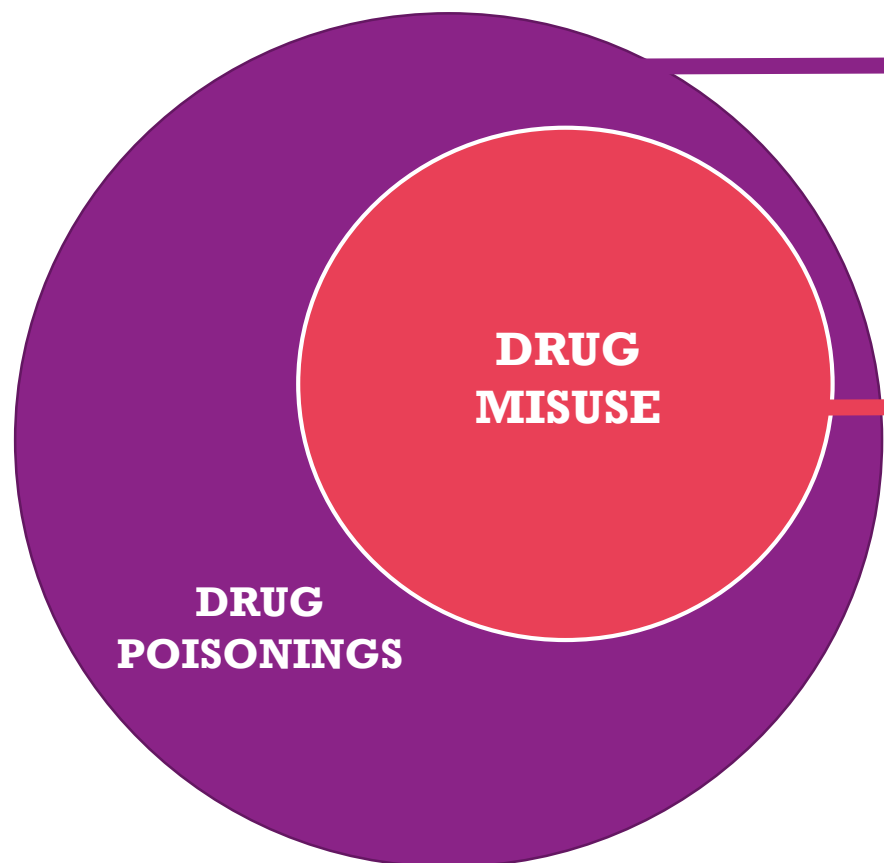


# C&M DRUG RELATED DEATHS CONFERENCE 2020

Time - V	Speaker
9:15 AM	Welcome
9:20 AM	<b>Prof. Raphaela Kane</b> , Pro VC Faculty of Health, LJMU – <i>Opening Address</i>
9.25 AM	<b>Prof John Ashton</b> - Former Regional Director of Public Health for North-West England
9:30 AM	<b>Mark Whitfield</b> - Public Health Institute, LJMU <i>The 2019 data for Cheshire &amp; Merseyside and the National picture.</i>
10:00 AM	<b>Neil Woods</b> - Former Undercover Drugs Detective Sergeant, LEAP UK: <i>The “war on drugs” and how the current legal situation in the UK is a cause of DRD.</i>
10:20 AM	<b>Kirsten Horsburgh</b> - Strategy Coordinator (drug death prevention), Scottish Drugs Forum: <i>Responding to record levels of DRD in Scotland</i>
10:40 AM	<b>Dr Sam Wright</b> - Senior Research Associate, Manchester Metropolitan University: <i>Developing End of Life standards for people who use drugs.</i>
11:00 AM	Q&A
11:30 AM	Break
11:40 AM	<b>Howard Reed</b> - Public Health Institute, LJMU: <i>Integrated Monitoring System (IMS) DRD module updates</i>
12:00 noon	Breakout discussion groups
12:45 PM	Feedback from discussion groups
1:45 PM	Closing remarks – <b>Prof. Viv Hope</b> , Public Health Institute, LJMU

# Deaths related to drug poisoning in England and Wales: 2019 registrations

# Drug related deaths across England and Wales, 2019



## Drug Poisonings

Based on the ICD code assigned as the underlying cause of death – includes non-illicit substances

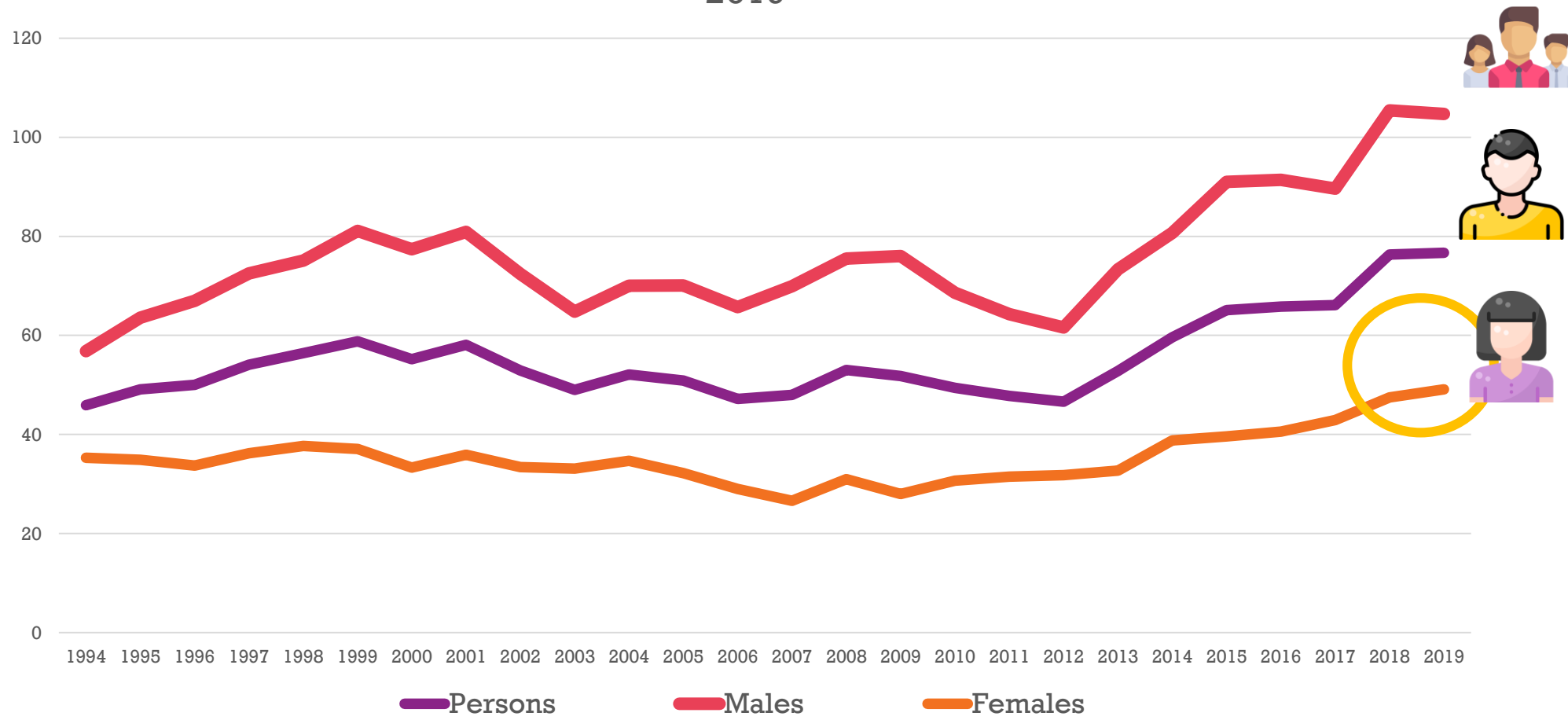
## Drug misuse

Where either the underlying cause is drug abuse or drug dependence, or the underlying cause is drug poisoning and any of the substances controlled under the Misuse of Drugs Act 1971 are involved.

[Deaths related to drug poisoning in England and Wales : 2019 registrations](#)

 Office for  
National Statistics

# Age-standardised mortality rates for deaths related to drug poisoning, by sex, England and Wales, registered between 1993 and 2019

