



NOVAS INITIATIVES
fostering social inclusion

HEADS UP

PREVENTING AND RESPONDING TO OVERDOSE IN MCGARRY HOUSE

A review of applied
good practice for
homeless services
and their partners



**GRADUATE
ENTRY
MEDICAL
SCHOOL**
UNIVERSITY OF LIMERICK
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 **Quality Matters**
supporting improvement in social services

HEADS UP

PREVENTING AND RESPONDING TO OVERDOSE IN MCGARRY HOUSE

A Review of Applied Good Practice for Homeless Services and their Partners

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Conducted by Quality Matters in partnership with the University of Limerick Graduate Entry Medical School on behalf of Novas Initiatives.

Designed by Mel Gardner: www.melgardner.com

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FOREWORD



BY JAN O'SULLIVAN,
MINISTER OF STATE
FOR HOUSING AND PLANNING

I would like to thank Novas Initiatives for asking me to write the foreword to this timely, honest and revealing research into preventing and responding to overdose.

This in-depth study is based on the experiences of residents and staff of McGarry House in Limerick. The relatively small research population is one of the reasons why this work is so powerful.

While confidentiality is of course maintained throughout the report the widespread prevalence of overdose among such a small group is a cause of great concern. The research explores this reality in a factual and non-judgemental way. It is one of its great strengths.

The lived experiences that give rise to this report are stark. 93% of residents interviewed had witnessed another person overdosing, with the majority of these residents witnessing an overdose within the last six months. Almost three quarters of residents had themselves overdosed.

Given the extent and seriousness of this issue Novas Initiatives are to be commended for showing leadership in honestly addressing the reality of overdose.

While the research population for this study was relatively confined the findings and the 14 recommendations have a very wide application in many settings and services. This research will make a very tangible difference to how we address the issue overdose throughout the country.

In doing so we need to pay very serious attention to the core themes that emerge from this study. For me these are:

- The value of co-ordinated, multi-agency responses in building a comprehensive strategy to assess risk and reduce harm;
- The need for evolving supports based on the very evident link between mental health and overdose risk;
- The capacity that exists among service users to respond to overdose situations they witness and make critical interventions; and
- The role that housing and homeless services can play in preventing overdose risk, and the positive role that both staff and residents can play.

I would like to acknowledge the role that a number of stakeholders played in contributing to this report. The medical profession, the HSE, the emergency services and the pharmacy sector all made valuable inputs. Quality Matters and the University of Limerick Graduate Entry Medical School are also to be commended for the clarity and accessibility of this report.

Novas Initiatives, its staff and the residents of McGarry House have shown bravery and vision in producing this report. "Heads Up" will inform my approach to this difficult and urgent issue, as I am sure it will for many others.

A handwritten signature in black ink that reads "Jan O'Sullivan". The signature is written in a cursive, flowing style.

Jan O'Sullivan, Minister of State for Housing and Planning

PREFACE



BY MICHAEL GOULDING,
CEO,
NOVAS INITIATIVES

Hello, and welcome to our report, 'Heads Up: Preventing and Responding to Overdose in McGarry House'.

As CEO of Novas Initiatives I would like to express my appreciation to all those involved with the development of this challenging and insightful report. I would like to thank in particular the 15 residents of McGarry House who enthusiastically gave their time to help us understand their experiences of overdose. The McGarry House staff team are commended for both participating in the research and sharing their stories, and for supporting the residents and the researchers in making the interviews and focus groups run smoothly. I would also like to extend gratitude on behalf of Novas Initiatives to our colleagues in other organisations who lent their support as key professional stakeholders; the HSE, the Homeless Persons Centre, Hogan's Pharmacy, the A&E Department of University Hospital Limerick, the Ambulance Service at University Limerick Hospital.

I would also like to thank the Service Users Interest Sub-Group of the Board of Management who took the initiative to commission this much-needed research and provided guidance to the research team throughout the process, prioritising the needs of McGarry House clients and ensuring this remained a priority throughout. The work of this group was complimented and supported by our expert Steering Group who provided a much needed multi-disciplinary perspective to the research:

- Rory Keane, Manager, HSE Addiction Services
- Gearóid Prendergast, Coordinator Mid-Western Regional Drugs Task Force
- Maurice Hoare, Regional Coordinator, Health Service Executive
- Marie Hogan, Hogan's Pharmacy, Limerick
- Anne Cronin, Head of Homeless Services, Novas Initiatives
- Helen Scales (Manager) and Sinéad Carey (Deputy Manager), McGarry House

Finally, I would like to thank the research team, Quality Matters and the University of Limerick Graduate Entry Medical School. It is rewarding and exciting for the Novas team to see the product of their hard work over the past number of months. We are proud to present this report.

This report provides an insight into the alarming rates of overdose experienced by the men and women who have lived in our accommodation service on Alphonsus Street in Limerick. It chronicles the experience of a group of people who are at high risk of overdose and fatal overdose on an ongoing basis, and a team who are working hard to help residents manage their risk and help prevent overdoses on the premises.

The recommendations of this report remind us that there are actions that our residents can take, there are initiatives that our staff can implement and there is a responsibility that we and our partners must bear in order to prevent overdose, respond to it when it does happen and reduce the rate of overdose deaths in our communities. Novas Initiatives look forward to working with our clients, staff and partner agencies to make this happen.

A handwritten signature in black ink that reads "Michael Goulding". The signature is written in a cursive, flowing style.

Michael Goulding, CEO, Novas Initiatives

ABOUT NOVAS AND THIS RESEARCH



BY ANNE CRONIN,
HEAD OF SERVICES,
NOVAS INITIATIVES

Novas Initiatives is the largest provider of homeless accommodation in the Mid-Western region. In 2013, Novas supported more than 1,200 individuals in Limerick City. McGarry House, which opened in 2002, provides homeless accommodation for 30 individuals and long-term supported housing for 37 individuals.

In recent years, the McGarry House staff team have observed the profile of residents changing – becoming younger, engaging in more chaotic drug use with increasing levels of opiate use. One of the most challenging consequences of these trends is an increase in overdose risk and in overdoses. In an 18 month period between May 2012 and November 2013, the team in McGarry House responded to 34 overdoses; an average of one overdose every two weeks. McGarry House had also been working with a number of high-risk substance using women who were pregnant, which was a considerable challenge for staff. In the months prior to this research, the team used the Housing Opiate Overdose Risk Assessment Tool to measure the extent of risk of overdose in the project: 16 residents were deemed to be at high risk of overdose, including a number of women who were pregnant. Managing this risk proved immensely challenging for the staff team.

- There is an urgent need to better understand overdose among homeless people so services like McGarry can:
- Provide better support to people to help them reduce their risk of overdose
- Help people to respond better if they witness someone who is overdosing
- Constantly improve responses to overdose when it happens

The team in Novas wanted to get a better understanding of the scope and nature of the problem of overdose among residents of McGarry House, and to assess how effective their efforts were in preventing overdose and responding to it when it happened on the project.

We are grateful to all who have been involved in the completion of this important project including the residents, staff and management of McGarry House, our colleagues in partner agencies who participated in or advised on the research, and Quality Matters and the University of Limerick Graduate Entry Medical School. Novas Initiatives are proud to contribute to a body of knowledge nationally on the issue of overdose among homeless people, and we look forward to implementing ambitious but pragmatic recommendations with residents in our homeless services and our partners in the Mid- Western region.

Warm regards,

A handwritten signature in black ink that reads "Anne Cronin".

Anne Cronin, Head of Services, Novas Initiatives

1

INTRODUCTION

This report details the findings of research conducted with the residents of McGarry House, staff of McGarry House and a number of professional stakeholders in the Mid-Western region between May and October 2013. The research was conducted through surveys, interviews and focus groups with residents and external stakeholders to explore the following issues:

- Personal experience of overdose among residents
- Experience of overdose as a bystander (residents and staff)
- Risk behaviours and perception of risk in relation to overdose among residents
- Understanding of overdose prevention and harm reduction among staff and residents
- The system of preventing and responding to overdose in McGarry House
- Recommendations for effective supports for people who may be at risk of overdose and those who provide professional support to them (residents, staff and external professional stakeholders)

There were six steps in the research process, as follows:

- Literature review
- Semi-structured interviews with residents, staff and key professional stakeholders
- Staff survey
- Development of key findings and analysis of finding in light of existing literature, relevant models and good practice
- System review including review of policies and procedures in relation to overdose prevention and management in McGarry House
- Development of recommendations from residents, staff and professional stakeholders through focus group discussions

Following from this introduction the second chapter provides a comprehensive literature review on the areas of drugs, treatment, homelessness, overdose, good practice in overdose response and overdose in the Irish national policy framework. The chapter following that outlines the methodology used in this research including limitations and ethical issues. Chapters four and five detail a comprehensive profile of residents, their substance use and experiences of overdose. There are then 8 short chapters which present the main themes emerging in research, which are:

- Ambivalence about Overdose among Residents and Staff
- Empowering Residents to Prevent and Respond to Overdose
- Interagency Prevention and Response
- A Coping Culture: Ensuring Effective Staff Support
- Staff Confidence, Capacity and Learning Opportunities
- Overdosing in McGarry House: Residents' Perspectives
- Promoting the Low Threshold Ethos
- High Risk Substance Use in Pregnancy

In conclusion, fourteen recommendations are presented, five of which are for implementation specifically in McGarry House, six of which require interagency implementation and three which can be implemented both in-house and at a regional level.

A number of tools and resources were developed in consultation with all stakeholders throughout the research, in conjunction with this report. These tools and resources may be available upon request from Novas Initiatives. Full information on these resources can be found in the final section of the report.

2 REVIEW OF LITERATURE

2.1 INTRODUCTION

This chapter provides a summary of what is already known about topics relevant to overdose, its prevention and management. Given that this research sought information on experiences of overdose among residents of a homeless service in Limerick, Ireland, this summary of the literature contains information on the following areas:

- Overdose in relevant Irish policy areas such as drug and homeless policies
- Drugs, homelessness and death from overdose in Ireland and comparative information from some other countries
- Overdose, fatal overdose and intentional overdose
- Bystander experiences (experiences of those who have been present during other people's overdoses)
- Strategies for effective prevention of and response to overdose

2.2 OVERDOSE POLICY IN IRELAND

The EU Action Plan on Drugs 2013 – 2016 seeks to enhance the effectiveness of drug treatment and rehabilitation and to reduce the number of direct and indirect drug-related deaths. However, the issue of overdose is largely absent from many national policy documents in Ireland.

The following table contains a list of national policy documents relating to problematic substance use and details the number of times overdose is mentioned in the reports, with key and additional points noted. Action 63 of the National Drugs Strategy calls for the development of an overdose strategy, this had not been published at the time of the report.

TABLE 1:
OVERDOSE IN
IRISH POLICY

National Policy Document	# OD mentions	Key Points	Additional Points
Interim National Drugs Strategy (NDS)¹	7	Action 40 of the NDS: Develop a response to drug related death through... a National Overdose Prevention Strategy	Use of benzodiazepines in OD needs to be addressed in National OD Strategy (4.38); transition from prison to community is major risk (4.49); paramedics should be trained in administering naloxone (4.86)
National Drugs² Rehabilitation Framework	0	N/A	N/A
National Protocols and Common Assessment Guidelines³	1	Risk Assessment includes History of Overdoses	N/A
National Community Detoxification Protocols for Benzodiazepines / Methadone	12 (+ 8 in appendices)	OD identified as key risk for detoxification, risk pamphlet for residents included	N/A
A Vision for Change: Report of the Expert Group on Mental Health Policy	5	OD identified as common mechanism for deliberate self-harm.	N/A

¹ Department of Community, Rural and Gaeltacht Affairs

² National Drug Rehabilitation Implementation Committee under the auspices of the national Health Service Executive

³ As above

Overdose or drug related mortality is not mentioned in many local and national reviewed documents, which highlights potential for increased coordination about, and attention to, the issue.

2.3 DRUG USE AND TREATMENT: LIMERICK AND THE MID-WESTERN REGION

Limerick is a county with a population of 191,809 people⁴, located in the Mid-West of Ireland, falling within the remit of the Mid-Western Regional Drugs Task force. Support for people with drug and alcohol problems in Limerick is provided through a number of statutory drug treatment services and community and voluntary treatment and support providers. Drug use in the Mid-Western region is estimated to be slightly below the national average, with 5.1% of people reporting the use of illegal drugs in the year prior to the most recent national prevalence survey compared to the national average of 7% (36). In 2012, there were 372 cases of people seeking treatment for drug or alcohol use in the county of Limerick⁵, and 684 cases in the Mid-Western Region area. The substance that people most commonly sought treatment for was alcohol, followed by cannabis and opiates.

2.4 DRUGS, HOMELESSNESS AND OVERDOSE: IRELAND

The European Monitoring Centre for Drugs and Drug Abuse (EMCDDA) describe drug-related deaths (also known as drug induced deaths, overdoses or poisonings) as when people die directly due to use of illegal substances, which often occurs in combination with other substances such as alcohol or psychoactive medicines (85). Here are some key facts known from research about overdose and related issues:

- On average, half of those who regularly inject heroin will die of overdose (63)
- The majority of drug deaths involve opiates, mainly heroin but also methadone and codeine (85)
- Another substance commonly implicated in overdose along with opiates is benzodiazepines⁶: their use is widespread and figures indicate that it is increasing in Ireland (36, 42, 43)
- Ireland had the highest level of reported problematic opioid use in the E.U in 2011⁷ (35) and the third highest rate of drug-induced deaths in the EU (39)
- In Ireland, the number of drug deaths is higher than the number of road deaths in any given year⁸ (40)

⁴ Irish Census Data, 20011: www.cso.ie

⁵ This figure represents treatment episodes rather than unique individuals accessing treatment within the year. As such, if an individual accesses more than one treatment services they will be counted multiple times.

⁶ Problematic benzodiazepine use generally happens as part of a consumption pattern of poly drug use (44, 47, 45, 46) and one in 10 people in Ireland with medical cards were receiving benzodiazepine prescriptions in 2002 (46).

⁷ Opioid use in Ireland is over seven cases per 1,000 population aged 15 to 64, compared to an EU average of around 4.2 cases per 1000 (35). While this is a decrease from 8 cases per 1000 in 2011,

⁸ 323 people died by poisoning in 2010; there were 212 road deaths in Ireland in the same year

TABLE 2:
KEY STATISTICS
- IRELAND,
LIMERICK AND
THE MID-WESTERN
REGION

Key Statistics About Ireland, Limerick & the Mid-Western Region ¹⁰	Number
Reported Drug Related Deaths in Ireland in 2010	575
Reported Drug Related Deaths in Limerick in 2010	25
Reported Drug Related Deaths in Ireland in 2009	652
Estimated Number of Opiate Users in Ireland in 2006	21,000
Number of People Estimated to be on Methadone Treatment in Ireland	8,000 to 9,000
Percentage of People who Reported Illegal Drug Use in Co. Limerick in 2012	5.1%
Percentage of People who Reported Illegal Drug Use in Ireland in 2012	7%
Number of People Counted as Homeless in Ireland in 2011	3,808
Number of People Counted as Homeless in the Mid-Western Region in 2011	273
Number of People Counted as Homeless in Limerick City in 2008	220
Percentage of People who were Homeless Using Heroin in 2005 ¹¹	22%
Facts About Other Countries	
Percentage of Drug Related Deaths Related to Opiates (Mainly Heroin, also Methadone) in the EU	80
Number of People Estimated to Die Each Year from an Opiate Overdose in the EU	10-20,000
Number of Deaths Caused by Heroin for the last 10 years in the UK	1,000

There is a strong link between drug use, alcohol use and homelessness in Ireland (50, 51, 52, 53). Research among 355 homeless people in four cities in Ireland in 2005 revealed that over one-fifth of the participants had reported heroin use in the last month (51). This finding is reflected in international research: one of the largest international studies on the topic, a study of 1000 predominantly young homeless people in hostels, day centres and on the streets of London, found that 88% of respondents were taking at least one drug and 35% were heroin users (54).

Overdose is a serious and significant risk for people who are homeless and use drugs (55, 56, 65). A study involving 30,000 homeless people in Boston, published this year, found that overdose accounted for the death of one third of people who died under the age of 45 who were homeless (97). The strong relationship between increased risk of overdose when homelessness and drug use is combined was highlighted in a study that analysed hospital records of over 7,000 homeless people and people who were not homeless. This study found that among patients who had been hospitalised for

⁹ Across four cities in Ireland

¹⁰ Sources: 32, 36, 37, 38, 41, 42, 48, 49, 51, 58, 85, 90

¹¹ The National Drug Related Death Index have stated that due to the way that data is collected and that some deaths by poisoning (overdose) will not be recorded, this figure is considered a conservative estimate (38).

drug-related conditions, homeless people were seven times more likely to die of that condition compared with the general population (85). Homeless people are also at an increased risk of mental health problems, self-harming behaviour and suicide (88).

EXPERIENCES OF OVERDOSE AMONG PEOPLE WHO USE DRUGS IN IRELAND

While information available about people who use drugs, rates of overdose and other relevant issues in Ireland is increasingly available through the National Drug Treatment Reporting System and the National Drug Related Death Index, there remains a lack of research on overdose in Ireland when compared to other countries such as the UK, US and Australia. There are two reports that have specifically looked at the issue of overdose in Ireland. Research carried out in a primary care setting in Dublin found that of those attending a general practice for methadone treatment, 42% had overdosed (61, 62). Searches of the Health Research Board database as well as a number of Irish journals and social and health research databases revealed only one study that explored the subjective experiences of people who use drugs in relation to overdose (93). This study, published in 2007, involved ten people in receipt of methadone maintenance from the Drug Treatment Centre Board (also known as Trinity Court) who had previously overdosed. In 40% of cases the most recent overdose had been intentional, all participants had witnessed overdose and calling an ambulance was either not done or was delayed in all events.

OVERDOSE RISK FACTORS

Understanding the risks associated with overdose, as well as people's own perception of their risk of overdose, is a vital step in developing effective strategies for preventing and responding to overdose. Research with people in a drug treatment service in Australia showed that that 80% of survivors of heroin overdose who had experienced a previous overdose within the past six months, did not perceive themselves to be at high risk (26). The authors of the research concluded that there was an 'unrealistic optimism' among drug users about their risk. In relation to general health, optimistic bias or an unrealistic optimism about one's own susceptibility to health problems has been well documented. Weinstein and Lyon (27) and Weinstein (107) noted that optimistic biases about personal risk are barriers to action and that acceptance of personal vulnerability is an important factor in progress toward adoption of precautions. A study that conducted a review of 31 overdose research papers from various countries(65), and which analysed risk factors for overdose into three different categories; individual, observer and organisational also identified two groups of people who are at a particularly high risk of overdose; homeless people and people leaving prison. These risks are depicted in the chart below.

As pregnancy and overdose was a very concerning issue for Novas, it is worth noting that this review of extant literature found that pregnancy was not identified as an increased risk factor for overdose.

TABLE 3: OVERDOSE RISK FACTORS

Highest Risk Groups

- Homeless people
- People recently released from prison

Individual Risk Factors

Drugs and Treatment

- Use of other central nervous system depressant in addition to opiates
- Using non-prescription methadone, topping up on methadone, using heroin instead of taking methadone or not adhering to methadone programme
- Sporadic use of heroin
- Higher heroin purity, lowered tolerance, using large quantities of drugs or ingesting unknown tablets
- Poly-drug use, benzodiazepine use, alcohol use
- Leaving treatment, changing treatment (e.g. induction or transition in treatment) or higher number of separate treatment episodes

Health

- Suicidal ideation, history of mental health problems, current psychiatric diagnosis / prescription, feelings of indifference or carelessness
- Access to anti-depressants through prescription
- High levels of hepatitis or cirrhosis

Other Circumstances

- Two weeks after release from prison
- More injectors in social circles
- Difficult life events e.g. recent bereavement, interpersonal conflict or accommodation problems
- Injecting in public places

Observer Risk Factors

- Fear of police involvement resulting in decreased likelihood of intervening
- Fear of social repercussions

Organisational Risk Factors

- Unable to access methadone / substitute medication
- Strict rules on methadone programmes – discharge from treatment results in high mortality rate
- Doses of methadone increased too quickly / doses are too high
- Use of multiple doctors or increases in psychoactive drug prescriptions

Other risk factors have also been identified for overdose. A review of drug treatment outcomes in Australia in 1998 by Darke et al found that previous experience of overdose was strongly related to subsequent overdose (98). This information is particularly important as it has been found that half or more of drug users have experienced non-fatal overdose (75, 79). Weakness due to recent illness, dehydration or under nutrition increases risk of overdose, particularly if the person's liver and kidneys are not working well (77, 78). Meta-analysis results by Green et al (76) showed that being HIV positive was also associated with an increased risk of overdose mortality. Experience of overdose is not a deterrent for future drug use or necessarily a motivator to seek treatment (68).

