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Upward trends in Drug-induced deaths
the case of France & Ireland

Background:

Historically, the use of heroin has been the main drug-related problem in both France and Ireland. Accordingly, both countries have implemented comprehensive health responses including prevention, treatment & rehabilitation as well as harm reduction services for decades. More recently, new trends in drug use such as an increased consumption of cannabis, cocaine, synthetic drugs (including NPS) and a rise in the abuse of prescription medicines (mainly benzodiazepines) have also been observed, posing challenges to addiction services and emergency wards. In this context, if thousands of drug-induced deaths are reported every year in Europe, information from national toxicology sources is scarce and cross-national comparisons are methodologically challenging. The aim of this contribution is to analyse trends in drug-induced deaths in France and Ireland, through the lens of drug-related public health responses implemented in the last decade. Based on comparative analysis of official population-based statistics recently released, we explored year-to-year variations in drug-induced deaths and substances implicated in poisoning deaths from 2010 to 2017.

Past-year illicit drug use prevalence, young adults (18-34 years)	21,8%	3,2%	1,3%	0,2%
High-risk users	2,20%			5 / 1 000 of which 85% in OST
1st time clients entering treatment	69%	10%		21%
All clients entering treatment	60%	8%		27%

Data from 2017

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Illicit drug use is more common among males and younger age groups (15-34 years)

One out of five treatment clients is female

Beyond the increased number of people with problem cannabis use, the higher proportion of cannabis users among treatment clients may be attributed to the existence of specialised consultation centres for cannabis young users (CJCs), as well as to a large number of referrals for treatment from the criminal justice system.

Numbers of first-time entrants reporting problem cocaine use as their primary drug have almost doubled during the last decade (FR/IE).

An increase in the proportion of clients entering treatment for the use of hypnotics and sedatives, mainly benzodiazepines, has been reported lately.
Problem drug and alcohol use among the homeless population is a serious concern with significant gaps in the provision of treatment and rehabilitation services, particularly in regard to attracting (and retaining) drug users with complex needs into treatment.

Past-year illicit drug use prevalence, young adults (18-34 years)	13,8%	2,9%	4,4%	0,4%
High-risk users				6,2 / 1 000 of which 51% in OST
1st time clients entering treatment	47%	28%		24%
All clients entering treatment	27%	12%		47%

Data from 2014/15

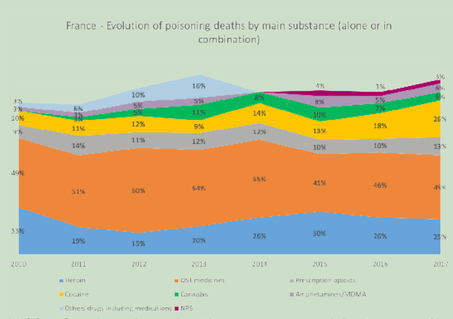
Illicit drug use is more common among males and younger age groups (15-34 years)

