Greater Manchester
Drug Early Warning System

Potent Synthetic Opioids (PSO) risk plan for Greater Manchester

Version 1.3. May 2024

1. Background

In the United States the adulteration of heroin with a range of fentanyl derivatives (*fentanyls*) has been associated with tens of thousands of deaths a year (CDC, 2018). Fentanyls were largely manufactured in China and sold online for use as street drugs. In 2019, China introduced generic controls on fentanyls. It is thought that in response to this, Chinese chemists switched to production of another group of *potent synthetic opioids* (PSO) commonly known as ***'nitazenes'*** (*benzimidazole opioids)*. Since 2020/21 a growing range of nitazenes and some other PSO have been detected in Europe (EMCDDA, 2022). In March 2024, a range of 15 nitazenes were brought under the Misuse of Drugs Act as class A drugs (Home Office (1), 2024).

As a result of a ban on opium production by the Taliban regime in Afghanistan, it is estimated that 2023 production of opium has fell by 95% (UNDOC, 2023). As nearly all UK heroin originates from Afghanistan there are widespread fears that there will be a heroin shortage in the UK, leading to more adulteration of street heroin with potent synthetic opioids.

Test results from both WEDINOS (Public Health Wales, 2024) and Scottish RADAR (Public Health Scotland, 2024) have shown that not only heroin but a range of other drugs such as *benzodiazepines* and *oxycodone* have been adulterated with a range of *nitazenes* (ACMD (1), 2023). In July 2023 a National Patient Safety alert was issued after a number of incidents in various parts of England and in particular a large number of overdoses and deaths in the Birmingham area, suspected and in some cases confirmed to be a result of heroin adulterated with *nitazenes* (OHID (1), 2023). There have also been cases in the last year where the non-opioid sedative *xylazine* has been found as an adulterant in heroin and is thought to have led to fatal overdoses in England (ACMD (2), 2024).

2. Purpose of this document

The emergence of these new potent synthetic opioids in Greater Manchester as either drugs of choice should there be a heroin drought or as adulterants in poor quality street heroin or other traditional street drugs would significantly increase the risk of opioid overdose deaths. In 2018 PHE (now OHID) advised local authorities to prepare for the appearance of potent opioids in their area (PHE (1), 2018). This guidance was update in 2023 (OHID (2), 2023). It states that local areas should:

- plan for how they will rapidly understand and assess the risk of any future threat, develop plans in partnership, and respond to the threat

- do everything they can now to review their arrangements and minimise the potential future impact of potent opioids (for example, through naloxone provision, treatment access and an effective local drug information system)

This document is the latest version of a **Potent Synthetic Opioids risk plan for Greater Manchester** produced on behalf on the Greater Manchester *Drug Early Warning System* (DEWS). The aim is to ensure a professional, co-ordinated, multi-disciplinary approach should credible information relating to risk be received and/or major incidence occur in Greater Manchester.

3. Plan and prepare for a future threat

According to OHID a local potent opioid risk plan should enable local partners to rapidly:

- understand the scale of the threat and assess the risk
- communicate the threat
- take actions to mitigate the threat

3.1 Understand the scale of the threat and assess the risk

The existing Greater Manchester *Drug Early Warning System* (DEWS) is a multi-agency system and equipped for understanding the scale and threat, assessing the risk, and communicating the threat.

The DEWS consists of a *Local Drug Information System* (LDIS) which has 1,000 Greater Manchester professionals who work with people who use drugs signed up to the online group and a well-established *Drug Alert Panel*. The Alert Panel benefits from using MANDRAKE, a Home Office licensed testing service to test available samples involved in incidents when they occur.

A GMP Gold command group to deal with major incidents of potent synthetic opioids has also been established and been shown to be effective when dealing with a recent potent synthetic opioid incident.

4. Mitigating against future threats

4.1 In the event of potent synthetic opioids appearing in the local market or as adulterants in the heroin supply, The Greater Manchester *Drug Alert Panel* (GMDAP) in co-operation with *Greater Manchester Police* (GMP*)* and local authorities will initially lead on the assessment of any potential threat. Professionals with relevant expertise can be brought onto the *GMDAP* if required. In the event of a mounting threat or major incidents *GMP* will establish a Gold group to plan a Greater Manchester wide response.

4.2 In light of the known threat GMP enforcement activity should prioritise any known or suspected local supply of heroin or other drugs adulterated with PSO.

4.3 Local commissioners should ensure that senior managers and other relevant staff of substance misuse and other commissioned services seeing large numbers of drug users are familiar with the latest version of this Risk Plan.

4.4 Local commissioners should ensure that substance misuse and other commissioned services seeing large numbers of drug users are prioritizing the training of staff, service users and others in overdose management and the use of naloxone and other interventions to reduce risk of overdose (including reducing opioid use 'on top' and optimising MAT).

4.5 Local commissioners should ensure that access to adequate supplies of naloxone are available in the event of an increase local threat - recognising that repeated doses may be required if PSO are implicated in an overdose.

4.6 Greater Manchester seized heroin samples are systematically tested for the presence of some PSO by GMP. This may need to include other PSO if recommended by the ACMD when best practice guidelines are produced (ACMD (3), 2022). Any positive results should be made available to the GMDAP.

4.7 The purity of Greater Manchester seized heroin samples has begun to be monitored by *MANDRAKE* (a joint GMP/MMU initiative) as part of the Greater Manchester drug trend study (GM TRENDS). Heroin purity is also selectively monitored by GMP for forensic purposes. In the event of anecdotal or forensic evidence suggesting significant decreases in potency or availability of heroin in Greater Manchester the GMDAP should consider alerting commissioners and relevant services to prepare for the possible appearance of PSO on the local drug market.