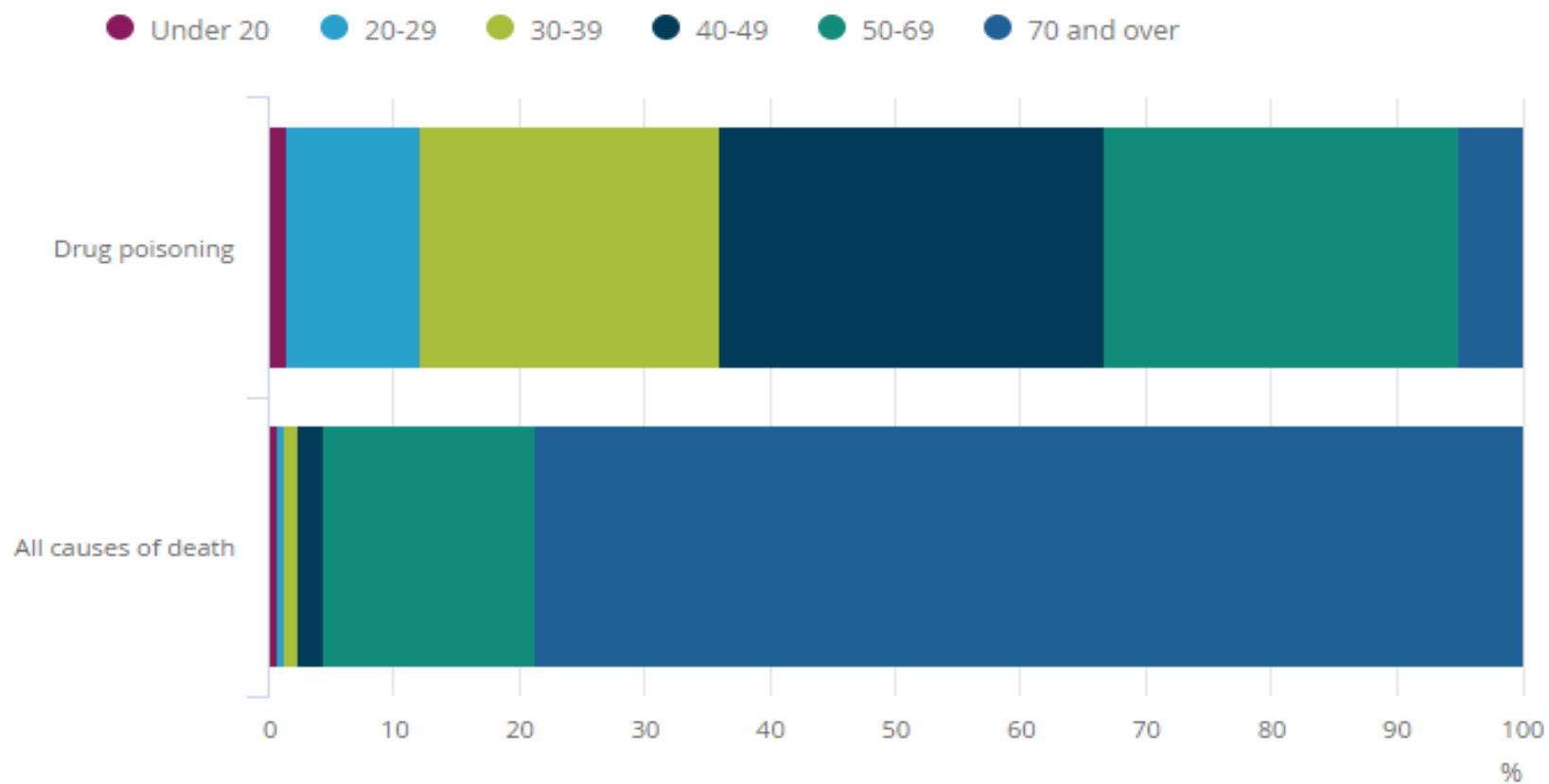


## Age-standardised mortality rate for deaths related to drug misuse, by sex, North West of England, 1993 - 2019



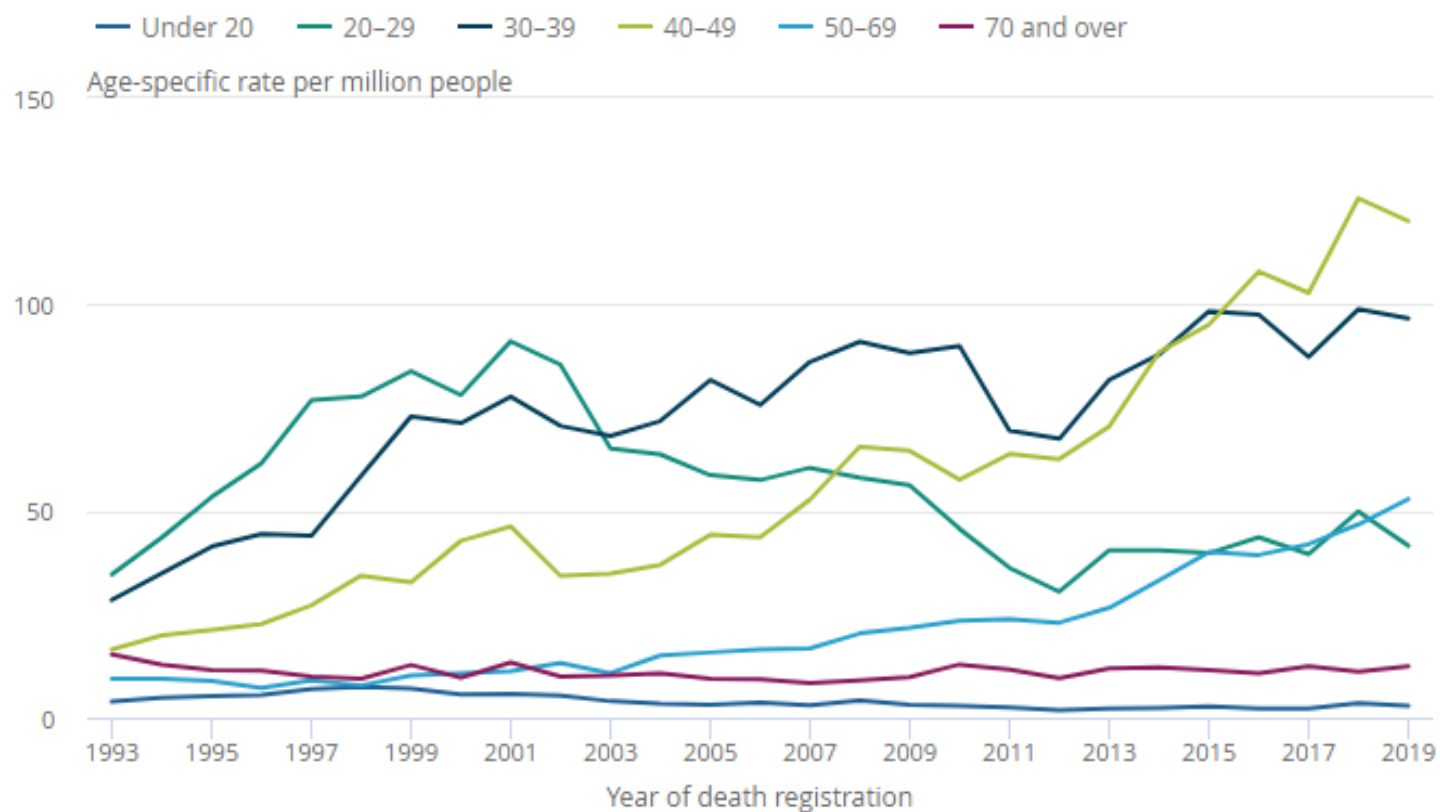
## Figure 2: Drug poisoning deaths disproportionately affect younger and middle age people

Percentage of drug poisonings and deaths from all causes by age group, England and Wales, registered in 2019



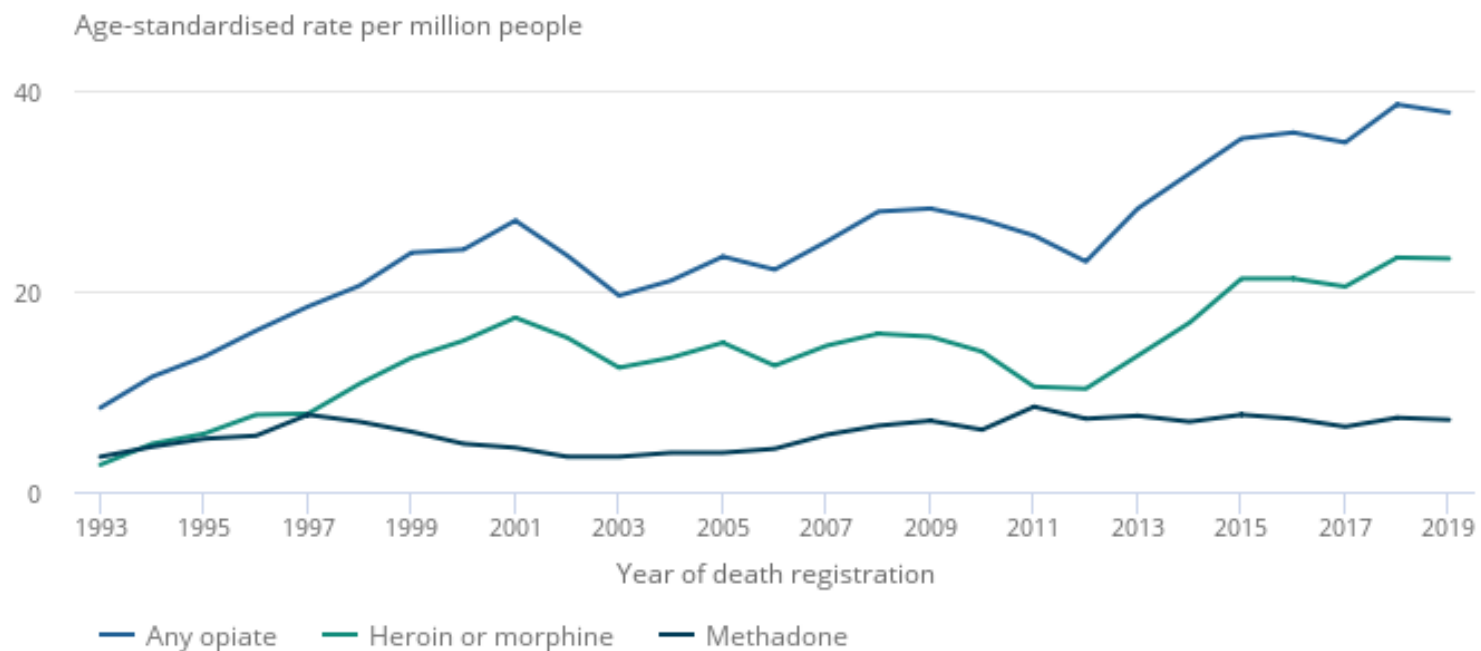
**Figure 4: Those born in the 1960s and 1970s, "Generation X", have had higher rates of drug misuse death over time**

**Age-specific mortality rates for deaths related to drug misuse, by age group, England and Wales, registered between 1993 and 2019**



## Figure 6: Rates of deaths involving opiates have decreased from last year, but remain high

Age-standardised mortality rates for deaths by all opiates, heroin or morphine, and methadone, England and Wales, registered 1993 and 2019

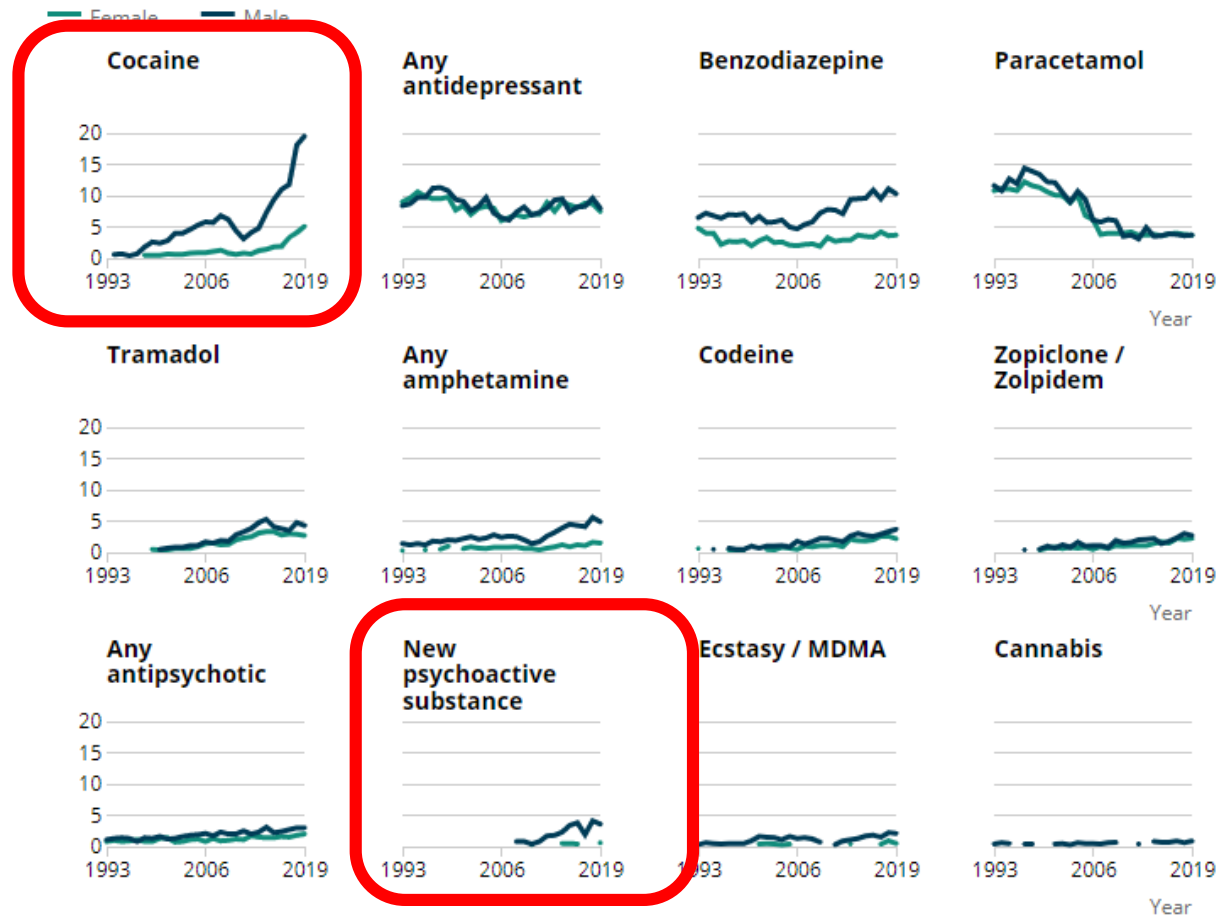


Source: Office for National Statistics - Deaths related to drug poisoning in England and Wales



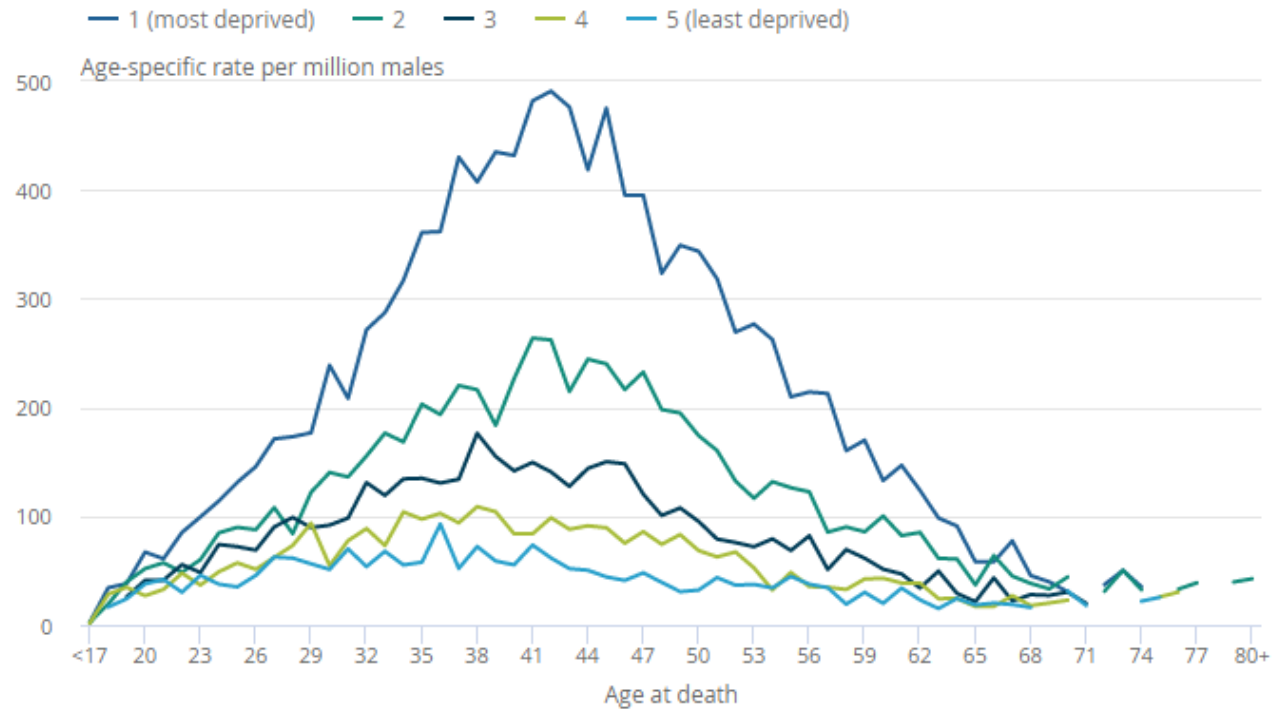
**Figure 7: Drug poisonings involving cocaine increased 26.5% for females and 7.7% for males between 2018 and 2019**