INTENTIONAL OVERDOSE

As is indicated in the section above, suicidal ideation (thinking about suicide) and mental health issues have been identified in the literature as a significant risk factor for overdose. Research with resuscitated heroin users in Scottish accident and emergency departments revealed that suicidal thoughts or feelings before overdosing were the underlying reason in almost half of all cases (67). Zador et al describe suicide and overdose as more of a 'spectrum of intention than a dichotomy' (68). This means that there is not always a clear distinction between intentional and unintentional overdose, that there is a strong association between mental health issues and overdose and that this should inform local and regional responses to this issue.

For people at risk of overdose, people who work with them and people who make policy around this issue, having information on the wide variety of ways that people in various positions can help to reduce overdose and fatal overdose is invaluable.

2.5 BYSTANDER EXPERIENCES

Bystanders (those who witness others overdosing) can play a crucial role in preventing overdoses becoming fatal by promptly calling emergency services and administering first aid. Understanding existing responses, whether effective or ineffective, as well as good practice responses, is crucial for the development and delivery of effective overdose response information.

PEERS

On average, heroin users overdose three times in their lifetimes (64). In a study of over 380 people in the US, almost all of the participants (92%) had witnessed an overdose and the most common number of overdoses witnessed among the group was five (18). Research in Ireland (61, 62) indicates that there is a much higher prevalence of first-hand experience of overdose in some settings within Ireland than that shown in the international research. A study of people attending general practice in Dublin's South Inner City for opiate substitution treatment, reported that 96% had witnessed an overdose, 92% knew a victim of fatal overdose personally and 17% had been present at a fatal overdose (61,62).

Overdose deaths are preventable: 60% of overdoses occur in situations where it is possible for someone to intervene and most overdose deaths (85%) do not occur immediately, but occur over a number of hours (66, 74). Heroin overdoses tend to occur in the company of other people and most commonly occur at home (72, 73), Fatal overdose most commonly occurs where medical help has not been sought or is sought too late (74). A review of the records on overdose deaths in London found that in one quarter of cases where death was not instant, if the witness had acted more swiftly by calling an ambulance or administered first aid, the person may not have died (101).

Research has found that some of the most common responses to overdoses include infliction of physical pain and CPR (68). There are some barriers to peers responding in the best way possible to overdose which can include being intoxicated themselves, under-estimating the danger of losing consciousness and fear of calling the police to the scene (18, 56, 64). In their research on overdose in Scotland in 2008, Rome et al (64) estimated that only 10% of witnesses called an ambulance when another person overdosed.

This research summary highlights that there are many situations where, if more peers had the skills and confidence to respond effectively to overdose, lives could be saved.

STAFF

There is a dearth of literature available on the experiences of non-medical staff in responding to overdose. One piece of research reviewed the experience of workers in Irish homeless services in relation to death, and found that workers did not expect to encounter death as part of their work (114). However, an important finding of this research was that if death is positively framed through formal and informal processes within the service, it can support workers to continuously improve working practices while working with the difficult and traumatic reality of losing clients. In practice, this may mean, for example, focussing on what the service did to improve the person's quality of life, and not just what they did not do to prevent the death.

The research highlighted the importance of workers being aware of the possibility of deaths among their client group. Having clear policies and procedures around death, providing training on professional boundaries, ensuring adequate professional supervision is in place, encouraging workers to mark the death of service users and ensuring there are procedures in place for the team to reflect on and learn from the death of a client may also support coping among workers on the event of a client's death (114).

2.6 OVERDOSE PREVENTION

This section analyses evidence of methods which have brought about a reduction in rates of overdose, as well as methods suggested by experts as to how overdose may be prevented in the future. Resoundingly, the most emphatic comment from authors is that a strategy involving multiple partners from all agencies who work with at-risk people, including a diverse suite of responses and interventions will be the most effective way to address it effectively. Effective responses to overdose include:

MULTI-DISCIPLINARY / INTER-AGENCY RESPONSES

Previously in this chapter, risk factors for overdose – things that if present increase the chances of someone overdosing- have been listed. The more individual, organisational and structural risk factors that are present, the more likely an overdose or fatal overdose is to occur; no individual measure is likely to have a significant and sustainable impact (65). A strategy that seeks to eliminate, mitigate or address as many risk factors as possible is most likely to be successful in reducing overdose rates.

Research consistently recommends that interagency, multi-faceted and comprehensive strategies are the most effective method of reducing overdose (65, 97, 91, 113). Such a strategy should involve a focus on preventative and harm reduction measures (113), primary care, public health and social policy measures to end homelessness (97) with a focus on supporting individual behavioural change, as well as making naloxone available (65).

This has significant implications for McGarry House in developing both local strategies to support their own residents as well as participating in and promoting regional overdose prevention strategies. The following interventions or strategies are normally recommended as part of a suite of methods for overdose prevention and response.

NALOXONE

Naloxone Hydrochloride is a drug that is administered to temporarily reverse opioid overdose (32, 81, 99) and can be administered as a nasal spray or an injection (15). In recent years there has been a marked increase in the use of Naloxone to reverse overdose in many countries. In May of 2012, the UK Advisory Council on the Misuse of Drugs noted that the efficacy of naloxone as a drug for reversing the effects of an opioid overdose is unquestionable (32). The World Health Organisation has listed Naloxone as an essential medicine as an antidote for poisoning (33).

In the US, the UK and many other countries injecting drug users have been successfully trained to save lives with naloxone (19, 20, 21, 22). Evaluations of naloxone distribution programmes have shown increased use of naloxone during opiate overdoses by participants resulting in reversals of overdoses (19, 20, 21, 22, 81, 82). An important point to note about naloxone is that there are few or no adverse consequences following administration (19, 20, 21, 60, 82, 117, 118). Naloxone is an effective way to reduce overdose deaths on a larger scale (19, 20). Other noted benefits of naloxone are that it has no potential for abuse and is inexpensive (81).

Currently, naloxone is a prescription only medication in Ireland. It is subject to controls in terms of who may prescribe it, and it may only be used by the person for whom it is prescribed. It can be used by certain medical personnel such as paramedics and some nursing staff in drug or homeless services (94). It is being considered for prisons (90) and by some groups nationally (95). There are a numerous models in other countries where naloxone has been given to and used by drug users and their family members with training and support by professionals (19).

There is potential for Ireland to replicate successful naloxone programmes from other countries where these have been proven to reduce death by overdose. Although the national overdose strategy had not been published at the time this research was completed, it is expected that implementation of naloxone programmes will begin in the near future in Ireland, based on recommendations from the impending national overdose strategy.

OVERDOSE, NALOXONE AND PREGNANCY

Given that in recent years prior to the research the McGarry House team had worked with a number of pregnant drug users, it was important that the team had an appropriate understanding of risks relating to overdose and treatment of overdose in this particular situation. This section is included in the literature as pregnancy, poly substance use and overdose were identified as key challenges for the staff of McGarry House.

While working with people who are using drugs and who are pregnant may raise specific concerns regarding both the service user and unborn child, the literature suggests that pregnancy does not put women at an increased risk of overdose (65). If a pregnant woman is having an opioid overdose, naloxone is still the recommended intervention to reverse her overdose (87), although it may carry some risk of early

labour or foetal withdrawal (83). The US National Library of Medicines notes that Naloxone should be used during pregnancy only if clearly needed (83).

The research remains unclear on whether there would be damage to human embryos or foetus through the use of naloxone. Research on animals has shown no damage to foetus or embryo but additional research is needed to confirm whether this is true for humans or not (83).

OVERDOSE TRAINING AND PEER PROGRAMMES

International research has shown that there is real potential for peers to play a role in reducing overdose and saving lives. Much of the research around the effectiveness of overdose prevention programmes has been done where service users were trained to use naloxone. Apart from the effectiveness of naloxone in reversing overdose a number of benefits of these programmes in relation to overdose prevention have been documented. These include improving participants' ability to recognise opioid overdoses, increasing overdose response skills and increasing confidence in responding to them (19, 20, 21, 80).

Peer education has been described by the World Health Organisation as:

The use of same age or same background educators to convey educational messages to a target group... Peer educators work by endorsing "healthy" norms, beliefs and behaviours within their own peer group or community and challenging those who are "unhealthy" (69, p8)

Peer education has been used in Ireland for drug use prevention (70, 71) and overdose prevention programmes have been conducted successfully with drug users in Ireland (92). While peer work among drug users has not been well-researched or documented in Ireland, it is a model that has been used in other minority communities such as Travellers, as far back as 1994 (116). Community members being employed or engaged to provide certain basic health services to their own communities is a concept that has been around for at least 50 years (115).

There may be lessons from the success of peer programmes, including improving access to services and empowering peers to educate one another. These lessons can be applied to peer education programmes for drug using peers in overdose prevention.

MOTIVATIONAL INTERVIEWING

Literature reviewed previously in this chapter has shown that there are a number of personal risk factors that can lead to overdose, and therefore personal risk factors that could be mitigated. However, for many people in addiction taking steps to change behaviour can be challenging, or seem unfeasible. One way that workers can support clients' motivation to make personal changes is by using motivational interviewing techniques. Motivational interviewing has been shown to be effective for alcohol and drug problems (9, 10, 11, 12), including effectiveness in reducing risky drug using behaviour (12), as well as a range of other health related behaviours (11). There are examples of programmes where motivational interviewing is used to help people who use drugs to reduce risk of overdose¹² and of the effectiveness of motivational

¹² Harm Reduction Coalition: <http://harmreduction.org/our-work/training-capacity-build/training-descriptions/negotiating-change/>

interviewing as an overdose prevention intervention¹³. There is potential for established therapeutic interventions such as motivational interviewing to be applied to the issue of overdose risk and prevention.

2.7 SUMMARY

The information contained in this literature review paints a stark picture. Being a drug-user in Ireland carries a high-risk of premature death due to drug overdose; this risk is significantly increased for those experiencing homelessness. However, the literature also shows that there is real potential for this risk to be mitigated through the implementation of evidence-based, coordinated and comprehensive overdose prevention and response strategies. While there is a dearth of policy-based goals in relation to reducing overdose in national policy in Ireland, this policy gap also gives rise to significant potential for communities, voluntary and statutory services to coordinate and develop cooperative, creative responses to this issue. It is hoped that the forthcoming national overdose strategy will guide and support these types of responses across health, substance use and homeless services.

One important facet of any overdose prevention strategy is supporting individuals to make small changes in their behaviour, which can decrease their risk of fatal overdose. This can be achieved through the provision of peer education, training and one-to-one interventions. Providing staff in high-stress jobs with adequate support and training can help to ensure that high-risk individuals receive effective support from caring and motivated staff teams in projects like McGarry House.

¹³ University of Washington: http://adai.typepad.com/adai_news/2012/11/interventionist-positions-for-study-of-opioid-overdose-prevention.html

3

METHODOLOGY

3.1 OVERVIEW OF METHODS USED

The aims of this research were threefold: to understand previous experiences of overdose and experiences as witnesses to overdose among residents and staff of McGarry House; to understand risk taking behaviour among the resident group and finally, to identify effective mechanisms for:

- Increasing knowledge of overdose risk and overdose prevention among residents and staff
- Decreasing risk taking behaviour among the resident group
- Increasing effective bystander responses to overdose

An action research approach was taken in this study. Action research involves individuals, practitioners and organisations in a process of understanding their practice so that they might improve (117). Researchers were provided with a mandate by the management of McGarry House and the Research Advisory Group to discuss potential ideas in relation to changes to working practices or working agreements where relevant and practical.

This study was designed as a narrative and descriptive analysis of the experiences of residents and staff in relation to overdose. Mixed quantitative and qualitative methods were used to collect data, including a documentary analysis.¹⁴ The study had six steps:

¹⁴ All data collection tools may be provided if requested from the authors

**TABLE 4:
STEPS IN THE
RESEARCH
PROCESS**

Step	Method	Details	
1	Literature Review		
2	Interviews	Semi-Structured Interviews	15 Residents of McGarry House
			15 Staff of McGarry House
			Nine Professional stakeholders: ambulance staff, A&E staff, pharmacists, harm reduction workers, coordinators and staff of statutory homeless and addiction services
3	Surveys	Survey of McGarry Staff	Online staff survey completed by 20 staff
		Survey of GPs who had ever worked with McGarry House Residents	Postal survey completed with four GPs
4	Systems Review	Review of a case study, and all policies and procedures in McGarry House relating to this case	All procedures, policies and a case study reviewed and cross-referenced with information from interviews
5	Focus Groups		Staff, residents & professional stakeholders
6	Collation		Final Report, Policies, Guidelines and Protocols Developed

3.2 SEMI-STRUCTURED INTERVIEWS (RESIDENTS AND STAFF)

Semi-structured interviews were conducted with 15 staff members and 15 residents. Interviews took between 35 minutes and 80 minutes, averaging 55 minutes. The researchers selected semi-structured interviews as the most appropriate methodology for this phase of the research as they allowed for similar themes to be explored across interviews, while also enabling participants to elaborate or discuss issues not anticipated by the researchers.

Pilot interviews were conducted with two staff members from a low-threshold community drug service. Minor changes were made to the interview schedule to ensure language was relevant, respectful and inclusive, although no substantial changes were made to the content of the interview.

INTERVIEW CONTENT

An interview schedule was designed around Rome et al's (2008) Stages in the Cycle of Overdose Management (64) and was modified to reflect the reality of the sequence of events in a homeless service.

The image on the right depicts an overview of the interview schedule for residents and staff which was based on the overdose cycle. For residents, the same chronological sequence was used but the model was re-phrased as a 'before, during and after' overdose cycle. This is because the cycle of overdose model used for the staff schedule reflects the workflow from a staff perspective and was not as relevant to the resident's experiences.



TABLE 5:
STAFF AND
RESIDENT
INTERVIEW
QUESTIONS

Staff Schedule	Resident Schedule
Pre: Basic Demographic Information	Pre: Basic Demographic Information
Risk assessment	Before overdose
Harm reduction	
Responding to overdose	During overdose
Working with emergency services	
Period immediately following overdose	After overdose
The week following overdose	
Death of a resident	

Where possible, questions for surveys and interviews drew upon a range of previous research using tested or validated instruments¹⁵.

INTERVIEW PREPARATION

A visual representation of the 'cycle of overdose' model was shown to the interviewee and a discussion on the expected trajectory, time and topics was explained to help safeguard against surprises and develop a shared understanding of the interview process with the participant. The issues of consent and child protection were discussed at the beginning of the interview which is discussed in further detail below.

To ensure a meaningful process for participants to feedback on their input, they were given the opportunity to approve recorded comments during the interview. Statements illustrating points around emerging themes were read back to the client immediately for approval.

PROFESSIONAL STAKEHOLDER INTERVIEWS

External stakeholders were identified by the management of McGarry House or by members of the Research Advisory Group. By way of purposive sampling, individuals were identified who held leadership or service provision roles in either partner organisations, funding bodies or those who were active in a relevant role. The purpose of these interviews was to assess perceptions of McGarry's role by partner agencies, and to look for areas of potential improvement in relation to interagency working that could support more effective overdose prevention and management strategies.

Semi-structured interviews were conducted by phone with nine of the 11 stakeholders identified. Consent for stakeholder interviews was provided verbally, although stakeholders were told that their identity, through their role, could be discernible in the report.

3.3 SURVEYS STAFF SURVEY

The purpose of the staff survey was to get a general understanding of staff experiences of overdose. The information from the survey was used to provide aggregate data and to inform the semi-structured interviews. Combined with the interviews, the results of the survey served to:

- Build a staff profile
- Understand staff experiences of overdose
- Understand staff perceptions of their role in relation to overdose
- Identify potential for staff development and support

The survey was developed using items identified in previous research (documented in the literature review), along with input from the consultation phase with key stakeholders.

Twenty of the staff team (compromising the majority of the McGarry permanent and relief team) completed the surveys.

¹⁵ A detailed list of instruments used to inform data collection is available from the researchers on request

GP SURVEYS

McGarry House provided a list of 15 GPs attended by their residents. All GPs were sent a survey either by email or by post, and a follow on call was made to all surgeries two weeks later. There was a total return rate of 4 surveys out of 15, a response rate of 26%. The aim of the survey was to understand the GPs' experiences and perceptions of their own role and that of staff in projects such as McGarry House, in relation to patients considered to be at high-risk of overdose, and to explore effective communication about patients at risk.

3.4 SYSTEMS REVIEW

In order to achieve a comprehensive understanding of the working practices and organisational culture in McGarry House, researchers cross-referenced information from staff and resident interviews with a review of written processes and procedures in the organisation. The research team received copies of all policies that detailed agreed responses and recording systems for procedures at each of the seven stages of the overdose model outlined above.

McGarry House also provided the researchers with anonymised records from one resident's file (with the resident's permission), and all other paperwork referring to that resident regarding the weeks prior to and after an overdose event. This case study provided researchers with the opportunity to understand how policies were operationalised and how information was recorded and reported in relation to an actual overdose.

3.5 FOCUS GROUPS

Focus groups were an important stage in the research as they enabled residents and other participants to feedback on recommendations and to provide a pragmatic critique of them. Additional recommendations were added after resident focus groups. Draft recommendations were presented at three focus groups; staff, the Research Advisory Group and residents. In each group, participants were asked to discuss the strengths and challenges in relation to each recommendation, and to identify resources or capacities needed for implementation. This information was used both to refine the recommendations and to support the development of a three-year implementation plan for the organisation.

3.6 DATA MANAGEMENT

Only the research team had access to field data from surveys and interviews. Exceptions to confidentiality (e.g. child protection or potential/actual harm to self or harm to others) were discussed with all participants prior to beginning the interviews. Participants in face-to-face interviews were offered the chance to review quotes with the interviewer, to ensure they were happy the data was accurate and their identity concealed. Participants were given the opportunity prior to beginning the interview to ask questions and to withdraw. Participants in interviews signed a consent / confidentiality form.

3.7 ETHICAL CONSIDERATIONS

The HSE Mid-Western Region Research Ethics Committee provided ethical approval for the initial research methodology. A number of ethical concerns were considered in conducting the research. Steps taken are outlined in the table below.

TABLE 6:
MANAGEMENT
OF ETHICAL
CONSIDERATIONS

Concern	Preventative Action / Response by Research Team
Capacity to consent (e.g. inebriation / head injury)	<ul style="list-style-type: none"> • Accessible information about the research was disseminated prior to the research taking place in language that was simple, accessible and understandable to residents • Staff of the project were fully informed of the research in order to help residents understand the research • Information provided at the beginning of the interview was accessible, understandable and clear. Particular care was taken to accommodate those with literacy issues or those for whom English was not a first language • Interview terminated if appropriate
Perception of compulsion to participate in evaluation in order to retain residency	<ul style="list-style-type: none"> • Ensuring residents understood clearly that their non / participation in the research would have no impact on their access to services. That if they did not consent to participate in the research they could withdraw at any point without it having a bearing on their tenancy or care
Trauma or upset during interview	<ul style="list-style-type: none"> • Prepared participants by reading through the interview schedule and discussing the nature of the questions that would come up and the potential for emotional distress • Were clear about the interviewees ability to cease recording or to leave at any point • Offered a chance to the participant to debrief 'off the record' with the interviewer after the research or referral to a key worker

In subsequent discussions with the management of McGarry house, it was decided that an expense payment of €5 should be paid to participating residents to cover any costs incurred. This was paid directly to residents by McGarry house.

3.8 LIMITATIONS OF THE RESEARCH

SAMPLE SIZE AND LOCATION

This research involved a relatively small sample size compared to other overdose research. Just 15 residents, 15 staff and nine key stakeholders were interviewed. While almost all staff who had witnessed an overdose participated in the research, the sample size for the total resident population at the time of research was 50%. It is possible that those who chose not to participate in the research may have had different experiences to those who did participate. The response rate for the GP Survey was 26%, with only four GPs responding out of 15.

SAMPLING BIAS

There is a possibility that there was sample bias in relation to GPs' responses. It is possible that only those who saw value in interagency working, the work of McGarry House or work with high risk patients responded to the survey.

MEMORY BIAS

Trying to recall experiences that involved loss of consciousness and severe inebriation may be difficult and the information provided may not accurately reflect what occurred prior to, during or immediately after overdose. This may be particularly challenging for people who habitually consume drugs that affect memory, such as benzodiazepines.

