



# Item No: 20

Meeting Date: Wednesday 26<sup>th</sup> June 2019

## Glasgow City Integration Joint Board

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### ALCOHOL AND DRUG PARTNERSHIP: DRUG RELATED DEATHS: STREET DRUGS SUMMIT

<b>Purpose of Report:</b>	To advise the Integration Joint Board on the outcomes of the Alcohol and Drug Partnership's 'Drug Related Deaths: Street Drugs Summit' held on 11 <sup>th</sup> April 2019.
<b>Background/Engagement:</b>	In January 2019, concerns were raised around "street valium" usage and increasing drug related deaths in Glasgow city. Glasgow City ADP were tasked with setting up a summit to explore the issues, examine the evidence and agree any future actions.
<b>Recommendations:</b>	The Integration Joint Board is asked to:  a) note the delivery of the summit; b) note the consultation on the draft report; c) note the development of an action plan; and d) expect an action plan at a future IJB meeting.

#### Relevance to Integration Joint Board Strategic Plan:

The development of proposals supports the attainment of a number of aspects of the stated vision of the IJB, including:

- Designing and delivering services around the need of individual carers and communities
- Focussing on being responsive to Glasgow's population and where health is poorest
- Supporting vulnerable people and promoting social well being

## Implications for Health and Social Care Partnership:

<b>Reference to National Health &amp; Wellbeing Outcome:</b>	The proposed developments relate to outcomes 1,3,4,7 and 9
<b>Personnel:</b>	At this stage, there are no staffing implications. These will be addressed in a future action planning phase which will come to the IJB in the Autumn.
<b>Carers:</b>	Carer involvement is built into ADP processes with representatives attending the summit on the day and involved in the construction of an action plan.
<b>Provider Organisations:</b>	The future role of provider organisations to support changing models of care will be key to the construction and implementation of an agreed action plan.
<b>Equalities:</b>	Inequality, alcohol and drug issues, mental health and human rights are inextricably linked. As part of the development work around the action plan an Equalities Impact Assessment will be undertaken for all aspects of service development.
<b>Fairer Scotland Compliance:</b>	The EQIA and actions identified as part of the development of the subsequent action plan will contribute to the HSCP's duty to tackle/reduce inequalities of outcome caused by socio-economic disadvantage,
<b>Financial:</b>	None at this stage. The action plan will consider proposals and link in with the existing ADP investment plans.
<b>Legal:</b>	None at this stage. Police Scotland were key contributors to the Summit and will remain key partners in any agreed action plan.
<b>Economic Impact:</b>	A negative impact remains with street drug use. It is expected that the action plan will include this area and address anti-social behaviour and a reduction in public nuisance.
<b>Sustainability:</b>	The action plan will be subject to monitoring and review.
<b>Sustainable Procurement and Article 19:</b>	None
<b>Risk Implications:</b>	As the process of developing an action plan continues to evolve, a risk register will be developed.
<b>Implications for Glasgow City Council:</b>	None

<b>Implications for NHS Greater Glasgow &amp; Clyde:</b>	None
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<b>Direction Required to Council, Health Board or Both</b>	Direction to:	
	1. No Direction Required	✓
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

## 1. Purpose

- 1.1 To advise the Integration Joint Board on the outcomes of the Alcohol and Drug Partnership's 'Drug Related Deaths: Street Drugs Summit' held on 11<sup>th</sup> April 2019.

## 2. Background

- 2.1 In early 2019, concerns were highlighted around an unprecedented increase in drug-related deaths in Glasgow city.
- 2.2 Available data showed that there was a 43% rise in the number of people who died of drug overdoses in Glasgow from January to October 2018 compared with the same period in 2017.
- 2.3 Concerns were raised that "street valium" (also known as street blues) may be linked to the increase.
- 2.4 Service providers feared that a recent spate of deaths among people in settled homelessness accommodation was also linked.

## 3. Proposals

- 3.1 Following early discussions within the Glasgow City Alcohol and Drug Partnership (ADP), it was agreed to set up a summit to explore the issues, consider the evidence and decide what additional actions partners could take to add to existing ADP plans.
- 3.2 The Summit date was set for 11<sup>th</sup> April 2019. The title 'Drug Related Deaths: Street Drugs Summit' reflected the need to use appropriate nomenclature (see Paper 4 in Appendices for Programme).

## 4. Summit Structure and Content

- 4.1 It was originally intended to have a focused event, inviting around 40 people for a half day. However, the level of interest and commitment from partner organisations meant a need to extend both the time and range of invitees.
- 4.2 Whilst there was considerable interest from around Scotland, the ADP decided to maintain a Glasgow city focus.

- 4.3 The event had 9 short inputs, focusing on supply issues, impact and responses. There then followed workshop discussions on what additional actions could be taken to address the issues. This had a strong partnership approach.
- 4.4 In preparation for the event, papers were prepared on 'Drug Related Deaths in 2017' (see paper 2 in Appendices) and Prevention and Harm Reduction for Benzodiazepine Use in Greater Glasgow and Clyde' (see paper 3 in Appendices).
- 4.5 Contributors included Glasgow University Forensic Toxicology, Police Scotland, HSCP Homelessness, HSCP Treatment and Care Services and Recovery Communities.

