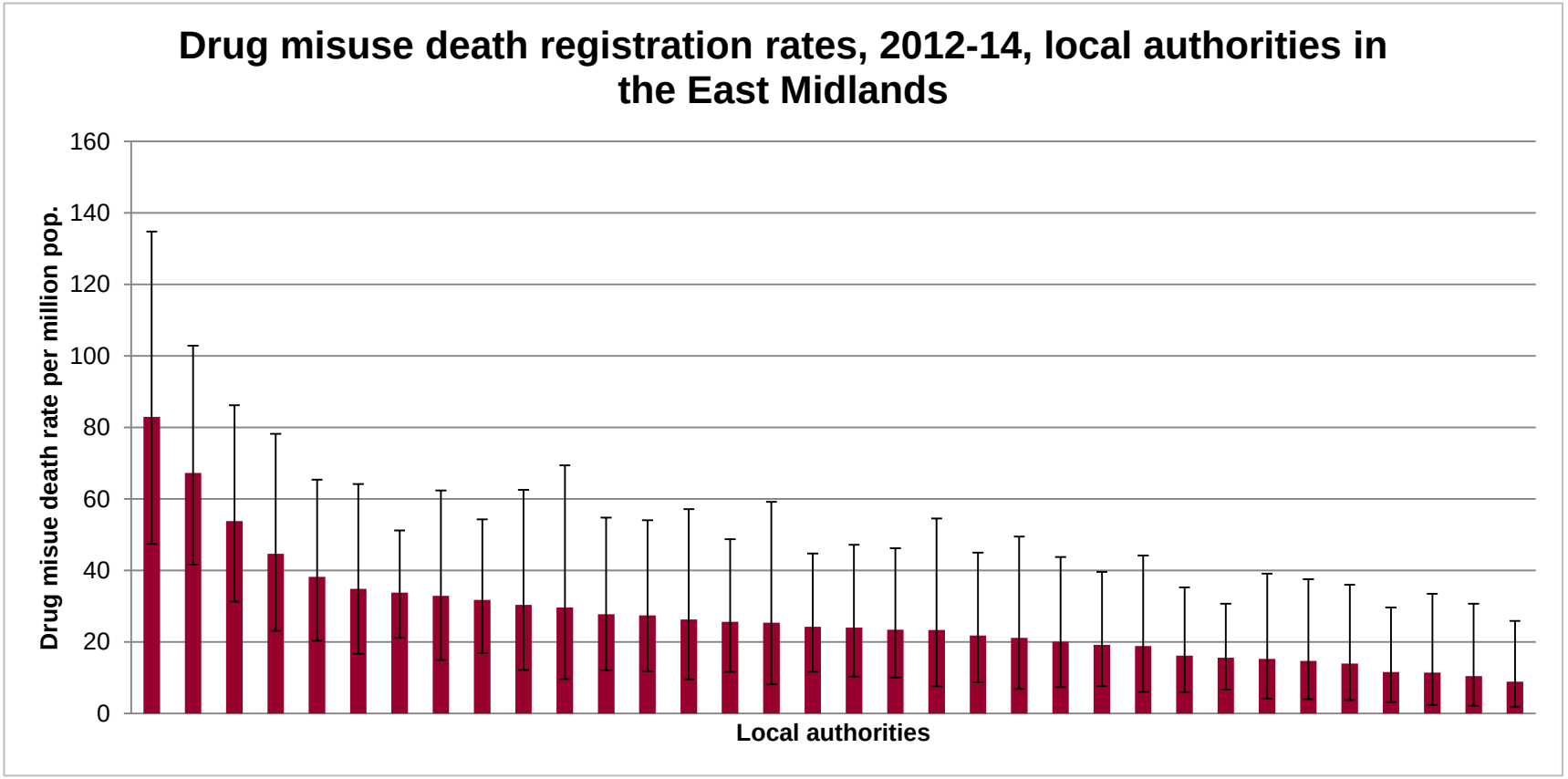
Regional variation



Regional variation – local data

- ONS published figures at lower tier local authority level for the first time alongside their 2015 report – see http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority
- Due to small numbers annually at LA level, figures were pooled into three year bands up to 2012-14 – nevertheless there are still wide confidence limits and the figures require careful interpretation
- Registration delays vary greatly between areas and this may also affect comparability between areas