Age-standardised mortality rates for selected substances, by sex, England and Wales, deaths registered between 1993 and 2019



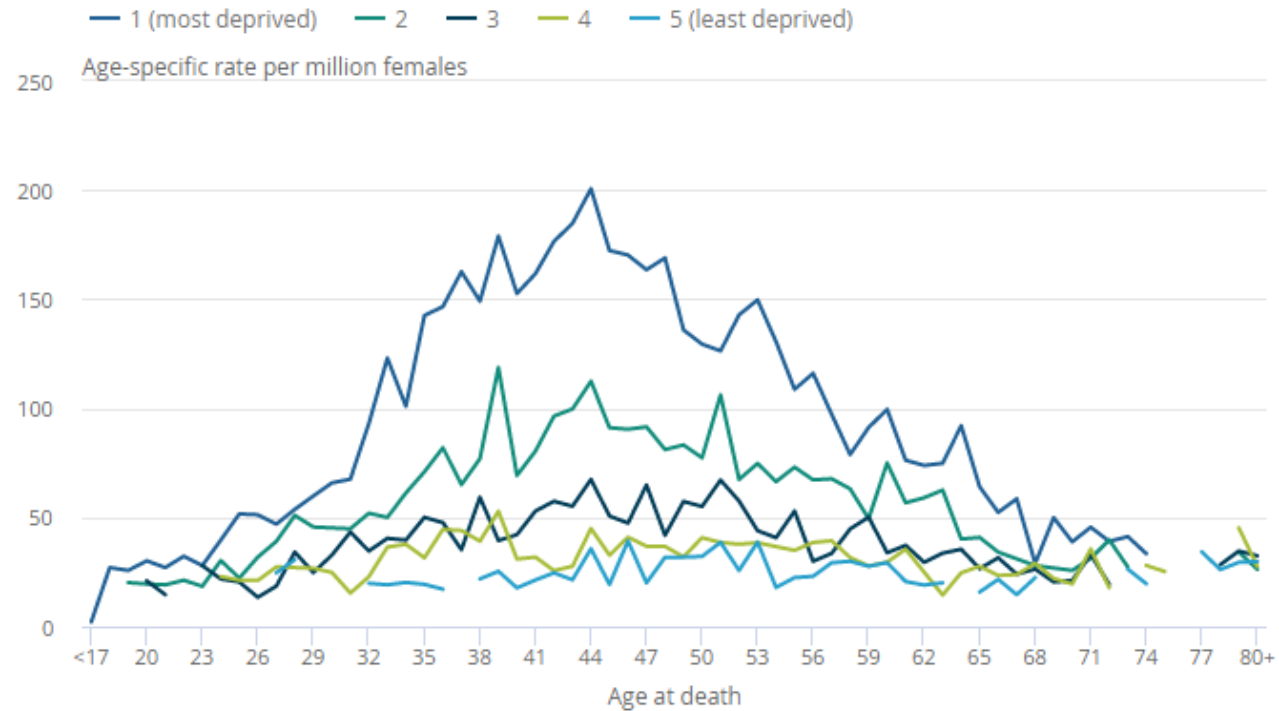
## Figure 8: English working age men living in the most deprived areas have significantly higher mortality rates from drug poisoning

Age-specific mortality rates for deaths related to drug poisoning, males by single year of age and deprivation quintiles, England, registered between 2010 and 2019 combined



## Figure 9: English working age women living in the most deprived areas have significantly higher mortality rates from drug poisoning

Age-specific mortality rates for deaths related to drug poisoning, females by single year of age and deprivation quintiles, England, registered between 2010 and 2019 combined



# **Cheshire and Merseyside DRD surveillance 2019**

# Cheshire and Merseyside DRD surveillance

- Limited surveillance implemented between 2007-2013
- Current system commenced in 2015
- From 2020, operational in all nine local authorities across Cheshire and Merseyside
- 19 panels have met during 2020 so far
- 2019 DRD annual reports published for each area
- Module is part of Integrated Monitoring System (IMS)

# What cases do we include in our local system?

A drug related death follows the ONS definition: “*A death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved*” – we also include toxicity from controlled non-illicit substances, NPS or alcohol.

**Reported by the Coroner.**

For the purposes of the monitoring system, all deaths in treatment are examined in order to establish whether a death might be considered to be drug *related* in a more general sense (effect of substance on mental or general physical health for instance). Alcohol is also included.

**Reported by Treatment agencies (mainly)**

## Registration delays have increased in 2019 in both England and Wales

For all-cause deaths registered in 2019 in England and Wales, 5.4% occurred prior to 2019. The percentage is much higher when looking at deaths relating to drug poisonings and drug misuse, with 54.5% and 54.4% of deaths occurring prior to 2019, respectively. Because of the length of time it takes to hold an inquest, around half of drug-related deaths registered in 2019 will have occurred in earlier years, and many deaths that occurred in 2019 will not yet be included in the figures.

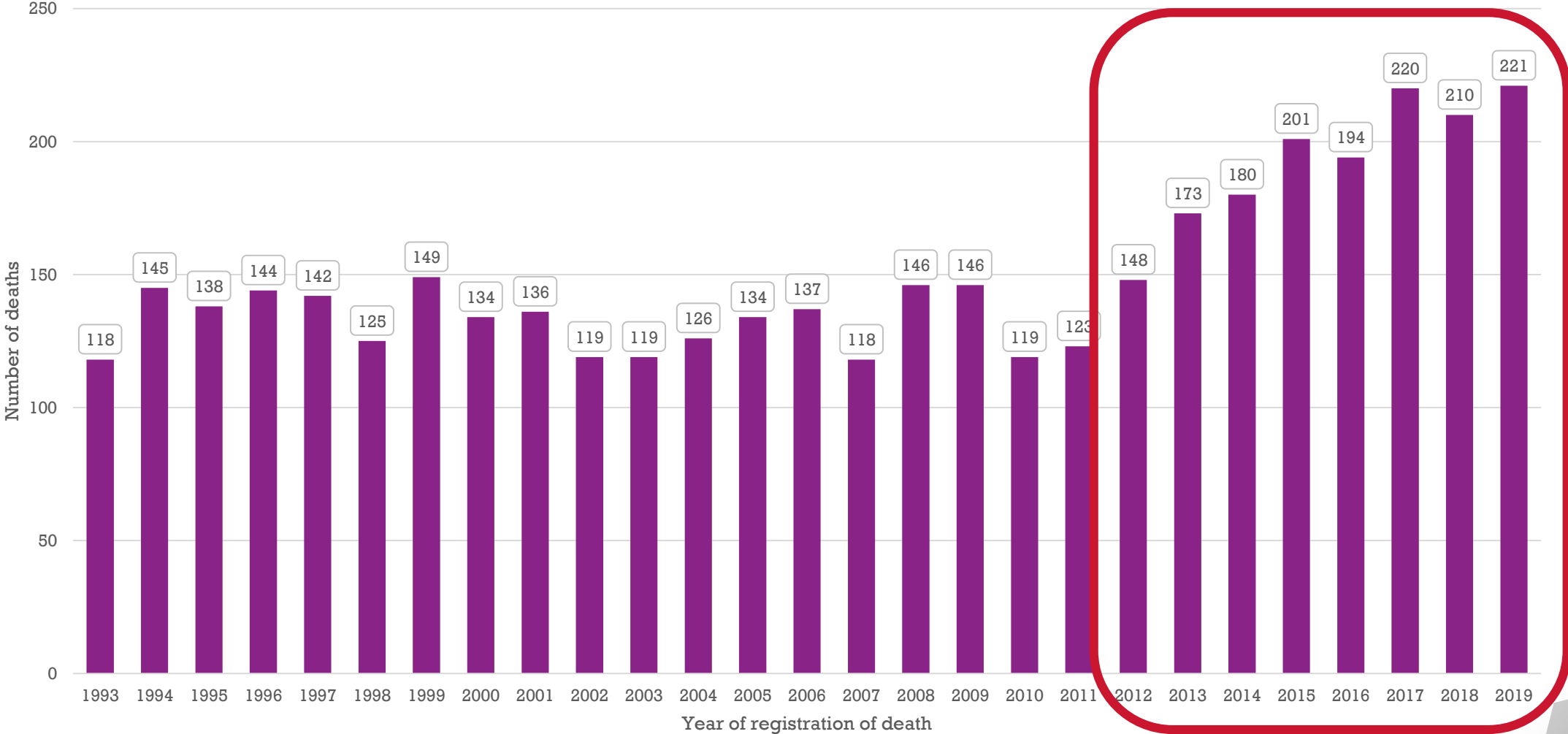
When calculating the average delay between occurrence and registration, the median is used rather than the mean, as the median is not affected by rare cases where it takes many years for the death to be registered. For drug poisonings, the median registration delay for England was 185 days in 2019 (up from 181 days in 2018) and 189 days for Wales (up from 168 days in 2018). The latest registration delay for England is the highest since the data time series began in 1993.

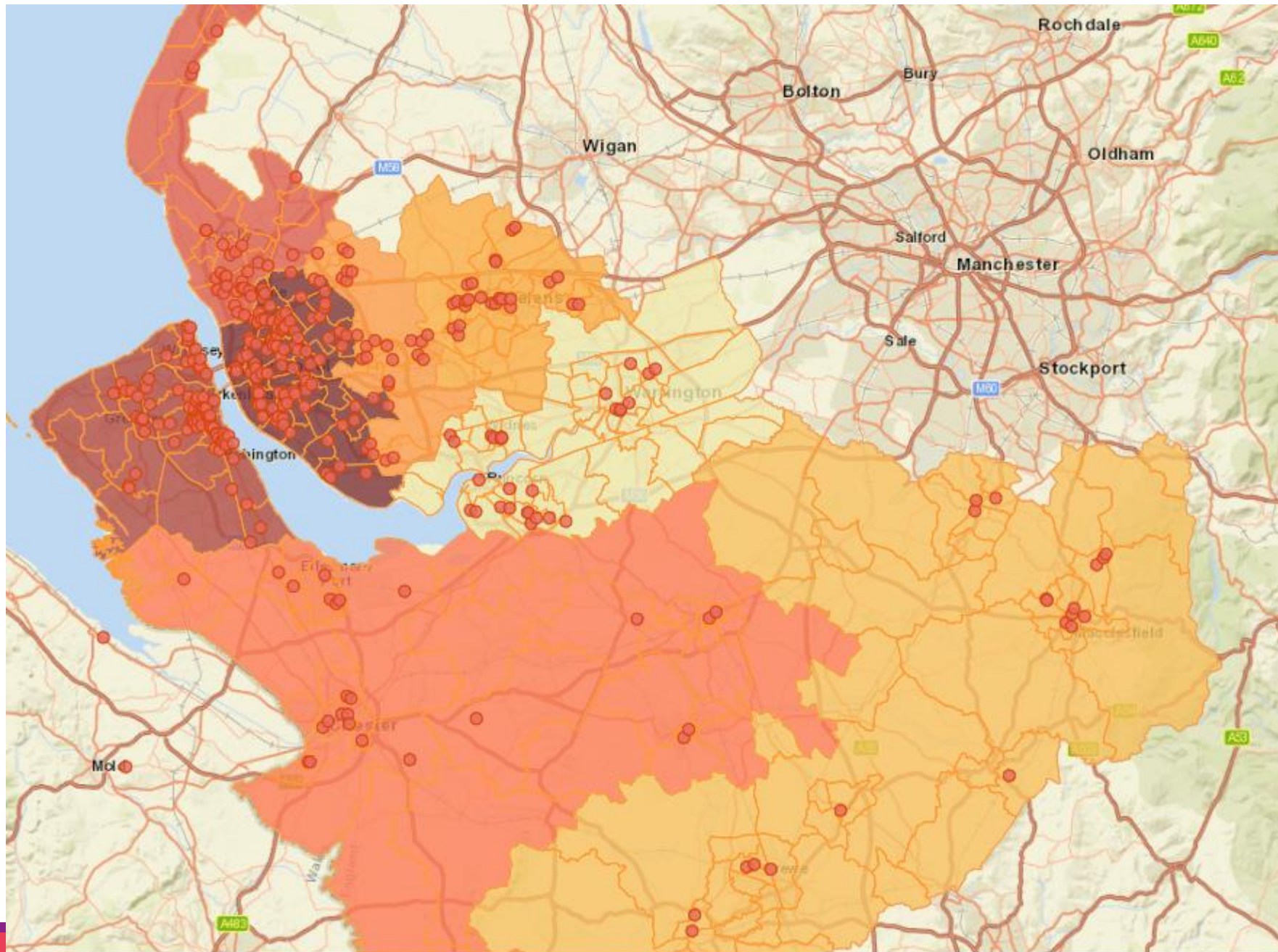
# Caveats with 2019 data

- Impact of Covid-19 pandemic has affected coroner data, both because access to the offices is restricted and inquests have not yet been completed. 2 main outcomes:
  - Significant delay in receiving cause of death for individuals in treatment
  - Significant delay in receiving details on DRDs outside of the treatment system