## **5. Action Planning**

5.1 **Workstream at the summit** focused on the following priorities:

- Priority 1: Improve our understanding of the scale and impact
- Priority 2: Improve our oversight and coordination of services
- Priority 3: Improve communication of the issues
- Priority 4: Develop new activity.

## **6. Next Steps**

- 6.1 The ADP has sent a draft report on the day to participants to check that the main points have been captured. (See Paper 1 in Appendices)
- 6.2 The ADP has tasked its 'Drug Harms' sub group to develop an action plan for consideration by Strategic ADP. Following this, the paper will come to the IJB.

## **7. Recommendations**

- 7.1 The Integration Joint Board is asked to:
- a) note the delivery of the summit;
  - b) note the consultation on the draft report;
  - c) note the development of an action plan; and
  - d) expect an action plan at a future IJB meeting.

## Appendices

### Paper 1: Draft summary report



## Drug Related Deaths: Street Drugs Summit

**Date:** Thursday 11<sup>th</sup> April 2019

**Location:** Recital Room, Glasgow City Halls

**Number of Attendees:** 57

**Contact:** Gillian Ferguson [Gillian.ferguson@glasgow.gov.uk](mailto:Gillian.ferguson@glasgow.gov.uk), 0141 276 6628

### Summit Outline

On 11<sup>th</sup> April 2019, Glasgow City ADP hosted a Street Drugs Summit, focusing on recent drug related harms and deaths in the city. Attendance at the summit was by named invitation with 57 individuals taking part.

The summit was chaired by Susanne Millar, Chief Officer Strategy and Operations/ Chief Social Work Officer, Glasgow Health and Social Care Partnership and Chair of the Glasgow City ADP. A welcome pack for each delegate included a background paper on published Drug Related Deaths figures in the city (Paper 2) and Prevention and Harm Reduction for Benzodiazepine use in Greater Glasgow and Clyde, a working document on new trends in benzodiazepine use in the city (Paper 3).

The day was divided into 3 sections: Supply, Impact and Responses with 3 speakers in each section covering a particular area for consideration and discussion by the wider audience. See summit programme (Paper 4).

- Supply - the street drug issues impacting on the city now
- Impact - who are suffering the worst harms from these street drugs
- Responses - current activity that is mitigating the harms

The most up to date estimate of the city's drug death figures, the current forensic toxicology of drugs implied in these deaths and the enforcement response were shared with delegates. The impact on Glasgow's homeless community, treatment service users and recovery communities was discussed. And the harm reduction response across the city was examined.

The Action Planning session concentrated on how to

- improve our understanding of the scale and impact
- improve oversight and coordination of services
- improve communication of the issues
- develop any new activity

These table discussions were recorded by scribes.

At the conclusion of the summit, it was agreed that an action plan would be developed from the recorded feedback and shared for comment with the ADP, before being circulated through the Homelessness Partnership and onto delegates.

## **Action Planning**

The workshops focused on the four summit priorities:

Priority 1: Improve our understanding of the scale and impact

Priority 2: Improve our oversight and coordination of services

Priority 3: Improve communication of the issues

Priority 4: Develop new activity

We have summarised the workshop feedback under each heading below.

### **Priority 1: Improve our understanding of the scale and impact**

#### 1.1 Information sharing

- a. formal Information Sharing Protocols required
- b. address barriers to sharing information
  - GDPR
- c. address delays to accessing information- need real time data from frontline
- d. identify new types of information eg dynamic information, qualitative information from frontline
- e. share available info and resources more widely
  - better use of critical incident reviews
  - share mistakes and problems as well as successes
  - Neo database-needle exchange data
  - learning logs
  - harm reduction information
  - STOP unit- Statement of Opinion unit, Police Scotland
- f. need oversight of what information is available and from who
  - police
  - emergency department
  - toxicology
  - ambulance service
  - Scottish Police Services Authority (SPSA)
  - Neo report
- g. raise awareness of services that are new
  - mobile injecting equipment provider (IEP) van
- h. share info with lived and living experience, families and carers

#### 1.2 Research required

- a. on those most at risk of drug harms- people with multiple and complex needs
- b. on the impact of welfare reform
- c. research information must be filtered down to operational level

#### 1.3 Address ongoing barriers to mental health services

- a. review membership of groups- ensure mental health representation

- 1.4 Strategy and activity needs to be informed by operational experience
  - a. ensure lived and living experience voices are embedded
  - b. ensure families and carers voices are embedded

## **Priority 2: Improve our oversight and coordination of services**

### 2.1 Services

- a. need to reduce barriers
- b. improve accessibility
- c. Out of Hours services required- currently Emergency Departments and recovery cafes
- d. increase 'stickability'
- e. immediate access
  - to wound management
  - on relapse
  - in crisis
  - through prisons and criminal justice services
- f. address the physical health needs of service users
- g. provide person centred care
- h. provide atypical benzo screening
- i. need to prioritise early intervention with vulnerable young people, particularly LAAC

