

From Quality Safety and Improvement Directorate

Reference: HSC (SQSD) 16/23

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Potent Synthetic Opioids Implicated in Heroin Overdoses and Deaths

For Action:

Chief Executives HSC Trusts including onward transmission to: community services; mental health services
Deputy Secretary, SPPG including onward transmission to: general practices; community pharmacy
Chief Executive, NIAS
Chief Executive, PHA
Chief Executive, BSO
Chief Executive, RQIA
Chief Executive, NIMDTA

For Information:

Distribution as listed at the end of this PSA.

Related documents

NatPSA/2023/009/OHID
DAMIS Alert – 25 July 2023

Implementation

Immediate

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed on:

<https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars>

Dear Colleagues

Potent Synthetic Opioids Implicated in Heroin Overdoses and Deaths

Summary

The Office for Health Improvement and Disparities have issued a National Patient Safety Alert ([NatPSA 2023 009 OHID.pdf](#)) on 26 July 2023 concerning an elevated number of overdoses (with some deaths) in people who use drugs, primarily heroin, in England.

Testing in some of these cases has found nitazenes, a group of potent synthetic opioids. Nitazenes have been identified previously in this country, but their use has been more common in the USA. Their potency and toxicity are uncertain but perhaps similar to, or more than fentanyl, which is about 100x morphine, therefore nitazenes pose a substantial risk of overdose, drug-related hospitalisation and drug-related death.

In Northern Ireland, there have been a number of overdoses identified which could be linked to nitazenes in the past three months. Locally, a Drug and Alcohol Monitoring and Information System (DAMIS) issued an alert on 25 July 2023 stating that over the previous four days, they had received information relating to 10 nitazene-linked overdoses in the Belfast area.

This National Patient Safety Alert provides further background and clinical information and actions for providers.

Chief Executives of HSC Trusts, PHA and NIAS are asked to:

1. Disseminate this circular to relevant staff within your organisation.
2. Appoint a member of staff to oversee the actions detailed below.
3. Trusts are asked to confirm that actions within the alert have been added to their safety and quality workplan for implementation and monitoring purposes by completing a 2nd Line of Assurance Template to the Governance and Safety Directorate, Strategic Planning and Performance Group at Alerts.SPPG@hscni.net. by 4th Aug 2023.

Deputy Secretary of Strategic Performance and Planning Group should:

1. Disseminate this circular to all relevant staff, General Practitioners and community pharmacy.
2. Assess the level of assurance provided by the Trust's 2nd Line Assurance Template and address any concerns.
3. Notify the Quality, Safety and Improvement Directorate of the Department (qualityandsafety@health-ni.gov.uk) of any ongoing concerns.

Chief Executive RQIA should:

1. Disseminate this circular to all relevant Independent Providers.
2. Implement relevant actions from this circular and through the usual RQIA monitoring processes assure implementation of advised approach/ best practice guidance.

Chief Executive NIMDTA should:

1. Disseminate this circular to doctors in training in all relevant specialties.

General Practitioners and Community Pharmacy should:

1. Implement actions below as applicable to their organisation.

Actions to be completed as soon as possible:

- a. All organisations where staff may encounter people who use drugs should ensure those staff are:
 - made aware of the risk of severe toxicity resulting from adulteration of heroin with potent synthetic opioids ,
 - able to rapidly assess suspected opioid overdose cases,
 - made aware the potency and toxicity of nitazenes is perhaps similar to, or more than, fentanyl, which is about 100x morphine,

- alert to the symptoms of opioid overdose in known and suspected heroin users
 - communicate these risks and harm reduction messages to those who use heroin and other drugs during any contacts,
 - ensure people who use heroin and others who might encounter an opioid overdose have naloxone available,
 - information should also be passed to community and voluntary sector providers as appropriate,
 - able to provide or administer naloxone if appropriate.
- b. All organisations that provide emergency care for opioid overdose should ensure staff are supported to:
- treat suspected cases as for any opioid overdose, using naloxone and appropriate supportive care.
 - recognise the duration of action of naloxone is shorter than that of many opioids and appropriate monitoring and further doses of naloxone may be required. In the community this could include injectable or intranasal naloxone, administering a single dose and waiting for no response before administering more.

In specialist medical settings only:

- treatment may involve the intravenous naloxone titration regimen recommended by the National Poisons Information Service.
- intramuscular naloxone can be used as an alternative in the event that IV access is not possible or is delayed.
- People who have overdosed may need longer-term monitoring in a medical setting for up to 24 hours even if reversal of the opioid overdose has occurred.

Background

The Office for Health Improvement and Disparities has reported that in the past 8 weeks there has been an elevated number of overdoses (with some deaths) in people who use drugs, primarily heroin, in many parts of England (reports are geographically widespread, with most regions affected but only a few cities or towns in each region).

Testing in some of these cases has found nitazenes, a group of potent synthetic opioids. Nitazenes have been identified previously in this country, but their use has been more common in the USA. Their potency and toxicity are uncertain but perhaps similar to, or more than fentanyl, which is about 100x morphine, therefore nitazenes pose a substantial risk of overdose, drug-related hospitalisation and drug-related death.

There is good evidence from reports that naloxone, the ‘antidote’ to opioid overdoses, works in these cases. The treatment required for an overdose that may be related to potent synthetic opioids is the same as for other opioid overdoses, but delivering it rapidly and completely is even more critical, as progression to respiratory arrest, and recurrence of respiratory arrest, are more likely.

