Pioneer Scheme Half-day Learning programme

Wednesday 23rd October 2019

KNOWLEDGE EXCHANGE

Drug and alcohol related mortality

With Tony Martin and John Campbell (Glasgow Alcohol and Drug Recovery Services)

1) What were the key learning points from this session?

Drug Related Mortality:

- It is hard to define Drug Related Mortality as it is complex to specify
- Most commonly it affects males aged 35-44, from deprived, socially isolated areas
- 4/5th have problems with alcohol and 2/5th in contact with Addiction services
- Multiple co-morbidities affecting both physical and mental Health
- >50% in prison and <20% have been arrested within 6 months of dying
- Most commonly died with at least 3 or more drugs in their system (+/- alcohol) which are most commonly heroin/morphine, methadone and benzodiazepines e.g. Etizolam

Glasgow Harm Reduction:

- Popularity of different drugs over time in Glasgow e.g. Ecstasy, temazepam that was injected and caused awful limb injuries when injected
- Cost of heroin/benzodiazepines/cocaine – is relatively cheaper to access these drugs now than 20 years ago
- Recent cases of Anthrax (2012), Botulism (2015) and HIV (since 2015) epidemic in Glasgow
- Reducing risk via lots of harm reduction programmes, such examples include:
    - More availability of paraphernalia – needle exchange, spoons, filters etc
    - Take home Naloxone (2007)
    - Introduction of Outreach Nurses
    - One hit kits (2011)
    - Introduction of Foil (2015)

- 2ml barrel syringes
- Harm Reduction Nurse (2018)
- Wound Care (2018)
- Mobile IEP (injecting equipment provision) Van (2019)

Alcohol Related Mortality

- Annual monitoring and reporting of alcohol related deaths
- Helps to form Alcohol related harms reduction programme
- Typically, males more than females (female 45-54, males 55-64), white Scottish, single or divorced, living in most deprived areas of Scotland
- Averaging 233 units/week
- Multiple issues causing or related to alcohol e.g. family life, relationships, co-morbidities, mental health, financial/employment, housing/homelessness, social isolation and bereavements
- Majority are in contact with alcohol related services, but level of engagement varied and very few maintained in this service
- Multiple unscheduled hospital attendances – via GP/A&E - average 8 a year plus increased interaction with psychiatry services in 21%

GP Clinical Case

- Role of optimal dose of Methadone – 80-120ml as offers tolerance
- Role of Addiction services – referral for Detoxification and supervision or Acamprosate, Antabuse/Disulfiram – better results for patients if done by Addiction services than GPs
- Role of residential detoxification and services available in Glasgow e.g. Crisis Drug Centre, Eriskay House, Garscube and Rainbow
- Use of blood spotting tests for HepB/C/HIV

2) What changes to practice might you consider?

- Lots of useful tools such as specifically asking about Cocaine use
- Asking about if people have any wounds that need checked
- As GPs – exploit any opportunities to try and get our alcoholic patients to engage, involvement with outreach services, long term harm reduction, detoxification and post discharge support
- Use of oral thiamine for alcoholics – if in doubt – prescribe and try to encourage patients to take!
- Offering HepC/HIV testing
- Better Hepatitis C treatments available now
- Urine drug test can be negative for street Benzos as reads negative for Etizolam

3) Any useful resources to share?

- Upcoming role of Alcohol Withdrawal in Primary Care Pathway tool
- “Deep End Alcohol Project” – outreach/physical health checks for alcohol issues, including child protection/ASP (adult support and protection) risk assessments