### 2.2 Staff training and culture change

- a. universal access to naloxone in the city
- b. include statutory and 3<sup>rd</sup> sector staff
- c. staff from different care groups need training on drug harms issues
- d. practical questions are routinely required addressing how service users use their drugs
- e. equip staff with skills to deal with trauma
- f. debriefing process required for GADRS staff, 3<sup>rd</sup> sector staff and recovery volunteers following service user death
- g. planned networking events
- h. address stigma
- i. ensure community engagement

## **Priority 3: Improve communication of the issues**

### 3.1 Communication strategy/ model required

- a. could be led by Public Health
- b. carefully considered messages- factually accurate
- c. messages can be tailored for the chosen audience
- d. messages and discussion with media should be pro-active- not defensive
- e. consider communication champions in each area
- f. messages need to penetrate to frontline staff and service users
- g. consider resource implications and identify budget
- h. protocol required for significant new events- eg fentanyl
- i. the model needs to include use of social media
- j. increase the profile of DRDs in partnership with the media
- k. national alert framework

## **Priority 4: Develop new activity**

### 4.1 Review of legislation e.g. Misuse of Drugs Act 1971

- a. continue to work with Scottish Govt.
- b. continue to make representations to UK Govt

4.2 Improve real time testing of drugs nationally

4.3 Buddy partnership scheme between Turning Point Scotland and Police Scotland- awaiting further detail

4.4 Non-fatal overdose pilot- address Information Commissioners objections

4.5 Develop a model for mental health crisis café

4.6 Pilot for Doppler Radar heat system in partnership with Scottish Govt and Digital health institute- awaiting further detail

### **Recommendations- next steps**

1. Map existing services, pathways and coordinated responses to multiple and complex needs and review response to DRDs and drug harms from
  - primary care- including shared care
  - emergency depts.
  - Police Scotland
  - Glasgow Alcohol Drug Recovery Services
  - homelessness services
2. Create City-wide action plan- managed by ADP Exec
  - linked to SG Rights, Respect and Recovery Strategy Action plan (draft expected Summer 2019)

### **Paper 1 IJB Notes:**

Draft report shared with contributors and feedback deadline set for 24<sup>th</sup> May 2019

Request to contributors:

- does this summary reflect key aspects of the day?
- anything significant missing?
- any other comments



## Paper 2: Drug Related Deaths in 2017 Summary

The focus of today's event is on the recent perceived increase in drug related harms, including deaths, in Glasgow City in 2019. The information below gives the context from 2017 and more limited information for 2018, but we believe it is useful in setting the scene and establishing the facts as we know them.

The latest "Drug-related deaths in Scotland in 2017" report published by the National Records of Scotland (NRS) in July 2018 revealed that there were 934 drug-related deaths in Scotland in 2017. This is the highest number ever recorded since records of drug-related deaths began and follows the increasing trend that there has been over the past 10 years. The report also indicated that in Glasgow City there were 192 Drug-related deaths in 2017, a 12.9% increase compared with 2016 and similarly the highest number of deaths ever recorded over the past 10 years. (See Graph below).

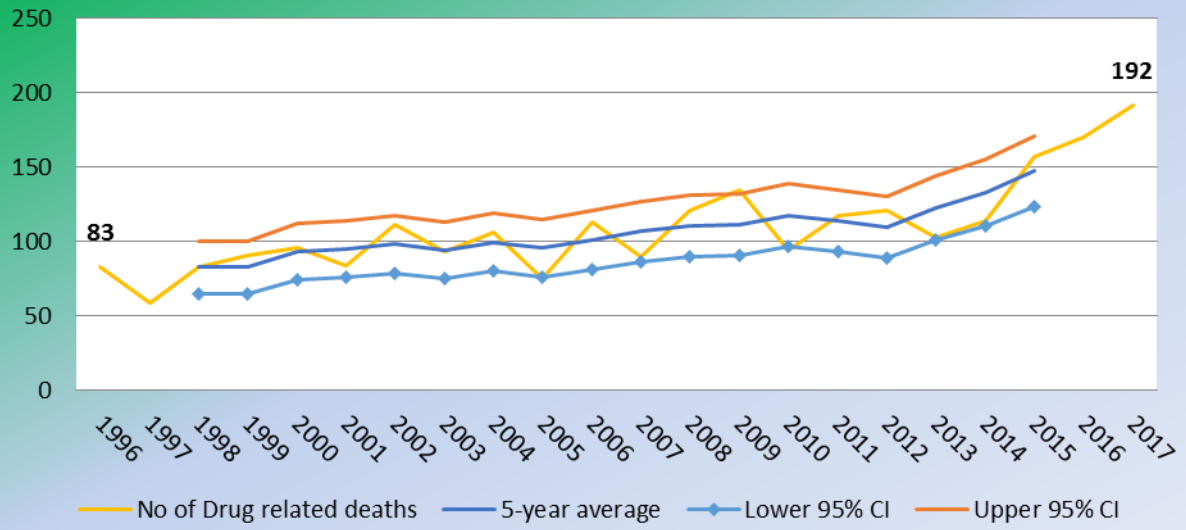
There are a number of common themes which emerge from the complete analysis of those who died in 2017:

