Written evidence from the Collaborative Centre for Inclusion Health and Find & Treat

Joint response from the Collaborative Centre for Inclusion Health, UCL (https://www.ucl.ac.uk/inclusion-health) and Find & Treat, University College London Hospitals NHS Foundation Trust (https://www.uclh.nhs.uk/ourservices/servicea-z/htd/pages/mxu.aspx).

Background

About us

1. The Collaborative Centre for Inclusion Health is a research group at UCL that aims to improve the health of vulnerable groups. We recently published research showing that the mortality rate among homeless people, people who are dependent on drugs, sex workers, and prisoners is ten times the general population.

2. Find & Treat is an outreach service that works alongside over 200 NHS and third sector services to improve health outcomes for homeless people, drugs and alcohol users, vulnerable migrants and people who have been in prison. The service reaches over 8,000 people a year, screening for diseases such as tuberculosis and hepatitis C and providing multidisciplinary, community based treatment. A high proportion of those engaged are rough sleeping, use drugs and are not engaging with health and harm minimisation services.

3. We focus on people who are dependent on illicit drugs or use drugs that are closely associated with dependence. In the UK, the majority of this group uses heroin or crack cocaine, though alcohol, cannabis and polysubstance use are common.

Importance of health inclusion

4. People who use heroin and crack cocaine are a relatively small group (the most recent estimates suggest 300,000 in England), but account for a large proportion of drug-related disease and crime. Drug use in this group usually follows adverse childhood experiences and other family problems. A high proportion of people who use heroin and crack have experience of prison, particularly those who are homeless. Use of illicit drugs in this group is different to the larger numbers of people who smoke cannabis occasionally or use drugs such as ecstasy and cocaine recreationally. Among people who use heroin and crack cocaine, the course of drug use is typically long (often decades). The motivation for drug use is mainly self-medication for untreated mental health problems or to prevent withdrawal.

5. There is a common narrative that people who use heroin and crack are a shrinking and ageing group with few new initiates. This is supported by reducing numbers entering treatment, with an older average age. However, there is some emerging evidence that there may be a new, younger cohort that has not yet presented to services. In our work with homeless people, we have noticed increasing numbers of young homeless people using drugs. Our recent study of hospital admissions for injecting-related soft tissue infections showed increasing numbers in all age
groups, including those aged 16-34. We are planning further work to understand recent trends in younger drug users.

**Health and harms**

- Most excess deaths among people who use drugs are caused by common diseases such as cancer. The main causes are likely to be smoking, homelessness, poor nutrition and lack of access to primary and preventative care (rather than the direct harms of drugs).
- Many of the excess deaths are avoidable through standard medical care.

6. People who use heroin and crack cocaine have poor health outcomes. This has been shown in many studies that recruit people who use drugs, follow them for a number of years and compare the risk of death to the general population. In the UK, people who have had at least one episode of treatment for heroin or crack dependence have 6 times the risk of death when compared to the general population.

7. There are relatively few studies on causes of death, but existing data shows that drug-related deaths (such as those caused by drug overdoses) are a minority. Although drug-related deaths have received a lot of attention in recent years due to an increase between 2012 and 2015, the number of people who use drugs who died due to any cause is unknown because drug use is not recorded on death certificates (except where drugs were the direct cause of death).

8. Studies that link data from services working with drug users to mortality data can show the full spectrum of causes of death. We have used this method to identify causes of death in a cohort of people who use heroin and crack cocaine, identified by a drug treatment service in South London. Figure 1 represents all deaths in this cohort, and also shows the risk ratio for each cause compared to the general population. Although ‘drug related’ deaths are the largest single group, they only represent about one third of deaths. Liver disease, COPD and accidents (other than overdose) are also important. The risk of death in every disease group is raised.
9. A significant component of the poor health outcomes among people who use drugs relates to poverty, adverse childhood experiences, homelessness, tobacco smoking and lack of access to services, rather than the direct effect of drugs. Hospital admissions data from the cohort in South London also highlight the importance of mental health problems, skin infections and head injuries, which have also been shown Scottish data. Many of these hospital admissions are entirely preventable (such as head injuries) or could be avoided through better medical care (such as chronic obstructive pulmonary disease).

10. When mortality and hospital data are compared, some important patterns emerge. For example, people who use heroin and crack cocaine have double the risk of death due to cancers, but are only half as likely as the general population to be admitted to hospital for treatment of cancer. The reasons for this are not yet clear, but are likely to relate to poor access and engagement with mainstream diagnostic and treatment services.

### Prevention and early intervention

- Use of heroin and crack is primarily a result of poverty, mediated by adverse childhood experiences and availability of drugs.

- Opiates are often used for many years, because they are used to self-medicate untreated mental health problems, and because addiction is difficult to overcome.