4.8 Biological samples from post mortem examination are routinely tested for the presence of some PSO in all suspected drug related death cases. Positive results should be passed on to the GMDAP. The ACMD has recently recommended that coroners test for a range of PSO following the production of best practice guidelines (ACMD (3), 2022).

4.9 Communications teams from GMP, local authorities, Health Trusts, OHID and Greater Manchester Combined Authority (GMCA) should be aware of this risk plan and be able to instigate a co-ordinated media response should the GMDAP deem the incidents or threat warrant it in line with the Greater Manchester drug alerts media protocol (GMCA/NHS in Greater Manchester, 2019).

5. When suspected incidents of PSO occur

5.1. Where 'spikes', clusters or multiple overdose incidents occur and/or the involvement of PSO is suspected, relevant A&E departments or paramedics should inform the GMDAP as soon as possible.

5.2. Samples testing positive from reagent or other onsite tests should be confirmed by more thorough testing procedures. Any samples testing positive with reagent or other onsite tests should be sent to MANDRAKE or tested by forensic service providers. Results of

any positive tests should be passed on as soon as possible to the GMDAP for risk assessment.

5.3. When the suspected involvement of PSO occurs, first responders, police officers and other professionals involved in handling and transporting samples should take precautions in line with guidance (PHE (2), 2018).

5.4. No media or social media comments as to the suspected contents of drugs or the possible involvement of PSO should be made until incident(s) have been assessed by the GMDAP. Mishandling of messages by the media or on social media may accidentally increase demand and potential increase the risk of drug overdose and death.

6. Communication response

In the event of confirmation of PSO appearing in the local market or as adulterants in the heroin supply:

6.1. Relevant information along with any recommendation of public facing warnings will be supplied by GMDAP to communications teams from GMP, local authorities, relevant Health Trusts, OHID and GMCA in line with the Greater Manchester protocol (GMCA/NHS in Greater Manchester, 2019).

6.2. Information from the GMDAP to relevant professionals and services will be cascaded through relevant networks by GMP, local authorities, OHID, *LIN* (NHS online information network) and the *Greater Manchester Local Drug Information System* (LDIS) etc.

6.3. Local commissioners will be informed and should ensure that local substance misuse service; local emergency services; primary care; services for homeless opioid users, hostels, pharmacists, and other partners etc area are informed.

6.4. *North West Ambulance Service* (NWAS) and local A&E should be contacted and alerted through the *Greater Manchester Health and Care Partnership* to the possible increase in cases and to the potential need for repeated doses of naloxone (Abdulrahim & Bowden-Jones, 2018).

6.5. In hospital settings: overall, higher doses of naloxone may be needed for PSO patients in comparison with heroin patients; PSO patients may require a longer period of observation in hospital than heroin patients (Abdulrahim & Bowden-Jones, 2018).

7. Substance misuse service response

Local commissioners should ensure that treatment and other services in contact with opioid users:

7.1. Ensure staff and service users have access to adequate supplies of take-home naloxone and that relevant services promote and increase the coverage of take-home naloxone and overdose training.

Legislation is to be enacted shortly that will allow the wider provision of Take-Home Naloxone (THN). This will allow police, nurses, homeless outreach services to increase supply for people who use opioids and their family and friends (DHSC, 2024), however at present the provision of THN can only be done by drug treatment services.

7.2. Increase efforts to reduce illicit opioid use amongst service users in *Medication-Assisted Treatment* (MAT). Optimise MAT treatment in line with the 'Orange Guidelines' (Department of Health and Social Care, 2017), especially ensuring service users receive optimal doses of methadone or buprenorphine to reduce the likelihood of 'illicit opioid use on top'.

7.3. Ensure there is rapid access to assessment and titration onto MAT for opioid users not in contact with treatment services – reducing barriers where necessary.

7.4. Ensure nitazene, fentanyl and xylazine test strips are available for distribution by relevant services to opioid users and inform the GMDAP of any feedback from these results. In practice it is unlikely all three strips will be used by people who use opioids to test any batch they have, so priorities will be dictated by whatever is known about the threat.

8. Messages to opioid users

It is important to recognise that service users may not be aware that they have taken PSO, or heroin mixed with a PSO. Evidence from the US suggests heroin users will adopt behaviours to reduce overdose risk and seek treatment when PSO was detected in local heroin supplies (Carroll, 2017).

8.1 Anecdotal evidence for the use of nitazene test strips, suggest that on a positive test of their dose a person who uses street heroin will still use the dose they have, but may mitigate behaviour, by for instance smoking instead of injecting, not using alone but using with somebody with a naloxone supply etc.

While the ideal would be to dispose of the dose and or hand it in to drug services so it may be able to be tested through the MANDRAKE/GMP scheme, this adaption of behaviour to reduce risk should be encouraged.

8.2. Relevant services should ensure that any alerts/posters sent by the GMDAP are displayed for waiting rooms, posted onto relevant social media etc.

8.3. Relevant services should work with local service user representatives and consider increasing outreach by staff and trained peer support workers to actively trace and contact opioid users in and out of treatment to inform them that PSO may be present in local heroin supply. This should be undertaken in a targeted, balanced manner so as to minimise drug seeking of strong opioids.

6.3. There is presently no evidence that higher doses of naloxone should be used in community settings. However, the reversal of a PSO overdose may be less likely than with heroin. Where the use of PSO is suspected, there is a need to call emergency services and transfer to hospital (Abdulrahim & Bowden-Jones, 2018).

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