- Ageing drug users are most at risk. 88.5% of those who died were aged over 35 (Typically the largest number of people who die are aged 35-44).
- Males make up 71% of the deaths although the number of deaths in females is increasing at a rate quicker than that of male deaths.
- Over three-quarters (75.5%) were known to live in the most deprived 20% of communities of Glasgow City.
- In 2017, 12.9% of people were also known to have applied for homeless accommodation.
- Over half of those who died had spent some time in prison (59.3%) whilst 20.0% of individuals had been arrested in the 6 months prior to their death.
- There has been an increasing trend in recent years for more than one drug to be implied in the cause of death. (85.6% of those who died had more than one drug or an underlying health complication).
- Co-morbidities such as physical health problems e.g. Respiratory disease (32.3%) and Mental Health problems e.g. depression (58.3%) or anxiety (31.7%) are also commonly found.
- Opiates continue to be the most common drug found at toxicology (87.5%)
- There have been recent rises in deaths in which benzodiazepines are also part of the cause of death, mostly atypical benzodiazepines such as Etizolam (63.0%)
- There has also been a recent increase in the incidence of Cocaine found as part of the cause of death. (Rising from 14 % to nearly 21% of deaths)

**Whilst investigation into the deaths in 2018 is still underway, local intelligence and monitoring of Drug-related deaths within Glasgow City suggest that this upward trend has not only continued but that the rate of deaths is increasing.**

Drug-related deaths in Glasgow City 1996-2017.

Drug-related deaths in Glasgow City 1996-2017



## Paper 3: Prevention and Harm Reduction for Benzodiazepine Use in Greater Glasgow and Clyde

***This paper is a working document looking at the prevention and harm reduction approach to Benzodiazepine use in Greater Glasgow and Clyde area.***

*It has been produced as a working draft as a means of bringing together a number of issues relating to the challenge of prevention and harm reduction of benzodiazepine use. It is prepared in the first instance for discussion at the Greater Glasgow and Clyde Alcohol and Drugs Planning Group. It is not intended as a comprehensive review of services or approaches, but considers current prevention and harm reduction approaches as well as some recent developments within treatment services, along with some opportunities for further development.*

\* \* \*

In recent years the dynamic and changing market in the production and supply of novel benzodiazepines means that they are more widely available and cheaper than ever. Often produced locally latest reports suggest 1000 tablets can be bought for around £80.

Since 2007 there has been increasing numbers of benzodiazepines appearing in the UK market. Some of these may be around for relatively short periods of time whilst others such as Etizolam remain popular, and problematic.



It is believed that these changes have contributed to an increase in their use and in the related harms, including a year on year increase in mortality where benzodiazepines are implicated and increasing reports of young people using benzodiazepines.

Whilst we recognise that the majority of people use benzodiazepines along with other drugs, we must also acknowledge the role that benzodiazepine use has in increasing risk. It also suggests that we need a new approach to reducing the risks for those who use street benzodiazepines.

Over the past few years Greater Glasgow and Clyde has seen a 300% increase where these benzodiazepines contributed to the death of individuals. Most of these deaths happened when benzodiazepines were taken with other depressant drugs

such as alcohol, heroin or methadone. This pattern is replicated across Scotland, see below.

All DRD's	2013	2014	2015	2016	2017
Sco-Benzodiazepines	28.3%	19.7%	27.1%	49.1%	59.1%
Sco-Diazepam	20.3%	14.0%	18.1%	17.8%	21.9%
NHS GG&C-Benzodiazepine	4.3%	10.9%	19.0%	52.5%	64.3%
NHS GG&C-Diazepam	4.3%	5.1%	11.3%	3.1%	5.7%
Glasgow City-Benzodiazepine	11.7%	5.3%	14.6%	52.9%	63.0%
Glasgow City- Diazepam	4.9%	5.3%	8.3%	4.1%	4.2%

This paper also seeks to consider the challenge created by benzodiazepine use within a public health context, with section 8 exploring key public health aspects. To set the scene for public health considerations, we refer to a US publication from 2018 considering the drug overdose epidemic from 1979 through 2016 (Jalal et al<sup>1</sup>). In commenting on the trajectory of drug deaths documented in the United States over this period, the authors made the following commentary:

***“Understanding the forces that are holding multiple sub-epidemics together in a smooth exponential trajectory may be important in revealing the root causes of the epidemic, and this understanding may be crucial to implementation of prevention and intervention strategies. Economic and technological “push” factors may be at work to increase supply, such as improved communications and supply chains, efficiencies in drug manufacturing and expanding drug markets, leading to lower prices and higher drug purities. Sociological and psychological “pull” forces may be operative to accelerate, such as despair, loss of purpose, and dissolution of communities. Elucidation of the dynamics of the “deep” drivers of the overdose epidemic may provide valuable new insights.”<sup>2</sup>***

## 1. Policy

**1.1** ‘Rights, Respect, Recovery a strategy for Scotland’ underpins the drug related work across Scotland and all six local ADPs will use the strategy to form their local plans. The strategy endorses a Public Health approach to drugs with better partnership working, working with people with lived and living experience, evidenced based interventions and a co ordinated approach to prevention work with better access to resources using a multi media approach. The strategy also acknowledges the importance of reducing inequalities and stigma to improve the lives of people who use drugs.