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* The figure represents causes of death in a cohort of 7844 people with at least one episode of treatment for heroin and/or crack cocaine dependence at South London and Maudsley NHS Foundation Trust, over a mean 7.3 years of follow-up. 679 deaths occurred. ‘Exp’ = number of expected deaths, given the age and sex of the cohort. ‘Ratio’ = the standardised mortality ratio, or the actual / expected deaths. ‘CVD’ = cardiovascular disease. ‘IHD’ = ischaemic heart disease. ‘COPD’ = chronic obstructive pulmonary disease (lung disease).
11. Most of our work relates to vulnerable groups who are already experiencing severe health problems. The common denominator in this group is adverse childhood experiences. Many people who use heroin and crack cocaine were excluded from mainstream education, kicked out of home, have experienced abuse or neglect, or have other traumatic experiences. Research has found that these experiences are strong risk factors for drug use\(^\text{11}\). Adverse childhood experiences are in turn strongly associated with poverty. We are currently conducting research that shows higher rates of child abuse and neglect, household adversity and knife crime in deprived areas. Factors contributing to initiation of drug use include drug use in social networks and availability of drugs (anecdotal evidence suggests fewer initiates during the ‘heroin drought’ of 2010-12).

12. People who become dependent on drugs are often self-medicating untreated mental health problems. Our data on hospital admissions shows that people who use heroin and crack cocaine are 250 times more likely to be admitted to hospital for treatment of psychosis, depression or personality disorder than the general population. Mental health problems are therefore an important factor in the sustained use of drugs. Homelessness also makes it more difficult to stop using drugs, due to the adversity of the situation, difficulty of engaging with treatment regimes, and lack of a safe environment to transition from heroin to substitute drugs. Finally, opiate withdrawal symptoms mean that cessation is extremely difficult once someone is dependent, and several doses per day may be required to prevent withdrawal.

13. There is limited evidence on the effectiveness of strategies to prevent initiation of drug use. Any effective strategy would need to address early life adversity, child poverty, and homelessness.

**Treatment and harm reduction**

- Drug harm reduction services are among the most effective and cost-effective public health interventions, but are being disproportionately affected by funding cuts.
- People who use heroin and crack have poor access to the NHS.
- There is a need for funding for programmes that improve linkage between the NHS and key services that work with vulnerable groups, particularly drug treatment services and prisons.

14. Harm reduction interventions have a strong evidence base. Needle exchanges, opiate substitution (such as methadone) and naloxone (an antidote to overdosing) distributed in the community can prevent deaths and save money\(^\text{12–15}\). These services have a successful history and have, for example, kept HIV rates comparatively low in this population.

15. Cuts to the government’s public health grant to local government have fallen disproportionately on these services, with an estimated £162m from 2013/14 to 2017/18\(^\text{16}\). Case studies have found cuts of up to 33%\(^\text{17}\), with further cuts planned. The impact of these cuts on local services such as needle and syringe programmes is largely unknown, as local availability is not recorded systematically.

16. There are substantial barriers to healthcare for people who use drugs, including lack of knowledge and stigma among healthcare staff, difficulty registering with GP surgeries, low expectations of health and normalisation of pain\(^\text{18,19}\). These factors mean that people who use drugs often present late in the course of a disease and need emergency treatment, which is expensive.
17. We are aware that some drug treatment services have established successful pilots that aim to improve access to the NHS for their clients, such as clinics to test lung health or liver health and refer to other local services for treatment. However, these pilots are poorly funded and reliant on the goodwill of addictions staff and other local clinicians. In many cases clinics have closed due to a lack of funding. For example, some drug treatment services hosted nurse-led clinics to treat bacterial skin infections, a substantial problem among people who inject drugs. Many of these clinics have closed in the past few years, while the rate of hospital admission due to severe bacterial infections among people who inject drugs has increased rapidly

18. Prisons are also an important point of intervention - two-thirds of people who inject drugs have been in prison. Among people arriving in prison, 42% of women and 28% of men report a ‘drug problem’, and 13% of men and 8% of the remainder start using illicit drugs while in prison. The Chief Inspector of Prisons has identified issues with general healthcare, including staff shortages, high rates of missed appointments due to a lack of a chaperone or appointment times not fitting with the prison regime, and medication (including opiate substitution) times being dictated by prison regimes. Provision of opiate substitution and naloxone on release appears inadequate, given the high risk of overdose death on release.

Best practice

19. We propose the following five principles for a drug policy that benefits the most vulnerable groups of drug users:

   a. Protection for evidence-based and cost effective harm reduction services, such as needle exchanges.

   b. Investing in new approaches to improve access to the NHS for people who are dependent on drugs.

   c. Fiscal and welfare policies that prevent child poverty.

   d. Peer-led outreach that can identify vulnerable people and help them access housing and treatment.

   e. Avoiding prison sentences where possible.

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References


