DRUG DEATH ACTION PLAN WORKING GROUP: FINAL REPORT TO GLASGOW CITY DRUGS & ALCOHOL PIG

1. Introduction / Background

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 DATs. This has been reflected in a local target in the Greater Glasgow DAT Corporate Action Plan to reduce deaths to 72 or less in 2004/5. In the Greater Glasgow NHS Board Area as a whole the number of deaths 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).

For this reason it was agreed that a short term working group be set up under the auspices of the Treatment and Care Sub- Group of the Glasgow City Drugs and Alcohol PIG in order to produce an action plan with the aim of reducing drug deaths in Glasgow City.

The working group has been involved in further analysing the 124 drug deaths in the GGNHSB area in the year 2002 (the latest year for which complete data are available) The analysis was split into deaths in Glasgow City Council Area (114) and deaths outwith GCC but within GGNHSB area.(10). The group has met on 4 occasions. Between meetings a range of sub- groups and individuals have carried out more detailed work covering:

- Prisons/ Prison Throughcare
- Homelessness
- Risk Factors / Assessment /Accessing Services
- Methadone Deaths / Other Prescribing and Poly- Drug Issues
- Harm Reduction Information

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2. Known Risk Factors

The main common features of drug deaths are:

- Injecting drugs (whilst information from Sudden Death Reports is incomplete, the police indicate that paraphernalia was present in 76 of the 2002 Glasgow cases)
- Mixing heroin and/or methadone with other central nervous system depressants, most commonly benzodiazepines and/or alcohol (benzodiazepines were involved in the toxicology for 87 deaths in 2002 ie 71% of the total; alcohol was detected in 66 cases ie 54%. 11 of these (had over blood alcohol counts of over 200mg / 100ml and 19 had BACs between 100 and 200mg/ per 100ml)
- Use of opiates when tolerance is low after a break in use /detoxification
- Most deaths as a result of overdose appear to occur amongst longer term users (from analysis of 52 Glasgow cases where using history was known 90% had been using for more than 5 years and 44% for more than 10 years) Many have had previous non fatal overdoses.
- Evidence suggests that mental health problems are relatively common amongst those who died. Of the total drug deaths in 2002, 84 (68%) were registered with PIMS.. Evidence provided by the police derived from Sudden Death Reports indicates that, of those for whom data is available on medication at time of death (n58), 31% were being prescribed anti-depressants (nb these may or may not been present in the toxicology at time of death).

In analysing the Glasgow data it is also clear that:

- That there were high numbers of drug deaths amongst those who had previously served custodial sentences (76 had ever been in prison, 51 of these in the previous year) a significant proportion of whom were recently released prisoners (24 within the first month and, most importantly,20 within 2 weeks of release- see histogram attached as appendix 1). This is a Scotland wide problem with approaching 30% (n 30) of those dying within the first year of release dying within the first 7 days. Of these 1 had methadone continued post release, 2

refused assistance/ denied having a drug problem and the rest had been placed on Health Care Standard 10 detox regime.

- There was a significant proportion of homeless people amongst the deaths (23) the majority of whom were living in a hostel accommodation at the time of death (15 in GCC Hostels + 2 in Salvation Army Hostels, 1 in Govanhill Women's Project, 3 no fixed address, 2 B&B accommodation). Of this group 5 were also in the group who had died within 2 weeks of release from prison.

These are therefore obvious "target groups" in terms of responses for those at risk.

It should further be noted that analysis of the 2002 data appears to indicate that drug deaths may peak during holiday periods with the highest numbers of monthly deaths having occurred in December July and April. This prompts questions about the accessibility of relevant services during holiday periods.

3. Witnesses/ Emergency Intervention

In the majority of cases overdoses are "witnessed" and emergency services called (93 cases ie 75 % of 2002 cases). However, although ambulances (n 73) or police (n 20) were called there were often delays between first signs of o/d being observed and ambulance control being contacted (ambulance not called immediately in 38% of cases). The evidence suggests that resuscitation was attempted by witnesses in a limited number of cases and was often inappropriate in first aid terms. In Glasgow, from cases where this information is known and the person was not seen to be clearly dead, resuscitation was attempted in 60% of cases. In almost half of these cases the techniques applied were not appropriate/ likely to be effective (face slapping , splashing water on face etc). This suggests that the signs of o/d are seldom recognised by witnesses until it is too late (people are often thought to have fallen asleep) and when they are aware of the signs it is clear that witnesses have limited knowledge of resuscitation techniques.