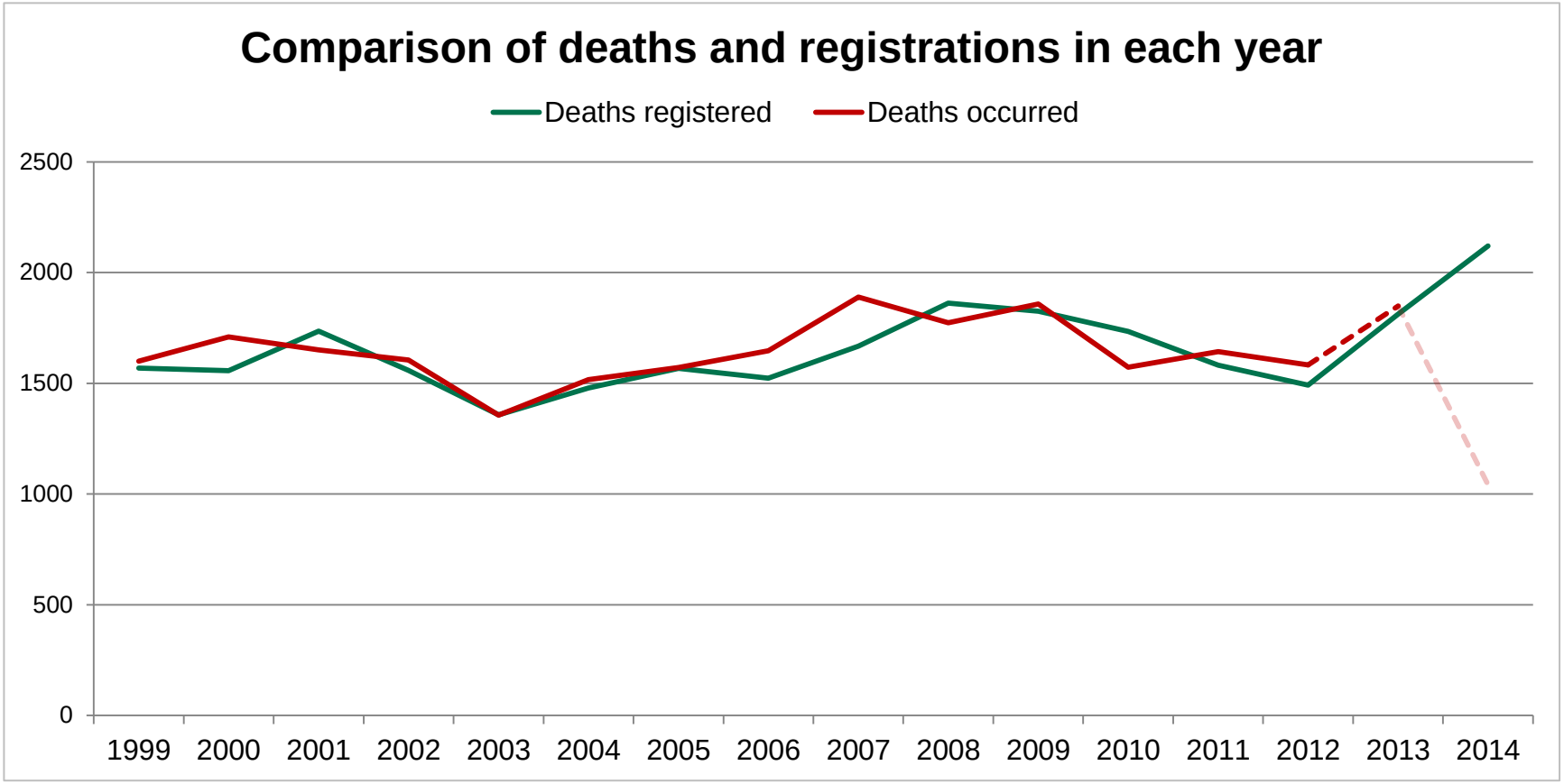
Regional variation – local data



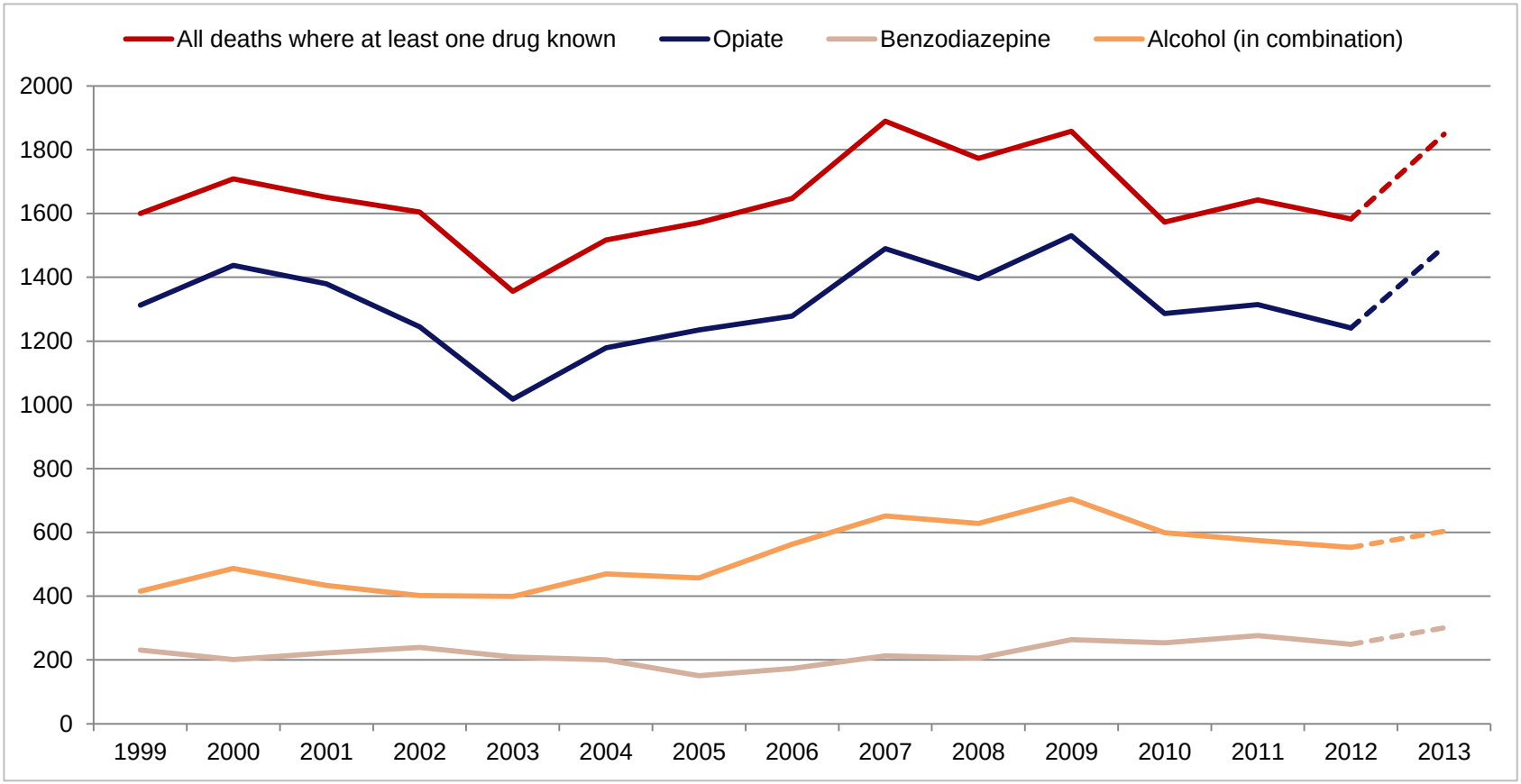
PHE analysis

- PHE acquired extracts of drug-related death data from ONS and carried out more detailed analysis, including matching with drug treatment data from the National Drug Treatment Monitoring System (NDTMS)
- Published two ‘Trends in drug misuse deaths in England’ reports: http://www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf
- Reported by year of death rather than year of registration
- These analyses highlight long term trends and this access to the data allows us to investigate drug misuse deaths in more detail, including by region, as well as to estimate the effect of treatment

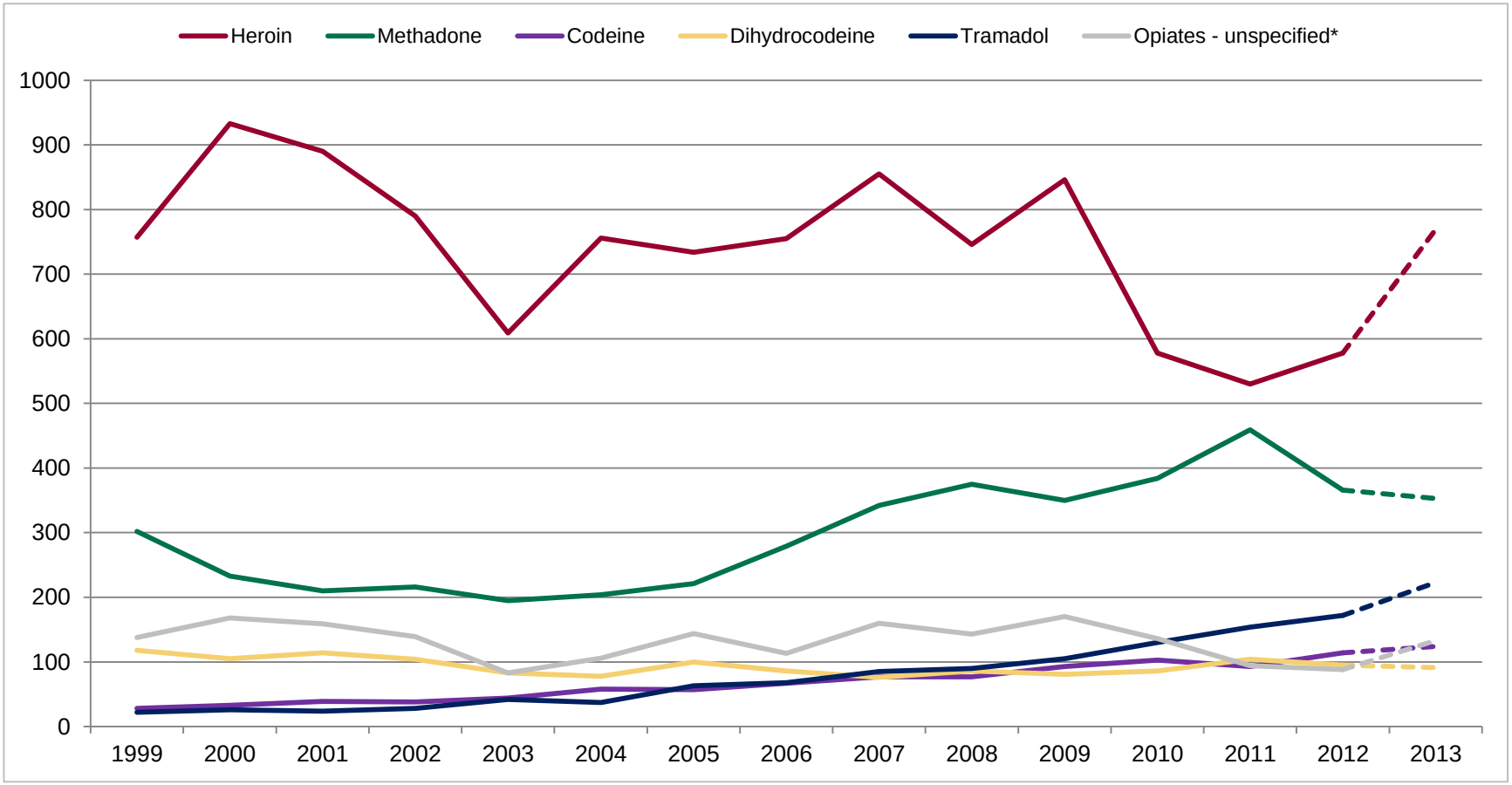
PHE analysis – impact of registration delays