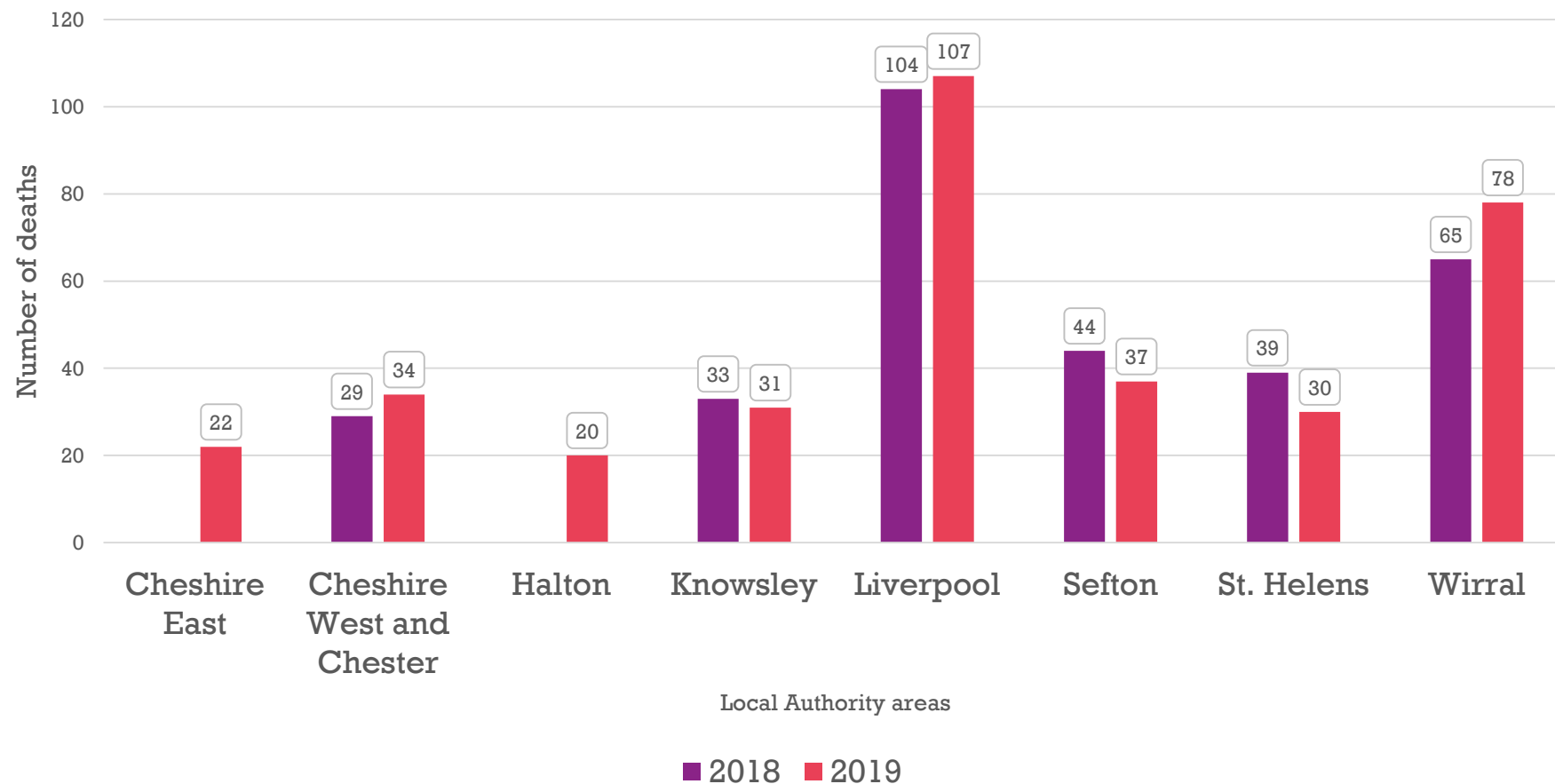
# Cheshire and Merseyside drug poisoning deaths, 1993-2019



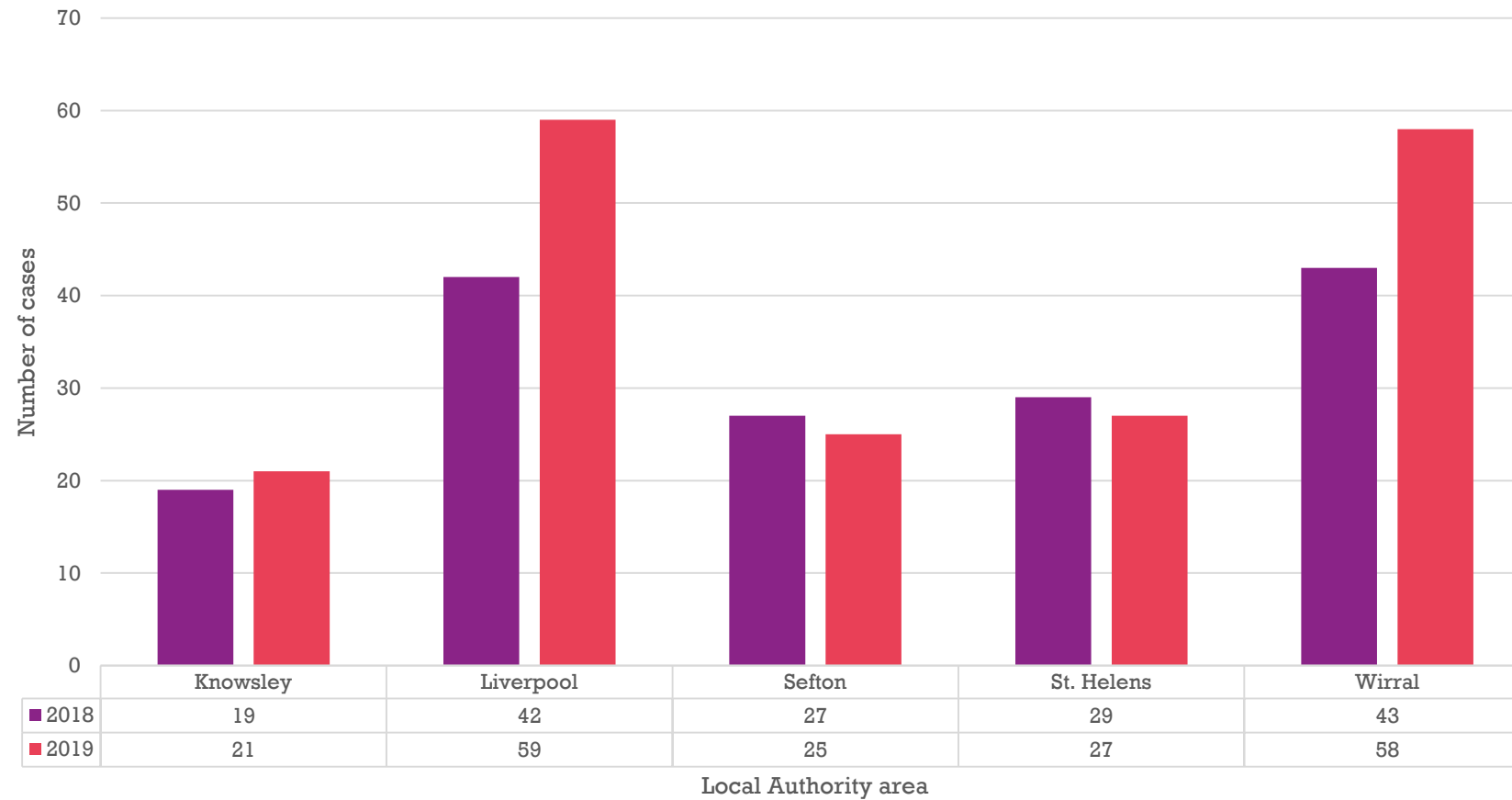


Location of deaths  
across Cheshire  
and Merseyside,  
2019

## Number of deaths reported to system by Local Authority, 2018-19



## In treatment deaths by local authority, 2018 and 2019



■ 2018 ■ 2019

### In treatment cause of death, Liverpool, 2018

Cause of death	Count
Natural causes	18
Mixed drug toxicity	12
Unknown	3
Opiate toxicity	2
COPD	2
Cancer	2
Alcohol toxicity	2
Head/brain injury	1

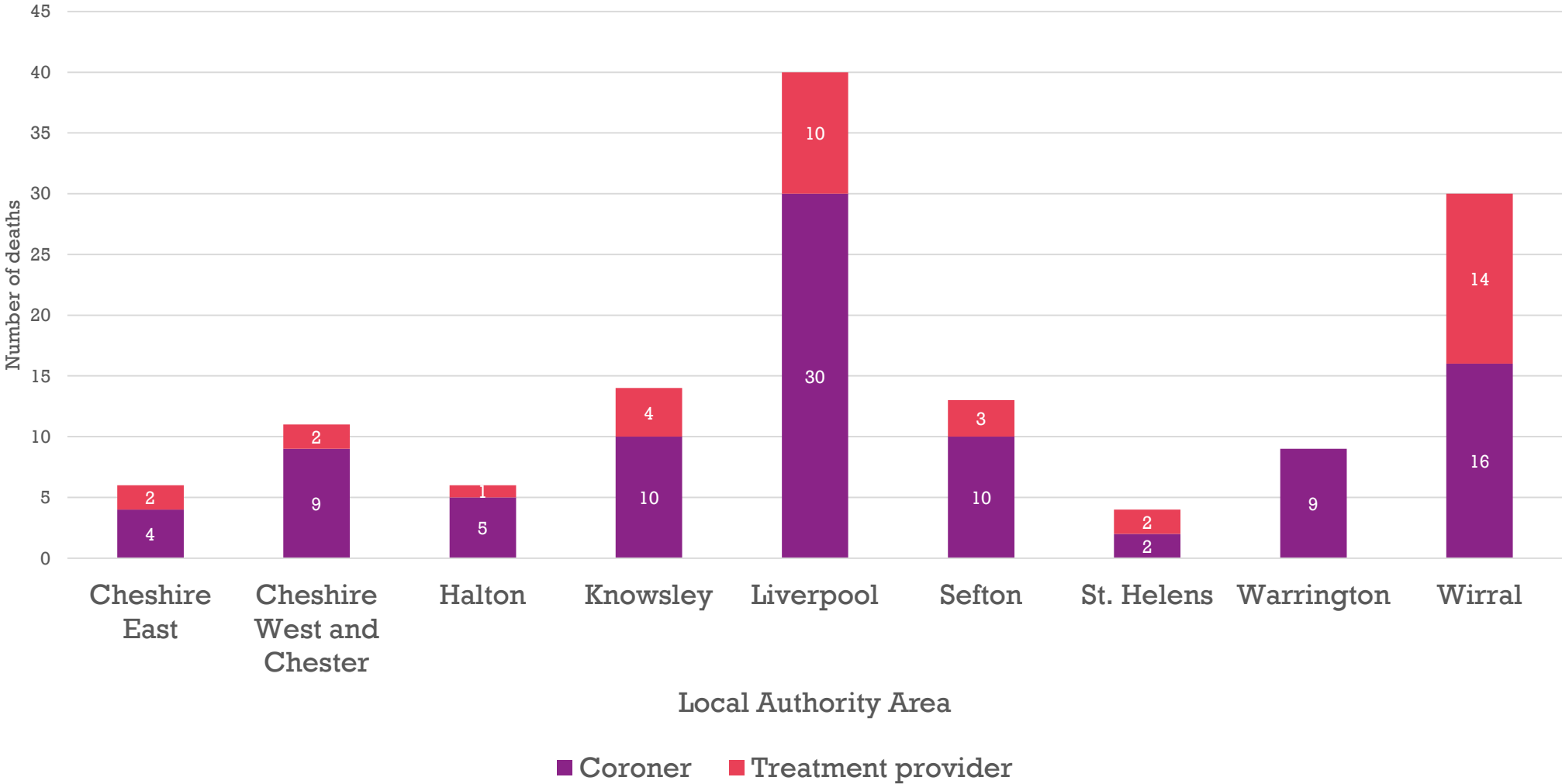
### Coroner only cause of death, Liverpool, 2018