4. Methadone Related Deaths

There were 30 deaths in the GGNHSB area (Glasgow City, 23 out of 30; GGNHSB outwith Glasgow, 7 out of 30) which involved methadone either as the main cause of death (13) or as being present in the toxicology report amongst other drugs though not identified as the main cause of death (17). 17, but not the same 17, were not registered in a methadone programme and were therefore obtaining methadone illicitly.

5. Deaths Involving Cocaine

Toxicology identified the presence of cocaine in seven cases. Following all investigations, it was deemed to be attributable to death in five of these cases, four of which were classed as cocaine only deaths. Death was considered to be cocaine related in another case where death was due to cocaine and amphetamine. In the remaining two cases, although cocaine had been detected, it was not considered to be contributory to death. In these two cases, death was due to heroin toxicity in one instance and a mixture of methadone, prothiaden and amitriptyline in the other. This trend requires careful monitoring given the apparent rise in use in Glasgow and the fact that cocaine can contribute to sudden deaths by way of several mechanisms such as raised BP causing cerebral haemorrhage, myocardial infarction / cardiac arrhythmias and elevated temperatures.

6. General Circumstances of those who Died

- 85% of those who died were male and 15% were female
- Over half of those who died were in the age range 26-30 (50.8%). A further 25.4 % were 31 to 45. 17.2% were in the age range 21-25 and 6.6% were in the age range 17- 20.
- Of those for whom data is available on marital status (90), 62% were single and 21% lived with a partner.
- Of those for whom information on their last recorded address is available (n 93) 36.6 % either lived alone (23.7%)or with a partner (12.9%) in their own dwelling. 24.7% lived with other family members and 5.7% lived in a non family members dwelling. The rest, ie 33.3 % were recorded

as residing in some form of temporary or supported accommodation (23.7% "hostel", 2.1% "b&b", 3.2% "temporary accommodation", 3.2% "hospital", 1.1% "supported accommodation")

- For those of whom data was available on children (n91), 52% had no children, 25% had one child and 23% had two or more children.
- In cases where information is available on employment status (n115) only 4% were in employment (n5) ie 96% were not in employment.
- Data to allow analysis of deprivation category was available for 113 cases. The great majority of these cases were categorised as being in the lowest deprivation categories ie 77% (n87) in Dep Cat 6 or 7, 14% (n16) in Dep Cat 5 and 9% (n10) in Dep Cat 3 or 4.

7. Previous Service Contacts

The working group instigated work to identify previous relevant service contacts by the individuals who died in order to identify potential opportunities for intervention and possible breakdowns in care pathways. Whilst this work has progressed well, in some cases it entails detailed analysis of individual case records in order to arrive at firmer conclusions and is therefore still ongoing.