4 PROFILE OF MCGARRY RESIDENTS

4.1 GENERAL OVERVIEW OF RESIDENTS PROVIDED BY NOVAS

This chapter provides a detailed profile of the residents of McGarry House and those who took part in this research.

Novas provided the following overview of the general McGarry House client group:

The McGarry House client profile has changed considerably since the service (formerly Bridgeland House) was opened in 2002. The most remarkable transformations, according to the McGarry team, concern the declining average age of clients, the extent of drug use generally and opiate use specifically.

During 2012, 114 persons were provided accommodation. Some 11% of these residents were less than 21 years of age and 48% were under 30 years of age, revealing a relatively young population in McGarry House¹⁶. The proportion of clients presenting with issues primarily relating to drug addiction was 27%, (compared with a Novas service average of 20%). Moreover, while drug use was not the immediate cause for accessing McGarry's supported accommodation for the remaining residents, it was understood to be contributing factor to homelessness for many¹⁷.

Two years previously, in 2010, the proportion of clients accessing the service primarily because of their drug use was just 17%, so dealing with drug addiction, particularly chaotic and poly-drug use has become an increasingly frequent facet of the daily duties of McGarry House staff. The rise in drug use among clients has been matched with a decline in persons presenting with issues around alcohol addiction. Other issues facing McGarry clients include mental health issues, family breakdown, poverty, poor education, experience of sexual and physical violence and legal issues.

McGarry House describe their clients as very often excluded from mainstream services and other voluntary agencies operating in the sector. They exist on the margins of society with little community support. Frequent family estrangement exacerbates their isolation.

4.2 OVERVIEW OF STAFF TEAM

McGarry House Temporary Supported Accommodation is led by a manager, deputy manager and team leader. There are 7.4 project workers employed as well as five night safety attendants, a dual diagnosis worker and a cook. A relief panel supports the team when the need arises to provide cover for annual leave, sickness absence, etc.

¹⁶ In 2010, two years previously, the proportion of McGarry House clients under 30 years of age was 42%.

¹⁷ On average two factors leading to entry were recorded by staff for each resident. For example if a resident was suffering from a diagnosed mental health condition and had recently experienced a breakdown in family relations, current drug use of that resident was not considered the overarching or immediate cause of the resident entering the service.

4.3 OVERVIEW OF RESIDENTS WHO PARTICIPATED IN THE RESEARCH

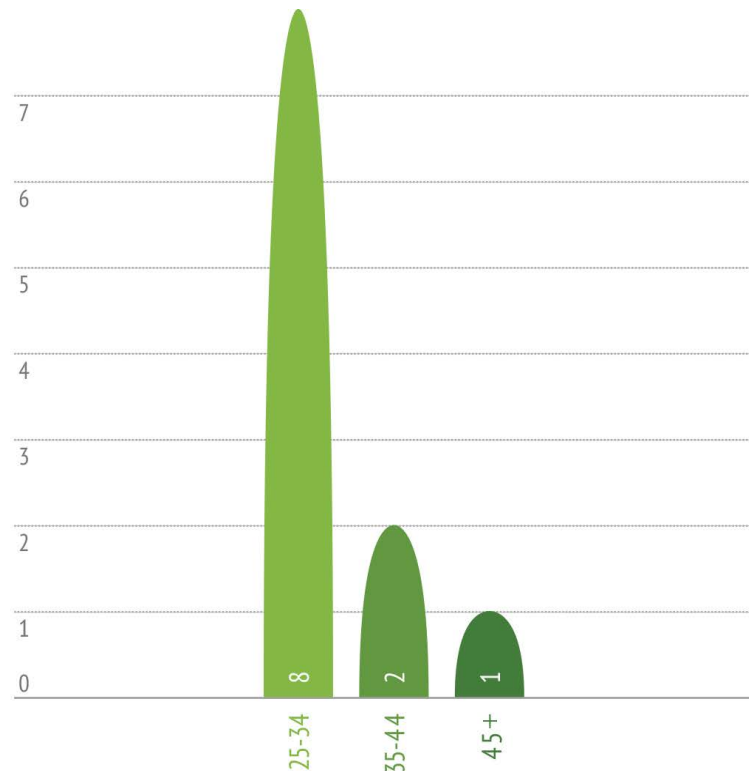
GENDER

Two thirds of residents (n=10) interviewed were men and one third (n=5) were women.

AGE AT THE TIME OF INTERVIEW

80% (n=12) of all interviewees were under 35, and of this group, a quarter (n=4) of all interviewees sampled were under 25. Of the remaining 20% of the residents 35 and over, just one resident was over 45 years of age. All residents were over 18 years of age.

FIGURE 1:
AGE PROFILE
OF MCGARRY
RESIDENTS



LENGTH OF TIME IN MCGARRY HOUSE

The majority of interviewees (60%, n=9) had been staying in McGarry House for at least six months at the time of the interview, with one third (n=5) having been there three months or less. One resident had been there between four to five months.

4.4 SUBSTANCE USE

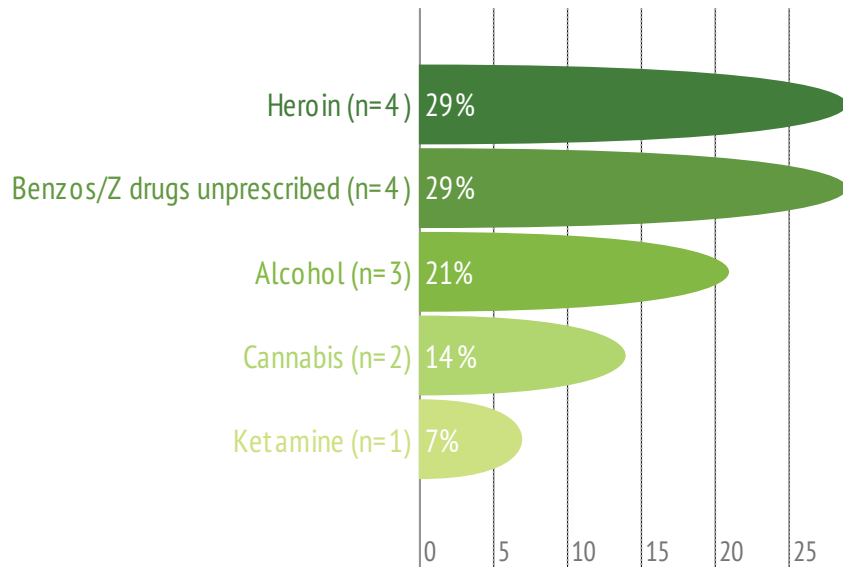
PRESCRIPTION MEDICATION TAKEN BY RESIDENTS AT TIME OF INTERVIEW

At the time of the interview, almost half of the residents (n=7) were being prescribed methadone. Three of those being prescribed methadone were also prescribed benzodiazepines, and one was being prescribed methadone, benzodiazepines and anti-depressants. 27% (n=4) of residents were being prescribed benzodiazepines; in all cases these individuals were being prescribed another drug that depresses the central nervous system (methadone or anti-depressants).

PRIMARY SUBSTANCE OF USE

Residents were asked to state their primary substance of use (non-prescribed). One resident was drug-free, stable on methadone and not using other substances. All other respondents could easily identify a primary substance of use. As shown in the graph below, the most common primary substances were heroin and benzodiazepines¹⁸ (each 29%, n=4), with the third most common primary substance being alcohol (21%, n=3). Other primary substances included cannabis and ketamine.

FIGURE 2:
PRIMARY
SUBSTANCE
OF USE



LENGTH OF TIME USING PRIMARY SUBSTANCE

When asked how long they had been using their primary substance, half of the residents who identified a primary substance (n=7) had been using it for ten years or more, over one third (n=5) had been using it between five and nine years, only two residents had been using it for three to four years. No one had been using his or her primary substance for less than three years.

FREQUENCY OF BENZODIAZEPINE CONSUMPTION

All interviewees were asked how often they used benzodiazepines. One third of residents said they rarely or never used these drugs (n=5) and all others said they used these drugs at least several times a week (n=9, 61%). Breaking this figure down further; over half of the residents said they used these drugs at least once a day (54%, n=8) and 27% (n=4) of all residents used benzodiazepines several times a day.

FREQUENCY OF ALCOHOL CONSUMPTION

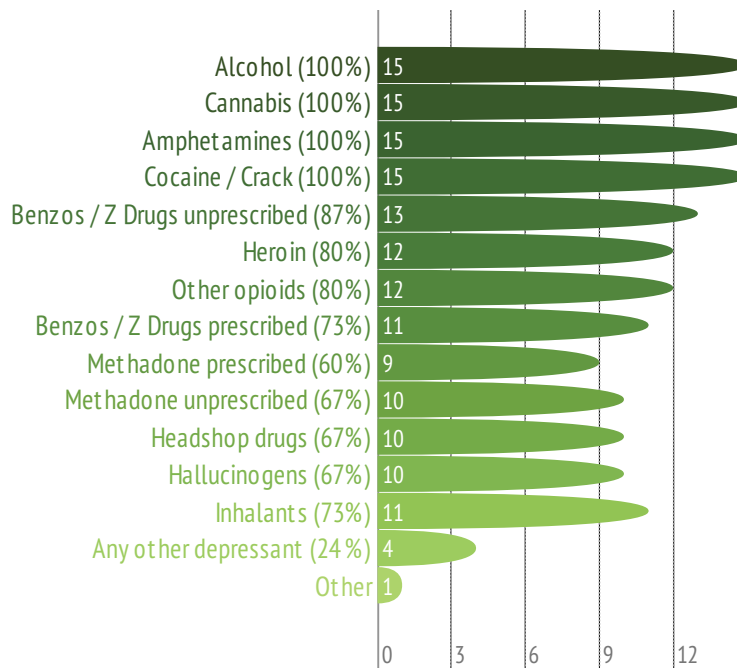
All interviewees were asked how often they drank alcohol. Almost 80% (n=12) used alcohol occasionally, rarely or never. Only 20% drank frequently; two residents at least once a week and only one interviewee drank daily.

¹⁸ Benzodiazepine within this report is an umbrella term for both benzodiazepines and benzodiazepine-like drugs (also known as 'Z' drugs). Examples of benzodiazepine-like drugs are zolpidem and zopiclone and street or brand names include Stilnocht and Zimmovane.

LIFETIME USE OF SUBSTANCES

All interviewees were asked if they had ever taken a range of substances. As portrayed in the graph below, all interviewees (n=15) said that they had used alcohol, cannabis, amphetamines and cocaine or crack at some point. All except for one resident stated they had used benzodiazepines. In total, 80% of residents (n=12) had tried heroin, likewise 80% had tried other opiates (excluding heroin or methadone) such as codeine, oxycontin. Almost three-quarters of residents (73%, n=11) had at some stage been prescribed benzodiazepines, and the same number had tried inhalants (glue, gas, etc.). Unprescribed methadone, head-shop drugs or hallucinogens had each been used by two-thirds of residents (n=10), with 60% having been prescribed methadone (n=9) at some point.

FIGURE 3:
LIFETIME
USE OF ANY
SUBSTANCE



INJECTING

Over half of the residents of the entire cohort (54%, n=8) inject frequently, including one fifth who inject daily and 27% (n=4) who reported injecting several times a day. One resident said that they sometimes injected and one said that they rarely injected. Interviewees were asked if they currently or had ever injected. Ten interviewees (66%) fell into the category of 'current or previous injectors'. 60% (n=6) of those residents who had injected had injecting careers of five years or more, 30% (n=3) had injected less than two years and one fifth of current or previous injectors had injected for three to four years.

5

KEY FIGURES: RESIDENTS AND STAFF EXPERIENCES OF OVERDOSE

This chapter provides an overview of the main figures relating to residents' reports of overdose, as well as those of staff, which can serve as a 'quick reference' guide to the findings. The residents' experiences and those of the staff are explored in greater detail in the chapters that follow.

5.1 NUMBER OF OVERDOSES

- Almost three-quarters of residents overdosed at least once in the past (73%, n=11)
- Of those 11 people; almost half had overdosed once (46%, n=5), almost one-fifth (18%, n=2) had overdosed between two and five times, 18% between six and 10 times and a further 18% more than ten times
- Of the two interviewees who said that they had overdosed more than ten times, one estimated that they had overdosed 20 times and another could not remember how many times but that it was "far more than ten"

5.2 MOST RECENT OVERDOSE

- 60% (n=9) of all residents interviewed had overdosed within the last year
- Over one-third (36%, n=4) of the eleven people who had overdosed had done so within the previous six months
- Almost half (45%, n=5) of those who had overdosed had done so more than six months ago but within the last year
- Two residents had overdosed in the past month: both of these individuals had overdosed in the week prior to the interview, and one of these people had overdosed three times in the past fortnight
- 64% (n=7) of those who had overdosed were with other people during their last overdose 36% (n=4) were alone at the time

5.3 WITNESSED OVERDOSES

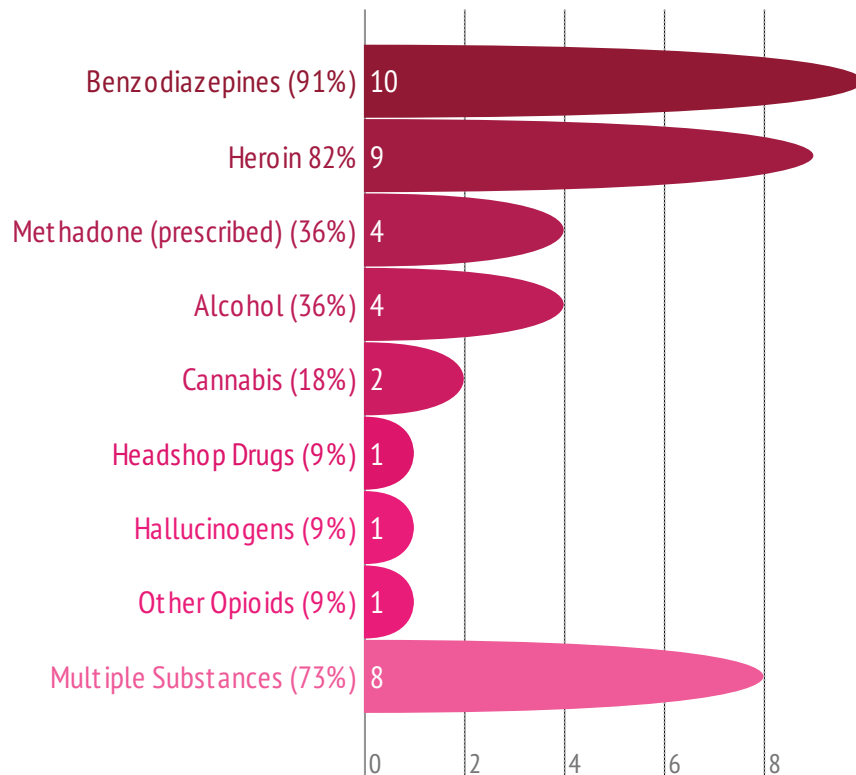
- All residents except for one (93%, n=14) had witnessed another person overdosing
- 60% of residents (n=9) had witnessed an overdose within the last year

5.4 SUBSTANCES INVOLVED IN MOST RECENT OVERDOSE

- The most common substance involved in the resident's most recent overdoses, according to those who had overdosed, was benzodiazepines. Almost all (91%, n=10) residents said that they had taken benzodiazepines at the time of their overdose. In 82% of cases, heroin was involved (n=9)

- Methadone was involved in four cases (36%), although five people (45%) were on methadone at the time of the last overdose, so in one instance the respondent did not recognise methadone as a factor potentially contributing to their overdose
- Alcohol was involved in over one-third (36%, n=4) of cases
- For almost two thirds of residents (73%, n=8), there was a cocktail of substances involved ranging from benzodiazepines, heroin, methadone, ketamine and alcohol
- In all of the cases at least two central nervous system depressants had been consumed. For two residents, heroin was the only substance involved

FIGURE 4
SUBSTANCES
TAKEN
AT LAST
OVERDOSE



5.5 CAUSES OF LAST OVERDOSE

Residents were asked to discuss what they felt had caused their last overdose. In some cases respondents gave multiple answers.

- Over one-quarter of residents (27%, n=3) felt that it was because of poly-substance use
- Over one-third (36%, n=4) spoke about a sense of hedonism or not wanting to stop
- Almost one-fifth (18%, n=2) residents felt that the heroin they took was stronger than what they were used to
- 18% (n=2) residents did not know what had caused the overdose

Another important finding was that three out of 11 had been recently released from prison or had recently had a long period away from substance use (27%).

MENTAL HEALTH

18% (n=2) of residents said that the last time they overdosed, it was because they were depressed. Over half (55%, n=6) of the residents who had overdosed said that they had been in particularly bad mental state in the days or weeks preceding the overdose:

I was not in a good space, I had been taking loads of tablets off and on for a few days, then I started feeling not right...my best friend died in the last month, and that's been going through my mind a lot, and this makes me want to use more. Resident

I felt like a nobody, with my birthday coming up I felt like I had nothing to show. I had lost everything in life. Resident

Four residents (36%) stated that they were okay or in good space in the weeks preceding, and that it was simply that they had taken too much or the wrong mix of substances.

5.6 STAFF EXPERIENCE OF OVERDOSE

Overall, 85% (n=17) of staff had been on shift during an overdose in McGarry House. 60% (n=12) of staff members had been on shift at least twice when an overdose occurred and one quarter of respondents had been on shift over six times. Only three staff members (15%) of the 20 who responded to the survey had never been on shift when an overdose had happened.

5.7 SUMMARY

Collectively the client group of McGarry House are at a high risk of overdose. This is due to the fact that they are experiencing homelessness and are engaged in high levels of poly substance use including, for most interviewees, regular use of heroin, methadone and benzodiazepines. Adding to the risk profile is the fact that the majority have previous experience of overdose and almost half have recent experience of overdose. There is a very high rate of overdose experience among the client group of McGarry House, with three quarters of participants having overdosed at some point in the past. This figure is at the higher end of the spectrum identified in other literature which ranges from 48% (18) to 64% (96). The results of this research also reflect findings in the literature that most overdoses happen in the company of others and not in clinical or professional settings (18).

The high proportion of people who had witnessed overdose in McGarry House is reflected in literature from Ireland (61) and abroad (96). In other countries, the figure for peer witnessing of overdose is lower than the figure found in this report, for example McGregor et al's found that in Australia only 70% had ever been present at another person's overdose (18).

6

THEME ONE: AMBIVALENCE CONCERNING OVERDOSE

6.1 INTRODUCTION

This chapter discusses attitudes of residents and staff members to overdose. The research has captured a sense of inevitability about overdose in both resident and staff participants that was at times accompanied by feelings of hopelessness or helplessness in the face of such high risk. A very real fear of death was also evident both among the residents and the staff team. Research findings show there is a strong desire on part of both residents and staff to address these issues.

This chapter reinforces findings in international research, which identifies a number of issues in relation to overdose such as unrealistic optimism about risk, denial of level of risk and ambivalence or mixed feelings about the desire to reduce overdose risk. These issues were discussed with all service users, and a number of issues also emerged in interviews with staff. In relation to and despite feelings of hopelessness or ambivalence, a number of opportunities for interventions for overdose prevention have been identified by all research participants and are detailed in the final part of this chapter.

6.2 UNREALISTIC OPTIMISM ABOUT OVERDOSE RISK

This research indicates that while the majority of residents are at a high risk of overdose, this is not translated into a concern for their own welfare. There is an evident denial of risk among residents when their assumptions about other's risk of overdose are compared to assumptions about their own risk.

Half of all residents who discussed the likelihood of overdose felt that it was very unlikely or unlikely that they would overdose again, while half felt that it was very likely of likely that they would overdose again. Almost half of the residents (n=7) interviewed were not at all concerned about future overdose, and one third were 'somewhat concerned'. Only 20% (n= 3) of the group were very concerned about overdosing in the future, even though the majority would be considered high risk.

When asked how often residents had worried about overdose within the past six months, 80% (n= 12) had rarely or never worried about overdose (over half never worried) and 20% (n=3) worried often or very often about it in the past six months.

One fifth of the residents (n=3) discussed times they had rationalised with themselves about their overdose risk.

He was gone very blue and making weird noises; that was very freaky. It made me think about for about an hour about giving it up, but it was back to the same thing that night; it made me think fair enough I'm not drinking - the guy was drinking who overdosed. Resident

6.3 THE INEVITABILITY OF OVERDOSE

Considering the profile of the client cohort outlined in the literature review of this report, most of the residents interviewed would be considered to be at high risk of overdose. Still, half of those who discussed it felt it was unlikely that they would overdose again in the future, half of them were not concerned about future overdose, and the vast majority of residents (86%, n=13) had not worried about overdose in the last six months. Viewed together this information indicates a level of denial, unrealistic optimism or at times a poor understanding of risk amongst the resident group about overdose risk.