Cause of death	Count
Mixed drug toxicity	21
Cocaine toxicity	10
Alcohol toxicity	10
Opiate toxicity	7
Other drug toxicity	4
Natural causes	3
Liver failure	3
Head/brain injury	1
COPD	1
Other	1

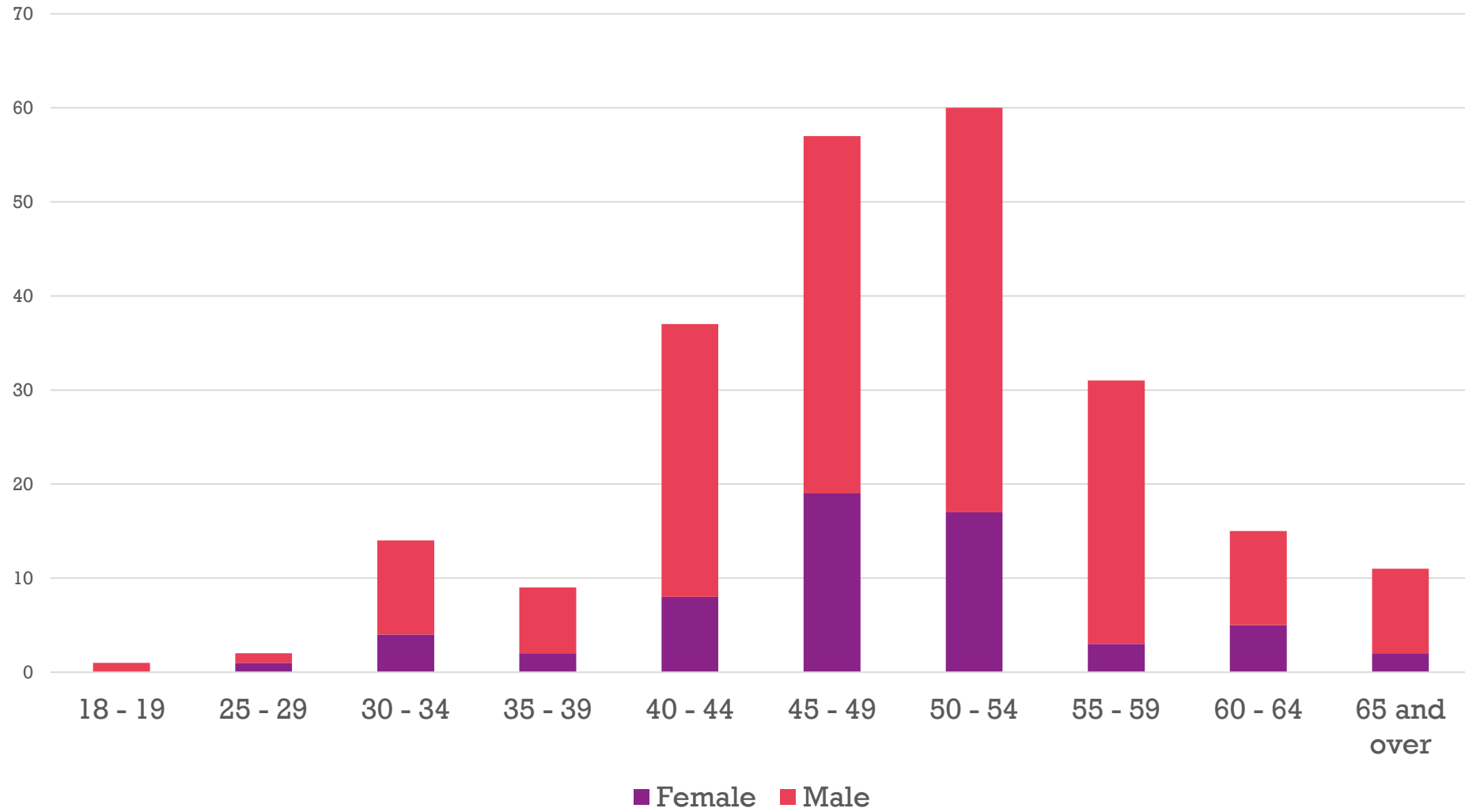
|  
Local Authority area

■ 2018 ■ 2019

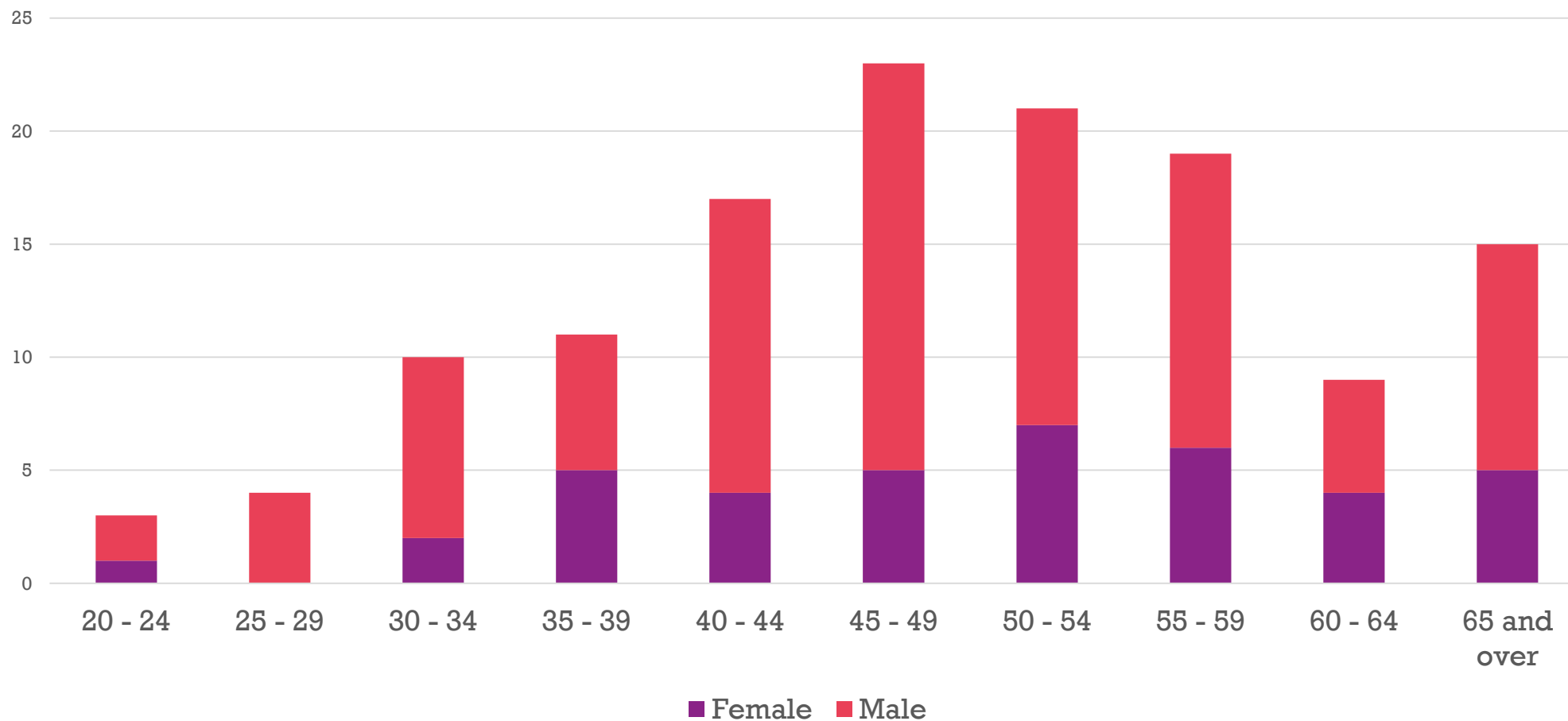
# Overdose deaths (includes alcohol toxicity) by local authority, 2019



