



Drug Related Deaths and Strategies for Prevention

A Working Group was convened by the Irish College of General Practitioners Drug Misuse Programme to examine the issue of drug related deaths in Ireland. Drug related deaths and how to prevent them was highlighted at the annual conference on the Management of Opiate Misuse in Primary Care in 2004. A recommendation was made at the conference to examine this issue in more detail. Personnel from a wide range of backgrounds and special interests were invited to participate in the drafting of this report and I wish to acknowledge their support and commitment to the publication of this report.

Drug Related Deaths is an important issue which has been highlighted at the World Health Organization (WHO) and at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)1 as being one of the main consequences of drug use and a major cause of death in young people.

In Ireland, a recent report from the Health Research Board, Drug Misuse Division2 reported that the majority of drug related deaths in Ireland occur in Dublin though the numbers of such deaths are increasing outside of Dublin. Current statistics suggest an increase in deaths from 39 (thirty nine) to 90 (ninety) in the Dublin area between 1995 and 2000 and from 4 (four) to 29 (twenty nine) outside of Dublin for the same period of time. While there are acknowledged inaccuracies in how the data is collected and coded it is clear that the numbers of drug related deaths are rising. Some clear risk factors also emerged from the report.

People most at risk include:

- 1. Male drug users (75%)
- 2. Drug users following detoxification
- 3. Polydrug users (89% tested positive for more than one substance)
- 4. Drug users on entry to or on release from prison 13%
- 5. Opiates used with alcohol and/or benzodiazepines contributed to many of the deaths
- 6. Drug users using alone

Drug related deaths have been identified by the EMCDDA as being preventable in many instances. With suitable education and improved awareness of the issues involved, the ICGP Working Group believes that lives can be saved and are therefore making the following recommendations:

National Strategy on Prevention of Opiate Related Deaths

- 1.1 A National Co-ordinated Strategy to prevent Opiate Related Deaths should be implemented urgently. Organisations such as the National Drug Strategy Team (NDST) or the National Advisory Committee on Drugs (NACD) may be ideally placed to take responsibility for the implementation of such a strategy. The implementation of a strategy should be reviewed regularly to assess its effectiveness and to review current literature on the subject.
- 1.2 Links between "Reach Out" the National Suicide Prevention Strategy, the National Para-suicide Register and the National Drug Related Deaths Register should be established in view of the considerable overlap between substance abuse and suicide.

Education and Training

- 2.0 The group has considered a variety of patient information material currently in use both nationally and internationally. It is important that information and resource materials are standardised across all treatment and support locations. Resource materials should include a range of media such as video, pamphlets, posters etc. The working group recommends that a subgroup is convened to examine in greater detail the range of materials and to advise on the appropriateness of same. Literacy and suitability for the target audience are essential considerations.
- 2.1 All personnel who treat drug users should receive training in overdose prevention. High risk individuals can be identified and members of staff should address risky behaviours with service users.
- 2.2 Consideration should be given to providing overdose prevention education groups for service users in each treatment/support centre. This is particularly important during times of increased risk such as the induction phase of treatment, during a detox programme and entry and exit from prisons.
- 2.3 Staff who treat drug users should receive basic life support (BLS) training through an accredited training programme.
- 2.4 Family members of known drug users should also consider receiving training in BLS.

Prisons

- 3.0 On discharge from prison all known drug users should be facilitated to link in with their local drug treatment agency. Contact numbers should be supplied in a "pre-release pack" which is given to each client. Pre-release information is particularly important for drug users who are not on methodone treatment as they are considered a higher overdose risk.
- 3.1 Prison service personnel should be made aware of the above discharge procedure. Contact should be made with local HSE services wherever possible in the event of the discharge of a known drug user.

Detoxification

4.0 All drug users undergoing detoxification, in both outpatient and inpatient settings should be made aware of the risks of overdose particularly following detoxification. Clients should be requested to sign to verify that they have received information and counselling with regard to the risks of overdose. Targeted overdose prevention programmes should be provided in all settings where detoxification from substances is provided.

Emergency Response

- 5.0 The Working Group supports the recent change in the Statutory Instrument which provides for senior ambulance personnel with special training to carry Narcan as an emergency response in an overdose situation. The Working Group also acknowledges the ongoing training of ambulance staff in managing an overdose situation.
- 5.1 Gardai should receive training in overdose prevention and receive training in emergency response in an overdose situation.

Research

6.0 The true extent of non-fatal opiate overdoses or near-misses is not known. The Working Group recommends that a research project be co-ordinated through the NDST to look at the feasibility of collecting this data in a formal way through a variety of agencies e.g. ambulance service, the Gardai, accident and emergency departments.

References

- 1. EMCDDA, "Overdose-a major cause of avoidable death among young people", Lisbon 12-1-05
- 2. Health Research Board, Drug Misuse Division, Overview of Drug-related deaths in Ireland, 1990-2002

Working Group

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