In interviews, all residents were asked whether they felt that overdose was an inevitable facet of drug use. Over half of residents interviewed (n=8) felt that overdose is an inevitable or unavoidable facet of drug use. 80% (n=12) felt that it was likely or very likely that a regular heroin user in Limerick will overdose in the future and only 20% (n=3) felt it was very unlikely. All participants (both residents and staff) believed that most drug users will overdose at least twice, and almost 60% (n=9) believed that most drug users will overdose more than six times.

An issue that became apparent through staff interviews was a sense that death from drug overdose is inevitable to some extent, and that it is fortunate that more residents have not died. Four staff members specifically discussed the inevitability of death, as illustrated by the following comment:

People die...You start to normalise and expect overdose, you develop a skin, you almost expect the next death. It's amazing that given the number of overdoses here, there's only been one death. Staff Member

Three staff (20%) also discussed a sense of feeling lucky or glad that there were not more deaths. However, it should also be noted that a significant minority of both residents and staff showed a resistance to the idea that overdose is an inevitable aspect of the drug user's life. Over a quarter of residents (n=4) said that overdose was not inevitable and two residents discussed peers or people they knew who had control over their use and had never overdosed. Three staff expressed determination in challenging any notion of acceptability of overdose:

Sometimes there's an air of complacency, that overdoses are expected. In a normal workplace, it's not normal and expected. It's not normal and it shouldn't be accepted as so. Staff Member

The acceptance of overdose as an inevitable feature of the life of a drug user and the work of a low-threshold homeless service worker was evident in interviews, however this was tempered by a sense among both participant groups that it was possible that drug users should not expect to overdose and that there are ways to avoid this. The sense of inevitability points to the need to support staff and service users to manage the reality and experience they face in relation to frequent overdose; the need for appropriate supports is discussed later in this report. The existence of ambivalence draws attention to a potential opportunity for interventions such as motivational interviewing to be used to support motivation and changes in individual risk behaviour.

6.4 FEAR OF DEATH

Although unrealistic optimism, denial or poor understanding of risk was evident, there was an almost universal fear of death from overdose across both residents and staff. When asked what their biggest concern was in relation to overdose, 80% (n=12) of residents said that they were afraid of dying from overdose.

For me, it's the thought of being found dead in active addiction, that's the really lonely death. Resident

Many staff also said a significant concern for them was losing a resident to overdose. Five staff members particularly discussed feeling responsible for life and death:

If they're in here, and monitored, that's their life saved. Better them in here than out there, because they're going to do it anyway. Staff Member

This seeming tension between fear of death and denial of risk highlights a contradiction that may present an opportunity for intervention by staff with residents. A number of models for intervention are explored later in this chapter and this informs a primary recommendation of the research.

6.5 PREVIOUS EXPERIENCES OF RISK REDUCTION

Residents were asked if they took any measures to reduce overdose when they were actively using and many struggled to recall such steps. Interestingly, when the researchers prompted with suggestions such as 'took a little bit at a time' or 'did not drink alcohol' a third of residents agreed that they had indeed taken actions that would have the consequence of reducing overdose risk. However, the action was normally taken to achieve another desired outcome:

I don't do it to prevent overdose, I just don't want to take loads of stuff. Then I get pissed / drink cans, and take whatever. Resident

While the sentiment was echoed by many residents, three residents in particular (20%) were emphatic that as long as there were more substances to take, they would take them regardless of risk to their health or lives:

If there was a big pile of drugs on the table I would take them until there was none left. Resident

Exploring and focussing on previous successes in making change is a technique used in motivational interviewing, recovery coaching and other models for working with people with substance use issues. Information in this section indicates that there may be opportunities to engage residents in such discussions to reinforce their confidence and sense of capacity in relation to risk reduction.

6.6 FACTORS CONTRIBUTING TO INTENTIONAL RISK REDUCTION

Previous experience of overdose, witnessing another's overdose or getting timely advice or expression of concern from a family member or professional were all mentioned as precursors to positive changes in behaviour. In all except one of the examples provided by the four residents who discussed positive change, the change in behaviour tended to be short or medium term with an eventual return to the high-risk behaviour.

I said I'd never mix drink and heroin again, never have since. Resident

I got clean again because I got a fright. The last thing I remembered was going off in the ambulance and seeing my girlfriend with my son in her arms. I was clean for four months, went to jail for nine months and then stayed off it for a few weeks after that. I'm back on it now. Resident

Three interviewees mentioned getting advice from professionals that led to a change in behaviour. Two interviewees highlighted the role of family members or peers in their behaviour change:

My dad just before he died told me not to go near the gear and I never have. Resident

One interviewee also cited an impact from a popular culture source; watching the film *Trainspotting*¹⁹:

A theme often emerging in addiction research - the intention to change, but encountering a trigger such as old friends or old places - was reflected in residents' attempts to reduce their risk behaviour and challenges to their ability to consistently apply this.

After overdosing a few times, I promised myself I was going to take less, but I always ended up taking the same. Resident

Residents were also asked to think of a time when they were less at risk or not at risk of overdose. Five residents (33%) recalled a time when they were drug-free as a time when they were at reduced risk of overdose and one interviewee was undergoing detox and felt he was less at risk at the time of the interview than he had been previously.

The information in this section indicates potential for workers to support motivation to change personal risk behaviours through encouraging service users to consider factors that have previously made it easier for them to change. For residents, the perception that being recently clean or detoxed as a low risk period presents an opportunity for education about high risks, in relation to decreased tolerance and increased overdose risk should a relapse occur.

6.7 AMBIVALENCE IN ADDRESSING OVERDOSE RISK

Findings demonstrate that while residents felt confident that they would be able to reduce their overdose risk, they were unwilling to do so. Further exploration revealed that in some cases residents felt that the only way they could reduce their risk was by ceasing drug use, while staff saw potential in other ways to reduce risk.

¹⁹ *Trainspotting* is a Scottish film from 1996 portraying the lives of a group of people addicted to heroin.

All interviewees who had previously experienced an overdose were asked about their capacity to reduce their risk of overdose. Over half of the interviewees who had previously overdosed (55%, n= 6) said it would not be difficult to reduce their risk of overdose, while 38% (n=4) felt it would be very difficult or impossible to do so. When asked the likelihood of them taking the steps necessary to reduce their risk of overdose over the next three months, ten of the interviewees answered this question. While seven interviewees (70%), said that it was unlikely or very unlikely that they would take steps to reduce their risk of overdose over this period. Three individuals (30%) who answered the question said that it was likely that they would reduce their risk in the next three months. These same three residents are preparing to go into treatment / rehabilitation in the near future, and another two residents discussed their intention to do so in the near future. Two of the residents interviewed specifically advocated for increased access to treatment as a way to reduce overdose.

I'm only at risk of overdose when I'm on gear.

Drug use and risk are too intertwined. Resident

Only one resident felt it would be 'impossible' to reduce their risk of overdose, all others accepted that they had the capacity to reduce overdose risk, with varying perceptions of how difficult this would be for them. For a number of residents, reducing overdose risk and stopping drug use were seen as synonymous. However for some, stopping drug use was not conceived of as a possibility in the medium term. These factors contributed to a sense of powerlessness for some respondents.

This was not a viewpoint that was shared by staff throughout the interviews, who reflected smaller harm reduction type changes rather than abstinence as the best way to reduce overdose risk. There is potential for staff to enhance and then to share their understanding of a variety of harm reduction and other therapeutic techniques with residents, in relation to reducing risk of overdose. Coupled with increasing motivation to reduce risk behaviour this may contribute to an effective individual risk reduction strategy.

6.8 THE NEED TO REGULARLY DISCUSS OVERDOSE

Residents were asked who they had ever spoken to about overdose and the answers most commonly given were:

- 80% (n=12) had spoken to peers or other residents about overdose
- Almost three-quarters (n=11) had spoken to staff of McGarry House
- Just over half (n=8) had spoken to their doctor
- Just under half of all interviewees (n=7) had spoken to staff in their methadone clinic
- Others included hospital staff (n=5), their dealer (n=3), prison staff (n=2) and one person had spoken to the Gardaí about overdose

Almost all residents said that they had ever discussed overdose, almost half of the residents interviewed said that they rarely spoke to staff in services about overdose and discussed a number of reasons which included paranoia on the part of residents that the staff would tell the Gardaí or that it would jeopardise the service being provided to them:

When I came into the hostel I was never told about overdose, I was told about it after I overdosed by the staff here. Resident

Residents were open and willing to talk frankly about overdose during the research interviews at no point did any of the participants say that they did not wish to discuss the topic with staff. One resident felt that it may have helped him to prevent overdose in the past if he had had more opportunity to discuss it:

If I talked about it before I may not have overdosed. Resident

There was enthusiasm from many of the staff interviewed about discussing overdose more regularly, both within the staff team and in their engagement with residents. Seven staff members felt the topic needed to be discussed with residents more:

The team is well educated in this area but I think there's a real lack of awareness about overdose among our clients and we need to be talking to them about it more. Staff Member

There are things we could improve here... we could make overdose a small topic of conversation in [team] meetings. Staff Member

When residents were asked what staff could do to help them regarding overdose, 60% (n=9) of residents felt that increased access to information was important. Residents discussed a need for regular information, information about benzodiazepines and about other risks:

Most of us are at risk of overdose, if you're sat down every once a month or two weeks and hearing all the negative things - what's bad and the risks - it mightn't help but it might help you think. If they hear it from a few different places it might make them think or hesitate if they're taking a hit or whatever. You might take fewer on the spot. Resident

People are ignorant about benzos so more information on benzos would be helpful. People think they're harmless and just chill you out, they don't realise they can make you overdose. Resident

You need regular information and reminders because you forget. Resident

Residents in the research expressed enthusiastic support for more opportunities to discuss overdose, to receive information about it and this desire to keep overdose on the agenda was shared by the staff team. There is potential for the McGarry House team to incorporate this learning into working processes, seeking opportunities to discuss overdose and provide information to residents in both structured and informal ways.

6.9 SUMMARY

The residents in McGarry House have indicated that they perceive other people to be more at risk of overdose than them, and have a sense of optimism about their own overdose risks. Previous research on overdose has shown a 'striking contrast' between personal perceptions of overdose risk and that of the chances of other people overdosing – specifically that people think other people are more likely to overdose than them, despite their own risk (18). This optimism is also well documented elsewhere in general health research too (27, 107).

Tensions are evident between McGarry residents' understanding of the risk of overdose, feeling like they have some capacity to reduce their risk, yet seeing it as unlikely that will do so. While it is important for residents and staff alike to adopt a pragmatic realistic attitude towards the issue of overdose and risk, it is essential that the sense of inevitability, hopelessness or fear of failure does not drive the dynamic around this between residents and staff in the face of such high risk of overdose. There may be potential for the creative use of tried and tested tools normally used in settings other than overdose. This may include motivational interviewing, recovery coaching, suicide intervention²⁰ and relapse prevention²¹, to support clients to recognise and respond to their own risk of overdose (examples of barriers in addressing drug use and risk behaviours raised within the research are documented in the table below).

Staff, residents, and external stakeholders all saw a role for staff to support residents' motivation, planning and actions around substance use and other risk factors for overdose. Recommendation four relates to the need for staff (in McGarry and/or partner services, such as the HSE) to undertake regular semi-structured discussions with residents in relation to overdose risk, strategies to avoid it and feelings underpinning their attitudes to overdose. This may include desire for harm or death, feelings of powerlessness or assumptions that death is inevitable. With appropriate training and support, staff can be empowered to professionally contextualise ambivalence.

It is also important to recognise the perspective of residents who advocate for increased access to treatment as an effective measure to prevent overdose. This is certainly reflected in literature, which generally advocates comprehensive, multi-faceted, multi-agency approaches to reducing overdose and fatal overdose (65, 91, 97).

20 ASIST- Applied Suicide Intervention Skills Training is the suicide intervention training programme endorsed by the National Office for Suicide Prevention: <http://www.nosp.ie/html/training.html>

21 Cognitive Behavioural Therapy (relapse prevention) / Reduce the Use Manual (Irish Resource)

**TABLE 7:
ADDRESSING
BARRIERS TO
CHANGING
BEHAVIOURS**

Residents' Experiences	Potential Supports by Staff
Residents feel that they have to stop using drugs completely, and do not feel ready for this and may feel disempowered from making any changes	<ul style="list-style-type: none"> • Explore alternative harm reduction techniques • Address ambivalence and support motivation in relation to drug use
Residents do not wish to make changes and are experiencing worthlessness, depression	<ul style="list-style-type: none"> • Developing coping mechanisms • Using suicide intervention techniques such as ASIST • Effective referral for mental health support (it was noted that there are real structural barriers to this)
General feelings of disempowerment	<ul style="list-style-type: none"> • Highlighting positive changes, strengths and past successes, using strengths based models of intervention
Residents don't feel they are at risk of overdose	<ul style="list-style-type: none"> • Discuss factual information about overdose risk, using tools, quizzes and measurements
Resident doesn't want to die, but doesn't want to take action to reduce risk either	<ul style="list-style-type: none"> • Weigh up pros and cons of current behaviours using tools such as Decisional Balance sheets • Explore ambivalence as in Motivational Interviewing model
Residents don't want to talk to the staff or don't disclose risk	<ul style="list-style-type: none"> • Ensure resident is fully briefed on levels of confidentiality in the organisation

7

THEME TWO EMPOWERING RESIDENTS TO PREVENT AND RESPOND TO OVERDOSE

7.1 INTRODUCTION

The importance of the role of residents as peers in preventing overdoses from becoming fatal was a theme that arose consistently through the interviews with residents, staff and external stakeholders. Residents are often witnesses to overdoses and have a good sense of what is an appropriate/inappropriate reaction when someone is overdosing. The research also found that residents had some manageable concerns that may currently prevent them from seeking appropriate help in time that could be easily addressed.

The information in this chapter reveals a tangible desire on the part of residents to be trained in overdose prevention and response, as well as enthusiastic support from the staff and external stakeholders for such an initiative. When the recommendation for the development of a peer education programme was brought back to focus groups for review, the recommendation to undertake a Peer Overdose Programme was refined to include specific issues around development, delivery and evaluation.

7.2 RESIDENTS AS WITNESSES TO OVERDOSE

Almost every resident who participated in this research (93%, n=14) had been present at another person's overdose, and 64% (n=9) of those who had had witnessed an overdose had done so within the last six months. 64% (n=7) of residents who had overdosed were with other people when they last overdosed.

Over half of the staff (n=8, 53%) discussed the importance of other residents in preventing and responding to overdose. In the survey, 70% (n=14) of staff stated that other residents are an important source of support during an overdose in the project.

Service users play an important role; the first alert is often through the service user. Staff Member

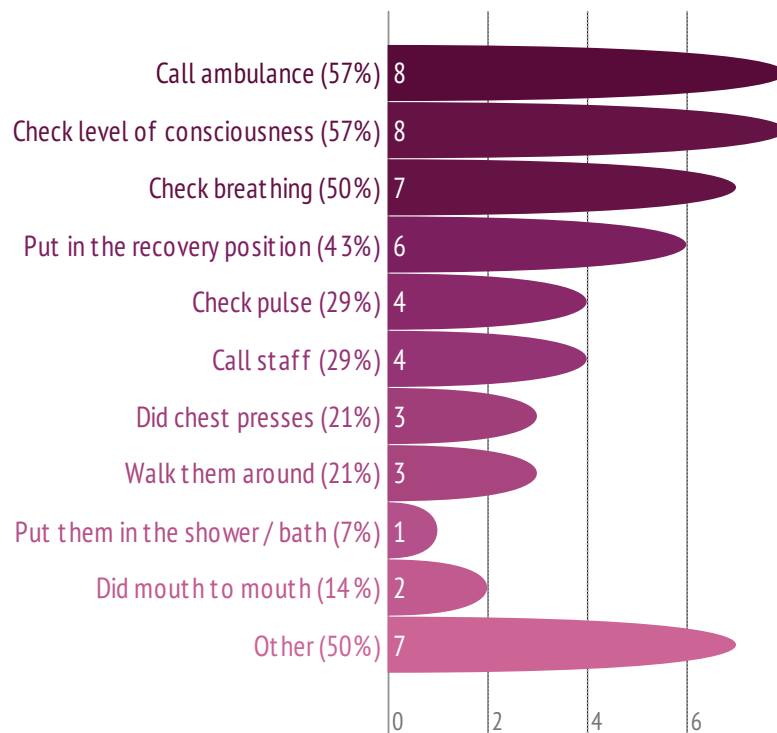
Residents always alert staff. Only for the residents, there would be more fatalities. During one incident it was the grace of God that we had a resident who was together, dependent and reliable because we needed him to let the paramedics in and help us manage the situation as the person was in very bad overdose and both of us needed to be there to manage him. Staff Member

Residents of McGarry House as a group of individuals have a strong likelihood of being witnesses to overdose. Residents already play an important role in overdose prevention in McGarry House and elsewhere, and have considerable potential for intervening where overdoses happen to prevent them becoming fatal.

7.3 APPROPRIATE AND INAPPROPRIATE RESIDENT RESPONSES TO OVERDOSE

Residents were asked to discuss what they had done the last time they witnessed an overdose. A list of possible actions was developed by referring to the list of 'appropriate' and 'inappropriate' responses outlined in Rome et al's research for the Scottish Government (64). The graph below shows the most common responses (at 57% each); calling an ambulance and check the person's level of consciousness by calling their name, shaking them, pinching them etc. In half of the cases, the residents said that they checked the person's breathing. In 43% of cases, they put the person overdosing in the recovery position. Nobody said that they had tried to make the person get sick (this can carry a risk of choking on vomit) and nobody tried to make them have a drink (this carries a risk of drowning or suffocation). Other responses that residents mentioned were throwing cold water over the person overdosing and putting a cold towel on their face.

FIGURE 5:
ACTIONS
TAKEN AT LAST
OVERDOSE



While the majority of residents responded in line with good practice, there were some reactions discussed that would be considered inadvisable:

- Three residents mentioned walking the person around; this is generally advised against, as the person is at much higher risk of falling and causing head injury
- One resident mentioned throwing his friend in the bath, which carries a risk of drowning
- Two residents said that they had injected the overdosing person with salt water

Residents were also asked if there was ever a time that they had delayed seeking medical help, and if so, why. Of the 14 people who had witnessed an overdose, six

respondents, or 42%, said that they had delayed seeking medical help at some point. The reasons for this were varied. One resident mentioned calling an ambulance and leaving the scene immediately for fear of personal consequences or the Gardaí arriving. Three residents said that they had been concerned about the consequences if the Gardaí came with the ambulance²²:

Yes, because we had so much shit in the house and we thought the police might come with the ambulance. Resident

Three residents said that they were trying to manage the situation themselves but in retrospect realised they should have sought help sooner:

Yeah, because the person overdosed a lot so we always thought we could manage it. The boys would lift her and throw her into the bath but it didn't always work. Resident

However, eight residents said that they had never delayed it, and saw this a priority response:

No, never. I've always done it immediately. I'd keep the ambulance on speed dial normally. Resident

The information provided by residents about previous responses to overdose suggests that while there is a common understanding of the value of calling an ambulance and putting someone in the recovery position, there are still a number of inappropriate responses being taken that could delay the implementation of appropriate responses that may prevent overdoses becoming fatal.

7.4 RESIDENTS UNDERSTAND CAUSES BUT FEEL THEY DON'T KNOW ENOUGH

Residents were asked how much they feel they know about things that cause overdose: 60% of residents (n=9) said they knew 'very little' or 'some' about what causes overdose, and 40% of residents (n=6) said that they felt they knew 'a lot' about what causes overdose. Residents were asked to list the things that they feel are the most common causes of overdose. The most common causes of overdose suggested by residents were:

- Poly substance use: 66% (n=10)
- Lack of knowledge of their limits or the purity of the drugs: 60% (n=9)
- Depression or being unable to cope: 33% (n=5)
- Hedonism / not wanting to stop: 36% (n=4)
- Reduced tolerance: 24% (n=4)

The following quotes illustrate a range of perceptions by residents about the causes of overdose:

²² It is worth noting that McGarry House do not call the Gardaí in the case of overdose

I think it's usually that they are taking a mixture like heroin and tablets, or mixing with alcohol. Or if you are on methadone and then taking gear or tablets. Resident

It's the luck of the draw... Everyone's body is different. People are taking too much and not knowing their limits. Resident

It's like the lotto, the unlucky lotto. Resident

You know something hits you hard and you feel you can't handle it, a tragic event, some people do it because of what life is like in places like this. Resident

I just want to take the full bang and whatever happens after that is what happens after that. Resident

Other factors noted by one or two residents include; the desire, particularly among younger drug users, to take more to impress their friends; using alone; and comorbid issues such as -poor health and diet, and a lack of understanding about overdose.