## In treatment deaths, by age and gender, C&M - 2019

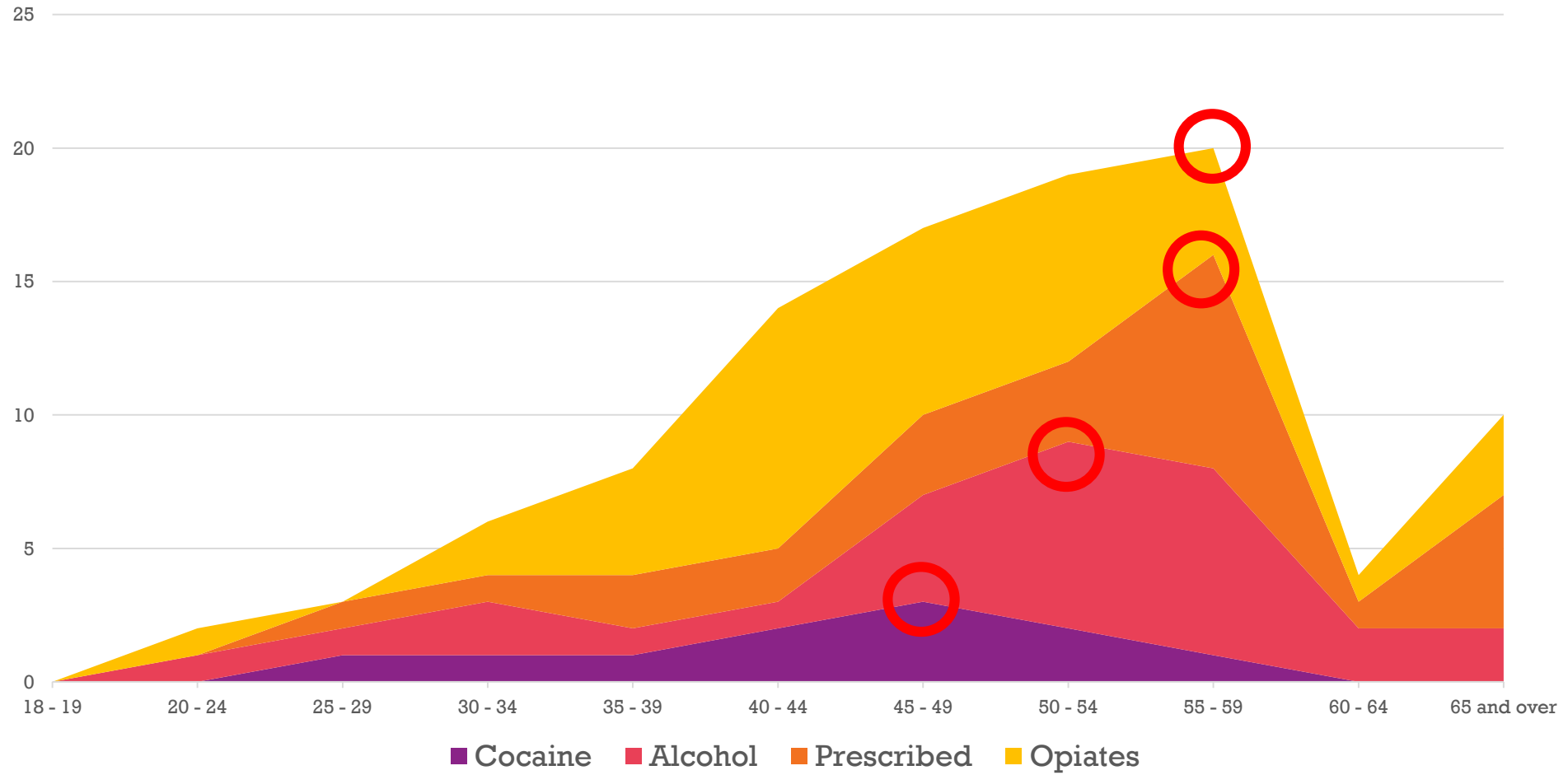


## Coroner reported deaths, by age and gender, C&M - 2019

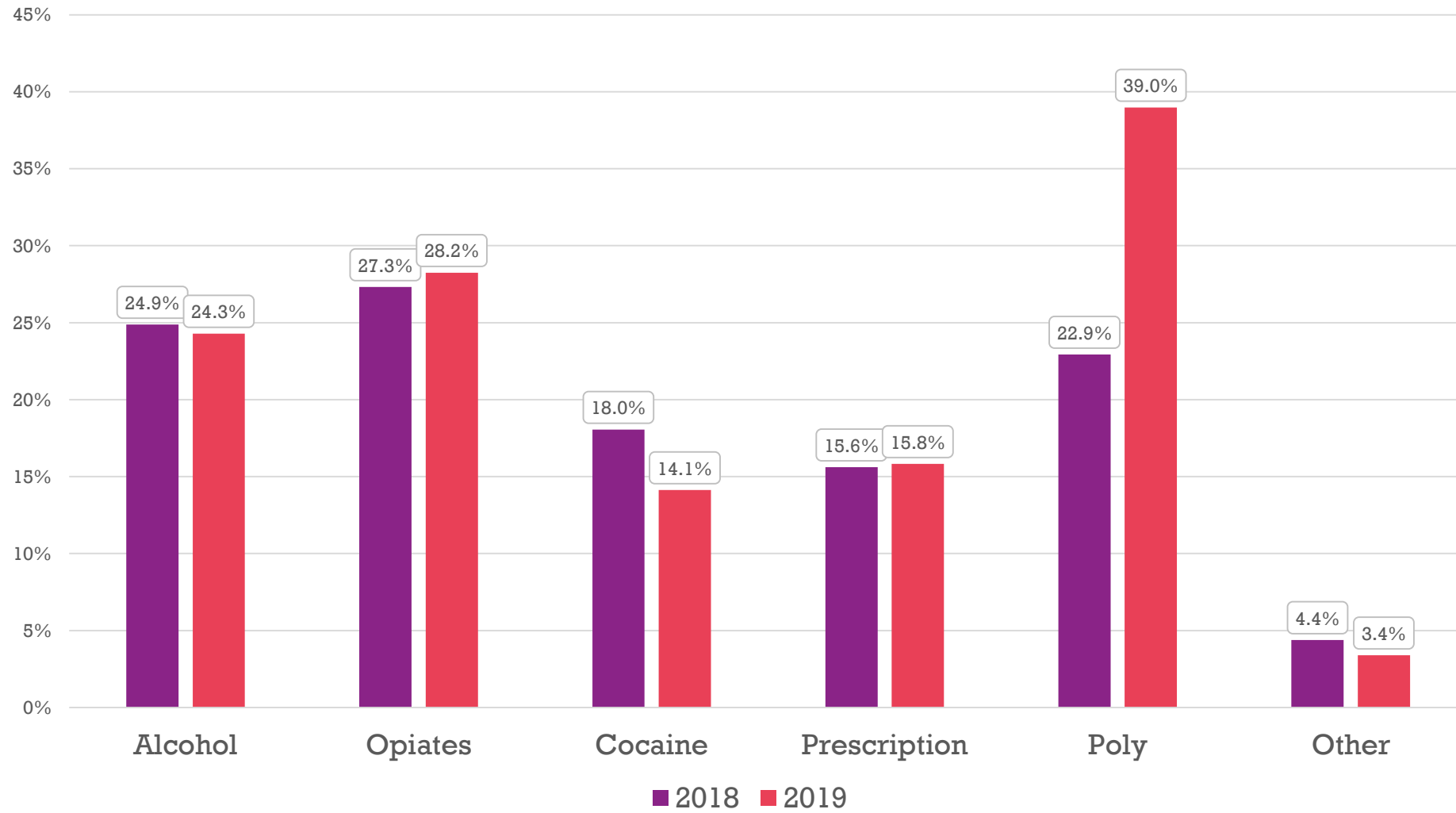




## Age of death by implicated substance, C&M 2019



## Implicated substances by coroner, C&M, 2018-19



## Controlled medication implicated in death, 2018/2019



## Changes in medication being prescribed, C&M, change from 2018 to 2019

Medication	Increase in prescribing	Medication	Decrease in prescribing
Paracetamol	184%	Co-codamol/Codeine	-52%
Quetiapine	153%	Olanzapine	-48%
Ramipril	127%	Amitriptyline	-37%
Propranolol	112%	Pregabalin	-32%
Sertraline	52%	Vitamin B	-31%

**Medications prescribed at time of death:**

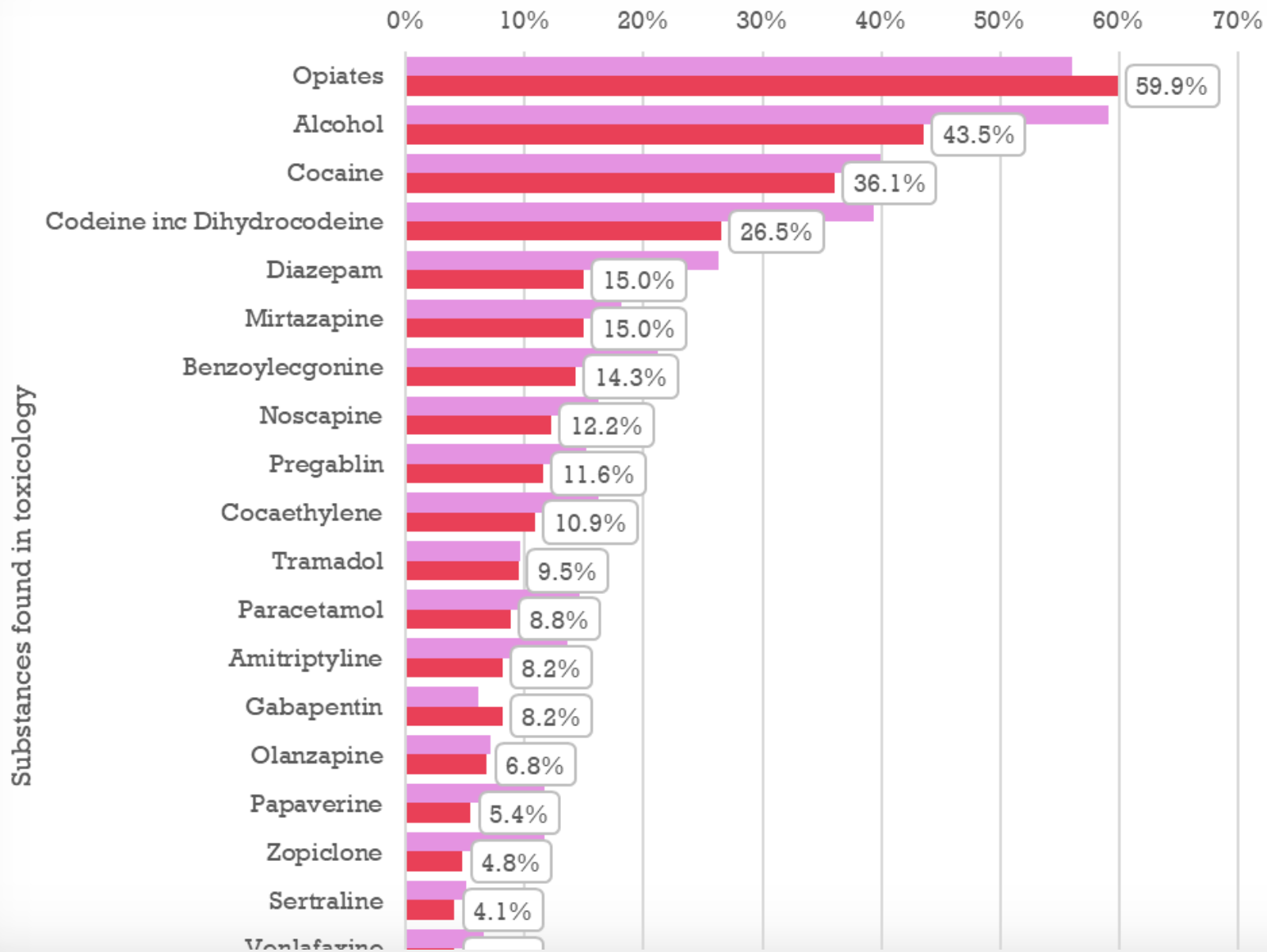
- Methadone 70mg
- Co-amoxiclav 250mg/125mg tablets - One To Be Taken Three Times A Day;
- Ferrous fumarate 210mg tablets - One To Be Taken Each Day; Folic acid 5mg tablets - One To Be Taken Each Day;
- Oramorph 10mg/5ml oral solution - 2.5-5ml every 4-6 hours as needed;
- Cyclizine 50mg tablets - One To Be Taken Up To Three Times A Day;
- Ensure Plus milkshake style liquid - one BD;
- Laxido Orange oral powder sachets sugar free - 1-3 sachets as needed per Day;
- Morphgesic SR 10mg tablets - One To Be Taken Every 12 Hours;
- Levothyroxine sodium 100microgram tablets - One To Be Taken Each Morning At Least 30 Minutes Before Breakfast, Caffeine-containing Drinks Or Other Medication;
- Carbocisteine 375mg capsules - Two To Be Taken Twice A Day;
- Uniphyllin Continus 200mg tablets - One To Be Taken Twice A Day;
- Fostair 100micrograms/dose / 6micrograms/dose inhaler - Two Puffs To Be Inhaled Twice A Day;
- Braltus 10microgram inhalation powder capsules with Zonda inhaler - Inhale The Contents Of One Capsule Once Daily, At The Same Time Of Day;
- Amitriptyline 25mg tablets - ONE AT NIGHT; Salbutamol 100micrograms/dose inhaler - 2 PUFFS AS REQUIRED.

**Past psychiatric status:**  
Divorced

No known previous contact with mental health service

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shire &

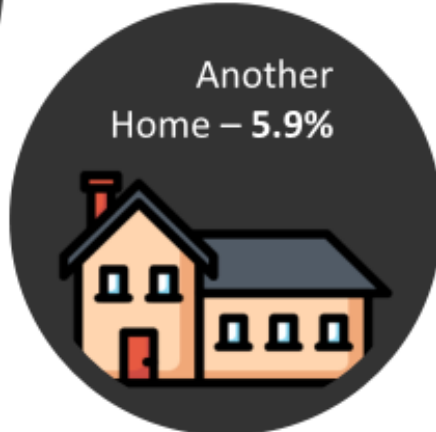
## Substances found in toxicology results, 2018-19



