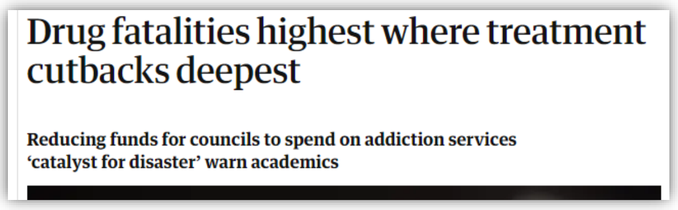
Developing a collaborative approach to monitor **drug related deaths** helps to improve care for people in treatment

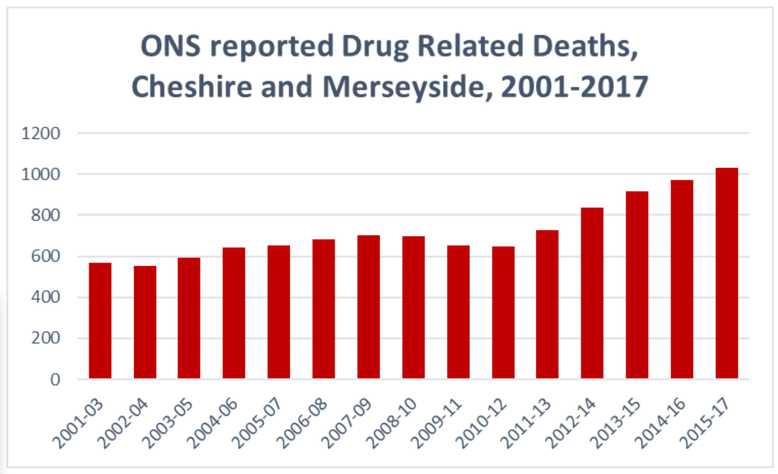
"The benefits of a regional collaborative drug related death surveillance system: Insights from development of a monitoring system in the North West of England" **Mark Whitfield, Howard Reed**

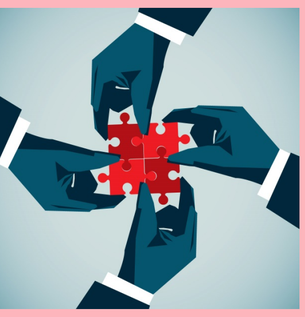
Drug Related Deaths (DRDs) across England and Wales are at their highest level since records began in 1993, with deaths from overdose being particularly prominent in recent years. Across Cheshire and Merseyside, a region in the north west of England, deaths are also at their highest level since records began. There may be many reasons for this including increased purity levels of street drugs, the increasing age of people accessing Treatment, and service cuts due to austerity.


Drug fatalities highest where treatment cutbacks deepest

Reducing funds for councils to spend on addiction services 'catalyst for disaster' warn academics

The Guardian, 14th October 2017





In response, seven of the nine local authorities within Cheshire and Merseyside region established a review process to examine DRDs in order to explore common themes, identify recurring issues and to share findings. The monitoring system was developed by Liverpool John Moores University's Public Health Institute (PHI) who collate information from various sources and who chair regular panels. The process is based on recommendations from the Local Government Association[1] and Public Health England[2].

[1] "Preventing drug related deaths" Local Government Association, 2017, [2] "Understanding and Preventing Drug Related Deaths", PHE, 2016

HOW DOES IT WORK

An online tool allows treatment services to record details of a death when it occurs

Everyone relevant in area is automatically notified

Research assistant visits local coroner offices on a quarterly basis to record deaths outside of the treatment system

Data is collated from other sources such as Needle Exchange records, and social services

Individual case reports are compiled quarterly and securely disseminated to all members of the local group

Panels meet every three months with representatives from various services to discuss issues and best learning

This is shared with surrounding areas by means of reports and wider area meetings

WHO ATTENDS THE PANELS?

- **Treatment service staff**
- **Consultant prescriber**
- **Local authority public health commissioner**
- **Social services staff**
- **Hostels**
- **COPD (Respiratory Care)**
- **End of Life Care**
- **Medicines Management**

Common Themes

Individuals tend to live alone which Naloxone may not be useful for

A high volume of medication is prescribed by GP's sometimes in excess of 20 per individual

Increasing numbers of older people accessing treatment have high levels of COPD/respiratory disease

People not in treatment are dying at a younger age

Sup-optimal prescribing of methadone is common, but there may be clinical reasons for this

Depression is the highest commonly identified mental health condition

Some actions resulting from DRD panels

- ✓ Pathways have been developed between drug treatment services and other services including palliative care and prison services
- ✓ Local protocols reviewed around bridging prescriptions
- ✓ Day programme in signing skills for staff was developed
- ✓ Awareness package for staff in COPD symptoms to give them greater confidence
- ✓ Focus on individuals living alone with risk assessments carried out
- ✓ Exploration of offer for individuals not engaging with treatment
- ✓ Liaison with nursing homes and sheltered accommodation for older people
- ✓ Campaign around smoking cessation implemented for treatment service staff
- ✓ Links strengthened with services assisting both families and services users through bereavement
- ✓ Recovery position training delivered to staff

Implementation barriers included data sharing issues (particularly with coroner data), funding for the system during a time of significant pressures on public health budgets, getting the key stakeholders together at the same time and dealing with the volume of deaths within the available time

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PHI Public Health Institute
LIVERPOOL JOHN MOORES UNIVERSITY