- A high percentage of individuals involved in the 2002 deaths were know to GCC Social Work Services at some point (77% n95) according to analysis of the Carefirst. The last contact of those for whom relatively up to date/ sufficient details were recorded (n83) was Criminal Justice in almost half (48%)of the cases, Addiction in 26% of cases, HAT/ HPT 8%, Adult Community Care 6%, Mental Health 5%, Hospital Team 4% and Children and Families 2%. Further examination of this data source appears to indicate limited joint work with Addiction Services. In addition, it appears that limited intervention work was given from a multidisciplinary perspective in a high proportion of cases even with very chaotic service users. Initial analysis has highlighted the reasons for this being mainly (but not exclusively) attributed to clients failing to attend appointments.
- 26 names could be identified from GDPS records. Of these 10 failed to attend a first appointment 6 had stopped attending before stabilisation, 5 had been discharged with a detox script (all prior to or during1999) and one case had been referred back to the GP as stabilised. The remainder were never properly established e.g. they had been assessed for a DTTO which was never granted.
- 30 names were identified from the GP Shared Care Scheme. 15 of these names were also on the GDPS list.
- Of the 84 individuals recorded on PIMS and had therefore been in contact with/ referred to the Alcohol and Drug Directorate / Mental Health Services at some point (some may not have attended appointments), 51 psychiatric records could be retrieved in the time available. An initial provisional analysis of these 51 cases indicates that the last referral or contact was with the Alcohol and Drug Directorate in 16 cases, General Psychiatry in 16 cases, General Medicine/ Liaison Psychiatry in 9 cases and Child & Adolescent Psychiatry in 6 cases. The remaining 4 individuals had been in contact with Psychology, the Co- Morbidity Team, the out of hours service and Psychotherapy. Only a limited number of these contacts were relatively recent ie 32% in a year prior to death (2 current patients, 6 died within a month and 6 between 1month and 6 months and 4 between 6 months and a year). Medical records indicated opiate abuse dependence in 28 cases. The diagnosis at last contact of was drug abuse/ dependence for 24, alcohol dependence for 6 and drug induced psychosis for 3. Other diagnoses, where made, were for mental health problems. 12 instances of referral but failure to attend the Alcohol and Drug Directorate were recorded. More detailed analysis of case notes is required to fully determine the nature of interventions. However the information available suggests a need for improved access to specialist addiction services and relevant training and support for psychiatric services in general.
- Of the people who died who had previously served prison sentences the majority (58% n 44) had been in Barlinnie, 18% (n 14) had been in Low Moss and 12% (n 9) had been in Corntonvale. Smaller numbers had been imprisoned in Greenock (4)and Polmont (2) and single individuals had been imprisoned in Kilmarnock , Edinburgh and Noranside. The length of sentence served (where this is known) was less than 1 year in 78% of cases. 66% had served less than 6 months. Of those who died within the first month of release 63% had served sentences of 1-6months, 26% sentences of 6-12 months with only 11% having served sentences of over a year. There were no deaths in the first month after release amongst those

who had served less than 1 month. Of those who had died within a year of release 55% had been offered and accepted an assessment and referral for transitional care under the SPS Addiction Service Contract. It has been identified that there are issues around joint working between community and prison based services regarding continuity and transfer of community based treatment plans on admission; effectiveness; efficiency and consistency of pre and immediate post release joint working between prison based and community based services; identification of those at highest risk prior to release.

- Of the 23 people who were homeless when they died 9 had previously served prison sentences. 6 of these deaths were in the first 15 days post release. There is limited evidence of contact with addiction services by the 17 people for whom records are available on the first software system (only 2 had been in contact with a drug worker).
- 42% (n51) of those who died had used the Drug Crisis Centre prior to death. However of those 51 individuals, 67% used the needle exchange only and 16% had been previously admitted.
- Only 9 individuals could be identified from GCC Social Work records as having previously been placed in residential rehabilitation. Only one of these had recently been discharged, having died 13 days later. The rest had been discharged more than a year before death.
- Of those for whom data is available on the time between last contact with GP and date of death (n70), 26% saw their GP between 1-4weeks prior to death and 16% saw their GP less than one week prior to death.
- Of those for whom data is available on reasons for last contact with GP (n67), 34% attended due to health problems attributed to drug/alcohol use in general and 21% attended due to mental health issues.
- Work still requires to be progressed to identify previous contact with A&E Departments to identify previous non- fatal overdoses in the 124 cases. However from records available at least 22% (n 25) had had previous non fatal overdoses.

The above information, whilst incomplete, 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, and that all services including specialist services should develop a proactive system whereby every attempt is made to re-engage with very chaotic clients (eg home visits) to enable health/ social care workers to initiate appropriate intervention packages.

There is also some limited evidence from the above that recent detoxification and loss of tolerance may have been implicated in some deaths. This would lead the working group to conclude that detoxification for whatever reason ,voluntary or enforced, must be treated with great caution and individuals involved must be warned of the danger of loss of tolerance. Ideally detox should follow proper assessment and be part of a care plan which includes other interventions and appropriate aftercare to minimise chances of relapse.

8. Priorities for Future Action

Ongoing Activity that Should Contribute

The working group felt that the best means preventing death among people involved in high risk activity such as injecting drug use is to encourage them to engage in services. A range of current developments ought to help in this respect i.e.