**1.2** The SG Public Health Directorate also identified one of their six priorities to be ‘A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs’ advocating the above principles and the importance of partnership working. All of these elements should be at the core of our work in reducing the harms associated with benzodiazepine use in GGC. The areas of work discussed in this paper are based on these principles.

<sup>1</sup> <http://science.sciencemag.org/content/361/6408/eaau1184>

<sup>2</sup> <http://science.sciencemag.org/content/361/6408/eaau1184>

**1.3** Reports produced by national agencies such as Scottish Drug Forums 'Staying Alive' Report and 'Older Drug With Drug Problems' Report also inform the prevention and harm reduction work across GGC. These reports aim to stimulate actions which can reduce the high mortality rate amongst people with drug problems in Scotland by encouraging wider and more holistic interventions.

**1.4** Benzodiazepine harms are a priority for all 6 ADPs in GGC as morbidity and mortality continue to increase. Glasgow City ADP Drug Harms subgroup and Clyde Drug Action Group have both identified a priority action of identifying and implementing a range of effective harm reduction interventions for the harms associated with novel benzodiazepine use and their role in increasing drug related deaths. This is complicated by the fact that the levels of use in GGC are not really replicated across the globe and most of the literature concentrates on dependency and use of far lower levels of use than we currently see. There is also a lack of research and accurate data on use and associated harms.

## **2. Data gathering and analysis**

**2.1** Currently, with the exception of drug related death data most of the data on benzodiazepine use is not of particularly good quality or consistency. The data on drug related deaths is the best we have to evidence that there is an increasing trend related to benzodiazepine use and the year on year increase in deaths shows that used in conjunction with other drugs benzodiazepines significantly increase risk. We need to improve our collection of data for substance use before a fatality occurs.

**2.2** The GGC Drug Trend Monitoring Group (GGCDTMG) working with the Acute Addictions Liaison Team try to capture hospital admissions across GGC however the monthly data is not consistent, with unexplained gaps in hospital submissions. This becomes more evident at times when we know from other sources there have been several cases with problems related to benzodiazepine use admitted to hospital and these are not captured in the Addiction Liaison logs that are received. Improving the quality of identification and recording of cases would give important information on benzodiazepine related problems and behaviours that result in unplanned hospital admission as well as inform the work to reduce harms to users.

Similarly staff in A&E reporting that they are often seeing multiple presentations daily. There is no way of capturing this currently therefore the overall impact of the benzodiazepine related problems to Acute services is unknown and patients are not always referred on to appropriate services.

**2.3** It is not always obvious when looking at Treatment Services information that a person is problematically using benzodiazepines. On initial assessment and follow ups first and second drug choice is recorded. If this is not noted as benzodiazepines they may not be included in the official statistics and the patients use of street names and terms makes it difficult to search for drugs in case notes.

**2.4** Another area for consideration is multi agency sharing of information which would alert us to any potential problems. A recent example of this was earlier this year when many agencies suspected that people they were working with were experiencing issues related to benzodiazepine use. Homelessness, Addictions, Acute, Public Health, Health Improvement, Police Scotland and 3<sup>rd</sup> sector services were all hearing reports of, or seeing users in distress due to suspected benzodiazepine use. Whilst we acknowledge that this information is often anecdotal

it can still be of real value; however there is currently no standardised process to allow agencies to alert others, only the use of their informal networks. Should one or two of the contacts be out of touch for any reason vital information could be left in the system whilst the problem in the community grows. A better alert system would help identify issues quickly and also help reduce double counting of cases if an individual is involved with more than one agency. An improved system would also help us to consider any further action required. The GGC DTMG are working on a better communication system for identifying trends, highlighting issues and how to get appropriate information out to services, users and the general public should the need arise however this needs multi agency management buy in to progress.

**2.5** Similarly the lack of any quick testing of substances is a very real issue for all users and services. Often users who have an adverse effect from a substance will present at services and offer them for testing. Even if there have been a spate of incidents we have no process in place to submit substances for testing and getting results out to services to inform their response or share with the wider user group. Police Scotland colleagues can submit substances to the Scottish Police Authority laboratories however substances involved in legal cases take priority so testing of submitted substances is not always quick. Currently sending a substance to WEDINOS is one of the quickest ways to get results however not everyone has access to the required paperwork for this and there are legality issues of posting illegal substances through the Royal Mail.