1/4 of clients entering treatment are female

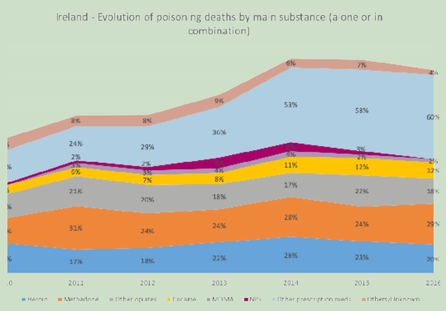
ie

French National Drug Strategy takes a broad approach to psychoactive substances and addictive behaviours, combining health, social and criminal responses. It addresses alcohol, tobacco and illicit drugs, as well as doping, gambling and screen-based addictions. The development of addiction research has been a crucial component of NDS; this includes the integration of addiction as part of national clinical research programmes, as well as the design of experimental approaches and evidence-based innovative responses.	**National Drug Strategy**	Ireland's national drug strategy takes an integrated approach to illicit drug and alcohol use. Initially focused on problem opiate use, notable changes in the nature and scale of the drug problem, Irish NDS addresses nowadays the widespread public concern regarding the misuse of cocaine, particularly when combined with other illegal substances, and alcohol, along with increased reports of problem polydrug use.
Financed by the social security system, two systems are involved in drug treatment: **General addiction care system:** General healthcare system comprising hospitals and general practitioners (GPs) is organised in three levels: 1st level care manages withdrawal and organises consultations; 2nd level includes the provision of more complex residential care; 3rd level expands the services to research, training and regional coordination. **Specialised treatment system:** 1) Specialised drug treatment and prevention centres (CSAPAs), created in 2007 and managed mainly by non-governmental organisations, provide anonymous and free outpatient and inpatient care as well as care for prison inmates. Both pharmacologically assisted and psychosocial treatments are provided in the same centres. 2) Also implemented in 2007, 'Drug-free' therapeutic communities provide inpatient treatment aiming the abstinence from drugs through community & cognitive-behavioural therapy (up to 2 years). 3) Youth Addiction Outpatient Clinics (CJCs) for young drug users (mainly cannabis users) provide Multidimensional Family Therapy since 2005.	**Drug treatment components**	Drug treatment is provided through publicly funded outpatient services (Health Service Executive, HSE), but also non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment. **Outpatient services:** 1) Specialised drug treatment centres 2) Low-threshold agencies 3) Specialised general practitioners which provide opioid substitution treatment (OST) in the community Some outpatient care is provided through mental health services and by private agencies. **Inpatient services:** 1) Residential centres/therapeutic communities run by voluntary agencies or within psychiatric hospitals 2) Hospital-based detoxification units With respect to both cocaine and cannabis, psycho/social treatment services have been developed under the NDS both directly by the HSE and through the Drugs Task Forces.
Since 1995, opioid substitution treatment (OST) has been the main form of treatment for opioid users and has been integrated into a total therapeutic strategy for drug dependence, including provison for drug users in prison. Methadone and high-dose buprenorphine are used for OST (in rare cases morphine sulphate is used for substitution treatment). Buprenorphine, introduced in 1996, is still the most widely prescribed substance for OST, although the proportion of clients receiving methadone is increasing. OST is mainly prescribed in a primary care setting by GPs and is usually dispensed in community pharmacies. Methadone treatment can be started only in specialised centres, hospitals or specialised units in prison.	**OST**	Since 1970, methadone has been provided by specialised HSE outpatient treatment clinics, by satellite clinics and through specialised general practitioners (Level 2 GPs) in the community, as well as in prisons. Nowadays, OST refers to the provision of both methadone and buprenorphine/buprenorphine-naloxone (since 2012); medication-assisted treatment includes methadone detoxification, methadone maintenance treatment and benzodiazepine detoxification. The expansion of OST has been possible through the expansion and development of HSE clinics, many of which are in community and voluntary sector premises, and the increase in the number of GPs and pharmacists participating in the Methadone Protocol.
Harm reduction facilities (CAARUDs) provide needle and syringe programmes (NSPs), advice on safer drug use, and general health promotion activities (referral, condom distribution), and social support (housing, employment, law support). CAARUDs are, for the most part, funded directly by the social security system. A state-subsidised kit containing sterile syringes and other paraphernalia is also available from pharmacies (for a small fee) or from dispensing machines (for free). Approximately 57 syringes per year are distributed or sold to high-risk drug users in France. Specific 'sniff and base kits' as well as foil are also increasingly made available to drug users at harm reduction sites. Since 2016, a naloxone product for nasal use has been available through hofffspital-based take-home programmes. In January 2018, the naloxone distribution programme was extended to all CAARUDs. In 2016, the first two experimental drug consumption rooms were opened in Paris and Strasbourg as well	**Harm reduction**	Harm reduction services are delivered by local authorities and community-based organisations. The provision of needle and syringe programmes (NSPs) is a central element of harm reduction service provision. There are three models of NSPs: fixed-site facilities, outreach syringe provision and pharmacy-based programmes. Needle exchange programmes are in place in areas that have traditionally experienced high levels of substance misuse. Approximately 27 syringes per year are distributed or sold to high-risk drug users in Ireland. In spite of improvements, it is acknowledged that there are still significant gaps in the availability of NSPs services around the country. In 2015, a 2-year naloxone demonstration project was initiated in Ireland. The project involved the distribution of a pre-filled syringe of naloxone on prescription and training opioid users to administer it. Two years later, 800 people had received training and 1 200 naloxone kits had been distributed.