The answers provided reflect the main categories of risk found in the literature (see literature review chapter and in particular (65)) and displays understanding by the residents of the causes of overdose but a lack of confidence in the accuracy of their own knowledge.

7.5 RESIDENTS ADVISE FRIENDS ABOUT OVERDOSE AND OTHER DRUG RELATED HARM

Over one quarter of residents (n=4) discussed harm prevention advice they had given to friends. Two participants mentioned warning newer users about purity, strength and overdose and one person mentioned that if the product they were selling was strong they would warn their customers not to take too much at once. One participant said that often if he is using with someone and can see they are too 'out of it' that he'll advise them to take it easy and not to use again, and that he expects his friends to do the same for him. Another resident explained the value of hearing harm prevention information from peers:

Professionals can say something and it'll register but when friends say it to me it hits home. It's the concern of friends. It's more the people and their concern, and their credibility. You can't beat experience. Professionals go to college and study but you can't beat actual experience. Resident

Residents also reported confidence in their own ability and that of their peers to manage overdose situations:

The Garda said that if I wasn't there she would have died. Resident

I'm pretty confident that the people I'm with won't panic and can help me. Resident

7.6 RESIDENTS WANT TO TRAIN IN OVERDOSE PREVENTION AND RESPONSE AND NALOXONE PROVISION

Residents in McGarry House have previous experience in advising peers about overdose prevention. The potential for peers to be a valuable source of information about harm reduction and overdose prevention may be a vital component of a suite of overdose prevention responses.

When asked about receiving training to respond to overdose, 87% (n=13) of residents indicated they were interested. Three staff members also specifically advocated training in overdose prevention and response for residents. 70% (n=14) of staff said that other residents are an important source of support when an overdose happens. When a draft recommendation was brought to focus groups of staff, residents and professional stakeholders there was enthusiastic support across all three groups for the training of residents as first responders and peer educators.

Three staff members and two service users specifically mentioned naloxone as a potential response to overdose. All professional stakeholders supported the introduction of a naloxone provision programme. When these findings were presented to the focus groups, there was enthusiastic support from residents, with every resident present saying that they would support its introduction and would not have concerns about training in naloxone provision or administering it to a peer who needed it. The staff team were supportive but raised the need for training and potential challenges regarding licensing and whether or not they would be allowed to use it, noting that this initiative would need to be led from HSE services. The research advisory group were also enthusiastically supportive of this and viewed naloxone as an important part of future service provision within the region.

7.7 SUMMARY

As frequent responders to overdose, in general residents had a working knowledge of appropriate overdose response, however, there were a minority of respondents who identified incorrect response information. This issue could be addressed through targeted, appropriate information campaigns. Peers may be one of a number of important sources of information for promoting understanding and addressing myths around overdose among high risk groups.

Reassuringly, 100% of residents who discussed the issue said that they would not be afraid to inform McGarry House if someone they were with was overdosing. The 42% of those who had witnessed overdose (n=6) who had delayed seeking medical help in the past is concerning, but not unprecedented; McGregor et al's research (18) found a similar figure of 40% had reported the same. Rome et al's comprehensive research (64) on overdose in the UK found that people gave similar reasons for delaying seeking medical help to the cohort in this research. Reasons included people thinking that losing consciousness was a normal part of the process of taking heroin, or people being afraid of the repercussions if the police showed up. Rome et al also found that people were too under the influence themselves to call and this delayed them from seeking help.

The evidence produced by this research, which replicates the findings of other recent research internationally, begs consideration of a number of facts when developing good practice responses:

- There is an opportunity to intervene in most opiate overdoses as death most commonly occurs one to three hours after injection and where medical help is not sought or is sought too late (74)
- Peers are very likely to witness overdoses (96, 21, 81)

- Most overdoses do not take place in the presence of staff, but in the presence of peers (21,81)
- Peers have the potential, if trained appropriately, to reduce the harm caused by overdose (18, 19, 20, 21, 22, 81, 82)

Residents and staff in McGarry House are enthusiastic about residents being trained in overdose response and the delivery of Nalxone. The role of peers as first responders and the potential for peers to prevent an overdose becoming fatal cannot be underestimated. There is significant potential for the challenging of myths and for providing education around appropriate responses including CPR and calling for help as well as supporting peers to help one another in relation to preventing and responding to overdose. The first recommendation of this report provides a detailed proposal for the development of a peer overdose prevention programme for McGarry House and / or the Mid-Western Region. When this recommendation was brought to the focus groups, a number of particular points were emphasised by the groups:

- The need for clear aims and outcomes and as well as the adaptation of evidence base to models where available is advisable in order to maximise impact
- That the training programme should be supported by / reviewed by professionals in relevant fields of expertise including adult education, emergency medicine etc
- Methods for delivery of the programme that are cognisant of barriers such as literacy, learning difficulties, English as a second language, mental health issues;
- Potential for promoting engagement with the programme through contingency management
- A comprehensive process review and outcome evaluation should be planned from the outset of the programme

8

THEME THREE INTERAGENCY PREVENTION AND RESPONSE

8.1 INTRODUCTION

All professional stakeholders valued interagency service provision for high-risk service users and like McGarry House staff, were enthusiastic about promoting and further developing interagency structures to ensure optimal overdose prevention and response in the region.

This chapter contains information on issues raised through the research that have implications for interagency working and communications. Themes within this chapter were identified through resident and staff interviews in addition to interviews with nine external stakeholders. Interviewees took an active role in commenting on the draft templates of agreements, which were developed as a result of the discussions and which may be provided by Novas Initiatives upon request.

8.2 THE ROLE OF MCGARRY HOUSE FROM THE PERSPECTIVE OF OTHER SERVICES

The issue of overdose is regularly on the agenda with McGarry House having managed 34 overdoses in the 18 months prior to the research. All external agencies (n=9) saw McGarry House as having a primary and important role in relation to overdose prevention, emergency response and aftercare. All respondents also noted that clients of McGarry House were particularly high risk, when considered against drug users in general.

McGarry house have a role in getting people off drugs and supporting change. It should happen where people live. A&E

A lot of the clients are in the at-risk group as they are actively using. A huge role that McGarry have is monitoring and being in time to rescue them, talking to them to support risk management and supports towards rehabilitation. Pharmacy

External stakeholders all agreed that McGarry House played a vital role in relation to overdose in the following areas:

- Informing other services of changes in patient's health and overdose risk behaviour
- Ensure patients are receiving detailed, tailored risk reduction advice, and sufficient support to apply this knowledge

8.3 NOVAS & THE HSE: CONFIDENTIALITY AND COMMUNICATIONS

- Emergency response to overdose
- Tailored post overdose supports

McGarry House is in a difficult position; they deal with the most chaotic clients coming through the system, people that nobody else will work with. The majority of those will be dealing with an addiction. HSE Worker

All GPs surveyed (n=4) also agreed that apart from providing psycho-social and harm reduction support to their at-risk patients, that staff in community housing services could assist doctors in their role by communicating overdose risk factors as these changed. Three of the four doctors also stated that staff in McGarry House and other projects could potentially support patient engagement with doctors by:

- Attending appointments if there are particular communication or behaviour issues
- Ensuring patients are getting detailed risk reduction advice
- Working with the doctor to support the person to address challenging behaviours where necessary

Novas and the HSE have a strong working relationship, providing services to a number of shared clients who are at high risk of overdose. Staff were identified by the HSE as having a lead role in responding to overdose.

While both organisations are working under strict data protection policies in order to comply with relevant data legislation, it was agreed by all who discussed this issue, that information sharing and confidentiality regarding overdose prevention needs to be strengthened. There is scope under the current law to facilitate this. An example of one challenge is highlighted here:

We don't have enough information, one nurse asked for information which I gave, but when I asked for information back this could not be given. Staff Member

As Novas and the HSE were in a process at the time to improve on interagency coordination, the primary improvement recommended was the inclusion in interagency protocols or agreements of overdose specific risk information and clarity in limits to confidentiality where a client is at risk. A standard list of risk factors that should be communicated between services (when consent to share agreement is in place) was considered a good idea. Relevant areas of risk include when:

- There is a significant increase or decrease in prescribed medication (this includes an individual not receiving methadone or being sanctioned for a period of days)
- There appears to be a significant increase, decrease or change in un-prescribed substance use or alcohol use
- The person has a suspected overdose
- The person attempts suicide
- The person seems unusually depressed or anxious, or staff suspect there is suicidal ideation or para-suicidal behaviour

- There is a change in mental health status or medication prescribed for mental health issues
- There has been a traumatic life experience or circumstance
- The service user has come into significant amounts of money

The HSE model for agreeing an extension of confidentiality was noted as good model that could be adapted by McGarry House. This involves any extension of confidentiality to be made by a number of key staff, rather than by one individual to ensure decisions are appropriately considered and that responsibility is shared.

An additional concern identified by staff in the HSE and in Novas was that while both organisations were working with large numbers of clients with complex needs, that information can sometimes get dropped. It was agreed that assigned liaison people within services may assist in resolving issues as they arise. Eight of the professional stakeholders agreed this mechanism could improve coordination.

Along with the procedures outlined above, all stakeholder interviewees, including HSE Staff, and McGarry House staff supported the proposal arising from the research to develop a common harm reduction checklist and toolkit as well as simple supporting processes, to ensure that harm reduction messages are coherent and coordinated. HSE staff were enthusiastic about supporting education programmes where possible where time could be provided and agreed through appropriate management structures.

8.4 MCGARRY HOUSE AND THE HOMELESS PERSONS CENTRE

McGarry House and the Homeless Persons Centre (HPC)²³ have a strong professional connection, in that referrals to McGarry House come through the HPC. It was noted that as the profile of homeless people has changed over the last several years, so has homeless service provision. The management of overdose was noted as an important service development in this regard, and the research and formal review of systems was welcomed.

The role of the HPC nursing staff was also noted as a particular asset to all organisations in dealing with overdose, and a resource that was both appreciated and utilised by McGarry House.

One process that facilitates communication between the organisations was the risk assessment undertaken by the HPC staff. The challenges of undertaking risk assessment with service users who may be intent on concealing risks was noted – it was felt that service users might minimise their level of drug use and risk behaviours in order to 'get a bed' in McGarry. A potential for skill-sharing in relation to risk assessment and ways to support service users to identify their risks at this point was identified.

8.5 MCGARRY HOUSE AND ACCIDENT & EMERGENCY DEPARTMENT

An average of one resident per fortnight in McGarry house requires hospitalisation. McGarry House and A&E staff interviewed reported predominantly positive experiences of interagency working. However on occasion there were some systems challenges which mainly relate to interagency communications.

²³ The HPC is a service run by the national Health Service Executive to support homeless people to access housing.

McGarry House request a discharge letter from residents, or confirmation of discharge from the hospital after they have been hospitalised due to overdose. This is to ensure that residents are medically fit to return to the project. A challenge arises when residents discharge themselves, or when they are discharged without a letter from the A&E department. Emergency Department staff understood the concerns of McGarry House and noted that in some cases new doctors may be unaware of the need for McGarry residents leaving the hospital to have a letter for readmission in to the hostel:

The current practice is that letters are sent to the GP, it was noted that these are needed with every client, and they should state that the client is medically fit for discharge and be given to the client also. Emergency Department Staff

What was clear from discussions with staff and medical services is that there may be different professional cultures that influence work with people in addiction. Staff members mentioned an occasional lack of understanding of the nature of addiction:

We've asked them how can we care for the residents afterwards...sometimes they just tell us to tell him to keep away from drugs which isn't always helpful in relation to our client group. Staff Member

It was noted by Emergency Staff that there are professional and cultural differences in the fields of emergency medicine and social care that may also impact:

There is reticence from the medical community in relation to harm reduction. We pick up the pieces for a lot of medical consequences of drug use. There is often a lack of clarity on the causes of the overdose, this information is difficult to obtain, that's a problem for the paramedics, and Emergency Departments. Although I think McGarry are getting as much information as they can. Emergency Department Staff

The Emergency Department discussed changes that are being undertaken in relation to their overall procedures which are intended to increase the scope of practice of pre-hospital emergency staff (ambulance staff). This, in turn, could improve the management of overdose situations due to an extended role for ambulance staff in assessing and treating overdose at first point of contact.

It was agreed that a short and simple interagency agreement clarifying procedures around discharge, and nominating a liaison person could be a useful way in which to address identified issues. The liaison persons could play a role in discussing and resolving any issues in relation to inappropriate referrals from McGarry to A&E (which it was noted occasionally arise), challenges for residents in getting discharge letters and any other issues as these arise.

8.6 MCGARRY HOUSE AND AMBULANCE SERVICES

It was clear from the interviews with McGarry staff that engagement with emergency services is highly valued. Ten of the 15 interviewees (66%) expressed gratitude and respect for the work of the emergency services and the high levels of professionalism with which it is undertaken. Eight (53%) of the interviewees commented that the emergency services had a good response time and provided a reliable service in this regard.

There was a concern and awareness from the staff team that residents could, at times, be considered as time-wasting and that this was a challenge for all concerned. This was largely based on the fact that residents could be difficult to manage, could refuse treatment, and could be repeat clients of emergency services. Almost half of the staff (46%, n=7) said that, at times, they have felt anxious about the clients or staff angering the emergency care staff.

I do worry about clients pissing of the ambulance staff. Staff Member

There was a strong sense of empathy and understanding towards the work and challenges faced by the emergency crew in negotiating with residents reluctant to avail of medical services. Over half of the staff (60%) expressed an understanding or empathy for emergency staff who did become frustrated with clients:

I fully understand that paramedics don't have the same connection with the lads that we do so may be more upset if the lads become abusive. They also have limited resources and are working under serious stress. It's as good as it can be considering both ourselves and the ambulance crew are working with very limited resources. Staff Member

Despite concerns regarding how uncooperative residents may be viewed by the ambulance staff, only two staff members mentioned particular incidents where the emergency team were terse with a client, and no staff member felt that residents' behaviour had resulted in a compromised level of care. One third of respondents (n=5) commented that they had a well-founded trust that despite the potential frustrations of the role, that a professional high standard of service would always be received by the residents of McGarry House. Two staff members (13%) noted that there have been significant improvements in the attitudes and professionalism of emergency staff towards their client group over the last five years.

Ambulance staff interviewed likewise noted the professional and informed approach of McGarry staff. It was however discussed that more could be done to empower McGarry House Staff to understand and therefore work cooperatively with the particular systems used on the emergency phone lines. It was suggested that the best way to achieve this was provision of flow chart of questions and considerations for McGarry House and a follow up information session provided by emergency care staff. If McGarry House staff are better informed of the particular processes used by those staffing the phone lines, then this may speed up processes and make communications more effective.

When asked if there were any areas where interagency working or response processes could be improved, it was suggested that staff always use mobile phones for emergency service calls, enabling staff to attend the overdose while remaining on the phone to emergency services. However it should be noted that McGarry had recently introduced such a policy across the service and this is clearly outlined in the draft policy appended to this research.

8.7 MCGARRY HOUSE AND PHARMACY SERVICES

The issue of medication management was raised by five staff as well as the pharmacist interviewee. The primary issues raised throughout the interviews were that the limitations of McGarry House might not be fully understood by medical professionals. As a result, medical professionals may assume that the role of McGarry House in relation to medical management is greater than it is currently, and may potentially result in less robust risk management strategies being employed by medical professionals (for example, a common technique used by doctors for managing people at risk of overdose who are on methadone is to prescribe methadone for daily dispensing rather than longer periods).

All stakeholders were in clear agreement regarding the limitation of McGarry House staff, which is that they are in a position to provide a lay assessment of risk, but not a clinical assessment. This means that staff can advise a resident who they presume to be at risk, not to take prescribed (central nervous system depressant) medication in the immediate term, although within their role are not able to: a) reliably or clinically assess risk of overdose, b) restrict medication to clients that request this, or c) understand the reactions between medications.

The need for absolute clarity on these limitations was noted by the pharmacist key interviewee:

They need to be careful that their role is one of safe-guarding the medicine on behalf of the client rather than assessing the client to be suitable to take the medicine. This should never be referred to as dispensing. Pharmacist

It was suggested that medical professionals may benefit from formal information from McGarry House as to their role in medication management and the limitations of this. It was recommended that the statement should highlight the following:

- McGarry's role can extend to providing a recommendation that someone does not immediately take medications that are central nervous system depressants (examples include benzodiazepines, z-class drugs, methadone, anti-depressants, and antipsychotics) following a layperson assessment that a resident has taken other central nervous system depressants (alcohol or drugs). This recommendation will not extend to anti-convulsants, asthma medication and medication for routine physical health conditions. If McGarry staff do not know which category a substance fits into then the doctor will be contacted for advice.
- It should be noted that this recommendation is lay only and staff have no way of ascertaining in a reliable manner the risk of overdose or residents' intake of legal or illegal substances.
- If services users insist on taking their medication against staff advice they have every right to do so, and McGarry will ask them to sign a disclaimer.

It is necessary that medical professionals understand the limitations of medication management in McGarry House to ensure that they can therefore take appropriate steps in relation to overdose risk management from a medical perspective.

8.8 MCGARRY HOUSE AND GPs

A GP Survey was sent to a total of 15 doctors, all named as GPs that clients in McGarry House had attended. Following initial send out and one follow up phone call, four doctors responded, representing a response rate of 26%. All doctors who responded had worked with patients who had stayed in McGarry House or another homeless

service, and all doctors had also been assigned a patient by the HSE who was both homeless and a problem drug user. In relation to patients from these groups, two of the doctors had provided methadone treatment and primary care, one had provided methadone treatment only and one had provided primary care only. All four doctors said that in relation to this client group, information was communicated between themselves and homeless / community service/s.

Three of the four doctors said that where there is a shared patient between them and a homeless / community service who was at risk of overdose, that the information flow could be improved between doctor and McGarry. Only one was satisfied that communications do not need to improve. One doctor noted that communication was 'patchy'; another doctor said that they find text messages most useful and another stated:

We need to meet up and set up a suitable communications system. GP

All doctors agreed that there is value in information flows between doctors and community homeless / drug services, where there is perceived to be a risk of overdose and where the patient has consented to share information, particularly in relation to: traumatic life events, suicidality, change in mental health status and / change in medication or in how person is using medication.

All doctors agreed that GPs have a role in relation to their clients in respect of the following:

- Provision of advice on poly-substance use
- Provision of advice on safer injecting practices
- Provision of advice on health issues that increase risk of overdose
- Provision of advice on tolerance / reduced tolerance
- Communication with other professionals (e.g. counsellor, workers in hostel etc.) regarding an individual's risk

Three out of the four who responded felt that GPs also have a role on advising on recognising and first response in relation to overdose.

One respondent noted that what is needed in relation to this topic is education for GPs regarding the treatment of poly-substance use and the prescription of medicines such as benzodiazepines, opiates and analgesics.

All four doctors stated that their practice has a policy regarding prescription of benzodiazepines / benzodiazepine-like drugs for people with substance misuse issues. Measures described included: specific policies including routine offering of detox to addicted patients and rules that emergency prescriptions are not provided for more than three days.

All four doctors noted that where their patient has another doctor, they communicate with them regarding benzodiazepines, and all agreed that it would be useful to have a more formal system established for these communications.

Three of the four doctors had previously or were currently supporting a patient to detox under the Community Detox Protocols for methadone or benzodiazepines. All three felt that the supports provided are of assistance to them and their patients. As one doctor stated:

They're great compared to what we had a year ago, i.e. no support. GP

8.9 SUMMARY

The importance of McGarry in supporting overdose prevention has been acknowledged by services, and this is supported by literature (for example, 110, 111, 112). However as is advocated by both Novas and the interagency stakeholders consulted here, the literature consistently shows that a multi-agency approach is likely to provide the most effective impact in preventing and responding to the problem of overdose (65, 91, 97, 108). There was strong sentiment amongst both the team in McGarry House and among external service providers and stakeholders of the importance of interagency working in effectively preventing and responding to overdose.

Throughout the process Novas staff and partner organisations were quick to identify concrete solutions refining and improving interagency processes. Some of these recommendations include: the development of a regional standard for harm reduction interventions and support, a peer overdose education programme and training for staff in working with service users with addiction issues. In addition a number of draft interagency protocols have been developed as part of this research process, for Novas and the agencies they are working with, which may be available upon request from Novas or the research partners.