The GGC Drug Trend Monitoring are currently working with Police Scotland, Glasgow University Forensic Toxicology Service, Glasgow Alcohol and Drug Recovery Service and Glasgow City ADP to develop protocols for the safe transportation and testing of drugs submitted to Glasgow University. This will be specifically for substances that are identified as unknown content causing concern, and will be designed as a pilot which will be evaluated in the light of other developments re drug testing.

**2.6** Dundee University have recently been working with Scottish Prison Service to look at testing of novel substances within the prison estate. Clarification needs to be sought on whether this will include prisons within GGC, as well as how, and to whom, the findings will be communicated. Work is already underway to develop protocols for testing of novel substances, including atypical benzodiazepines, from within the prison estate in GGC. This work is being led through the GGC DTMG and partners include SPS Barlinnie Prison, Police Scotland and Glasgow University toxicology. Results would be fed back to the above and would inform overall intelligence on substance use within GGC.

One of the above options should increase the intelligence around the use of novel substances and inform local services and interventions.

**2.7** GC Drug Harms Group has established a short life working group to identify options for drug testing looking at evidence across the globe as well as recent developments in the UK. A paper will be prepared and preferred options will be explored in more depth however this will take time and ultimately resource. The paper will take in to consideration developments within the Scottish Police Authority Forensic Service who are planning to increase their capacity to enable real time testing of drugs seized from criminal proceedings. Once this is established they will consider the possibility of offering a purchased testing service to partners.

### **3. Literature and international policy**

**3.1** Most of the global literature and research deals with either people who get addicted to prescription medication or people who use smaller amounts of illicit benzodiazepines, often along with other drugs.

**3.2** The problem we are facing in GGC is people using large amounts of atypical benzodiazepines, many of which are new to the illicit market and change over time. Prevalence and patterns of use are not fully understood making it difficult to develop effective harm reduction resources for service users or training for staff.

Having asked the question of colleagues from the Eurocities Substance Prevention Group it would seem that no other country within the EU has a pattern of use that reflects the one we are trying to tackle.

**3.3** This is reflected in the lack of information in the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) portal where benzodiazepines are dealt with in prescribed medications or NPS categories, with amounts discussed being far lower than the 40-50 tablets consumed that we receive regular reports of, often taken along with other drugs.

**3.4** The lack of research and information impacts on the production of evidenced based interventions and information for services and users. The main body of international evidence points to the use of CBT as the most effective intervention with/without a planned detox.

**3.5** Investigating the Role of Benzodiazepines in Drug Related Mortality (2016). The National Forum on Drug-Related Deaths commissioned work addressing why benzodiazepines are common in Drug Related Deaths and what role they play, particularly at the high doses often reported. This Report presents the findings of a systematic review of evidence in relation to the use and misuse of benzodiazepines and highlights significant gaps in knowledge.

### **4. Treatment**

**4.1** Treatment services are faced with the difficulty of engaging with users of benzodiazepines that are being taken in large quantities, often with other substances and with no thought given as to what the chemical content may be or what harms may be associated with their use.

**4.2** Unlike Opiate Replacement Therapy there is not a strong evidence base for benzodiazepine prescribing as a treatment for problem benzodiazepine use and a lack of understanding of the prevalence and associated harms of novel benzodiazepine use contributes to the challenge of developing an effective care pathway for users.

**4.3** Currently in Glasgow the main intervention when patients present with problem benzodiazepine use is to encourage a reduction regime using their own supply of illicit drugs. There are obvious risks related to this approach. A GGC guideline for a planned benzodiazepine detox as a treatment option is currently waiting for clinical governance sign off.

**4.4** To further complicate treatment current drug tests used in services are limited and do not identify which benzodiazepines have been taken and in some cases do not detect some of the novel benzodiazepines at all.

**4.5** South Glasgow Alcohol and Drug Recovery Service (GADRS) are currently planning a piece of research looking at amounts of benzodiazepines consumed by patients on Opiate Replacement Therapy within their service to inform services to enable them to support this group of patients in an evidence-based manner.

## **5. Multi-agency Approach**

**5.1** There is recognition that the most effective way to move forward is for services to work together to address drug issues including those who use benzodiazepines as part of their poly drug using behaviour.

**5.2** The recent establishment of Clyde Drug Death Action Group was in response to the rise in drug related deaths and the increased implication of street benzodiazepines in these deaths. Tackling benzodiazepine use is one of the main aims of the group.

**5.3** Many of the findings of Taking Away the Chaos Health Needs Assessment, whilst focussing on the needs of individuals who inject in Public in Glasgow City Centre, apply to those who are using high levels of Benzodiazepines as part of their drug use regime. Multiagency working is a key principle of the report. Criminal Justice, Homelessness, Addictions and third sector work together to address the multiple needs of this group.

**5.4** The expansion of the Housing First Model is an example of multiagency working that puts the person at the centre of the treatment package, looking at the other social and health issues that may impact on drug use.