Poisoning deaths have slightly decreased between 2010-15 (-4,8% - General Mortality Register - CépiDc).
According to the Special Mortality Register (Drames), opioids-related deaths have fluctuated from 75% to 84% between 2010-17. In 2017, 78% of fatal overdoses implicated opioids, mainly methadone and heroine. Proportions of deaths from heroin and methadone change inversely: when one increases the other decreases and vice versa. Cocaine-related deaths have risen over time (from 10% to 26%).
Deaths in which cannabis, amphetamines, MDMA, NPS and other substances (mainly benzodiazepines) were implicated have been progressively increasing during the last decade.
There is an underestimate of at least 30% of the number of poisoning deaths due to the misclassification of deaths, obstacles related to judicial proceedings, and the voluntary participation of toxicologists in registration procedures.



49% of poisoning deaths were aged between 25 and 44 years and males accounted for 78% of poisoning deaths.
Drug-induced mortality rate among adults (aged 15-64 years): 7 per million inhabitants (2015)



54% of poisoning deaths were aged between 20 and 40 years and males accounted for 67% of poisoning deaths.
Drug-induced mortality rate among adults (aged 15-64 years): 69 per million inhabitants (2015).

Poisoning deaths have slightly increased between 2010-15 (+7,7%, National Drug- Related Deaths Index - NDRDI).
Opiates, including heroin, methadone and opiate analgesia, continue to be mainly responsible for deaths by poisoning (69% in 2016). Prescription medicines (mainly benzodiazepines and pregabalin) are also implicated in many poisoning deaths (60%). The number of deaths due to cocaine - alone or in combination with another drug - has increased significantly between 2004-16 (from 7% to 12%).
The percentage of deaths due to polydrug poisonings rose from 44% in 2004 to 62% in 2016.
The number of drugs involved in each poisoning death has also risen over time. In 2016, an average of four drugs was involved in polydrug poisoning deaths compared to an average of two in 2004.

Conclusion:

While in France drug-induced deaths have decreased by 4,8% between 2010-2015 (from 392 to 373), in Ireland they have increased by 7,7% during the same time period (339 to 365).
In both countries, opiates (namely heroine and methadone) have been the main drug group implicated in poisoning deaths over time. Since 2010, opiates have represented between 75% - 84% of poisoning deaths in France, while in Ireland they represented 56% in 2010, reaching up to 69% in 2016. In France, 85% of high-risk opioid users avail of OST (51% in Ireland) and the overall provision and coverage of harm reduction services is higher. Difficulties in accessing OST in Ireland include the lack of local services in some areas and the scarcity of healthcare providers trained/habilitated to initiate treatment.The share of cocaine-induced deaths has also increased in both countries: from 10% to 26% of drug-induced deaths in France, from 6% to 12% in Ireland. As cocaine use is a relatively recent phenomenon, it requires more appropriate health responses in terms of treatment and emergency care provision.
In spite of national particularities, evidence from both countries confirms some worrying trends already observed elsewhere in Europe. The increase in opiates and cocaine-related deaths may partially be explained by a wider availability of prescription and non-pharmaceutical opioids (including fentanyl derivatives and novel synthetic opioids), but also of stimulants such as cocaine and crack cocaine across the European drug market.
In both countries the misuse of prescription medicines is already a topic of concern whose implications have not been addressed by national drug strategies yet..