- 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 (eg Homeless Addiction Team, clinics, needle exchange service, Clyde Place Assessment Centre , commissioning plans re hostels closure and Purchased Service Review outcomes)
- The current revision of the SPS Addiction Policy with a greater emphasis on "harm reduction" approaches in addition to ongoing discussion around the prisons throughcare care contract and improved liaison between SPS, GCC Social Work and GDPS. Development of alternatives to / diversion from imprisonment including the Drug Court/ DTTOs the "Time Out Service" and proposed Arrest and Referral scheme will also assist.

These new developments will take time to impact. Also, where significant changes in service configuration are taking place, it will be important to ensure a smooth transition to new models from the service users perspective ie without any inadvertent temporary deterioration in service quality or breaks of continuity in care plans.

However the working group feels that there are some immediate and specific actions it would recommend to prevent drug deaths. Section 8, the working groups action plan sets these out in detail indicating lead responsibility for action, estimated timescales and whether particular proposals have resource implications. The main themes are as follows.

8.1 Preventing Overdose Campaign/ Training

Given the number of deaths that may have been avoidable if ambulances were called more quickly/ appropriate first aid action was taken, initiate a comprehensive campaign aimed at ensuring those at risk of overdosing are aware of the key risk factors (including risks of injecting, mixing opiates / methadone with benzos / alcohol etc) and that the maximum number of relatives, friends or staff who are likely to witness an overdose can recognise the symptoms and know what to do in terms of appropriate first aid action.

Target outlets for materials and initial training would include : Health/ Social Care Addiction Services; Purchased Addiction Services; Homelessness Accommodation; Family Support Groups; Needle Exchanges; Methadone Dispensing Pharmacies; Minimal Interventions re non fatal overdoses in A&E Depts.

In addition the working group would offer its support to the Joint Training Board in its consultation over draft core competencies re drugs and alcohol / training needs for generic staff groups in contact with those with drugs/ alcohol problems. It would recommend that any training developed as a result should include awareness of risk factors involved in drug deaths in order to encourage proactive onward referral to specialist addiction services and the appropriate level of intervention with those vulnerable and at risk.

8.2 Prisons / Prison Through Care

The working - group welcomes the current revision of the SPS Addictions Policy and would support a greater emphasis on harm reduction approaches. Many of the working- group's recommendations relate to means of improving and establishing joint working between community based a and prison based services.
This would initially involve completing the task of process mapping the route individuals take from community to prison and from prison back into the community to identify any breakdowns in care pathways and joint work to develop a service model which links treatment programmes in prison and community. This model should cover:

- Continuity and smooth transfer of community treatment plans (including methadone prescribing) immediately on admission to SPS establishments
- Pre- release assessment and identification of those most at risk
- Effective and efficient pre and post release contacts and information exchange between prison and community based services to ensure immediate continuity of treatment post release
- Ensuring immediate access on release as required to
- primary care services,

- social care support and rehab services
- housing and housing support services

Early discussion between community based services in Glasgow and SPS to agree such a service model and put in place an implementation plan is recommended. In order to further facilitate joint working the following are also proposed:

- IT solutions should be developed to allow immediate sharing of assessment and other information between community services and SPS
- Joint training be developed that involves both SPS and community based practitioners in the addiction field

Further recommendations include

- Given that prison provides an opportunity to access a "captive audience" to services, enhance SPS capacity to initiate treatment in prison (continuity must be ensured on release for those introduced to treatment)
- Explore the possibility of developing means of assessing those at highest risk of death prior to release so that they can be prioritised.

8.3 Homeless People / Homeless Accommodation

- A strategic cascade training programme has been developed for statutory and voluntary sector staff in the homeless field re issues around drug misuse. Improved dissemination of appropriate harm reduction info has also been also proposed. This will involve piloting training in OD prevention/ first aid for staff and service users in 2 hostels(see also 7.1 above).
- It has been estimated that instances of over 100 people who had taken non fatal overdoses had been discovered by hostel staff in the past year. These instances should be formally noted and improved/ rapid investigation of such incidents should take place to inform future care/ service development and avoid recurrence.

Other recommendations relating to homelessness settings identified are.