**5.5** Another approach currently being explored in GGC is Trauma Informed Practice and the introduction of this across a variety of services could have an impact on the effectiveness of interventions and treatment.

**5.6** The GGC Drug Trend Monitoring Group work to highlight trends that may cause concern and impact on other services such Children's Services, Homelessness and Criminal Justice. If trends are identified inputs to staff are offered to address concerns and increase confidence of workers in dealing with the drug related behaviours.

Recently intelligence from workers on the ground has highlighted issues with the increased use of cocaine and benzodiazepines. Sessions have been arranged with each Glasgow City Sector for staff who work in Children's Residential Services and initial discussions have taken place with Criminal Justice and Homelessness to provide the same. This offer is open to other ADP areas through the ADP co coordinators who are represented on the Drug Trend Monitoring Group



**5.6** Improved communication and sharing of information between partner agencies, as well as within services would be a positive step in early identification of emerging issues and intervention where needed.

## **6. Harm reduction approaches**

**6.1** The arrival of novel benzodiazepines has led to difficulties with even the basics such as - What will we call them? What do they look like? What are they?

For people who use benzodiazepines the questions may be different - Where can I get them? Can I get them easily? How cheap are they? Will they get me 'out of my face'?

Our priorities as service providers and public health partners are fundamentally different from users.

**6.2** Issues like these are making it really hard to develop effective harm reduction information that will actually have an impact on their use.

It is difficult to develop messages and a consistent approach for a group of drug users who are taking large quantities of, perhaps previously unknown substances that they know may have risks, but will still use them. We know there are many wider social factors that impact on people who use drugs and personal safety may not be a high priority. If a person is ambivalent about their life, messages such as test dose, don't mix drugs, space your drugs out are likely to be of limited effectiveness. Similarly producing posters and leaflets about possible risks has been shown to have little impact. We need to explore what else might work better and to do this we need to improve the flow of information and change the way we develop resources.

**6.3** Lack of testing; lack of knowledge of significant differences in effects of a range of atypical benzodiazepines; lack of research and lack of evidence base mean that prevalence and patterns of use are not known, making it difficult to develop effective harm reduction resources for service users or training for staff.

Pharmacological variances such as different half-life and onset time of a variety of benzodiazepines make it difficult to be precise in communications

Poly drug use is known to be extremely dangerous but are there particular combinations that are more risky than others including the order drugs are taken?...we just don't know.

**6.4** How do you target a user group who are ambivalent about their lives and who have so many other factors that impact on their drug use

We may need to be more pragmatic in our approach offering practical information such as not to carry quantities of drugs not just for legal reasons but to limit overdose risk, carry naloxone, as while it is not effective for benzodiazepine overdose if you have used benzodiazepines with opiates it may give you a chance until you can get help.

**6.5** Co- production of materials, working with people who have lived or living experience may help develop better and more effective interventions at all levels.

**6.6** Poor communication of incidents that happen in other services or out of hours and lack of access to testing also present a challenge in alerting services and

workers when there may be concern around a particular substance. We cannot act quickly when we do not know what we are alerting against.

**6.7** Information for staff in services is also made more difficult due to lack of evidence. A resource is currently being developed, based on the information we have, to highlight to workers some of the key harm reduction messages relating to Benzodiazepine use. Workers can use the resource as a tool to engage with patients to discuss risky behaviours and ways to stay safe. At present this is the best approach we can take. We can only make people aware of what the issues are and what they can do to reduce their risk of harm.

**6.8** There are other areas that we are exploring including the use of peers and /or outreach workers to try and engage with users to highlight the dangers poly drug use and the use of street benzodiazepines.

## **7. Recovery approaches**

**7.1** Recovery Oriented Systems of Care aim to improve chances of Recovery for individuals who use drugs and those who have been on the recovery journey are an asset that we don't always use in our planned prevention and harm reduction work.

## **8. Public Health**

**8.1** The need for increased public health leadership at local and national level has been stated clearly by the Scottish Government and therefore all options need to consider how this can be strengthened.

**8.2** The SG Public Health Report 2018 stated that the approach to substance use needs to be as diverse as the people affected and should focus on the root causes of harm. It acknowledges that we need to understand what drives consumption; considering price, availability and marketing as well as the underlying structural determinants such as socio-economic circumstances and the regulatory and legislative context. This can only be achieved by partners working together to achieve a common goal, reduction of harm.

**8.3** In GGC Public Health are taking a more pro-active role in the substance use agenda, having highlighted this as a board wide priority. This includes leading on work to highlight the risks of drug use in pregnancy, to both users and midwifery staff, including benzodiazepine use and the impact on pregnancy, as well as involvement at strategic planning groups, local, regional and national.

In GGC the current Prevention and Education model is being reviewed and the way the model functions may change significantly, moving from a set of core elements for P&E to a whole population approach. The hope is that this will lead to more effective interventions for particular groups including e.g. early years, young people, older adults, vulnerable groups. This approach would identify age and stage appropriate education and interventions to address issues around substance use.