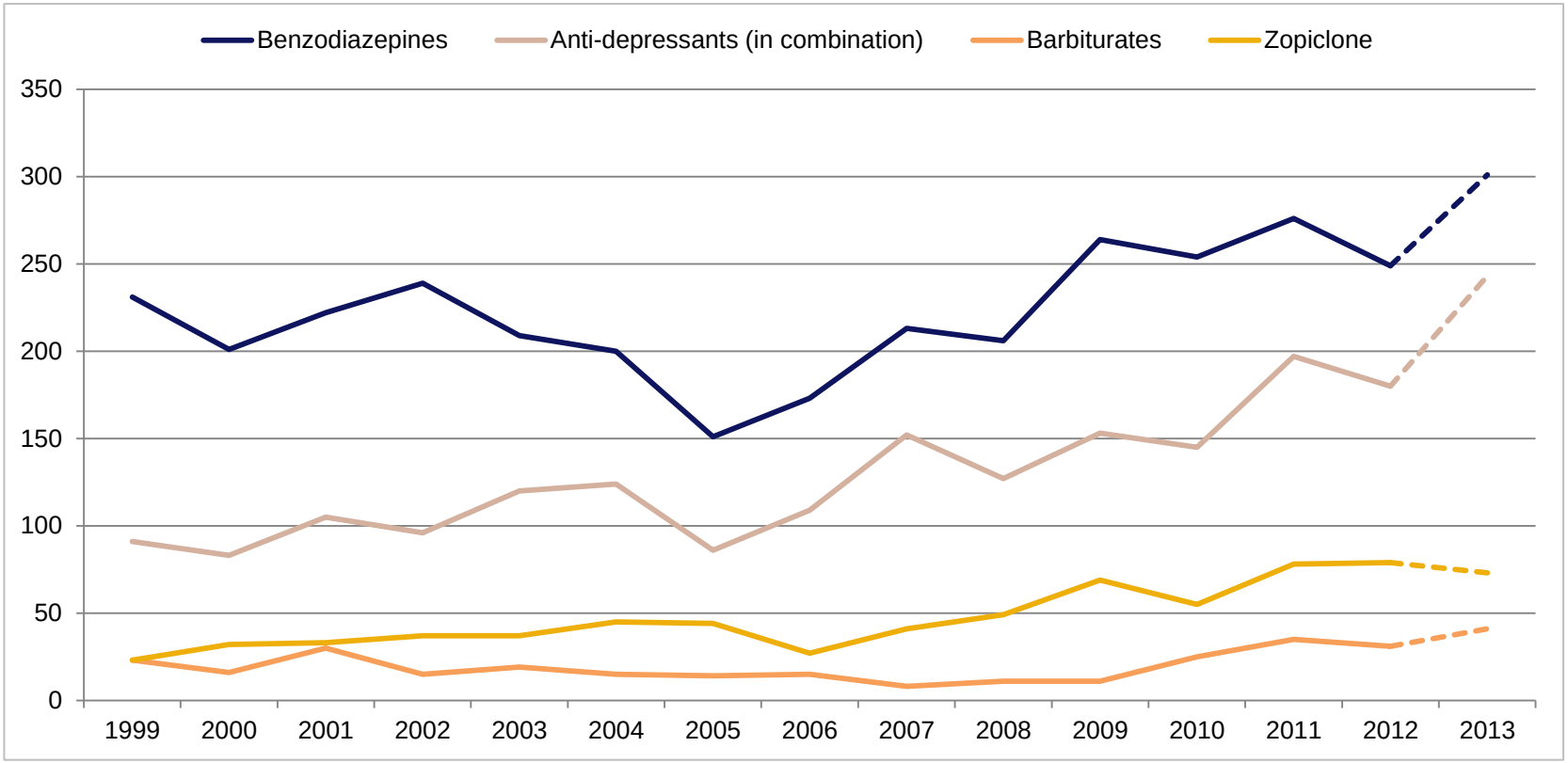
PHE analysis – national – by substance



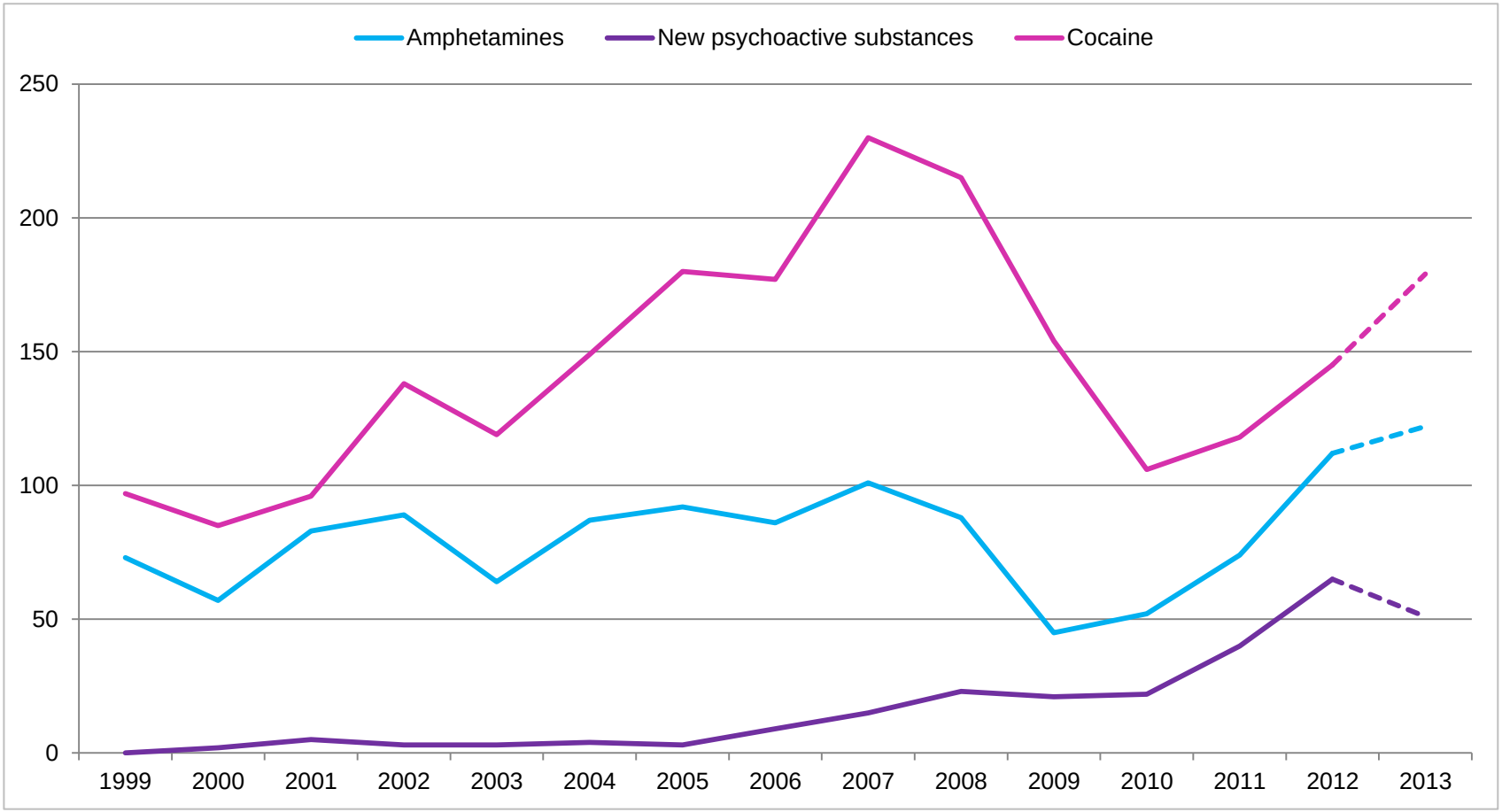
PHE analysis – national – opiates



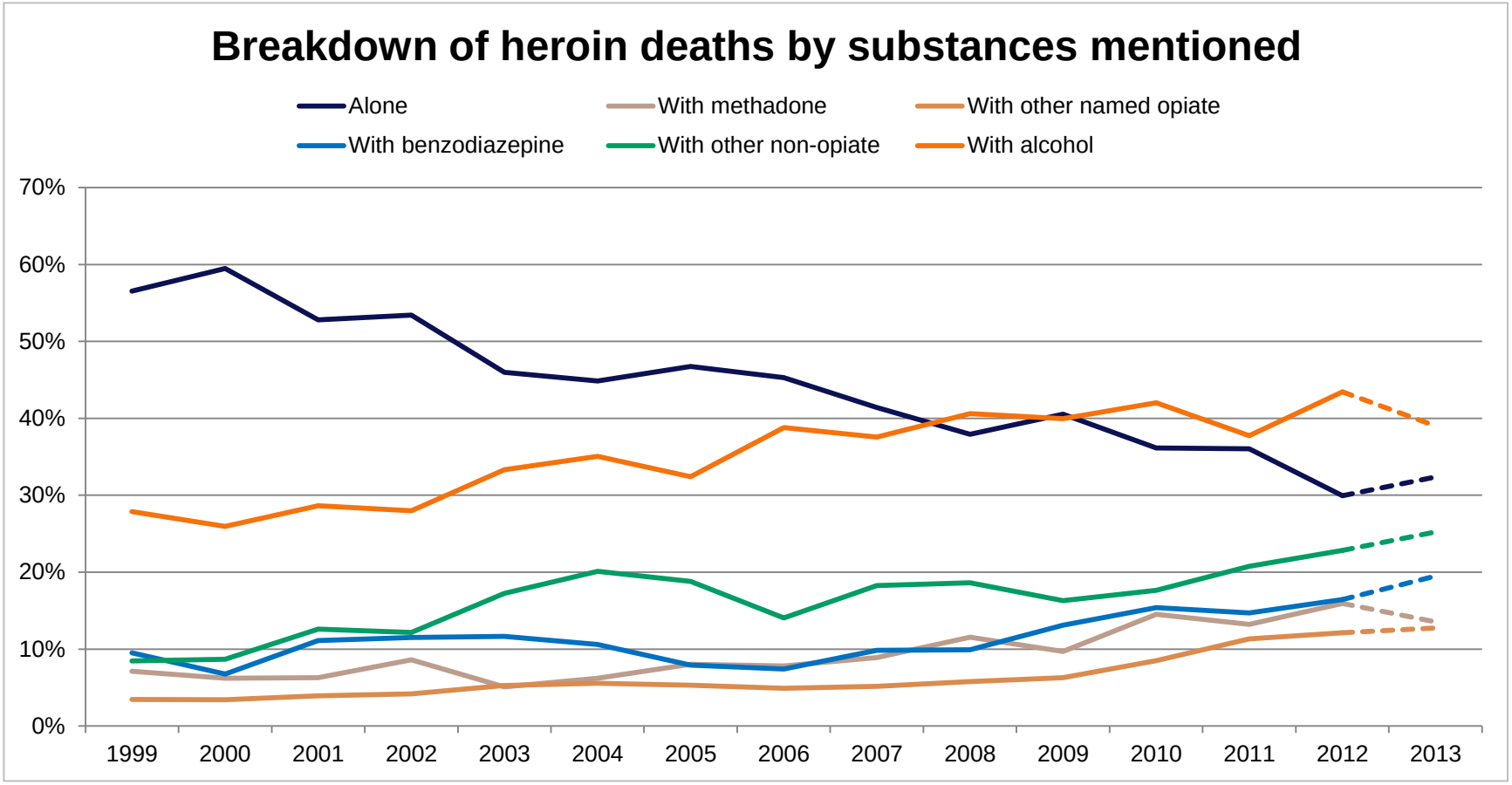
PHE analysis – national – anti-depressants, sedatives and hypnotics