People who have overdosed may need longer-term monitoring in a medical setting for up to 24 hours even if reversal of the opioid overdose has occurred.

Those in contact with heroin users should be alert to the increased possibility of overdose arising from 'heroin' containing synthetic opioids, be able to recognise possible symptoms of overdose and respond appropriately.

However, adulterated heroin is not the only risk – there have been findings of potent synthetic opioids in fake oxycodone tablets, and less commonly in fake or 'street' benzodiazepines and in synthetic cannabinoids (SCRAs).

There is no evidence for absorption of synthetic opioids through the skin but usual precautions, including masks, should be taken when handling unknown substances, especially if they have become airborne.

In Northern Ireland, a number of overdoses have been identified which could be linked to nitazenes in the past three months. The Drug and Alcohol Monitoring Information System (DAMIS) issued an alert on 25 July 2023 stating that over the previous four days, they had received information relating to 10 nitazene-linked overdoses in the Belfast area.

Additional information can be found in:

Nation Patient Safety Alert available here- [NatPSA_2023_009_OHID.pdf](#)

Annex A - the DAMIS Alert of 26 July 2023 re Overdoses

Annex B – DAMIS Alert of 19 June 2023 re Nitazenes

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Safety Strategy Unit
Department of Health
Room D1.4
Castle Buildings
BELFAST
BT4 3SQ
Tel: 028 90523775

qualityandsafety@health-ni.gov.uk

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed [here](#).

Thank you for your attention to this important matter.

Yours sincerely

David Wilson

Quality Safety and Improvement Directorate.

Distributed for Information to:

Medical Directors, HSC Trusts
Executive Medical Director/Director of Public Health, PHA
Director of Nursing and Allied Health Professions, PHA
Safety Lead, PHA

Director of Performance, Safety and Service Improvement, SPPG
Director of Primary Care, SPPG
Safety and Quality Alerts Team, SPPG
Head of Nursing & Midwifery, QUB
Head of Medical School, QUB
Director of Centre for Medical Education, QUB
Head of School of Pharmacy QUB
Head of School of Medicine, UU
Head of School of Nursing, UU
Head of Pharmacy School, UU
Chief Executive, NIPEC
Staff Tutor of Nursing, Open University
Director, HSCQI
NI Centre for Pharmacy Learning and Development
Clinical Education Centre

DAMIS Alert Issued 26 July 2023

Dear DAMIS Network member

DAMIS has received information from partners in the Belfast area of over 10 overdoses occurring within the last 4 days all of which involved yellow tablets thought to be benzodiazepines, these are being sent for testing. There is a possibility these may also contain opioids and may be linked to the previous DAMIS alert (attached 19 June 2023).

Please also remind your clients to exercise extreme caution when taking any substance if they are unsure what is in it. The main advice is:

- Take a test dose to start out with – start with a smaller dose than you usually would.
- Avoid taking more than one substance at a time – the majority of drug related deaths take place when someone has taken more than one drug – further information is available at: [Mixing: reduce your risk of harm | HSC Public Health Agency](#)
- Never use alone – make sure there is someone with you who can ring an ambulance

If you have any further information relating to this report or similar circumstances, can you please forward it to DAMIS at DAMIS@hscni.net

Kind Regards

DAMIS (PHA) Coordinator



DAMIS Alert Issued 19 June 2023

Dear DAMIS Network Member

DAMIS has received information from partners regarding yellow Metonitazene tablets (see attached), purchased online, which were found to contain Nitazene.

Nitazenes are a category of new synthetic opioids (NSO), also known as 2-benzyl benzimidazole opioids. This group of chemical compounds exert broadly similar effects on the body, with varying levels of potency. NSOs are extremely potent opioid receptor agonists, this means that they have a significant effect on opioid receptors in the body and in turn depress the central nervous system. This also means a significantly smaller amount is required to get the desired effect and this poses an increased risk of respiratory depression. Nitazenes have been known to be administered by many routes including intravenous, oral, sublingual, nasal and vaping. The effects include reduced breathing, reduced heart rate, constricted pupils, drowsiness, euphoria, nausea and itching.

As we approach concert/festival season please work to raise awareness of the potential potency of Nitazenes within your service.

Please highlight to anyone you work with who uses this substance, the importance of

- a) Starting with very small doses, as purity /strength of different batches can differ, and a substance may be much stronger than you realise
- b) Not taking more than one substance in any session, as mixing substances can significantly increase the risk of fatal overdose.

Please also see attached for information on harm reduction for Volatile Substance Abuse and on reducing your risk of harm [Mixing: reduce your risk of harm | HSC Public Health Agency](#)

If members have any further information relating to Nitazenes, can you please forward it to DAMIS at DAMIS@hscni.net

Please note that the information provided to DAMIS may be suspected (i.e. not confirmed) or form part of an ongoing investigation and therefore, members should be aware that DAMIS alerts and emails are only issued to DAMIS Network members to inform relevant service providers / anyone who works with service users so appropriate support and harm reduction advice can be provided.

DAMIS alerts/ emails or information contained within them should not be shared or posted on social media or to be shared with the media. If it is appropriate for information from DAMIS to be shared with the general public, PHA Communications will adapt this information in terms of public and/or targeted health messaging via agreed procedures.

Kind Regards

DAMIS (PHA) Coordinator