9

THEME FOUR A COPING CULTURE: ENSURING EFFECTIVE STAFF SUPPORT

9.1 INTRODUCTION

Overdose is a relatively common experience in McGarry House, with the staff team responding to an overdose every two weeks prior to the research. Staff described their team as having a strong sense of professionalism, resilience and coping in relation to overdose. This resilience was considered a strength within the team, although it should be noted that if not managed, a drive to be resilient in the face of stressful situations can mean, at times, that staff do not seek supports when these are required.

The research indicated that there are diverse experiences of stress across the staff team. The majority of staff reported experiencing stress during and after high-stress incidents and carrying stress home with them. Staff noted that debriefing and supervision supports were not always provided routinely, or consistently accessed by staff. There was need identified for clear systems of staff support in order to ensure that high-stress incidents do not result in unmanageable work related stress.

9.2 CHALLENGING FACETS OF WORKING WITH OVERDOSE

In the survey, when asked about the most challenging facets of overdose, staff named the following factors:

- Half (n=7) named death and fear of death and factors that may contribute to this including delays in arrival of the ambulance crew, or that staff will not reach them on time and be able to respond
- Half (n=7) named as a challenge their frustration with residents who repeatedly overdose and seeming lack of care for themselves or failure to change behaviours in the aftermath of an overdose
- Half (n=7) also named the aftermath of an overdose, including staff stress levels and the lasting impact of seeing someone overdosing as the most challenging issues

Other challenges named in the survey included frustration about residents refusing medical treatment or being dismissive or abusive to ambulance staff (n=2); the feeling of powerlessness when caring for the client or watching the ambulance team care for the client (n=3). Other challenges mentioned by one or two staff included managing the environment and the risks from blood and needles, managing the other services users while trying to respond to the overdose, working with pregnant women at risk, poor interagency collaboration around identification of risk and sharing information

and the sense of powerlessness in being able to develop appropriate procedures and policies around the issue.

The client going blue and black in front of you, the client passing out in your hands, the blood, needles and environment...the aftermath - the weeks, months and year after - the image haunts you and eventually if the client dies, the feeling of loss. Staff Member

Staff in McGarry House identified a number of personal and professional challenges in working with a high-risk client group which can be mitigated in order to ensure stress remains at a manageable level.

9.3 STRESS AND COPING WITH STRESS

Generally, staff in McGarry House felt that working with low-threshold service users, while rewarding, can also be frustrating, challenging and difficult work (n=9).

It's incredibly frustrating for staff to witness the same person overdosing again and again. It's hard to see how vulnerable they are. Staff Member

With the exception of one staff member, almost all staff members (93%) discussed experiencing stress in their line of work in relation to overdose. Particularly stressful situations highlighted included monitoring heavily under-the-influence residents, trying to revive someone or keep them alive whilst waiting for ambulance staff, managing other residents and the day-to-day running of the project during and in the aftermath of overdose, worry about residents who have overdosed and who refuse to go with the ambulance (specifically that they will overdose again) and for a particular group of staff members, managing heavily pregnant women who were active poly-substance users.

I see colleagues burning out or struggling and sometimes I struggle myself, waiting for people to die, watching people die. Staff Member

Responding to an overdose is hard, it's frustrating, it's upsetting and afterwards, after they're gone in the ambulance you're just wrecked, you're tired. Staff Member

Staff who participated in interviews were asked about whether and how stress relating to overdose affected their lives outside work. One third of the staff team stated that they had not experienced stress or trauma relating to overdose at home, however two thirds (n=10) of the staff team had experienced one or a number of the following:

TABLE 8:
MCGARRY
TEAM'S
EXPERIENCE
OF STRESS²⁵

Symptom	Explanation	No.	%
Affected Family / Relationships	Stress from overdose has affected family / home life in almost half of staff	7	46%
Smoking	One third of staff have at some point increased their smoking as a result of stress from overdose	5	33%
Anxiety, depression or sadness	Two-fifths of the team have experienced anxiety, depression or sadness at home relating to overdose in work	6	40%
Affected sleep	Almost half of the team said that their sleep had been affected or they had sleepless nights as a result of stress related to overdose	7	46%
Increased alcohol use	One staff member reported that s/he had increased alcohol intake in the days following an overdose	1	6%

In interviews, almost half of the staff team discussed times where they found stress management difficult. The reasons that supports to manage stress were not accessed was considered in part to be related to a drive to be seen as professional, to accept stress from overdose as simply 'part of the job' and a desire not to be seen as too emotionally connected to the work and residents, which in itself was considered to be unprofessional or a sign of lacking in appropriate boundaries. This is highlighted in the following comments:

There are times that on reflection I needed [formal support after overdose] but didn't pursue it because I thought I was fine, and everyone else seemed to be getting on with it. Staff Member

They are worried (staff) that it will be seen as unprofessional - that you have allowed things to affect you that you shouldn't have and that therefore you are not very good at your job ... eventually I just told myself to cop on. Possibly it would have been good to talk to someone, but I didn't feel like I could ask. Staff Member

The McGarry team generally felt that stress is a normal and expected part of their working lives, although at times if not managed properly it can affect their health and their home lives. There are times when appropriate support is not availed of for a variety of reasons which can readily be addressed through reviewing and improving support systems as documented in the following section.

²⁴ Note that the symptoms of workplace stress are taken from (3).

9.4 SUPPORT SYSTEMS IN MCGARRY HOUSE

Relationships between project staff and project management are very supportive and the informal support structures that are in place are valued by staff. While support structures were largely regarded as satisfactory, there is potential to improve and formalise these, according to interviewees.

Staff were asked a number of questions in surveys about support they received after the last overdose:

- 82% (n=14) of those who had ever responded to an overdose in McGarry said they did need or somewhat needed support after the event; 18% (n=3) felt they did not need support
- 41% (n=7) said that they had received the support they needed after the last overdose, 59% (n=10) of staff were not completely satisfied with the support they had received
- Almost one third (n=5) of staff said they needed a team debrief and almost a quarter (24%) said they needed to debrief with a colleague, 18% (n=3) said that a debrief with management was needed

Staff were asked about their most important sources of support in an overdose situation:

- Almost all of the of staff (n=16, 94%) said other staff are an important source of support when an overdose happens
- 85% (n=14) of staff said that emergency crew are an important source of support
- 70% (n=12) of staff said that other residents are an important source of support when an overdose happens
- 60% (n=10) said that managers or on-call managers are an important source of support during an overdose situation

Staff were asked by survey to rate how much they agreed with statements relating to the support they receive, the knowledge they have and the capacity they have in relation to overdose. Of the three statements relating to support; 1) support in understanding professional role and responsibility in relation to overdose, 2) support in figuring out the best way to work with high-risk individuals and 3) support in the aftermath of overdose; support in the aftermath scored the lowest, although the difference between the three areas was marginal.

The potential for improvement in the current support structure was evident in interviews: 60% of staff (n=9) discussed the need for the current system of support after overdose to be formalised and/or improved:

After the client is gone we have great informal support, tea and a fag afterwards and discuss it between ourselves. Management are told. All that being said, we don't always have time for that informal chat and you might not get a formal debrief from management. Generally the informal support is good enough, but there may be times when it's not, when you're more traumatised. Staff Member

Four staff (26%) also discussed the fact that ensuring the whole team are engaged in on-going formal supervision could help staff to manage their stress. Generally, the sense that the informal support system was highly valued and helpful was evident in staff interviews, as was the appreciation for management support:

We have excellent informal support from great management and a great team. Staff Member

While there are positive relationships between management and staff, and strong informal support systems, there is potential for gaps in the support and stress management systems in McGarry House to be improved through the formalisation of staff support systems, particularly around overdose incidents.

9.5 SUMMARY

The staff team in McGarry House consider themselves to be strong and resilient in the face of high-stress incidents such as overdose. Staff provide support to one another in the aftermath of overdose and are generally effective in this area. However, there are times when, in a drive to be professional, to accept stress from overdose as simply 'part of the job' and not to be seen as too emotionally connected to the work or the clients, staff may not seek additional support they may need. This knowledge should inform a support system that can respond to the diverse and changing needs of staff. Although that McGarry staff have good coping strategies there is need for additional support, which they are not always receiving.

In research on the capacity of health teams to respond to addiction, Cartwright and Gorman (102) found that support was a vital facet of participant confidence in working with addiction and that even where the area of knowledge was served through the provision of educational support, the impact was more significant on their feeling of being supported by the organisation than on their knowledge. The authors concluded that the provision of education alone to support staff to work in this area was of 'negligible' effect without support, but support alone is not enough either.

McGarry House should ensure that an appropriate range of formal and informal supports is available to staff in the aftermath of overdose. These supports should be available and offered to all staff. This range of supports should be developed in consultation with staff, and should be reviewed and monitored regularly for effectiveness, consistency and quality. More detailed considerations for implementation of such a system are contained in the Draft Overdose Policy, appended to this report.

Implementation of an effective informal and formal support structure as outlined in the policy, combined with a targeted training and education programme will provide supports for the McGarry team to improve the organisations capacity to prevent and respond to overdose.

10

THEME FIVE

STAFF CONFIDENCE, CAPACITY & LEARNING OPPORTUNITIES

10.1 INTRODUCTION

This chapter provides a picture of the staff team's confidence in their knowledge and capacity to support effective overdose prevention and response. The information was collected primarily through survey. The survey questions were adapted from a model developed in the UK in the 1970s, and used in a number of studies since, to assess how general health workers felt when working with addiction. This model is particularly relevant to this research; in the UK study as in McGarry House, staff are working with an issue that is not a primary function of their work but has developed to become an important and challenging facet of their work, e.g. in McGarry their role is to provide housing and general support.

This research describes a team that is well-trained and confident in their knowledge and capacity relating to preventing and responding to overdose. This chapter also identifies how time and resources may be prioritised for training and development.

10.2 TRAINING

PREVIOUS TRAINING

In the year and half prior to the research alone, the team in McGarry House have received a wide range of training on diverse subjects: over half of the staff team had been trained in understanding poly-drug use, almost half had done harm reduction training, over a quarter had attended mental health training, a third had attended first aid training and four members had attended relapse prevention training. Approximately half of the staff team had also attended training in motivational interviewing in the last two years. Management noted that at the end of 2012, all staff of McGarry were trained in motivational interviewing.

Consultations with Novas management revealed that no staff member can begin working in McGarry unless they have certified first aid training. When asked in the survey whether they had up-to-date certified first-aid training, 60% (n=12) of the staff team were confident that they had it at the time of the survey, one quarter did not have it or were not confident that they had it, and 15% (n=3) were unsure. There may be a need to update some staff training if first aid certification has expired.

POTENTIAL TRAINING

Despite declining resources, Novas Initiatives have invested heavily in the training of the McGarry staff team in recent years as noted above. Interestingly, there were instances where staff mentioned that despite being trained in certain areas, they still did not feel appropriately qualified to undertake interventions relating to overdose, these areas included first aid or in harm reduction (one staff member each discussed these topics).

The research indicates a number of gaps and areas for potential team development, including the following:

- Up-to-date relevant first aid training for all not yet trained or who need recertification
- Information/training in management of body fluid spills / hazardous materials
- Therapeutic techniques that may support 1-2-1 interventions around overdose such as Motivational Interviewing or Relapse Prevention for those not yet trained
- Training / facilitation in boundaries, crisis management and debriefing
- Harm reduction training, which includes specific applied learning on overdose prevention for those not yet trained

In focus groups, the team discussed the idea that training alone was not sufficient given that many training programmes such as first aid and motivational interviewing do not have a specific application to overdose. The focus group suggested that on-going team learning and review should be undertaken through team meetings, specific organisational learning time or supervision. Diverse learning opportunities may be explored by the organisation including, for example:

- In-house uncertified training where there is sufficient expertise (e.g. debriefing training provided by management, bodily fluid spill management provided by medically trained staff)
- In-house applied learning: team or staff/management review of application of training to specific work environment
- Skill-share / uncertified training between McGarry House and partner organisation with different, relevant skill sets (e.g. McGarry supporting Homeless Person Centre to work with drug using people / Ambulance staff supporting McGarry in handing over appropriate information)
- Certified / uncertified training provided by external training provider to McGarry team
- Interagency training: certified / uncertified training provided by external provider to McGarry and colleagues in other organisations in the city/region

10.3 STAFF CONFIDENCE OF THEIR CAPACITY AND KNOWLEDGE REGARDING OVERDOSE²⁵

The McGarry Team are experienced in working with people at high risk of overdose. Almost all of the staff team (95% n=19) in McGarry House have been working for at least two years with people who are homeless or people who have addictions, with 60% (n=12) of the team having worked for at least five years in the sector. Almost all of the team, 95% (n=19) has also worked in McGarry House for at least two years. McGarry staff were asked to score their own knowledge and capacity in relation to preventing and responding to overdose. Generally, the scores were high and would suggest that there is no area that urgently needs to be addressed. The results do, however, indicate that there are some areas of skills and knowledge where staff have less confidence. These areas could be prioritised for training, team discussions or other learning opportunities.

The areas where staff showed considerable confidence are:

- Capacity to call an ambulance and give the correct information
- Capacity to put someone in the recovery position
- Knowledge of drugs, alcohol and overdose
- Knowledge of appropriate response to an overdose situation
- Capacity to advise residents about risk factors and prevention

Lower scoring areas were predominantly skills based:

- Capacity to manage an overdose situation
- Using first aid to respond to an overdose situation
- Debriefing other residents and staff if there has been an overdose
- Knowledge of safer injecting in relation to overdose

While the capacity to advise residents about risk factors and prevention was one of the higher scoring areas in the survey, only 10% (n=2) of staff said they were 'very confident' in providing information on overdose risk factors.

This suggests potential priority areas for learning; while the team has training and expertise in many areas, there may be a need to create learning spaces that facilitate them to apply such skills to overdose situations. Skills bases that may benefit from such a process include first aid, debriefing and crisis management, as well as information on applied overdose harm reduction including issues such as safer injecting.

10.4 OVERDOSE: PROFESSIONAL LEGITIMACY AND ROLE AMBIGUITY

External stakeholders all agreed that McGarry have a vital role in preventing and responding to overdose among their client group. While there was a general sense

²⁵ The experiences of staff in non-clinical settings such as McGarry House in relation to overdose have been largely un-documented in research. However, some research has explored the experiences of general health staff who found themselves working with drug and alcohol problems without previous experience or specific training. Shaw et al (105) argued in 1978 that when workers feel that they have the right to do the work that they are doing, when they feel adequately knowledgeable about their work, and when they feel that they have adequate support (known as role legitimacy, adequacy and support) that this can enhance motivation and esteem for workers in undertaking new, different and challenging roles. In research on the capacity of health teams to respond to addiction, Cartwright and Gorman (102) found that the provision of education alone to support staff to work in this area was of 'negligible' effect without support, but support alone is not enough either. Research by Skinner et al's with over 350 health professionals (104) found that workforce development interventions aimed at an organisational or systems level rather than focusing exclusively on knowledge skills and experience of an individual worker was the most effective means of supporting workers to respond to challenges.

on the McGarry House team that they have an important role in relation to overdose and that it is a vital facet of their work, there were indications that the team were ambiguous or not always clear about the limits of their role in relation to overdose prevention and response.

Role legitimacy – the feeling that one has the right to address certain client issues – has been shown in other areas to be an important factor in worker's confidence in their capacity to address an issue (106). The McGarry House team were asked whether they felt that they had the right to ask residents questions about their drug or alcohol use if they had concerns about their risk of overdose, 70% (n=14) of the team agreed or strongly agreed that they had the right. However, a quarter of the team neither agreed nor disagreed which may indicate a level of ambiguity about their role in relation to this, and one person strongly disagreed. Likewise, the team were asked if they felt that they had the right to ask residents for any information relevant to their risk of overdose and 65% (n=13) either agreed or strongly agreed that they did. Again, a third of the team neither agreed nor disagreed with this. One person strongly disagreed.

Staff were asked whether they thought that residents in McGarry believe that have the right to ask them information about drugs or alcohol, if they are concerned about them overdosing. There was a much stronger lean towards ambiguity in relation to this. Approximately two thirds of the team (n=13) neither agreed nor disagreed with this statement and just under a third (n=6) either agreed or strongly agreed.

There was evidence of some ambiguity about the limits of the staff role in relation to overdose. There were instances where staff (n=2) felt that certain tasks in relation to overdose prevention or response were outside their remit. One issue, which has been addressed previously in this report, is the issue of medication management, which was discussed by two staff members:

The biggest risk is the fear that we hand out methadone and inadvertently contribute to an overdose, we have no medical training, it would be hard for us to manage. Staff Member

Professional stakeholders also raised this issue and recommended that the McGarry team provide absolute clarity to doctors and pharmacists in relation to the staff role. There were other examples where staff expressed uncertainty about their role in relation to overdose prevention and response. For example, one staff member discussed the fact that they felt it may be someone else's job to debrief the resident on their return to the project from overdose, where the general sense in focus groups with staff and during interviews that it was the responsibility of all staff:

This system needs to highlight the seriousness of the risks [after someone returns from hospital]. This could be a role for the Dual Diagnosis worker, although if she is not there then who does? Is it the managers role? Staff Member

Working with heavily pregnant poly-substance using women was also named as a challenging issue:

As a team, we really did our best but we didn't have the skills to deal with it, or adequate cover. We needed a doctor or nurse. Staff Member

10.5 LEARNING IN THE ORGANISATION

The importance of the role of McGarry staff in relation to overdose prevention and response is broadly acknowledged and there is potential for the specific requirements and limits of the team in relation to this area to be clarified both internally and with partner organisations.

A quality organisation is one which is reflective and consistently learns and develops their practice using a strong evidence base gleaned both from external good practice but more importantly from information gathered systematically about clients, their outcomes and what is and isn't working in the organisation (119, 120, 121). During the interviews 60% (n=9) of the staff members gave examples of McGarry House being a learning organisation:

The client overdosed and I called for help downstairs. The new worker gave the wrong name, I rang the ambulance on a landline, but it was the wrong room. I had to ask clients, I had to run about the building. When I found them, [the other staff member] was still giving CPR - It was fine, but I was really frightened. We now use walkie-talkies and only call the ambulance on the mobile; we changed our processes because of that experience. Staff Member

However in relation to the issue of overdose or where clients have died, two staff members pointed out that these are learning opportunities for the organisation that should be availed of in the future:

We never ask this question, what would we do differently... it will happen again. Lessons weren't learned. We should discuss it. Staff Member

Implementing formal debriefing, ring-fenced time for reflection and learning, and as mentioned previously, dedicated time for reflective practice could maximise learning for the team, particularly where the cost of external training can place an undue burden on the organisation and there is such significant learning to be gleaned from real-life work situations.

10.6 SUMMARY

The staff team at McGarry House are well-trained, confident, knowledgeable and reflective in relation to the issue of overdose prevention and response. This chapter highlights that staff self-assess as having considerable experience, and for the most part feel they have enough knowledge and skills to help residents prevent overdose and to appropriately respond to it. Opportunities for further development of capacity and confidence have been identified, which can build on what was considered by staff to be generally fit for purpose system within McGarry House.

The research indicated that there is some ambiguity among staff regarding their role in relation to overdose²⁶. The recommendations for the report include developing clear and cohesive procedures outlining the staff role, as well as consulting with other relevant external stakeholders including doctors and pharmacists about the limits of the role of McGarry staff in relation to medication and risk management.

²⁶ In their research on nurses, Revicki et al (7) found that an increase in role ambiguity led to a decrease in job satisfaction and increased perceived stress.

Training priorities can be identified from this research and used to update skills for some staff, fill gaps in skills for others, and bring new skills to the team. Key areas to be considered in a training plan include practical application of first aid, harm reduction, therapeutic models, staff debriefing and general overdose prevention. The research also highlights that there is potential for the team to implement formal reflective practices or learning opportunities by putting additional mechanisms in place to formalise learning from day to day activities.

11

THEME SIX RESIDENT EXPERIENCE OF OVERDOSE IN MCGARRY HOUSE

11.1 INTRODUCTION

This chapter explores residents' experiences of overdose in McGarry House. Overdose is discussed through a seven-stage cycle, shown in the diagram below.²⁷ The cycle begins with the resident moving into the project, progresses to the provision of harm reduction interventions and continues through to processes for; responding to risk, when a resident overdoses, what happens after a resident overdoses, and finally what happens when the resident returns to the project, or in the unfortunate event that a resident fatally overdoses.

The aim of this chapter is to highlight the experiences of these processes from the residents' perspective. Where possible, each stage in the cycle is discussed from the perspective of residents, however in some instances, residents did not have stories to share or opinions on a particular stage in the cycle. In most instances this was due to their own experience of overdose and the fact that they were unconscious or affected at the time resulting in a poor memory of events.