PHE analysis – national – stimulants and NPS

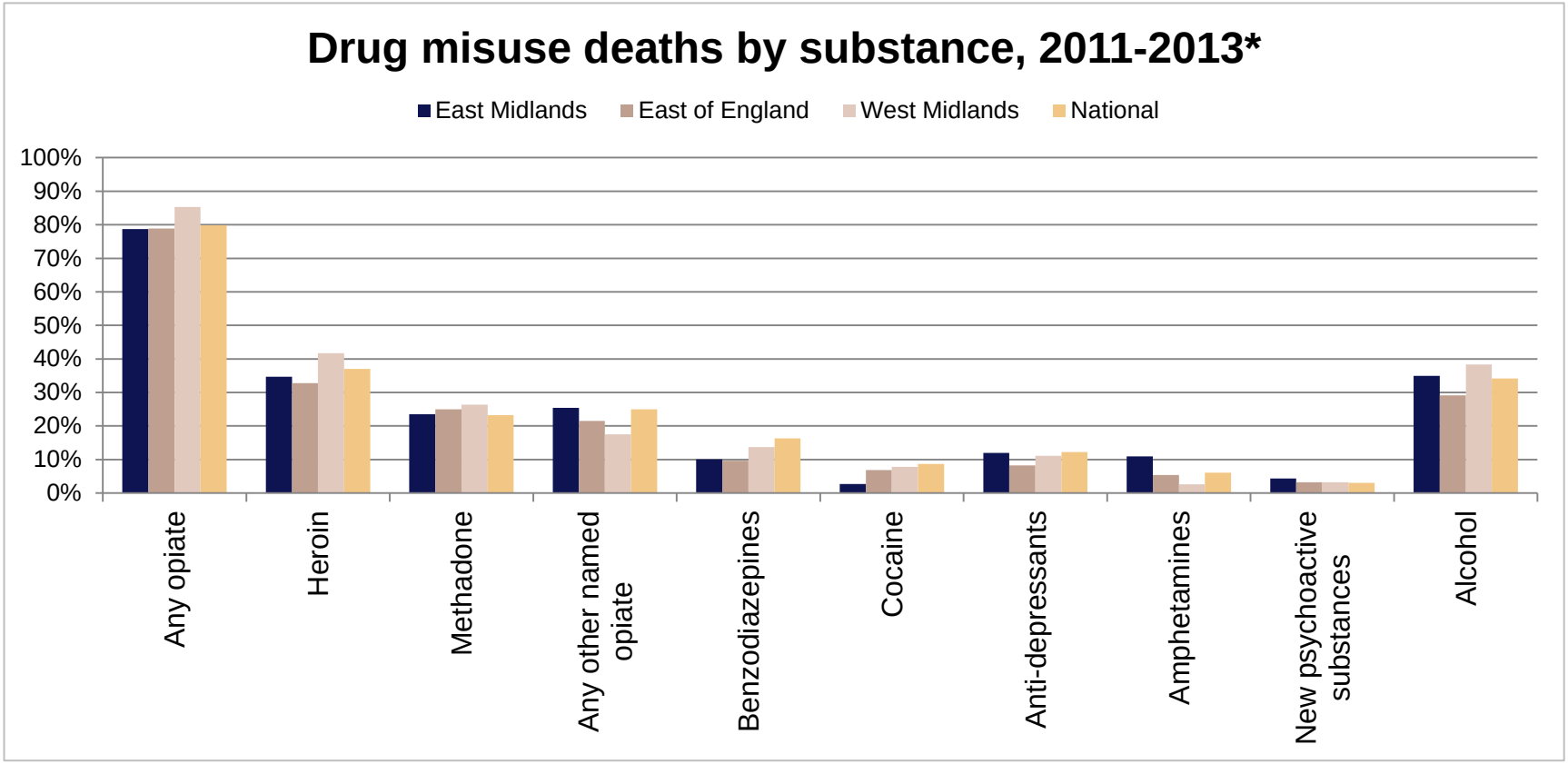


PHE analysis – national – poly substance

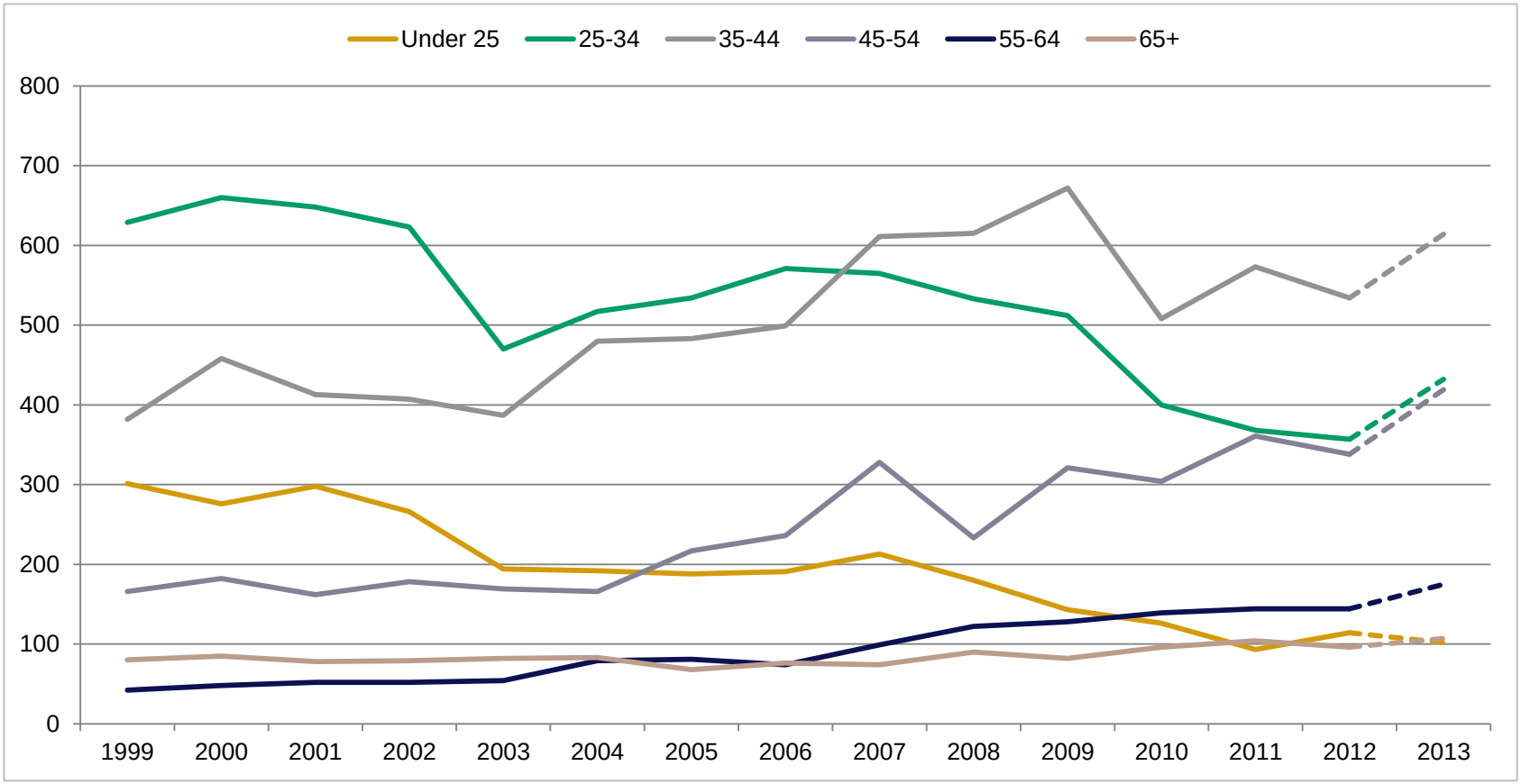


PHE analysis – regional – by substance

*Note: May be subject to slight change as some deaths have yet to be registered.

