

# **DRUG DEATH ACTION PLAN WORKING GROUP: EXECUTIVE SUMMARY OF FINAL REPORT TO GLASGOW CITY DRUGS & ALCOHOL PIG**

## **1. Introduction**

Reversal of the upward trend in drug related deaths and reduction of the total number by at least 25% by 2005 is one of the key national targets set for Drug Action Teams.

- Drug related deaths In the Greater Glasgow NHS Board Area increased by 29% between 2001 and 2002 (from 96 to 124).
- In the Glasgow City area the increase was even greater over the same period at 63% (from 70 to 114).

A short term working group was set up under the auspices of the Treatment and Care Sub- Group of the Glasgow City Drugs and Alcohol PIG to produce an action plan to reduce drug deaths in Glasgow City.

## **2. Risk Factors**

Analysis of the 124 drug deaths in the GGNHSB area in the year 2002 confirmed a range of risk factors highlighted in established research.

- Injecting drugs
- Combinations of drugs (most commonly opiates with benzodiazepines/alcohol)
- Use of opiates when tolerance is low e.g. after a break in use /detoxification
- Longer term users and previous non fatal overdoses.
- Co-existent mental health problems

In analysing the Glasgow data it is also clear that:

- Many had been in prison previously and 20 died within 2 weeks of release.
- 23 were homeless, mostly living in hostel accommodation.
- There were peak periods for deaths at holiday times, suggesting difficulty in accessing services

## **3. Witnesses/ Emergency Intervention**

- 75% of cases were witnessed
- Although ambulances or police were called there were delays in 38% of cases.
- Resuscitation was attempted in a limited number of cases but was often inappropriate.

## **4. Methadone Related Deaths**

30 deaths in the GGNHSB area were methadone related with methadone being the main cause in 13. 17 of the total were obtaining methadone illicitly.

## **5. Deaths Involving Cocaine**

Cocaine was present in 7 cases and was the main cause of death in 4.

## **6. General Circumstances of those who Died**

- 85% of those who died were male and 15% were female
- Over three quarters of those who died were in the age range 26-45.
- For those of whom data was available on children 52% had no children, 25% had one child and 23% had two or more children.
- Only 4% were in employment, i.e. 96% were not in employment.
- The majority were in deprivation categories 6 and 7.

## 7. Previous Service Contacts

Most of those who died had been in contact with a wide range of services at some point including both generic and addiction related health and social care services (details in full report).

The working group's investigation of these service contacts suggests the following.

- Significant numbers of those who died were in contact with generic non (addiction) specialist services but either were not referred on or refused an onward referral if offered.
- A number had had previous contact with/ referral to specialist addiction services but had been lost to the system eg through failure to attend appointments or lack of aftercare post treatment.

This suggests that

- more generic services should become more alert to the signs of risk/ vulnerability to drug death and more proactively refer onwards,
- specialist services should develop a proactive system whereby every attempt is made to re-engage with very chaotic clients.

## 8. Priorities for Future Action

### Ongoing activity that should contribute

- Expanded access to a well supervised methadone programme which includes social care support
- Introduction of Community Addiction Teams (CATs) / integrated health and social-care provision and the development of the single shared assessment leading to integration of care and improved care management.
- Recent and planned service developments targeted at high risk groups such as the homeless.
- Revision of the SPS Addiction Policy with a greater emphasis on "harm reduction" approaches and improved liaison between SPS, GCC Social Work and GDPS.

### Specific actions to prevent drug deaths detailed in action plan.

**Preventing Overdose Campaign** using " Know the Score" OD prevention materials and **Training** in risk factors/OD symptom recognition/ appropriate first aid action for staff, users and relatives/ friends who may witness an OD.

**Prisons / Prison Through Care** Development of a service model linking prison and community treatment systems to ensure continuity on admission/ release and improved identification and care of those at risk.

**Homeless People / Homeless Accommodation** Staff/ user training re ODs, improved recording and investigation of non- fatal ODs, rapid access to addiction services and development of appropriate accommodation options (with support).

**Risk Factors / Assessment /Accessing Services** Data - base containing known details and service contacts of those who died to be used to improve risk assessment and inform service improvements that avoid breakdowns in care pathways.

**Methadone Deaths and Prescribing Difficulties** Training, support and guidance re prescribing and supervision for those involved in delivering the methadone programme, systematic provision of advice to service users re risks of poly-drug use / need for safe methadone storage (take homes) and enhanced access to 7 day supervised consumption.

**Continued Improvement in Liaison between Agencies Over Drug Deaths** Setting up a standing " Glasgow Drug Deaths Monitoring and Prevention Group" involving key agencies to ensure rapid sharing of information on deaths/ street drug trends and report on progress in implementing proposals to reduce deaths.

**Other Issues requiring longer term consideration** include: exploring the viability of supervised safe injecting facilities and nalaxone administration in emergencies by staff in residential settings/ users/ users relatives; exploring opportunities for service intervention at A&Es at point of non-fatal overdose; developing good practice guidance on detoxification.