While this chapter focuses on the resident's perspective, the overdose cycle was also used to guide discussions with staff, and to analyse organisational policies and the case study. This information was then used to inform the development of a draft overdose policy for the organisation which is appended to this report.

11.2 THE OVERDOSE CYCLE



The following diagram and table shows the seven-stage structure and corresponding process that guided the interviews and also provides the structure for this chapter.

²⁷ This model draws on Rome et al's model (64) which is discussed in further detail in the methodology section

For each of these seven areas, procedures in the organisation were identified as follows:

Stage	Description in the Overdose Cycle	Processes in the Organisation
1	Resident moves in	Risk assessment
2	Risk identified	Harm reduction
3	Resident overdoses	Responding to overdose
4	Emergency services	Working with emergency services
5	Resident goes to hospital	Procedures immediately following overdose
6	Resident returns	Procedures in the week following overdose
7	Resident dies (in some rare cases)	Death of a resident & staff support

11.3 RISK ASSESSMENT

Residents did not highlight any concerns with the issue of risk assessment during interviews. While some residents noted in focus groups that they may be inclined to hide the extent of their drug use from staff, generally, residents reported that they did not feel judged by staff and had positive relationships with them.

11.4 HARM REDUCTION

HARM PREVENTION, OVERDOSE AND MENTAL HEALTH

The results of this research show a strong correlation between poor mental health or stress and overdose²⁸. Benzodiazepines were involved in the vast majority of residents' most recent overdose experiences. 45% (n=5) of those who had previously overdosed had intentionally overdosed at least once. Residents were asked to recall what was 'going on for them' in the weeks leading up to the overdose. 45% (n=5) of the residents who had overdosed said that they had been in particularly bad mental state in the days or weeks preceding the overdose:

I was not in a good space, I had been taking loads of tablets off and on for a few days, then I started feeling not right...my best friend died in the last month, and that's been going through my mind a lot, and this makes me want to use more. Resident

²⁸ The connection between overdose and mental health has been well documented in the literature and is detailed in the review of the literature in this report.

I felt like a nobody, with my birthday coming up I felt like I had nothing to show. I had lost everything in life. Resident

OVERDOSING IN MCGARRY HOUSE

Interviewees were asked if they would feel safer overdosing in McGarry House than elsewhere, and around three quarters of residents (n=12) said that they would. One resident felt that when using drugs with peers, they felt their peers would respond and call an ambulance if needed. Two residents said 'sort of' with one individual highlighting that because concern about overdosing when there are only two room checks per day. When residents were asked to explain why they felt safer overdosing in McGarry House, they gave a variety of responses, which are paraphrased below:

- Well trained staff who care about the residents
- Staff are quick and effective in their responses
- The staff know who is high risk and who to keep an eye on
- The room checks promote safety

The following statements illustrate such sentiments:

Because there is more professional people here so even if you lock yourself in the room, it's better than doing it in a shed down town where you might not be found for days. Resident

They are very fast and they are good and they are fast at getting to people. You can't wrong them for that. Resident

Residents were asked whether they felt McGarry staff were a 'safety net' for them, if this increased their chances of engaging in risk behaviour. All who were asked stated that this was not the case. As mentioned elsewhere in the report, residents rarely took preventative action to decrease their likelihood of overdosing or of an overdose becoming fatal, which includes choosing safer locations to use, such as McGarry House.

SOURCES OF HARM REDUCTION INFORMATION

Residents were asked if they had ever discussed overdose with individuals, groups or professionals, and what their sources of harm reduction information were. The most common source of information that residents volunteered was staff members in drug and homeless services, which was mentioned by 80% (n=12) of residents. Specific services mentioned included McGarry House, the HSE Addiction Services and the Ana Liffey Drug Project although a number of times residents referred generically to staff in 'the hostel' or 'workers' or 'the safer injecting workers'.

The second most common source was their peers, either through discussion or observation, which was mentioned by 40% (n=6) of interviewees:

I'm clean now but friends have told me to be careful of my tolerance. Resident

The third most commonly cited source of harm reduction information was GPs. Three interviewees (20%) mentioned this. Three residents also mentioned posters and leaflets

that they had seen, although on further questioning it became clear that the literature had not been in relation to overdose, but other facets of harm reduction such as safer injecting. The Probation Service and family members were mentioned by one resident each. A number of residents also discussed the idea that they 'just know' a lot of overdose harm reduction information:

[In relation to heroin, tablets and overdose]...I always knew before, when I was last homeless and on tablets, nobody ever told me but I knew. Resident

It is worth noting that a third of residents (n=5) discussed their perception of the futility of harm prevention advice. Three residents (20%) highlighted in particular that whatever learning or advice they had previously been given was irrelevant when they began to take drugs, as the only thing that would stop them was having no more access to drugs.

I don't know if they had told me beforehand if that would have changed anything. Resident

However, despite the perception of some residents that harm reduction advice may not be useful in some instances, an issue noted by a third of respondents (n=5) was the lack of available information on overdose and harm reduction. Over half of the residents (n=8) said they would appreciate more harm reduction information:

...the last time the treatment centre talked to me about overdose was a year and half ago, I would like for them to do it again. Resident

11.5 MANAGING OVERDOSE

As noted previously, all residents except for one (93%, n=14) had witnessed another person overdosing and almost two-thirds of residents who had witnessed an overdose (64%, n=9) had done so within the last year. Resident experiences as overdose responders and the potential for supporting further capacity building was such a consistent theme throughout interviews that it has been discussed in detail in Theme Two: Empowering Residents to Respond to Overdose and Recommendation One, which discusses the development of a peer education programme.

11.6 WORKING WITH EMERGENCY SERVICES

Engagement with emergency services (i.e. ambulance staff) was an issue that was primarily raised by and discussed with staff. This may be due to the residents' memories being unclear as they were overdosing. However, all residents were asked whether how helpful or not they found ambulance staff when they were present at another person's overdose. Over half of those who answered, seven people out of 13, said that they had found the ambulance staff very helpful, with five residents saying they had been very unhelpful and one person stating that they had been 'somewhat unhelpful'.

Positive stories about engagements with ambulance staff showed that residents valued when their role was acknowledged, as illustrated in the example below.

I rang the ambulance and the ambulance said that if I wasn't there she would have died. Resident

One resident recalled a time where he had been supported to manage the person overdosing by the emergency services while the ambulance was waiting:

I stayed with him, and I rang the ambulance. The person on the phone told me turn him on his side and then to give him CPR, and I did that. It saved him. Resident

A number of residents discussed occasions that they had refused medical care when they had overdosed. Four (26%) residents recalled a time that this had happened. In three of these cases the residents discussed not going in the ambulance, or resisting going in the ambulance.

After they've resuscitated me I wouldn't see the point in going in the ambulance, being left in a bed for a few hours and being told to go home. Resident

My mother called it and I was just refusing to go, I knew what I had taken I felt in myself that I was grand. Resident

11.7 IMMEDIATELY AFTER OVERDOSE

As with the issue of working with emergency services, the time immediately after overdose was more of an interest to staff than residents, as they could discuss issues with managing the project, debriefing and checking in with other service users. As with the previous stage, residents may have compromised memories in relation to this area. However residents discussed concerns regarding being in hospital. Three residents (20%) discussed leaving the hospital prior to being discharged. It is interesting to note that research in an Irish emergency department revealed that of 65% of people who overdosed, although most were critically ill, discharged themselves against medical advice (62).

Sometimes I've ended up in hospital and they'd want to keep me in and I'd always leave. I didn't want to be there and listen to the doctors, and I'd want to go drinking. Resident

11.8 RESIDENT RETURNS / THE DAYS FOLLOWING OVERDOSE

A priority identified by the organisation regarding the return of a resident after overdose is the engagement of the resident in conversation to discuss their risk of overdose, their well-being, whether there is anything to be learned from the incident, and what, if any, additional support the resident needs. Residents were asked for their opinion on conversations they have had with staff about their overdose after it happened. Some residents reported positive experiences saying that they had felt supported.

Yeah it was helpful, the fact that they weren't speaking to me like ... I expected them to be angry, they were just trying to tell me that they were watching me, and telling me that my tolerance was at rock bottom. They checked me hourly, I felt very cared for. Resident

However, two residents provided advice on the discussion after overdose, and how staff can avoid underestimating the level of knowledge of the resident in relation to their situation:

Don't treat people like they know nothing, respect their experiences, they've probably heard all of it before. Resident

11.9 DEATH OF A RESIDENT AND STAFF SUPPORT

Given the temporary nature of the tenancies in McGarry House, the issue of death of other residents from overdose was not something that those residents participating in interviews had significant experience of. However it is of note that for most residents, the fear of death from overdose was the most prominent concern in relation to overdose (see Theme One – Ambivalence), and that a number of staff had previously expressed concerns in relation to the support that other residents received after a resident had overdosed.

11.10 SUMMARY

The aim of this chapter was to give dedicated space to illustrate resident experiences at the various stages of the overdose cycle. These experiences and recommendations presented by residents in relation to each area have informed the development of the recommendations at the end of this report, as well as the draft overdose and harm reduction policies amended to the report.

12

THEME SEVEN

PROMOTING THE LOW THRESHOLD ETHOS

12.1 INTRODUCTION

McGarry House have a harm reduction ethos which is mentioned in a number of the organisation's policies. It is evident from physical features in the building such as the presence of safe disposal bins for needles in the resident's rooms, the provision of harm reduction based interventions by staff, and in the training records of the organisation showing staff have been trained in the past year in poly drug use and harm reduction. Despite these efforts, there remains some ambiguity in embedding and practically implementing the harm reduction ethos into the day to day work of the organisation.

12.2 HARM REDUCTION ETHOS

McGarry House provide personal sharps bins for residents in every room. The team support their clients to manage treatment medication such as benzodiazepines and methadone. The organisation previously provided a needle exchange to their residents and the staff team is trained in harm reduction and first aid. McGarry House emphasises in a number of policies the harm-reduction ethos of the project and it is clear from staff interviews that staff feel that they have a role in supporting residents with their active substance use. It was evident from interviews with residents that there was considerable respect for the staff team, their expertise and their openness:

They are really respectful, it's like me to talking to you it's totally confidential, I can talk about anything and no one else will know what I said. I appreciate that. Resident

12.3 PERCEPTIONS OF NEGATIVE CONSEQUENCES FOR DRUG USE

However, one concern that was clear to researchers was a perception among some residents that there can be negative consequences for drug use in the hostel, which can make them reluctant to disclose their drug use to staff.

Almost half of the residents (n=7) recalled stories of feeling feeling unclear about what the consequences would be for certain substance related behaviours within McGarry House. In focus groups, residents stated a concern that there would be consequences to them honestly talking about drug use.

These concerns regarding perceptions about consequences for drug use were also shared by the staff team, a number of whom felt that they were either not clear enough themselves about consequences for different types of substance related behaviour or who were concerned that the team were not communicating the organisation's low threshold policy clearly enough to residents. The concern was that if residents felt that there would be negative consequences for substance use (even if this was simply an issue of perception, rather than based on experience) that they would not disclose information that could indicate overdose risk to staff, or that they would delay in seeking help from staff if someone was overdosing in the project.

12.4 SUMMARY

Despite efforts on the part of the organisation to be clear on the issue, some residents still worry about punitive consequences for drug use in McGarry House. There is an acknowledged tension between the role of McGarry House as a landlord with legal obligations in relation to drug use on the premises, and the role of McGarry House staff in using an evidence-based approach (harm reduction) to support their residents who are active drug users. Previous work has been undertaken between McGarry management and the Gardaí in relation to this issue but there is potential for McGarry to develop greater policy clarity on this in conjunction with relevant Gardaí with expertise in this area.

13

THEME 8

PREGNANT WOMEN AND HIGH RISK DRUG USE

13.1 INTRODUCTION

As illustrated in previous chapters, the fear of death from overdose was a significant concern that staff in McGarry had for the residents there. On a number of occasions, residents in McGarry were pregnant and continuing to engage in high risk substance use. For the staff team in McGarry, the fear of death was exacerbated where the death of the women could also mean the death of her foetus. While staff felt under-qualified to provide the support needed, they were also proud of the fact that they had managed to support such a vulnerable group of women at such a difficult time. The need for specialised support and interagency work was highlighted as potential responses by the team.

13.2 PREGNANT WOMEN IN MCGARRY HOUSE

Prior to this research being undertaken, McGarry House had provided support to a number of pregnant women who were also chaotic drug users. All of the women were methadone users and intravenous heroin users and all gave birth while they were resident in the hostel. McGarry House carried out an assessment of the women, and found that they were all high risk for overdose. It was an intensely stressful time for the team:

When the pregnant girls were here, we were so under pressure. It was constant. We were constantly worried about overdose. We were constantly worrying about the unborn babies. They had high chances of overdosing. It put an awful lot of pressure on us... As a team, we really did our best but we didn't have the skills to deal with it. Staff Member

Working with this specific client group was relatively new to the team, and working with a number of women in this situation through the final stages of the pregnancy created great demands on the organisation. There were statements in interviews that indicated confusion for some staff regarding risk of overdose, use of naloxone and other issues and highlighted a need for education around this issue.

Although the staff had found the time very stressful, and they did not feel they were the most qualified people to support pregnant drug using women, they were also proud of the fact that they had managed to support such a vulnerable group of people at such a difficult time:

We really, really looked after the pregnant women at a very vulnerable time. Staff Member

13.3 INTERAGENCY WORKING AND SPECIALISED SUPPORT

In a risk assessment conducted at the time, the team in McGarry noted that the accommodation provided by McGarry house was not suitable. It was noted that for women in this difficult position, intensive specialised support is needed. However, the team were concerned that social workers would not work with their clients until the third trimester, when they conduct a pre-birth assessment, which may be 'too late for drug users'. Suggestions for how to address the gap in service provision internally included the development of a programme of on-going support for pregnant residents to be provided by female staff.

However, both management and staff clearly articulated a need for specialised support in the area for this high-risk group:

Specific, specialised services for pregnant women is needed and specialised trained staff are needed. Staff Member

There is no service for pregnant drug-using women in Limerick... If we were to do this, we would need highly specialised staff, nobody here is qualified to work with that group. Staff Member

Apart from the need for specialised services, the team also highlighted challenges with interagency working with this group:

We have communicated with the maternity hospital when we had pregnant drug users. Apart from that we hadn't discussed concerns with other agencies. No other agency has contacted me with concerns either. We don't have enough opportunities to talk to them about it. Staff Member

13.4 SUMMARY

Although pregnancy in and of itself does not increase risk of overdose, the consequences of fatal overdose may be even more serious where there is a loss of two lives, and the need for staff to feel that they can provide appropriate support and risk management to pregnant substance using women is intensified. Provision of both education and information for staff, and of specialised professional support systems for the women may support better risk management with this group.

14

RECOMMENDATIONS

International research has shown that while there is no single solution for reducing overdose deaths, a strategy involving multiple partners from all agencies who work with at-risk people, including a diverse suite of responses and interventions will be the most effective way to address the issue²⁹. There are three main levels at which overdose and death from overdose may be addressed³⁰:

Clients

- People can reduce their own risk, by taking certain precautions.
- People can help reduce their friends' risk, by knowing how to respond if they think they are overdosing.

Services

- Services like McGarry can help their clients to understand risk and how to reduce it.

Services working together / government

- By training people at risk of overdose in first aid and giving them access to naloxone, services like McGarry can help overdoses from becoming fatal.
- Different organisations can work together to help reduce overdose at a local, regional or national level.

There are thirteen recommendations³¹ arising from the research. Five of these relate to internal systems, five relate to interagency strategies and three can be applied both locally in McGarry and regionally in Limerick/the Mid-Western Region.

²⁹ See section 4.6 of the main report for full literature review of evidence for this.

³⁰ Frisher, M., Baldacchino, A., Crome, L. and Bloor, R. Preventing opioid overdoses in Europe: A critical assessment of known risk factors and preventative measures EMCDDA, 2012.

³¹ One of the recommendations is for an Overdose Policy for McGarry. The research team drafted a policy for McGarry and that policy outlines in detail the recommended processes for risk assessment, harm reduction, overdose response, supporting residents and staff after overdose and procedures around the death of a service user. If you are interested in the detailed information about procedures in the project, please have a look at the policy which is at the end of the main report.

It is important to note that some recommendations will depend on availability of time, resources and strategic priorities and the regional and national level, particularly where the recommendations involve other agencies, apart from McGarry House. For example, developing a naloxone programme would need to be done in conjunction with the HSE and medical services locally and in line with HSE strategy.

RECOMMENDATION 1: PEER PROGRAMME FOR OVERDOSE RISK AND PREVENTION

Development and evaluation of a peer skills and education programme on overdose risk, prevention and management. A peer skills and education programme would support residents to understand overdose risk, take steps to prevent overdose, and manage effectively if they are around someone else overdosing. Such a programme must be accessible as possible to the most marginalised groups such as those with literacy issues, mental health issues or English as a second language.

RECOMMENDATION 2: HARM REDUCTION APPROACH AND SYSTEM

Develop a process to deliver harm reduction information in a way that is consistent and accessible, and agreed at an interagency level. Aspects of this process include: agreement on the messages to be delivered to service users with different risk profiles, the use of a regionally agreed checklist to record interventions and ensure consistency and the development of resource libraries. Coordinated provision of harm reduction information or interventions would help service users to receive consistent and comprehensive harm reduction messages.

RECOMMENDATION 3: OVERDOSE POLICY

Novas to redraft the organisation's Overdose Policy to more accurately reflect current practice and support consistent good practice across the organisation. A draft policy, which reflects staff suggestions for systems development is attached to this. Having practice agreed by the team and recorded in a 'live' policy (meaning it is reviewed often and changed as needed) would further promote consistent and high-quality service provision for residents.

RECOMMENDATION 4: OVERDOSE PREVENTION INTERVENTIONS

Develop overdose prevention interventions using established therapeutic techniques, and ensure that future training in therapeutic techniques is tailored to consider the issue of overdose. The McGarry Team are generally well-trained in therapeutic techniques such as motivational interviewing and relapse prevention/CBT. Novas can consider how therapeutic techniques can be used to enhance overdose prevention interventions, such as responding to resident ambivalence and denial, and supporting motivation to reduce overdose risk, with the ultimate aim to support a reduction in risky behaviours. This new way of working can be monitored regularly through team meetings, learning groups and 1-2-1/supervision sessions.

RECOMMENDATION 5: RISK ASSESSMENT REVIEW

Review and develop the client risk-assessment form to ensure information collected is relevant, necessary, adequate to assess overdose risk, that the information is not previously collected and available elsewhere (e.g. in HNA or other shared documents), and that it is clear who is responsible and when for ensuring completion and review of the assessment. Develop a quick-view chart/whiteboard in the office to ensure priority risk information is shared consistently across multiple shifts and across the whole team.

RECOMMENDATION 6: LOW THRESHOLD APPROACH

Put McGarry's low-threshold policy to Gardaí (specifically those with a role in the National Drug Strategy) for approval, to ensure that the organisation is working within the law, while continuing to work from a non-judgemental, evidence based harm reduction approach. Furthermore, the organisation must ensure that their low-threshold approach is communicated consistently and regularly to residents.

This is to encourage residents to communicate concerns about overdose and risk to staff as promptly as possible. Regular communication of this policy to residents is essential due to the transient nature of the client group.

RECOMMENDATION 7: CONFIDENTIALITY AND INFORMATION SHARING

To promote a sense amongst the residents that their information is treated with absolute dignity and respect, reassure residents that personal information they share with their key-worker is only shared across the team when necessary for the management of risk. Ensure the system of confidentiality is communicated regularly and clearly to residents to promote more frank disclosures of risk behaviours by residents to staff.

RECOMMENDATION 8: STAFF SUPPORT SYSTEMS

An appropriate range of formal and informal supports to be made available to staff in the aftermath of overdose. This range of supports should be developed in consultation with staff, and should be reviewed and monitored regularly for effectiveness, and consistency. More detailed considerations for implementation of such a system are contained in the Draft Overdose Policy, appended to this.

RECOMMENDATION 9: NALOXONE DISTRIBUTION PROGRAMME

There is potential for Novas to explore, in conjunction with partners, opportunities for a naloxone distribution programme for residents. Programmes that have shown to be successful in other countries have involved naloxone kits and training on overdose response, safe storage and handling, aftercare etc.