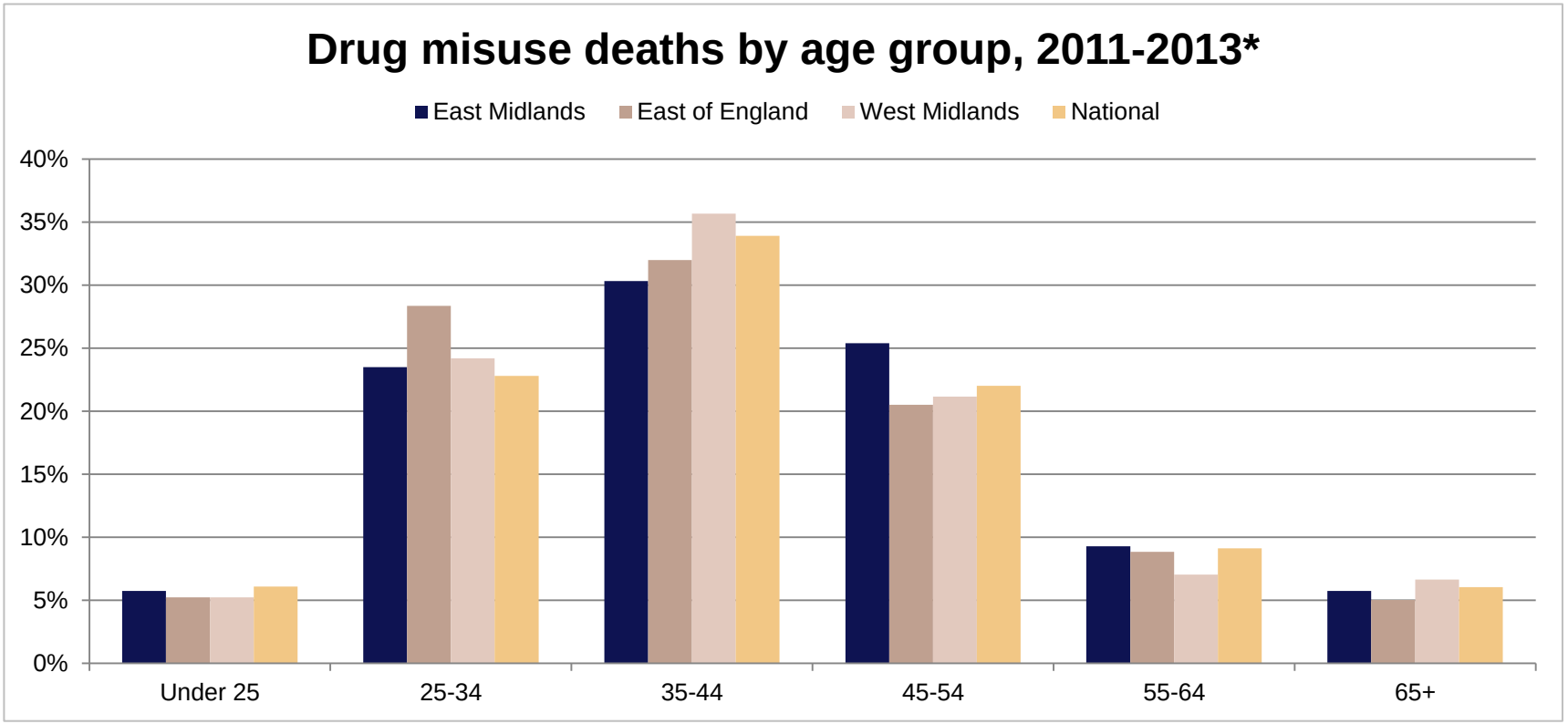


PHE analysis – national – by age

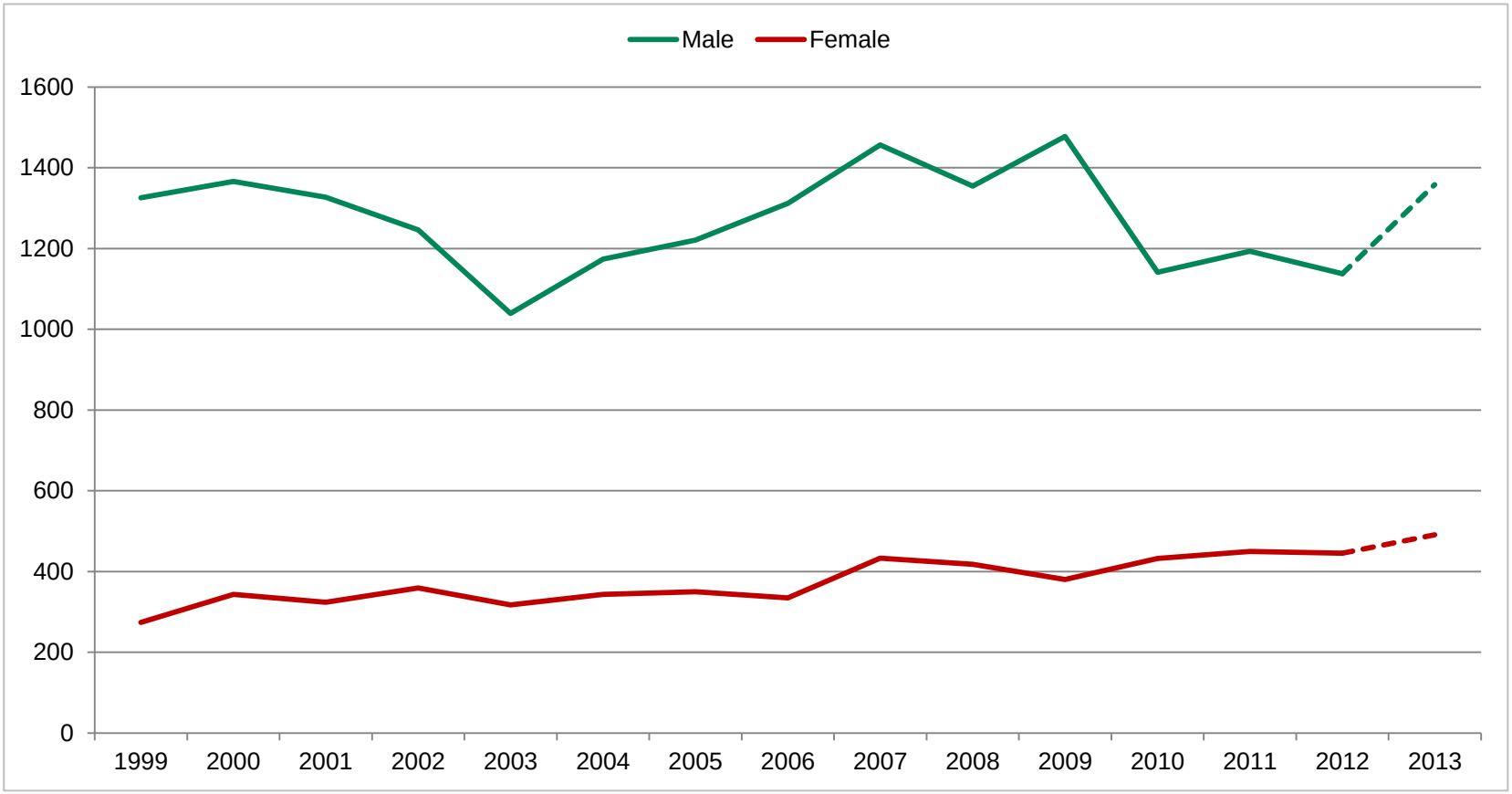


PHE analysis – regional – by age

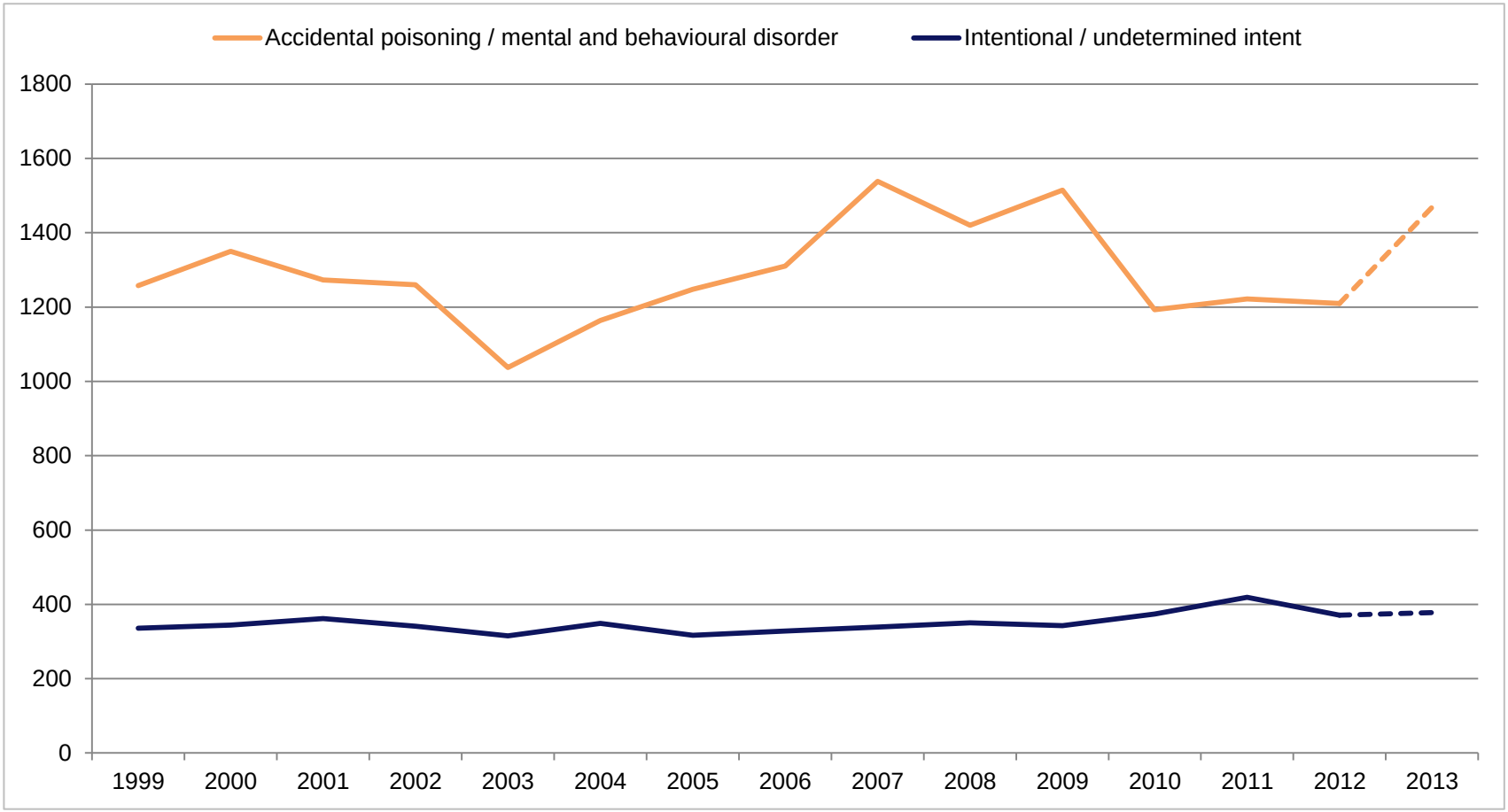
*Note: May be subject to slight change as some deaths have yet to be registered.



PHE analysis – national – by sex



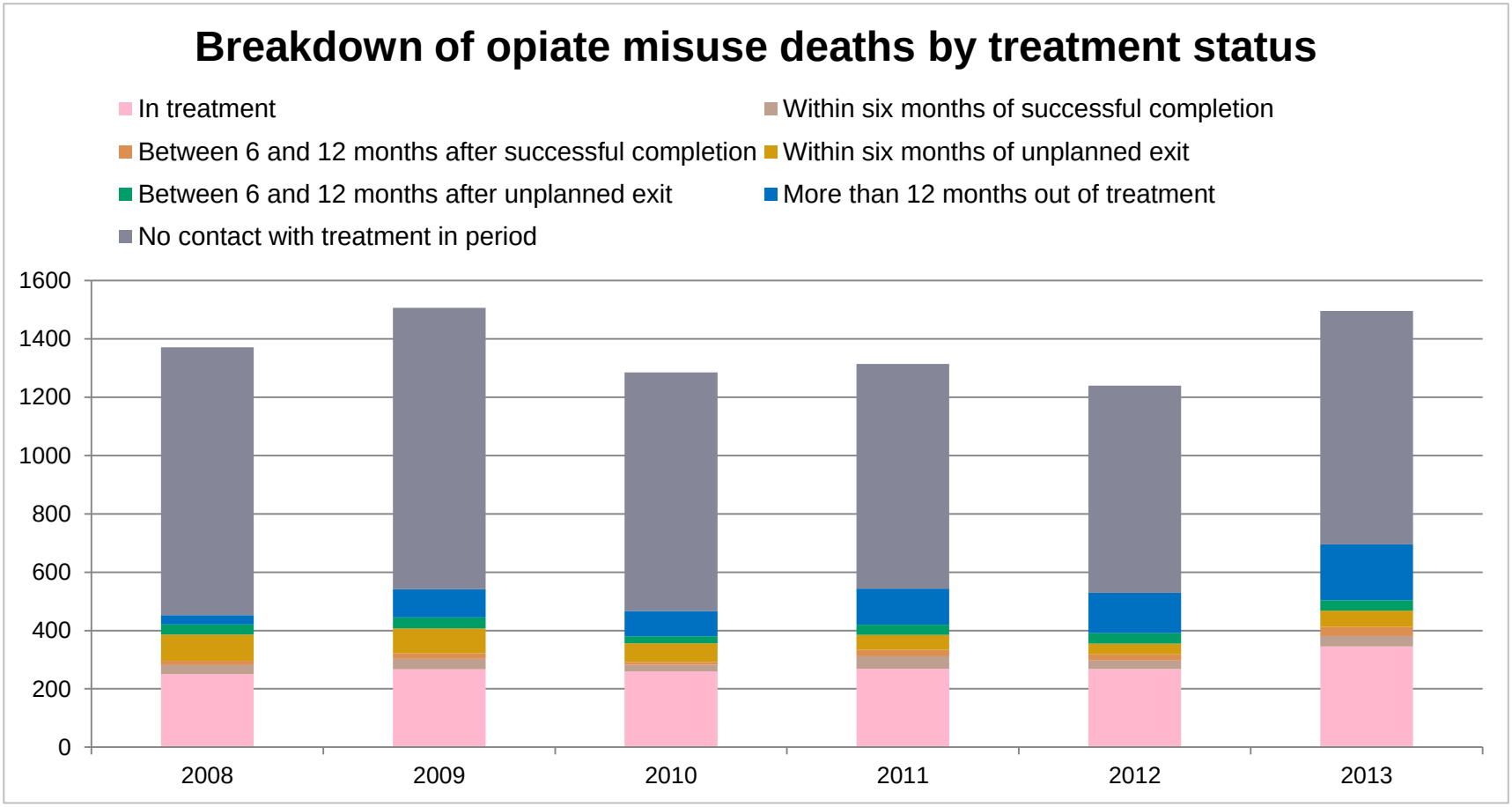
PHE analysis – national – by underlying cause of death