- Need for rapid access to addiction services when required- this entails ensuring that a sufficient service capacity is available through the HAT and in areas where homeless accommodation is available eg through additional Social Work posts agreed re hostels closure and arrangements for clinics/ prescribing.
- Tendency for detoxed / stabilised users to relapse in hostel settings eg after accommodation in Clyde Place / on release from prison noted. Need for immediate access to appropriate accommodation with support.
- Need to develop a policy of non- exclusion re "difficult to manage" but vulnerable users and associated appropriate service responses / protocols. Need to link into hostel closure and recommissioning programme in this respect.

8.4 Risk Factors / Assessment /Accessing Services

The compilation of a data- base of 2002 deaths currently underway with the intention of identifying a core set of risk factors and predictors. This evidence will subsequently used to ensure best working practice through:

- Use of above to develop tools to be built into the joint assessment for those working in the field in order to facilitate early identification of highest risk individuals and to react appropriately.
- Consider any amendments required to single shared assessment process resulting
- Use of data- base to identify key breakdowns in care pathways and develop concomitant service improvement proposals

It is further proposed that interagency protocols be developed regarding best practice procedures in following up when vulnerable/ at risk users fail to attend appointments.

8.5 Methadone Deaths and Prescribing Difficulties

Analysis of methadone-related deaths indicates that methadone is frequently obtained illicitly. In addition a significant number of deaths of those on the methadone programme involved heroin. It

may therefore be necessary to examine why these individuals resorted to additional heroin. Other forms of poly- drug use were also evident. Take home doses were implicated in a number of deaths (both of persons prescribed for and for others who had access to their supply) The following are therefore proposed.

- Increase the participation and confidence of GPs involved in the methadone programme by continuous training and support in prescribing and supervision to avoid difficulties encountered with methadone dose assessment, take home doses, the use of methadone tablets and benzodiazepine prescribing.
- Introduction of GDPS Prescribing Guidelines to all areas of the methadone programme
- Advice to those on programme re safe/ secure methadone storage recommended
- Increased capacity required for 7 day per week supervised consumption for at risk patients recommended.
- At the start of methadone treatment advice should be given to users and their associates about the dangers of polydrug use (inc alcohol and benzodiazepines)
- Alcohol abuse can become a significant factor after stabilisation on methadone and this risk must be recognised in the management of those on the programme.
- Further examination of benzodiazepine prescribing practice generally but in particular in relation to those on the methadone programme / known injecting drug users
- Recommend that the DAT and PIG are regularly updated on trends in methadone deaths.

8.6 Continued Improvement in Liaison between Agencies Over Drug Deaths

The benefits of interagency collaboration over drug deaths became self evident over the period that the working group has been meeting. As part of its deliberation a "Rapid Reaction Team" was proposed, whereby a group which meets regularly is set up so that pathologists / toxicologists can more quickly and regularly share relevant information on recent deaths eg (unusual trends / atypical reactions to drugs) with the police and addiction services and visa versa re trends in types, purities and contaminants in street drugs. This would allow rapid dissemination of information to relevant professionals /agencies in the field. The group also felt that a refined version of the Drug Deaths Working Group comprising key players from health, social work, police, pathology and SPS should continue to meet on a quarterly basis in to provide joint oversight of the implementation of these proposals, assess trends in drug deaths and to report on progress on a regular basis to the DAT and PIG. The group concluded that since it was likely the same agencies/individuals would be involved in both groups they should be rolled into 1 group responsible for the information dissemination, reporting, monitoring and implementation tasks described above. A draft remit and proposed list of member agencies for the " Glasgow Drug Deaths Monitoring and Prevention Group" is included as appendix 2.

8.7 Other Issues requiring longer term consideration

If the working group were continued it would wish to explore the following issues in the longer term.

- Research / literature review re the viability/ possible benefits of supervised safe injecting facilities
- Further research required into opportunities for encouraging people into services / harm reduction interventions at point of non- fatal overdose in A&E settings and the possibility of eg ambulance control services informing community services of non fatal overdoses so to aid identification of the most vulnerable individuals and facilitate appropriate service responses.
- Development of interagency guidance good practice on the appropriate role / timing of detoxification within care plans, aftercare to avoid relapse etc
- Give consideration to the possibility of piloting of naloxone administration by staff within residential settings/ hostels in emergencies
- Research / literature review re " take home" naloxone for users / users partners /relatives etc

9 Action Plan