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Drug Related Deaths: All Causes Mortality

Emerging again as an issue

In 2012 a distinct rise in Drug Related Deaths was noted nationally

First rise in approximately 10 years

This has now continued in subsequent years and has emerged as a distinctive trend

Initial response

- Work done in 2015-2016
- Period Covered 2012-2015
- Contributed to PHE enquiry
- Included in the joint Collective Voice and NHS Provider Alliance publication

Findings:
198 cases examined. All drug cases (103 alcohol cases also examined – not in scope for the PHE work

- Accidents (inc. RTAs) : 6%
- Suicides (12, of which 11 were hangings-all men)
- Homicides:2%
- Unclear CoD / Narrative verdicts 28%
- Physical Health: 48%

Physical Health

- Any respiratory or circulatory issue: 28%
- Any G.I. issue (Inc. alcohol): 21%
- Any cancer: 12.5%
- Multiple factors: 38% (Inc. acute and chronic infections)

Caution….

This was not an academic study !

Detailed examination of the clinical situation from the point of view of a service deliverer who felt they had to do something about this presenting and growing issue.

BUT-

It was very through and did have access to:

All historical and current drug and alcohol records

Some GP records

Mental health information

Corners information

Current situation (from a clinical perspective)

In 2022 : **39**

Physical health/Natural causes : 27 . Primary or contributory.

No current cause of death : 8

Suicide : 1

Accidents (some related to alcohol) : 3

People (included above) on End-of-Life Pathway : 8

People on intensive assertive outreach (included above) : 5. Several refusing treatment.

Causes of death among people who used illicit opioids in England, 2001–18: a matched cohort study

Dan Lewer, Thomas D Brothers, Naomi Van Hest*, Matthew Hickman*, Adam Holland*, Prianka Padmanathan*, Paola Zaninotto**

***Lancet Public Health* 2021**
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See **Online/Comment** https://doi.org/10.1016/ S2468-2667(21)00278-4

Findings and Discussion

We found increasing mortality rates due to COPD across the study period, which persisted after adjusting for ageing in the study population.

Deaths due to respiratory cancers did not increase in parallel. This observation might suggest that the increase in COPD- related deaths is caused by increases in smoking crack cocaine and other drugs that damage the lungs through particles and thermal injury.

Non-communicable diseases are likely to become more important in this population as the average age increases.

Little research has been done into interventions that can improve access to care for non-communicable disease, despite well documented barriers.

Findings and Discussion

Historically, research has focused on prevention of overdoses, infections, and crime.

Community drug treatment services are sometimes the only point of contact between people who use illicit opioids and health services, and cuts in funding have meant that these services now provide a narrow range of services with little scope for holistic care.

These services need resources to care for clients with increasing health and social needs.

So, what are we going to do about it?

What can we do about it ?

Transactional, verses Compassionate, Humanitarian Services

Transactional Service

- Needle Exchange Home Delivery
- Supervised Consumption
- Naloxone Distribution
- Long-arm Prescribing/Reviews
- Remote service delivery

Compassionate & Humanitarian Approach

Who and what are we talking about ?

- Aging
- Compromised Health (Mental and Physical Health)
- Isolation and stigma
- Complexity (including concurrent alcohol use)
- Stretched and reduced wider services
- Disproportionately represented in areas of deprivation

And what are we doing? What can we do?

- Direct face to face provision wherever possible (1:1 and Groups)
- A workforce equipped for the circumstances
- Physical and Mental Health literate and competent workforce
- Psychologically equipped to deal with (e.g., trauma, complexity and loss)
- Specialist training (e.g., Mental Health First Aid, Blue Light)
- Flagging System or Zoning System (right intervention/ right time)
- Risk awareness and escalation (including Peers, Volunteers and Partners)
- Engage with the experts – Acute Health , GPs , A & E etc

Cocaine Related Deaths

We have responses for opiate, alcohol and dependant users.

Are these an entirely different group of people?

What is going to be the response ?

Do we need to look towards lessons from the Club-Drug years ?

Warrants significant further investigation

Considerations

We are mitigating deprivation and wider societal factors

We are mitigating Long Term Conditions and lifetimes of ill health and related behaviours (including unwise personal choices)

We are mitigating trauma

I have considered the In-treatment population (as that is my sphere of influence)

We are not the experts in all the things our people need

We can better equip our workforce

Smoking !

Caseloads and updated performance framework

***Cocaine and out of treatment deaths

THANK YOU

Questions, comments, ideas and discussion welcome.