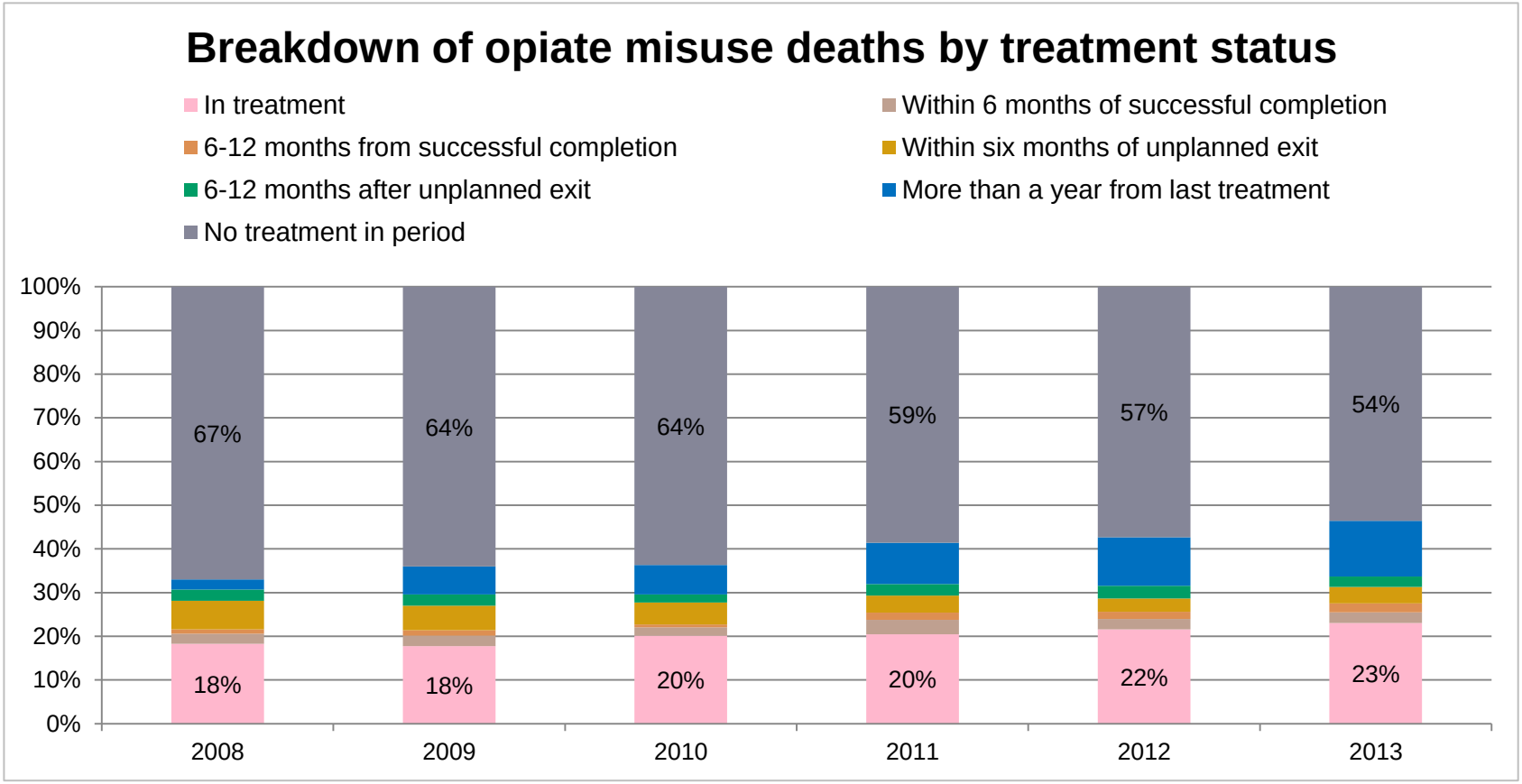
Match of drug poisoning data to NDTMS data

- Using an existing matching protocol, we were able to link opiate misuse deaths to NDTMS treatment data, covering the seven year period 2007-2013
- We then categorised opiate misuse deaths as follows:
  - In treatment
  - Within 6 months of successful completion
  - Between 6 and 12 months following a successful completion
  - Within 6 months of an unplanned exit from treatment
  - Between 6 and 12 months following an unplanned exit from treatment
  - More than 12 months from latest treatment contact
  - Never had treatment contact
- Analysis was reported for each year from 2008 to 2013, to allow for a ‘run-up’

Match of drug poisoning data to NDTMS data



Match of drug poisoning data to NDTMS data



Match of drug poisoning data to NDTMS data

- The analysis demonstrated that up to 2012 there was:
  - Similar proportion over time where the person had recently been in treatment (defined as within past year)
  - Slight increase in the proportion in treatment when they died
  - The majority still had not been in treatment in the period studied (i.e. since at least 2006)

- By contrast, prevalence and treatment data suggest that the majority of opiate users have had recent treatment (see White et al, 2015 for a more detailed analysis)

- However, the 2013 increase was slightly more marked among those with recent treatment than those without

Match of drug poisoning data to NDTMS data

- A low proportion (around 4%) had a successful completion in the past year – this has increased slightly over this period, although this is in the context of rising successful completion numbers

- Analysis captures community treatment only. Early indications from matching to prison treatment data over a limited time period seem to suggest around 6% had left prison treatment in the previous year, with 2% of the total having prison treatment without community treatment.

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Take home naloxone: The pharmacy option