For younger people there has been a move towards a multiple risk approach, building confidence and resilience with actual substance awareness not being introduced until later years.

Evidence suggests that any learning is better achieved as part of a wider programme and not as a one off session so a co-ordinated approach is important. In GGC the

introduction of the Substance Misuse Toolkit for Education will help to achieve this and allow services who may have a contribution to make to the learning to be brought in at age appropriate times.

**8.4** Evidence also suggests that many young people who may experiment with alcohol and/or drugs will not go on to have any lasting problems and this is perhaps a normal way of experimenting and pushing the boundaries. We need to ensure that they have access to factual advice and information so as they can make informed choices about their own behaviours.

**8.5** However evidence also shows that people with more difficult life challenges are more likely to go on to develop problems with not only substances but other risky behaviours. The ACEs model looks at this in detail and is being used widely to inform practice across GGC.

**8.6** Again it must be recognised that there are many other underlying determinants that impact on behaviours, including the problematic use of drugs. There are high levels of multiple deprivation and extreme poverty in some areas within GGC and these must be considered in our overall approach to prevention and harm reduction. Similarly the impact of national legislation such as welfare reform should be explored as a possible contributory factor. These wider social issues may require radical approaches, wider than GGC to make a difference.

## **9. Identifying At Risk Groups**

**9.1** The changing nature of the drug market and the resulting change in drug use amongst some of the more vulnerable people in society has meant that we should take stock of the approaches we take. Work such as 'Taking Away the Chaos' has already made us rethink our work and how we engage with our target populations. The establishment of forums such as the City Centre Engagement Group where we actively engage with those who are currently using drugs, often some of our most chaotic users, should help inform our work as we move forward.

**9.2** If we are to try and change the culture of drug use we may need to change the way we identify those at risk of developing problems and become more pro active in our approach to addressing the multiple issues that impact on the choices they make.

**9.3** Co production of services is one way of doing this, as is co production of resources. People with lived experience are represented on many of our structures and forums and this is a positive step that can be built on.

**9.4** There are other innovative ways of engaging with people who are using drugs such as the Photovoice approach where people are provided with cameras and encouraged to capture the reality of their lives, including their daily routines around drug use. The aim is to improve understanding and ultimately responses to what is the reality of their everyday lives, making interventions more focussed and more effective.

**9.5** The creation of personas, whereby service user journeys can be shown through an amalgamation of user experiences. This allows users to highlight their issues and experiences, both negative and positive, in a way that is anonymous and non identifiable. Personas help to identify the motivations and expectations that drive behaviour allowing service design to be informed by real life experience.

**9.6** The above are just a few examples of ways we can work with others, including those who use drugs to identify opportunities for early intervention.

## **10. Other Areas of Activity**

**10.1** Support for those affected by a drug related death is available through Family Support Groups across GGC as well as by the nationally commissioned service Scottish Families Affected by alcohol and Drugs (SFAD). A resource was recently developed by FASS (Families Affected by Drug and Alcohol Use) and NHSGGC Alcohol and Drug Health Improvement Team that looked at the impact of other people's behaviour on families following a drug related death. The Raising Awareness of the Impact of Drug Related Deaths (2018) resource can be used to highlight to staff and communities how stigma and shame impacts on a family in the aftermath of a drug related death and how small behaviour changes can lessen the impact of this. The pack is available for services across GGC and training can be accessed by contacting FASS

## **11. Areas for Discussion and Action**

- **Identifying literature and/or commissioning research on trends and drug use impacting GGC (Section3)**
- **How do we improve collection and sharing of data of emerging drug trends (Section 2)**
- **How do we improve communication networks to highlight possible problematic substances and incidents(Section 2)**
- **How do we improve access to quick testing of substances and communication of results to frontline services and users (Section 2)**
- **How do we better engage with lived and living experience to improve harm reduction and prevention activity (Sections 6 and 9)**

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## Paper 4: Programme

DRD: Street Drugs Summit  
11<sup>th</sup> April 2019  
Glasgow City Halls Recital Room

09.30am	Breakfast rolls	
10.00am	<b>Introduction</b>	Susanne Millar
10.10am	<b>Supply</b> Street drugs- the facts Availability- National and local context Enforcement response <b>Q&amp;A</b>	Hazel Torrance, Toxicology Alan Ferguson, STOP Unit David Hill, G Division, P.S.
11.10am	Comfort break	
11.30am	<b>Impact</b> Homelessness and complex needs GADRS service users Recovery Communities <b>Q&amp;A</b>	Jim McBride Kelda Gaffney Claire Muirhead
12.30pm	Lunch	
<b>1.15pm</b>	<b>Responses</b> City Centre & City-wide Harm Reduction Treatment & Care response Challenges moving forward	John Campbell Charlie McMahon Saket Priyadarshi
<b>2.00pm</b>	<b>Action planning</b> – multi agency planning and activity, communication of issues, oversight and coordination of harm reduction message, understanding of scale and impact, other contributing factors	
2.45pm	<b>Summary and Close</b>	Susanne Millar