INTRODUCTION

Drug-related deaths (DRDs) - major mortality cause in Europe. Mortality trends vary between countries. Opioids present in all DRDs. Proportion of all DRDs occurs in context of polydrug use. Suicide is often linked to use. Complex patterns revealed in some epidemiological studies, including methodological & more rarely, biological explanations. Evidence of deaths from prescribed opiate analgesics remains limited, most EDs in Europe linked to synthetic opioids e.g. illegally produced methadone. Close monitoring of changes in drug trends - associated with availability of licit opioids, illicit use of newly available opioids. Evidence of deaths from prescribed opioid analgesics present in majority of DRDs. Substantial numbers of opioid deaths in those aged under 65. In the UK, evidence points to increased risk for those aged under 65. The majority of DRDs occur in younger people, 11% of deaths occurring in under 25s. At odds with opioid-related OD in older adults. DRDs more likely to occur in younger people (11% of deaths occurred in under 25s). Some young people at risk of OD due to lack of experience & insufficient access to appropriate emergency services, as well as increased incidence of certain drugs such as fentanyl. Migrants / Refugees: Are often aware of serious situations & may have difficulties accessing & engaging with health professionals. Roma populations: Are widely discriminated against throughout Europe. Such marginalisation makes them less likely to access services & treatment - potentially a protective factor. Equally, drug problems likely to be hidden in such families & PUDs in Roma families not encouraged to seek treatment. Research and mapping undertaken by: Danny Morris, Neil Hunt. Report Author: Gill Bradbury

METHODOLOGY

Scotand, Denmark, Italy, Spain, Estonia & Lithuania

MODELS OF COMMUNITY AND PEER-BASED OVERDOSE PREVENTION SERVICES

CONTEXT

HAMPIES: People at particular risk of OD & DRDs - Loss of a close relative due to OD or DRD. Family members often further marginalized. Patterns of drug-taking behaviour may be more dangerous due to environmental conditions - using alone in unsanitary public places. People living with HIV & TB: Generally have poorer health & some illicit drugs can interact with antiretroviral & TB medications; this makes people more susceptible to OD due to compromised physical health & medication interacions. People involved in sex work: This is a group of highly vulnerable people who may not access services unless specifically targeted. Increased efforts needed to engage this population in drug services & overdose prevention programmes. Prisoners: Risk of dying from OD greatly increases in periods immediately after release from prison, due to high rates of relapse & lower opioid tolerance. This is a critical time for action, when ensuring continuity of care & targeted interventions can both support treatment engagement & save lives.

RECOMMENDATIONS & CONCLUSIONS

To influence national policy, important to provide strong evidence base to support development of programmes. Effective systems for robust data collection, monitoring & notification are required to better monitor national & EU standards & definitions & consistently used criteria for identifying DRDs & specifically, opioid-related OD. Should include reliable methods for collection of overdose data, ambulance attendances & emergency services interventions - to identify fatal & non-fatal OD - to inform local service planning. Essential is accurate & quality assurance of data. In absence of all, those who might witness an OD be required to call emergency medical services. Many fail to do so because of hours of prosecution. Police forces & ambulances services should be trained to reissue review policy of police present at OD scenes. Require open discussion of legimitates concerns, inter-agency partnerships & local agreements on best practice in primary intention of public health. People admitted to hospital following OD should be routinely observed with OD prevention ICUs, alongside details of drug treatment & harm reduction services. Ambulance staff should also carry this info to distribute to people who OD & any witnesses of the scene. Drug-related deaths should be able to provide a rapid response to those seeking support following an OD.

FINDINGS

SCOTLAND

2011: 584 DRDs – More from methadone than heroin.

Peer education model: Peer-led training – Harm reduction, MOP, drug treatment & peer support.

Brief Interventions (BI) model of training – Takes 10-12 minutes.

BI model improves credibility & uptake.

Due to reasons other than drug use, interventions tailored to individual needs.

More through basic life support training undertaken if required.

Peer-led & group therapy increases cohesion & morale.

OD death: Peer-led training is effective & efficient when delivered in close cooperation with local drug treatment programs – as supported by various international initiatives.

Training of peers: Half-day drugs awareness then, two days - OD prevention & management in detox units; harm reduction services; Protocols.

Service must actively support survivors in addiction activity. Peer networks established & linked to local Coordinators from each Health Board. Volunteer Training & Support Officer participates in monthly meeting with group.

Peer trainers, with local coordinator, trained pharmacists. This increased individual credibility & enabled same peers to deliver training in pharmacies.

Handbags: each peer gets handbag with naloxone & other good practice for peers to train peers, while bags only have supply THN.

20 peers trained at all levels of planning & implementation of OD programmes.

Peer engagement has additional benefit in reducing stigma & discrimination – drives professionals to appropriate commitment & skills that peers bring.

DENMARK

2011: 265 DRDs.

City of Copenhagen collaborated with Danish Drug Users Union (DDU) – equal participation of all partners in OD prevention & management.

DDU involved in planning & development.

Project’s main objectives: To determine context & structure of OD prevention course & how to deliver training programmes.

Ongoing training, support & definition also provided by DDU.

2010: DDU established one-year pilot project – OD death in one Danish municipality in order to assess feasibility for wider scale-up.

City of Copenhagen funded Health Centre to educate peers (paid DDU Therapeutics to respond to OD.

20 peers trained to respond to All – Allocated several doses of naloxone to use in community.

14 ODs reversed in 10-month.

Copenhagen demonstrated simple, sustainable way to prevent ODs in Denmark, in current models.

Project shows OD prevention is effective & efficient when delivered in close cooperation with local drug treatment program via peer-led approach – as supported by various international initiatives.

"There are no plans for naloxone distribution, overdose education is not routine within services. We do however discuss overdose vulnerabilities – maybe through OPAS, however, or other means. but we are not yet registered as such as we believe access is good, and it is well supervised."

Dr. Emils Subata, Virenus Centre for Addictive Disorders, WW Collaborative Centre for Harm Reduction

2011: 123 deaths - Highest rate of OD deaths in Europe.

Opioids, mainly 3-methadone (95% of deaths where results known, 584 DRDs in 2011: 285 DRDs.

DDU involved in planning & development.

Project’s main objectives: To determine context & structure of OD prevention course & how to deliver training programmes.

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"Involving people who use drugs increases access to environments which are otherwise closed to professionals – thereby enhancing access to people who may not be involved with treatment services..."