Kevin Ratcliffe, Consultant Pharmacist, Substance Misuse, CGL

Currently being revised

Please check back on this link at a later date

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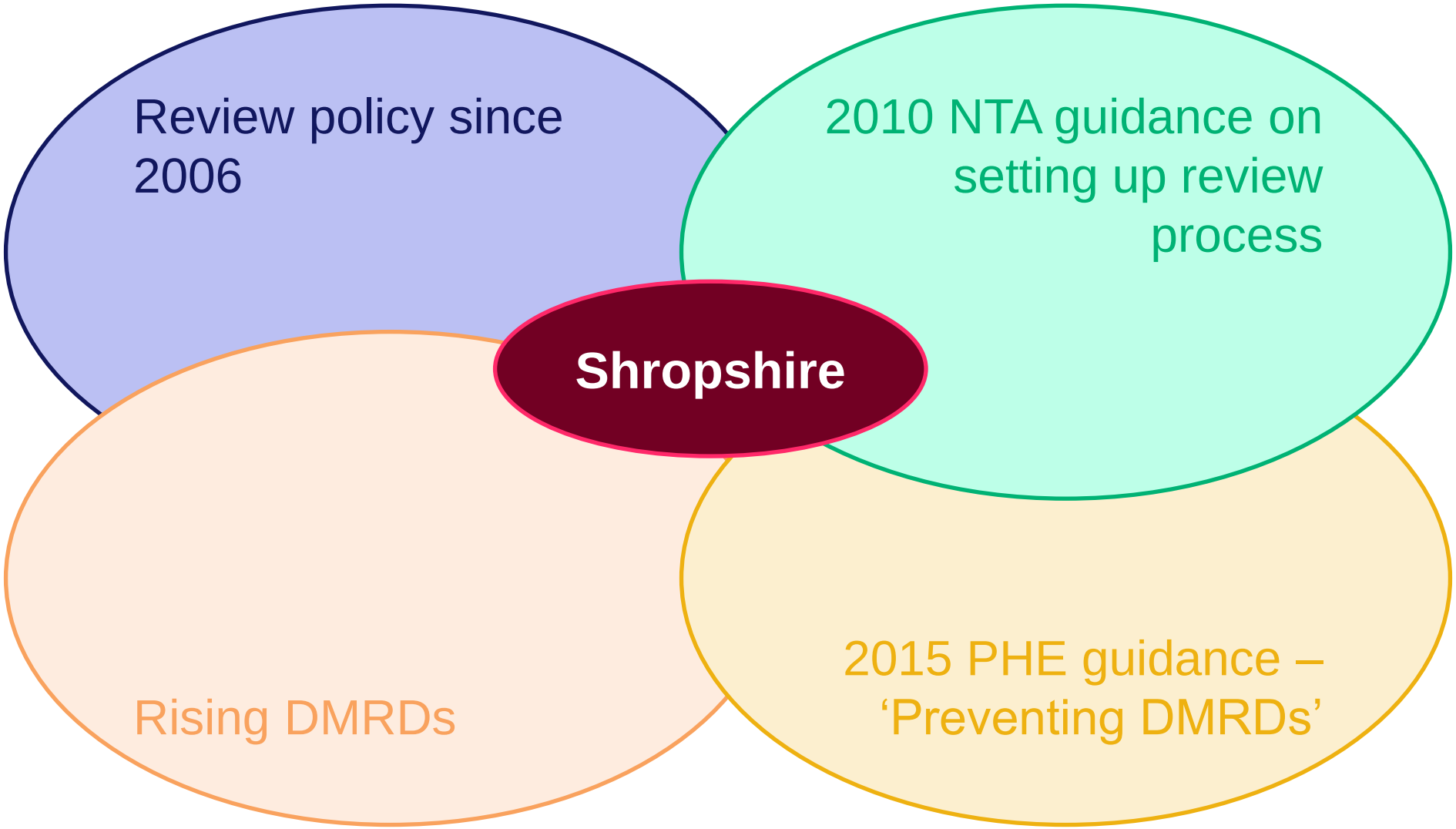
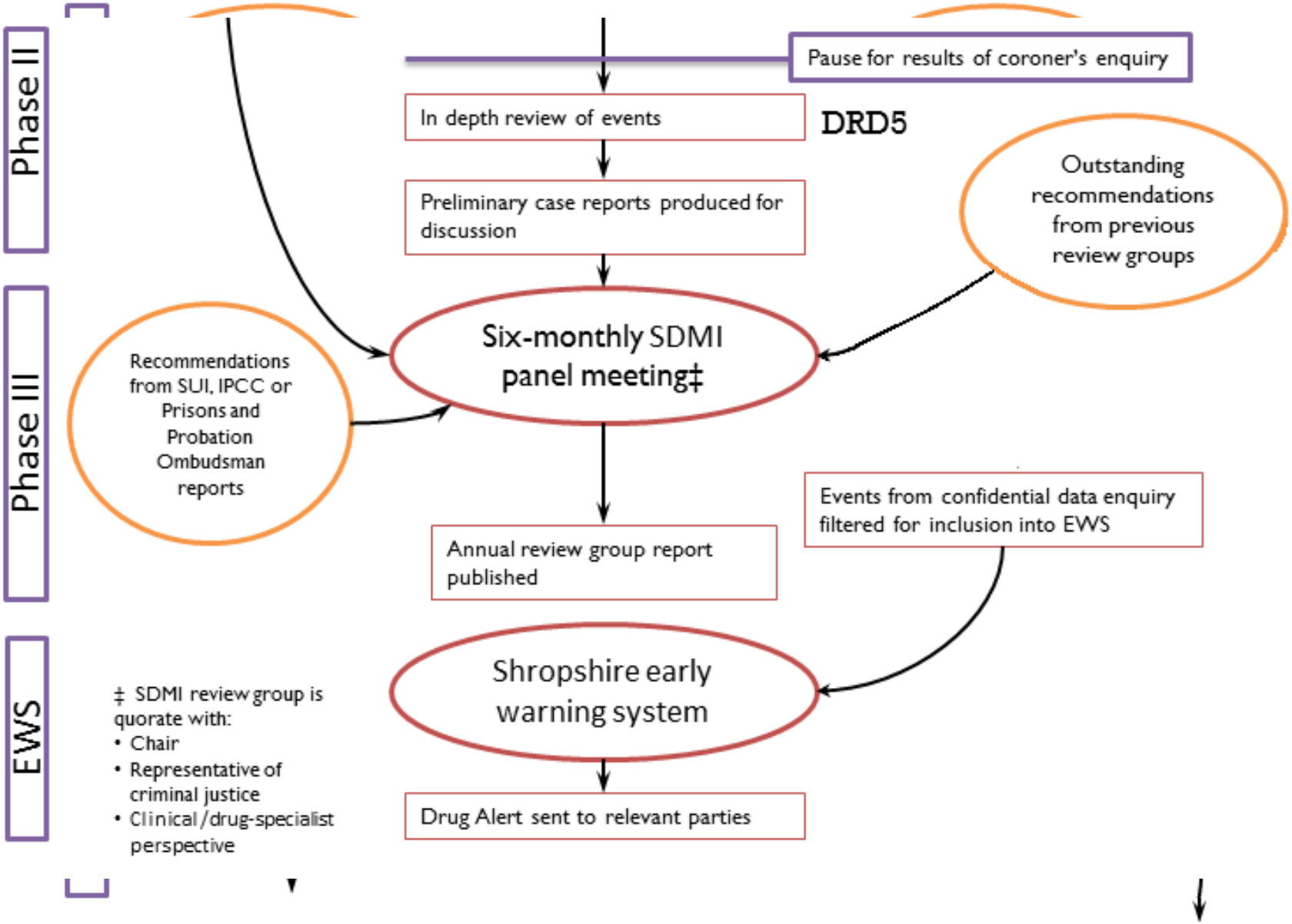
Establishing a drug-related death inquiry system

Andrew Dalton, Public Health Specialty Registrar, Health Protection Team, West Midlands, Public Health England

The Context


Review policy since 2006
2010 NTA guidance on setting up review process
Shropshire
Rising DMRDs
2015 PHE guidance – ‘Preventing DMRDs’


Phase II
Phase III
EWS
Pause for results of coroner's enquiry
In depth review of events
DRD5
Preliminary case reports produced for discussion
Outstanding recommendations from previous review groups
Six-monthly SDMI panel meeting‡
Recommendations from SUI, IPCC or Prisons and Probation Ombudsman reports
Events from confidential data enquiry filtered for inclusion into EWS
Annual review group report published
Shropshire early warning system
Drug Alert sent to relevant parties
‡ SDMI review group is quorate with:
• Chair
• Representative of criminal justice
• Clinical/drug-specialist perspective

Clarity of purpose

Be clear on:

- What you are trying to do
- Who is going to be included (stakeholders etc.)
- Which events to include
- **What you want out of it – small number of actionable recommendations?**

Definitions

What is a DMRD?

Suicides? Alcohol? NPS? Prescription medications? Contact with services? Non-fatal events?

Pragmatism

Do something well

don’t try to do it all and fail

Manageable workload – ‘two’ stage review process

Definitions

Which events you can capture

Which events you can learn from

Local expertise & support

Use it!

e.g. deciding which events to review

e.g. in reviewing events

“Public health” support & belief is vital to lead the process

Clear reporting processes

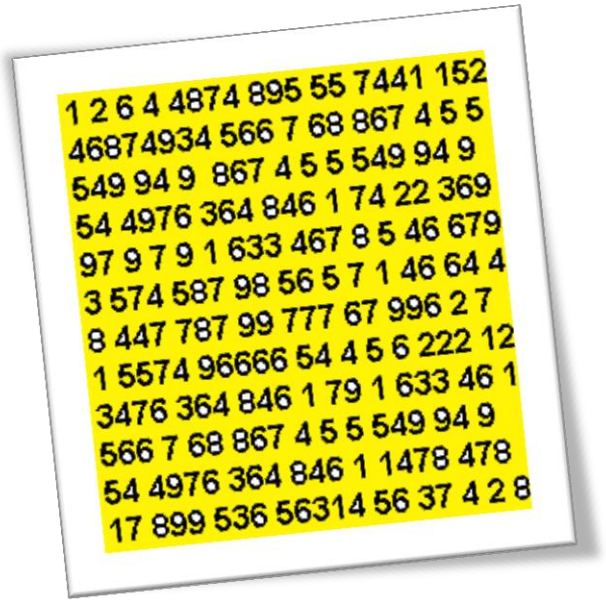
Support from above strengthens process

Coroner

Coroner support very beneficial in setting up process

- Access to data – they collect a lot: duplication
- Weight of their office
- Must fit in with their work - timeliness?

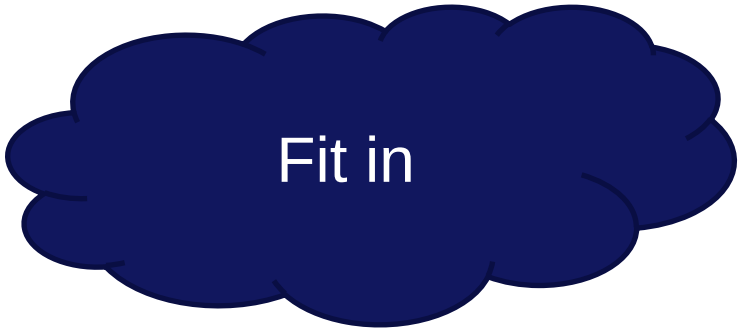
Don’t be scared of data



Practical measures

- Use existing documents
- Provide & use pro forma/ templates through the process

- Part of role/ work plan
- Clear actions & responsibilities to set theory into practice



- Fit into existing processes, data collection, time frames etc.

Last bits

- Sources of ‘notification’
  - Which to use
  - How to capture ‘most’ events
- Feedback loop within process?
- Practice with the documents –
  - Retrospective “baseline audit”
- Arranging face-to-face meetings

?? Systematic process Vs. best use of resources ??