Own Home – 62.2%



Another Home – 5.9%



Hospital – 22.9%



Place of death: in treatment cases, 2019

Outdoors – 3.7%



Hostel\* -4.3%



Single –  
**67.3%**

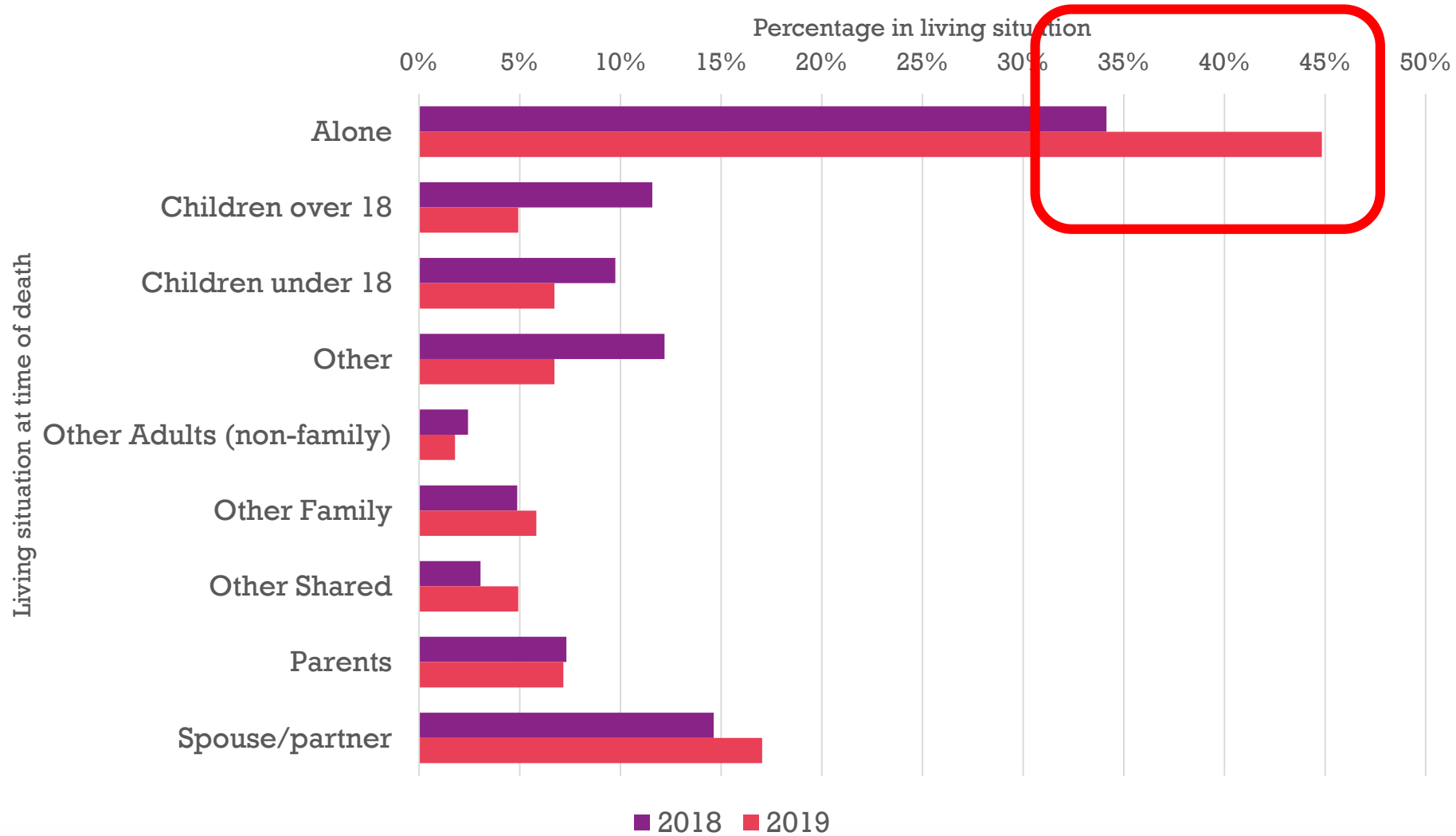


In relationship/married – **26.8%**

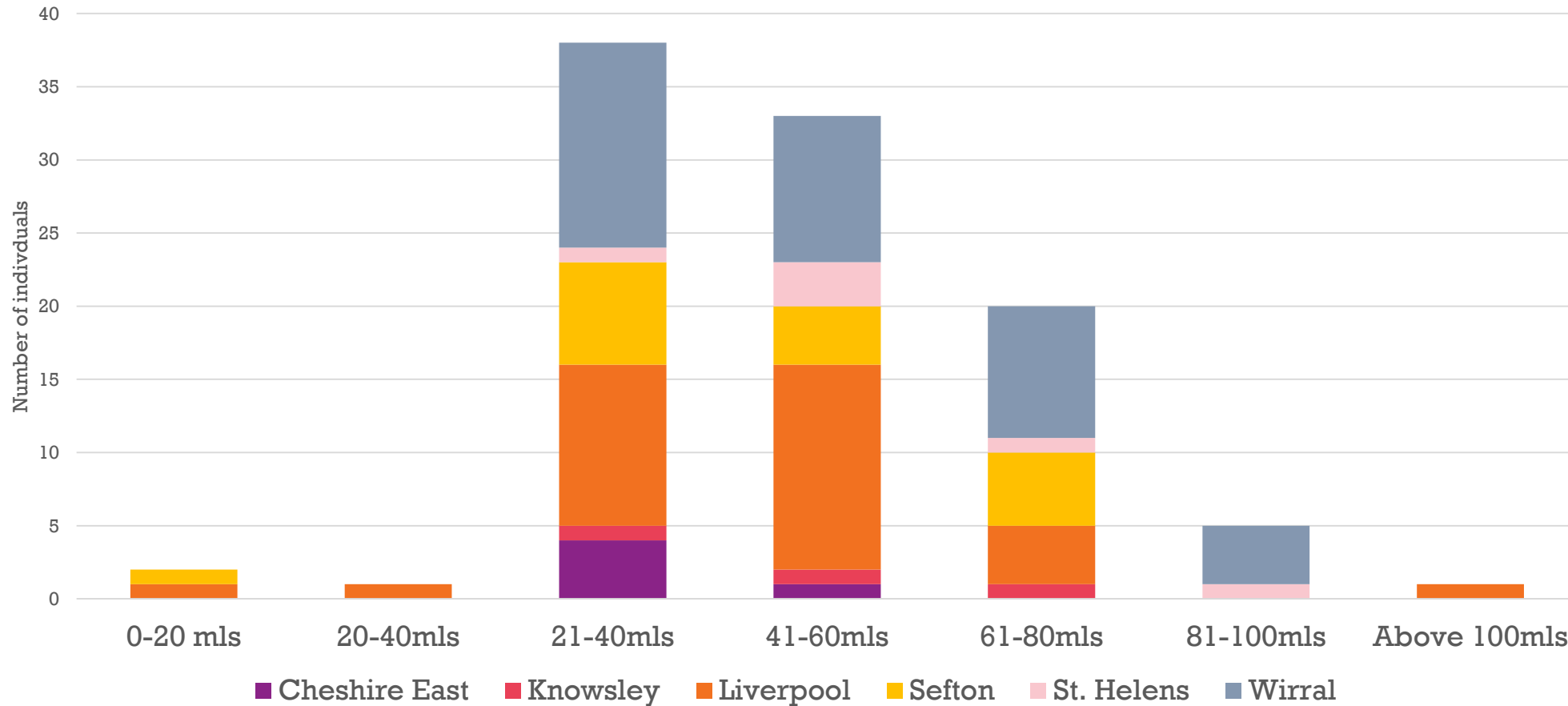
Separated/  
divorced/  
widowed –  
**5.9%**



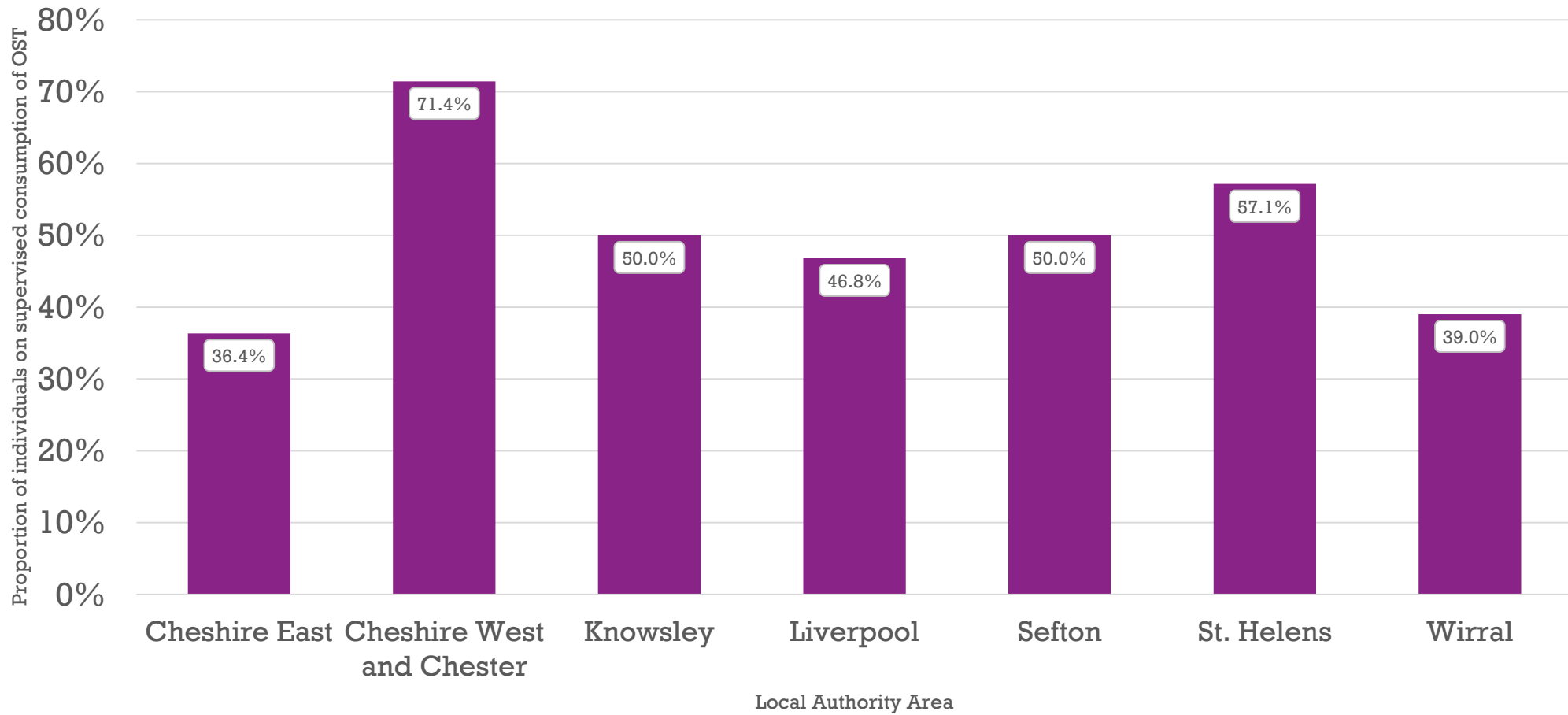
## Living situation, in treatment deaths, all areas, 2018/2019



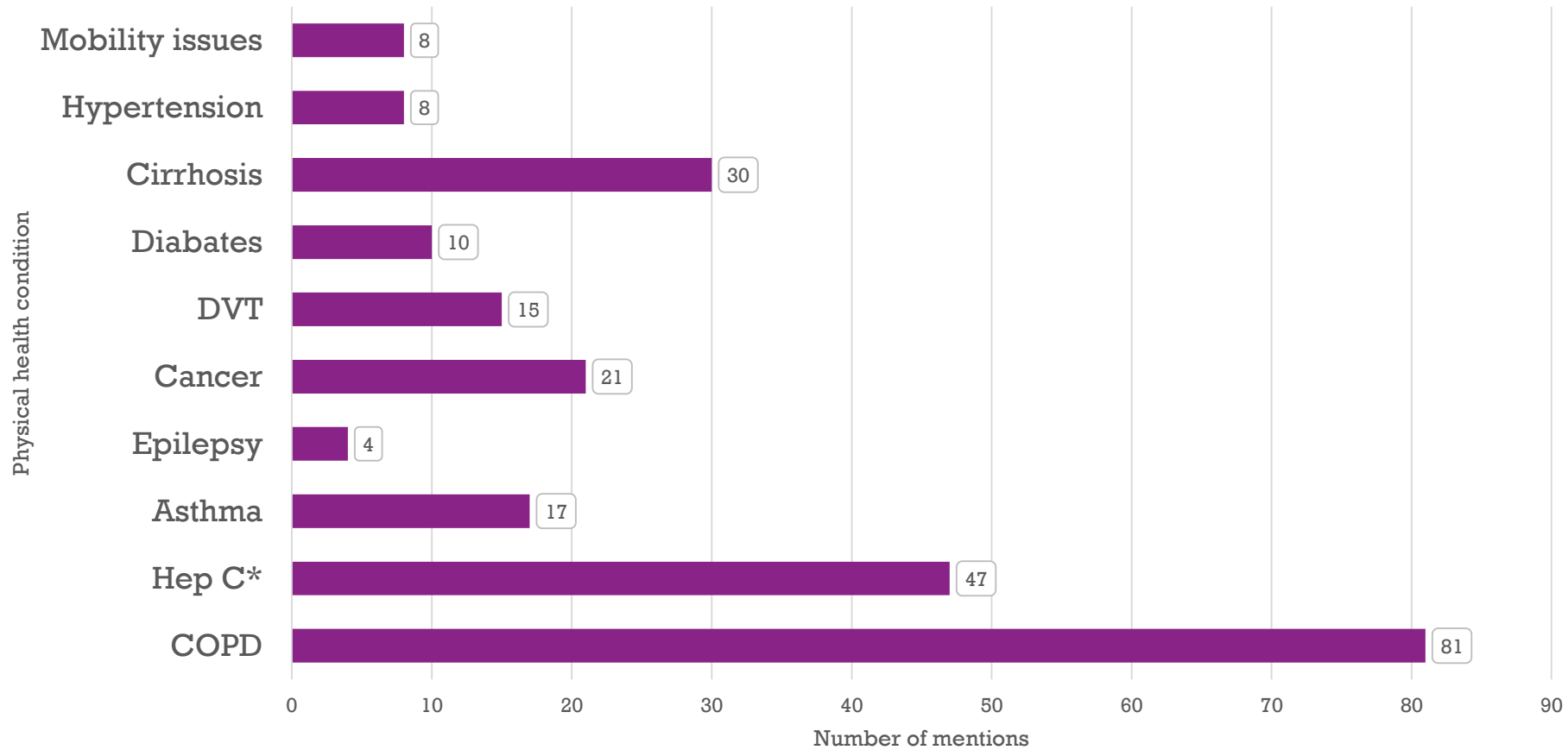
## Amount of methadone prescribed (mg), by local authority, 2019