Never forget the **point** of what you are doing

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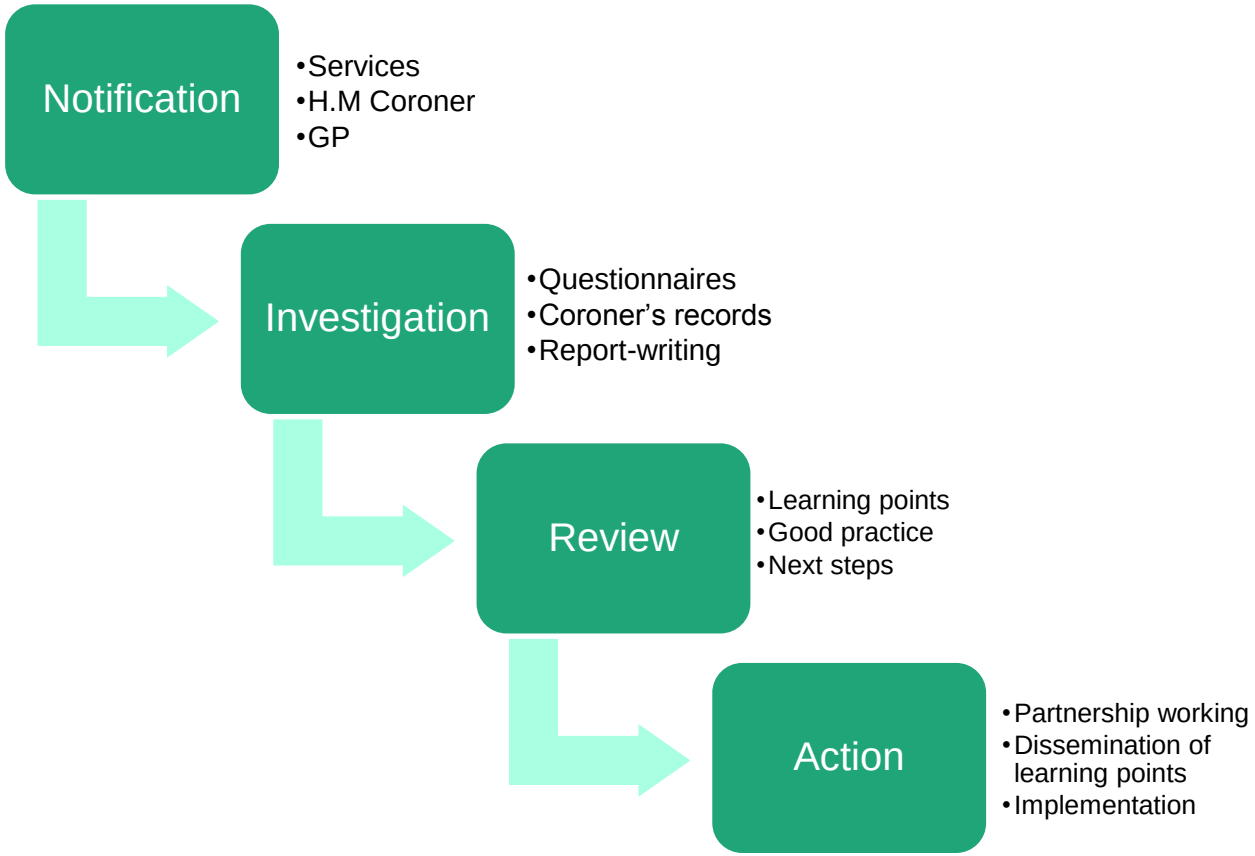
Reducing drug-related deaths in Nottingham

Bethan Hopcraft, Strategy and Commissioning Officer, Nottingham Crime and Drugs Partnership

Background

- Confidential Inquiry Review Group has been running for over 10 years
- Overdose awareness training and naloxone
- Lowest proportion of DRD in core cities in 2014 (25.7 per 1m population, *n*=24)

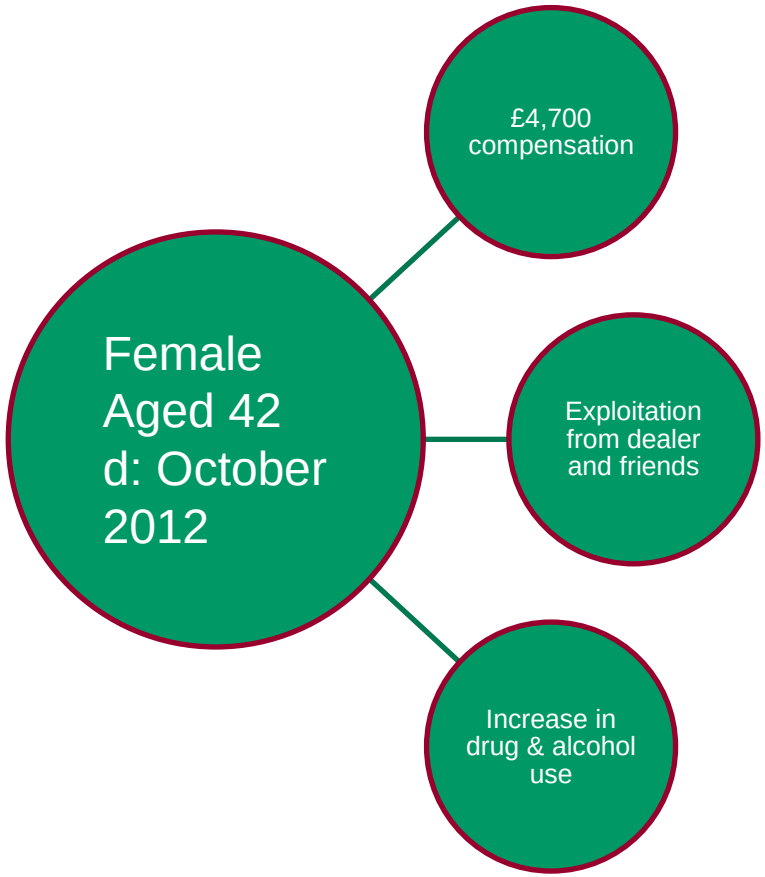
Confidential Inquiry Review Group



Outcomes of Meetings

- Learning points
  - Dissemination to services
  - Involvement from H.M. Coroner
- Identification of issues and patterns
  - DSVA and Safeguarding
  - Aging-opioid cohort
  - Near-miss recording
- Projects
  - Take-home naloxone
  - Pregabalin and gabapentin local guidance
  - Drug alerts

Case Study (2012)



- Contact with housing association
- Information-sharing
- Increase in provision for advice

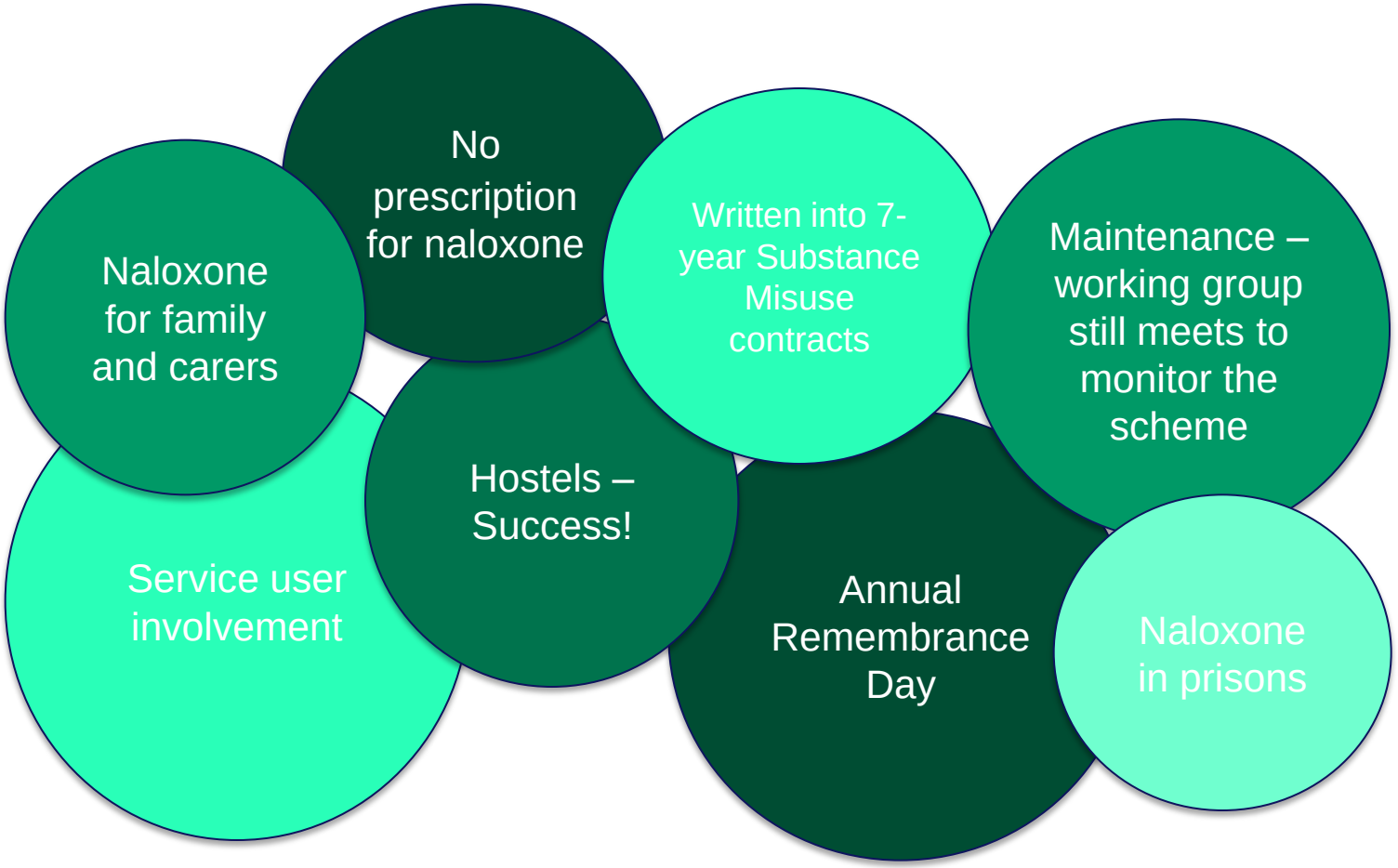
Barriers

- Definitions
  - NPSAD Report - St. George's
  - Social/medical
  - Cost savings
- Timings
  - Coroner's records
  - Meeting dates – not reactive
- Run through Local Authority
  - Time

Naloxone

- Has been used successfully in 72 cases
  - Each pack costs only £18.03
- Nottingham is considered as a flag ship for the take-home naloxone scheme
- Fluctuating purity of heroin
- Police
- Training
- Timeline

What next?


No prescription for naloxone
Written into 7-year Substance Misuse contracts
Maintenance – working group still meets to monitor the scheme
Naloxone for family and carers
Hostels – Success!
Service user involvement
Annual Remembrance Day
Naloxone in prisons

Contact

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💻www.nottinghamcdp.com