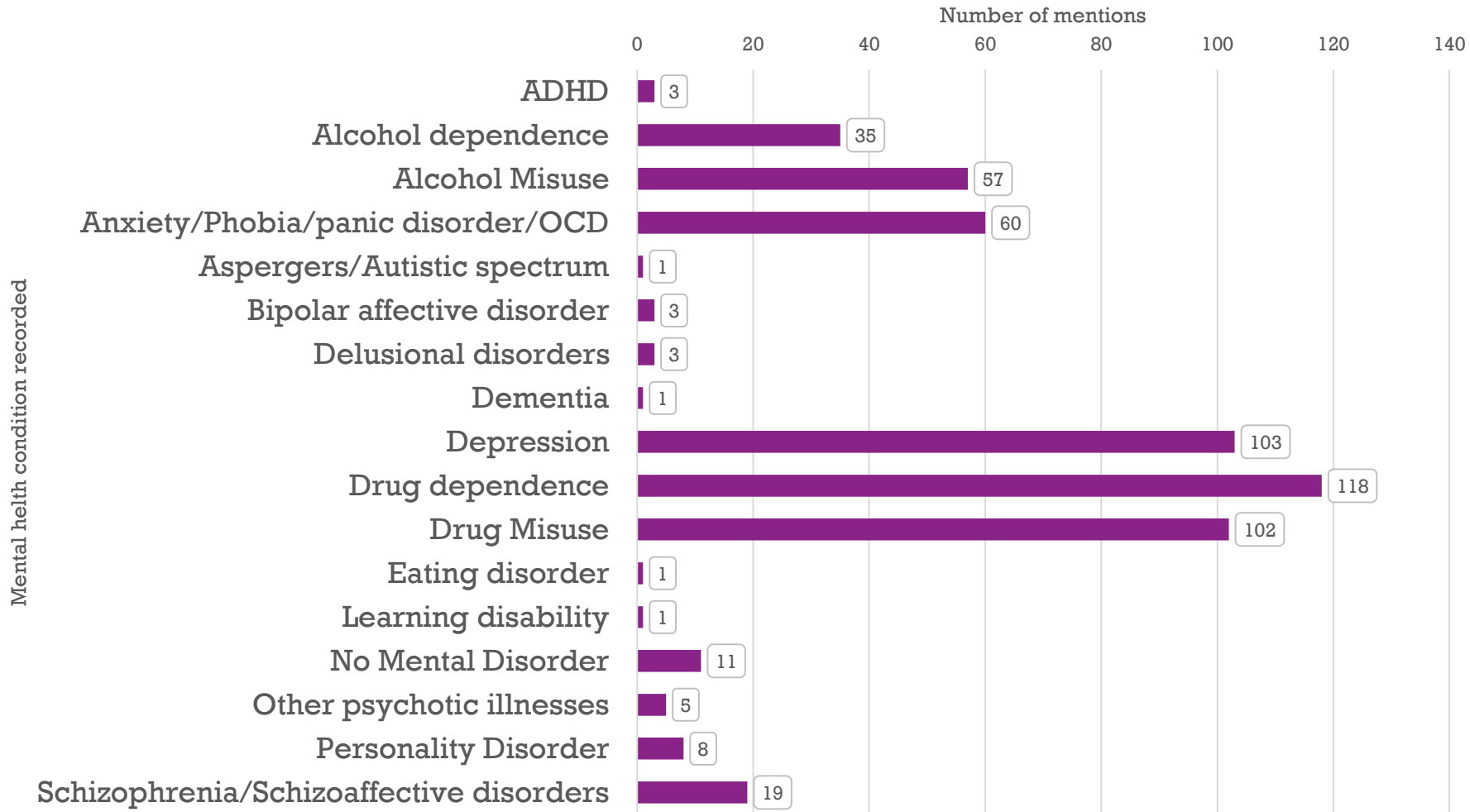
## Proportion of individuals on supervised consumption of OST, 2019



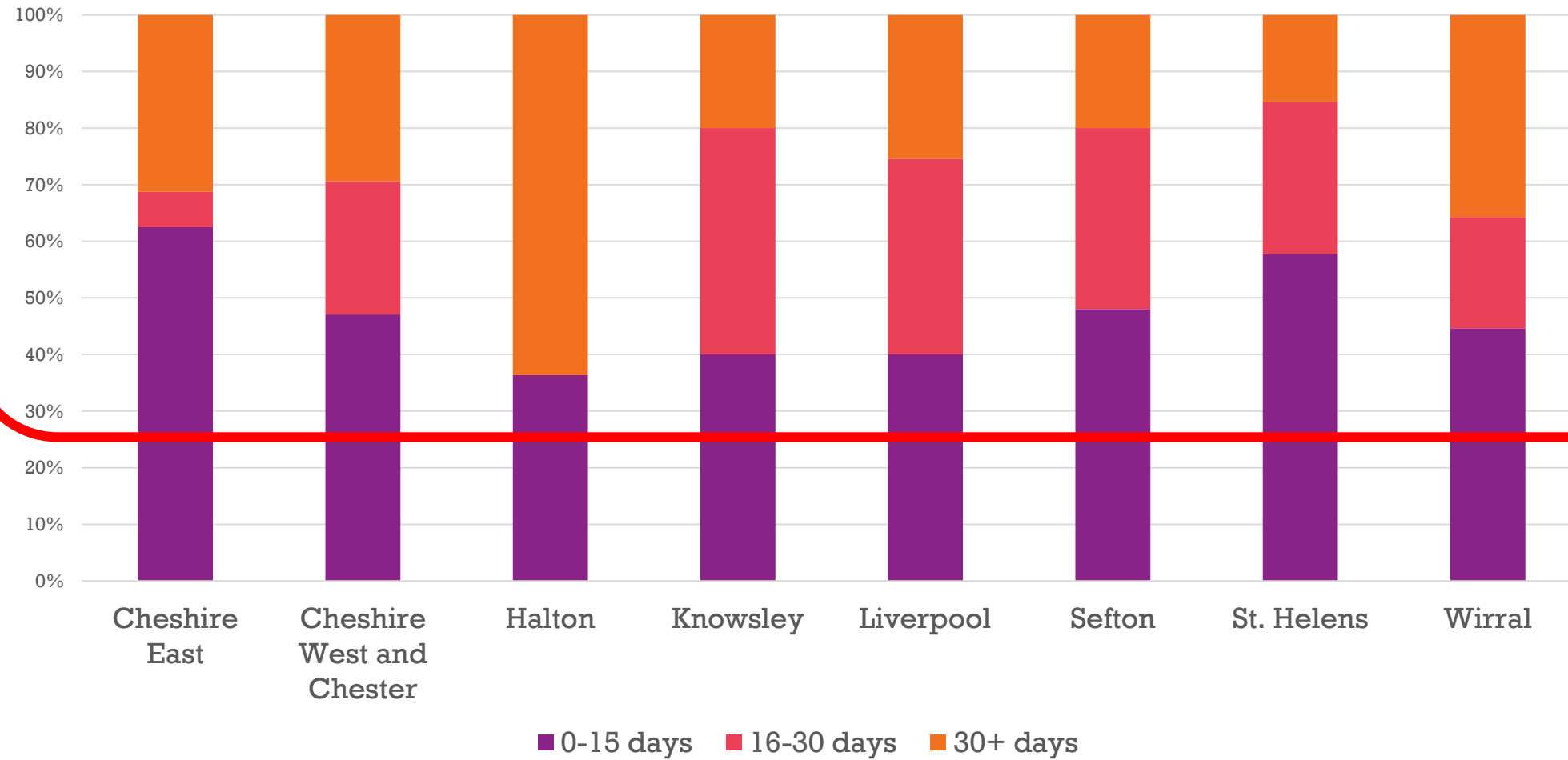
## Physical health conditions noted, in treatment deaths, Cheshire and Merseyside, 2019



Mental/substance use health conditions noted, Cheshire and Merseyside, 2019

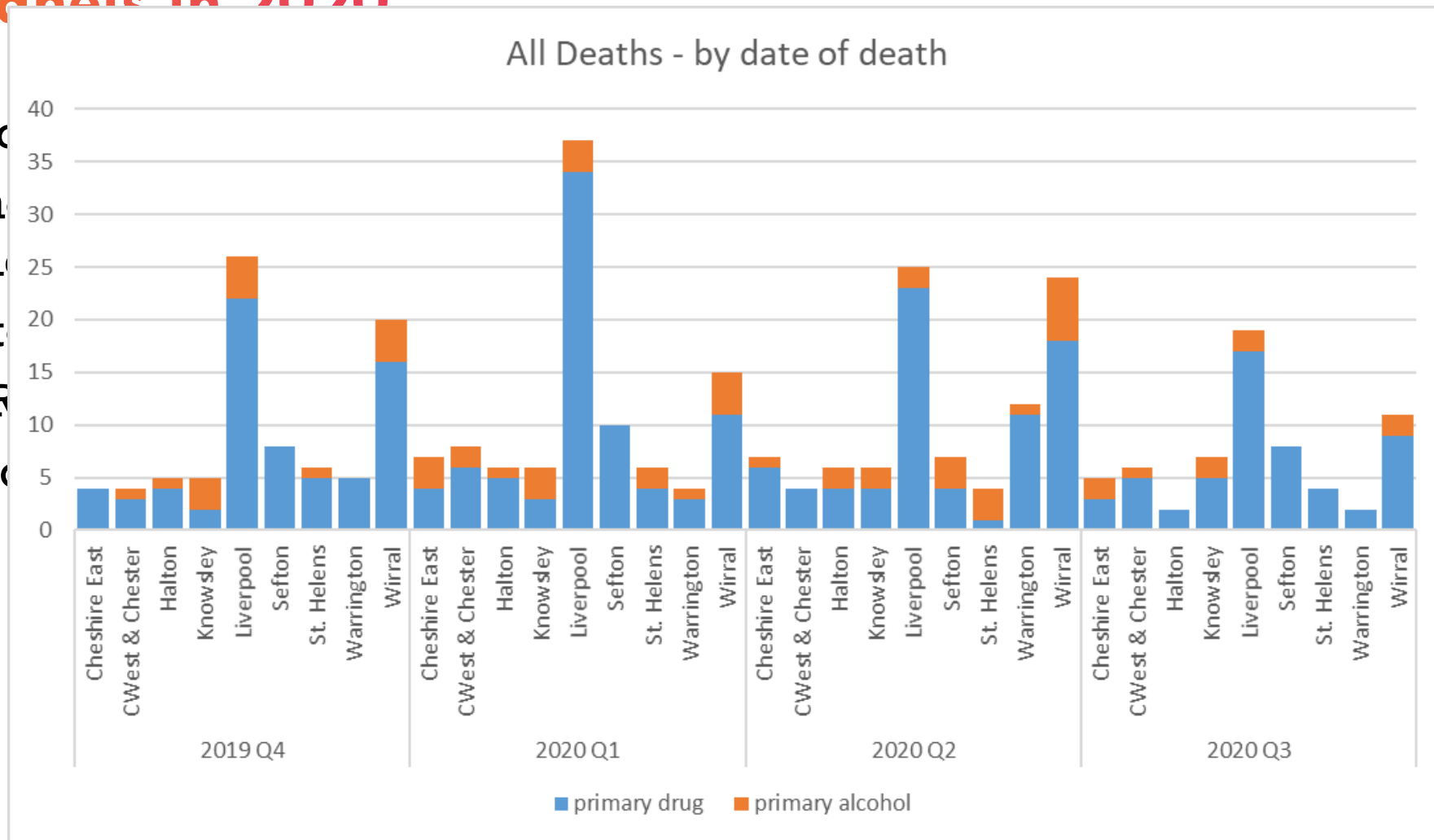


## Days between DOD and last date of contact with treatment service, C&M deaths, 2019



# DRD panels in 2020

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- Liverpool 2020



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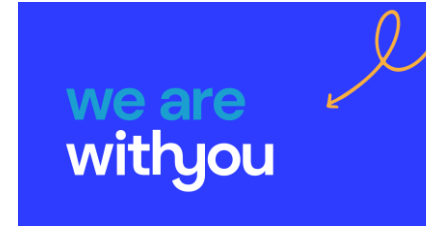
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## DRD panels in 2020: Main themes discussed

- Disconnect between treatment providers and mental health services.
- Issue of large back payments from DWP.
- Hospitals not sharing discharge summaries with treatment providers.
- Bereavement support for both family/friends and staff.
- Access to Naloxone for individuals not in treatment.
- How to keep individuals living alone safe.
- How can services reach hazardous/harmful drinkers.
- How can we make terminally ill service users comfortable?
- Pathways for pain management and contraindicating prescribing.
- Support for individuals in custody after end of sentence.
- Engagement of individuals through COVID-19.



# Thank you to commissioners and partners



and many different NHS, third sector and other organisations who have contributed to panels throughout the last year