RECOMMENDATION 10: INTERAGENCY PROTOCOLS: EMERGENCY SERVICES

To support optimal interagency communication between McGarry and Emergency Services, it is recommended that interagency protocols be formalised to agree and guide: consent for sharing information, requirements for discharge letters from the hospital to support readmission to McGarry and a system for communicating regarding inappropriate referrals. In addition to this, information sessions by the emergency services to Novas staff on communicating during overdose with emergency professionals could help to implement this.

RECOMMENDATION 11: INCLUSION OF OVERDOSE IN INTERAGENCY PROTOCOLS WITH THE HEALTH SERVICE EXECUTIVE

It is recommended that the new protocols being developed between McGarry and the HSE (in development prior to this research) include explicit agreements about how overdose risk is communicated between the two services.

RECOMMENDATION 12:
PERSON CENTRED
ASSESSMENT
TRAINING

This recommendation is that person centred risk assessment training is developed and undertaken collaboratively by the Homeless Person's Centre and Novas. There is a concern that residents are not providing key risk information at risk assessment because they are concerned about negative consequences for service users if they disclose their drug use – negative consequences may include not getting a bed, or feeling judged. The aim of such training is so that staff can encourage service users to feel comfortable providing information such as drug use, which can indicate overdose risk at an early point.

RECOMMENDATION 13:
GP AND
PHARMACIST
COMMUNICATION

A standard information letter can be developed for GPs and pharmacists which details McGarry's role in relation to medication management and overdose prevention. This is to support shared understanding and ensure that GPs have the information required to undertake appropriately robust overdose prevention measures.

RECOMMENDATION 14:
SUPPORTING
HIGH-RISK
PREGNANT DRUG
USING WOMEN

Develop an interagency response including relevant services such as McGarry, addiction services, maternity and social work services to consider responses not limited to but including:

- The instatement of a clinical support such as the Drug Liaison Midwife Service in the region
- The needs of staff in services working with this group including information, education and access to specialised professional advice
- A broader strategic holistic approach in the region looking at and responding to the needs of women who have substance misuse issues, including pregnant women, in relation to treatment and other support

15 APPENDICES

The research team developed a number of additional tools and resources for Novas Initiatives and McGarry House, in some cases in conjunction with partners. These tools and resources may be available upon request from Novas Initiatives:

- Draft Overdose Policy for McGarry House
- Draft Harm Reduction Policy for McGarry House
- Interagency Protocols: HPC
- Interagency Protocols: Emergency Services
- Information Sheet for GPs and Pharmacists
- Overview of a Number of Peer Education or Overdose Prevention Models
- McGarry House Harm Reduction Resource Library: example

The draft overdose policy for McGarry House is included here. The research team developed this draft policy following a comprehensive systems review that involved policy and procedure analysis, interviews with staff and residents, and on-going consultation with management. However, the team in McGarry and Novas Initiatives were reviewing the policy for application in their service at the time of publication, so the organisation's final draft is not presented here.

DRAFT OVERDOSE POLICY Novas Initiatives

SECTION 1: POLICY OVERVIEW

1A: PURPOSE OF THE POLICY

Novas believe that timely and appropriate staff intervention can reduce the risk of serious health implications or death through overdose. The purpose of this policy is to clarify how the organisation manages all aspects of overdose from risk assessment, to response, to support after an overdose. The policy also outlines interagency communications and staff supports in relation to overdose.

1B: SCOPE OF THE POLICY

This policy applies to all staff, volunteers and locum staff working within the organisation. The level of intervention in the case of an overdose will be determined by the level of skills, experience and training of the staff member. This policy should be read alongside: the Harm Reduction Policy, Protocol for inter-agency working between HSE Mid-West Drug and Alcohol Service And NOVAS; Confidentiality Policy; Protocol on

Room Checks; Serious Incident Report form and guidance notes and the Health and Safety Statement.

1C: ROLES AND RESPONSIBILITIES

Staff: It is the responsibility of staff to work in line with this policy and to raise any issues regarding its implementation with management at the earliest opportunity. If there are any aspects of this policy that staff do not fully understand, the staff member should raise this with management as soon as possible.

Management: It is the responsibility of management to support staff to implement this policy, through provision of adequate resources, training and debriefing. It is the responsibility of management to monitor systems outlined within this policy to ensure they are adhered to by staff and are as effective as possible.

1D: PRINCIPLES FOR THIS POLICY

- i. McGarry House will endeavour to support our residents to prevent overdose, and prevent any overdose becoming fatal (see Harm Reduction Policy), however it is ultimately the decision of service users to engage in high-risk behaviour and the organisation will equally endeavour to promote residents' agency, choice and responsibility in relation to overdose risk.
- ii. Staff should aim to respond to overdose quickly, calmly and swiftly.
- iii. Staff safety is paramount; in dealing with suspected overdose staff must also follow health and safety procedures and not place him/herself or anyone else at risk. Staff should always carry latex gloves on their person while on shift to ensure a quicker, safer response to overdose.
- iv. The team should always err on the side of caution and call emergency services where there is a suspicion that a resident is overdosing.
- v. All staff should engage in formal debriefing following an overdose incident. This is to ensure that any staff member who may need additional support after the overdose has an opportunity to identify it with management.
- vi. Both staff and management share responsibility for preventing, identifying and responding to workplace stress. If a staff member finds they are having an on-going negative reaction to an overdose incident or service user's death (such as: increased feeling of stress, anger or upset, lack of sleep, depression, inability to leave the situation outside of their home environment) then staff should inform staff line manager of this. The organisation, through the manager, has a responsibility to ensure that workplace stress is managed and that there are appropriate supports in place for staff. Through supervision or debriefing, suitable supports will be explored.

1E: RESOURCES TO SUPPORT OVERDOSE RESPONSE

Resource	Purpose	Location
Mobile Phone	To speak to emergency services while responding to overdose	
Walkie-talkies	For staff to communicate while responding to overdose and preparing for emergency services	
Grabber Needle-stick Gloves Body Spill Cleaning Kit	To clear hazardous materials from the area around the overdosing person if needed	
Disposable Gloves	To protect staff from bodily fluids	Carried on person & spare located in...
Defibrillator	To restart someone's heart where it has stopped	
Cardex / Medical records	To provide to emergency services on arrival	

1F: TERMS USED IN THIS POLICY

High-risk: While any homeless drug user can be considered high-risk when compared to the general population, within McGarry House high-risk relates to an individual who is considered to be particularly vulnerable to overdose at the time. This may be due to any of the factors increasing risk identified in section 2B below.

Service User / Resident: these terms refer to those residing in McGarry House and may be used interchangeably

SECTION 2: INTERAGENCY COMMUNICATIONS IN RELATION TO OVERDOSE

2A: GENERAL RULES IN RELATION TO CONSENT

Service users are asked to provide consent for McGarry House to share information relating to overdose risk with GPs, pharmacies and the HSE. If consent is not provided or is withdrawn, then McGarry will operate in accordance with procedures identified in section 2C below. Refer to confidentiality policy and interagency consent forms between the HSE and Novas for further information.

2B: INFORMATION SHARED IN RELATION TO OVERDOSE (WITH CONSENT)

The following information will be shared between engaged agencies that have a role in relation to overdose prevention where an increase in risk has been identified:

- There is a significant increase or decrease in prescribed medication (this includes an individual not receiving methadone or being sanctioned for a period of days)

- There appears to be a significant increase, decrease or change in un-prescribed substance use or alcohol use
- The staff member becomes aware of a serious deterioration in liver health (high levels of hepatitis or cirrhosis)
- The person has a suspected overdose
- The person attempts suicide
- The person seems unusually depressed or anxious, or staff suspect there is suicidal ideation or parasuicidal behaviour
- There is a change in mental health status or medication prescribed for mental health issues
- There has been a traumatic life experience or circumstance
- The service user has come into significant amounts of money

In general the role responsible for sharing information will be the key worker, the Manager or where appropriate the dual diagnosis worker. Information will be shared verbally or by email or letter as appropriate.

2C: INFORMATION SHARED IN RELATION TO OVERDOSE (WITHOUT CONSENT)

If consent for sharing information has not been provided or has been withdrawn by the client, but where real and serious overdose risk has been identified which requires an interagency response, then this decision will be taken by a manager in consultation with the management team. In any case of an extension to confidentiality, this will be explained to the resident with a clear rationale for the decision provided.

2D: INTERAGENCY PROTOCOLS

McGarry House have interagency protocols regarding overdose prevention and response with the HSE, the HPC and Ambulance Services. These protocols include guidelines for communication with these agencies, as well as guidelines for resolving issues. They are located _____.

SECTION 3: PROCEDURES IN RELATION TO OVERDOSE PREVENTION AND RESPONSE

3A: BOOKING IN

The approach of McGarry House in relation to overdose will be explained as part of the booking in procedure, which will include the following points:

In McGarry House the residents' well-being is paramount; if they have any concerns that another resident is overdosing, or concerns about themselves, they should bring it straight to staff and know that (in these exceptional circumstances) they will not be penalised if telling staff means that staff know the resident alerting them was using illegal substances on the premises.

McGarry House take a proactive approach to overdose; risk and prevention plans will be explored in more detail with their key worker over the coming days.

3B: RISK IDENTIFICATION AND MONITORING

Until an individual completes the full risk assessment they will be considered by staff to be at high risk of overdose. The risk assessment will help the staff member and resident

to identify their level of overdose risk and develop an Overdose Prevention Plan. Risk Assessments and Overdose Prevention Plans will be reviewed every month to five weeks by resident and keyworker. Risk Assessment and Overdose Prevention Plans are discussed in further detail in the Harm Reduction policy.

Where a client is identified to be at higher risk of overdose it will be communicated as follows:

- Verbal handover to staff on the following shift outlining specific risks and details of any additional monitoring or interventions required (up-to-date information should be handed on consistently from shift to shift until the risk has depleted).
- Written handover on [whiteboard] in the office that the person is high risk of overdose³²

3C: MONITORING OVERDOSE

Staff will endeavour to monitor and provide support to the best of their ability and considering the time and resources available, however, McGarry staff are not medically trained to assess level of risk, and service users are responsible for their own well-being. Staff have a duty of care to all of the other residents and so may have to refer the resident on to emergency services, even where the resident does not want medical care.

Signs and Symptoms of Overdose: Most overdoses set in over the course of hours (instant death occurs in only 15% of cases). There are many signs and symptoms that can alert staff to the possibility of overdose.

Depressant substances (e.g. opiates, benzodiazepines, alcohol, anti-depressants): awake but cannot speak; slow heartbeat and pulse, inability to respond to verbal commands, slow breathing, blue lips and/or fingernails; gurgling, raspy breathing, choking sounds, passing out, throwing up, pale face and limp body.

Stimulants (e.g. cocaine, crack, meth, speed, ecstasy): extreme agitation or anxiety, foaming at mouth, very rapid heartbeat, pulse, elevated body temperature, quick, shallow breathing; chest pain, pressure; choking or gurgling sounds, throwing up (note that stimulant poisoning can turn into stimulant overdose), suddenly collapsing or passing out, shaking, seizure, heart attack, and stroke.

Solvents / volatile substances: irregular heartbeat, decreased levels of oxygen and respiratory depression and may contribute to overdose.

Higher Risk of Overdose: Where staff have concerns about residents who appear to be at higher risk of overdose but are not presenting as immediately at risk of overdose (e.g. staff believe they intend to use heavily, have had a traumatic or difficult day etc. but are not presenting as heavily under the influence)

- A nominated staff member should let the resident know that they are concerned and offer support
- Staff should seek the resident's permission to carry out additional room checks if the staff member has a serious concern for the resident's well-being at that time.

³² e.g. Quick reference chart on high-risk clients, this could contain, recent events and agreed service response. To be discussed with staff. The role of the chart is to support efficient exchange of information between shifts (i.e. shifts that are not joined by a handover meeting).

- Staff should ensure that any follow up is recorded and handed over to staff on the following shift

Immediate Risk of Overdose: If the individual becomes unresponsive to verbal or physical cues at any point i.e. pulling ear, rubbing knuckles across chest, then staff will call emergency services. However, there may be instances where it is not suitable or the best option to call emergency services immediately. Where a client is heavily under the influence but still responsive, there are three levels of possible response:

Observation in the Communal area

- The resident is asked to remain on the couch in the foyer for observation.
- Their breathing, pulse and level of consciousness is monitored every twenty minutes.

Increased Room Checks

- The resident returns to their room and staff perform room checks every twenty minutes.
- Where staff feel the resident is becoming higher risk s/he may be asked to move to the couch for increased monitoring.

Referral to Medical Services

- Where staff feel the resident is too high a risk and they cannot adequately support them to prevent overdose, an ambulance may be called for the resident, even if they are still responsive and / or state that they do not want medical care.

3D: RESPONDING TO SUSPECTED OVERDOSE

There are two key staff roles: one staff member responds to the resident and one liaises with Emergency Services.

Staff Member One: Resident Responder

1. Ensure that another staff member is calling an ambulance
2. Retrieve protective equipment from the office or request it be brought to staff immediately, including latex gloves, needle-stick gloves and grabbers
3. If other residents are present, clear the area. Having a crowded room with other residents can cause confusion and panic and make the situation more difficult and stressful to manage.
4. Ensure staff are wearing latex gloves prior to any possible contact with bodily fluids
5. Make sure the area is safe and check for sharps. Manage any hazards to ensure staff are not at risk before intervening
6. If the resident is unconscious or becomes unconscious, first aid should be administered, if there is a staff member with appropriate training. If no staff members on the shift is first aid trained:
7. Check to see if they are breathing and make sure nothing is blocking their airway
8. Put the person in the recovery position
9. Stay with the person until the ambulance crew arrive, and follow any directions

Staff Member Two: Emergency Services Liaison

1. Dial 112 or 999 on the mobile phone
2. Answer the ambulance crews questions
3. Print the service users cardex / medical forms
4. The person with the mobile should bring both the phone and walkie-talkie to the overdose
5. Any paraphernalia that could determine what the resident has taken but does not present a risk of harm or injury to anyone handling it (e.g. tablet packets, plastic baggies) should be bagged and given to the ambulance crew

The Role of Other Residents during an Overdose: Residents can play an important role in recognising and alerting staff to another resident overdosing. There are also times due to extenuating circumstances that residents may play a role in management of the overdose situation, for example in supporting other residents who may be upset, admitting emergency services etc. Staff should not invest responsibility for any tasks to residents who appear under the influence.

Where a resident plays any role in identifying or responding to an overdose, his/her contribution should be acknowledged and validated.

Accompaniment to A&E: Only in exceptional circumstances will residents be accompanied to A&E (e.g. where the resident is normally accompanied to hospital appointments and there are adequate staff numbers available).

SECTION 4: IMMEDIATELY AFTER AN OVERDOSE

Once the resident has departed, staff should undertake the following:

1 **Manage other Residents**

- Address any other resident's concerns as quickly and calmly as possible.
- Ensure that any residents who played a role in recognising, alerting staff or responding are acknowledged and validated.
- Check that there is no overdose risk to any residents the individual may have been using with.

2 **Contact Management**

If the overdose occurs at a time when management are not on site, staff should call the on-call manager. If the overdose is fatal, see section 7 for procedures on the death of a service user.

3 **Debrief**

Once staff members are happy that other residents are ok, staff members should make themselves unavailable to residents for 10 to 15 minutes to undertake an informal debrief; specifically how they are feeling after the overdose, what went well, what could be done better / any learning to share with the organisation, and how they are feeling about going into the rest of the shift. Staff should take care to ensure they listen to one another's experiences and views non-judgementally, employing active listening skills. Staff should record in the log book that informal debrief was completed for all staff on shift

4 **Complete Paperwork**

- Serious Incident Notification report (as outlined in the Incident reporting policy)
- Case File: a note in the client's file indicating that the incident occurred with details contained in the incident report, a copy of which should be put in the client's file
- Log book: a note to other staff to read the incident report and to be vigilant for risk when the client returns, and to ensure other residents who were present or who may otherwise be affected are not affected at a later time, and any specific follow-on instructions

5 **Follow Up with Overdose Victim**

If the service user went to hospital, the hospital should be contacted before the end of the shift, and if contact is not made or the shift ends within two to four hours of the person going to hospital, this should be handed over to the next shift and a note left for management explaining why contact was not made. Handover information to be passed on to include:

- Summary of events
- Any additional follow up required including contact with the hospital, follow up with the resident, follow up with other residents or interagency communications.
- Other

If the service user is reluctant to go in the ambulance, Staff should remind the service user that they may overdose again, that their life may be in danger and that staff are not medically trained to prevent this. If the service user refuses to go in the ambulance then:

- Staff should encourage the service user to stay on the couch so staff can monitor them
- Staff should continue to be vigilant in monitoring the person's vital signs if they appear to be still heavily under the influence or close to overdose.
- If the service user reverts to unconsciousness, an ambulance should be called again. If the service user refuses to go in the ambulance after slipping back into overdose, staff should call the on-call manager to discuss calling the Gardaí to ensure the service user goes to hospital.
- If the service user returns to his / her room then staff should check on him/her every XX minutes until staff are confident that the risk has passed

SECTION 5: THE DAYS FOLLOWING AN OVERDOSE

5A: READMITTING THE SERVICE USER RETURNING FROM HOSPITAL

Ideally, the project readmits a service user when s/he has been discharged formally from hospital. Realistically, many service users leave the hospital prior to formal discharge for a variety of reasons; the absence of a discharge letter or phone call will not prevent a service user from being readmitted.

- If the service user has a discharge letter or the hospital can confirm the resident was discharged by them, s/he should be readmitted and engaged by staff
- If the service user does not have a discharge letter and does not seem at risk of overdose, s/he should be encouraged to return to the hospital for a formal discharge letter to prove to McGarry House that s/he is medically suitable to be in the hostel and no longer at risk of overdose. In some instances the organisation can offer a taxi to pay for the resident to return to hospital to get this letter.
- If the service user does not have a discharge letter and still presents as at risk of overdose (e.g. suicidal or heavily under the influence) then s/he should be readmitted conditionally – until the risk of overdose has passed and staff feel confident to allow him/her to return to his/her room. As soon as possible the service user should be engaged by staff and will be met by management in the following days to discuss the importance of formal discharge.

5B: HARM REDUCTION IN THE AFTERMATH OF OVERDOSE

Service users who have recently overdosed are considered by the organisation to be high risk. As soon as possible after the service user returns, a staff member (this may be their key worker, the dual diagnosis worker or any suitably knowledgeable staff member who has a relationship with the resident) must engage the resident in a 1-2-1 discussion about the overdose as described in the Harm Reduction Policy.

It is the responsibility of the person on-shift when the person returns to ensure that this intervention is conducted, or that it is handed over to the next shift. No more than two days should lapse between the service user returning and this intervention taking place. It should be carried over on the log book until it takes place, and key points for the session and next steps recorded in the client's file / support plan / risk of harm assessment.

5C: INTERAGENCY COMMUNICATIONS

The following organisations will be informed of the overdose:

- Methadone Prescribing GP or clinic
- Dispensing Pharmacist
- Other

Where it is considered useful, an inter-agency case meeting may be called to support any actions that have been identified as supporting the resident to address any of life factors which are adding to the issues, which may precipitate overdose, i.e. issues with family, mental health issues.

5D: STAFF LEARNING AND SUPPORT

Regardless of whether they feel impacted, affected or in need of support after responding to an overdose, all staff on shift during an overdose will receive a formal debrief with a member of the management team within 3 days of the event. The primary aim of a formal debrief is to assist the staff member to manage short term and long term stress than can potentially be caused by high-stress work place incidents such as death or near death experiences such as overdose. This is done through a discussion about the staff assessment of their own and the team's response to the incident, sharing any learning with management and discussing further support options, if they are needed

This will be undertaken in a quite private space, with ideally fifteen to twenty minutes of uninterrupted time. The following will be discussed and recorded in the staff file:

- **Facts:** Discussion of core facts concerning the incident.
- **Thoughts and feelings:** Discussion of emotions that were experienced during the incident.
- **Reaction / symptoms:** Has the individual experienced any reactions or symptoms (stress, lack of sleep) that are connected to the event? If there are symptoms or reactions then there will be a discussion about positive techniques for managing these and whether further follow up is useful.
- **Learning:** An opportunity to review any learning for the individual or organisation.
- **Close:** An opportunity to formally close the session and review any of the main points.

Additional external professional support is available on request by staff or management. If management feel that staff need external support, the staff member is obliged to avail of it, even if they feel it is not required.

SECTION 6: DEATH OF A SERVICE USER AND STAFF SUPPORT

6A: PROTOCOL FOR RESPONDING TO THE DEATH OF A RESIDENT BY SUSPECTED OVERDOSE

If a service user dies on the premises, the ambulance will be called as a priority, note that it should be stated that there is a suspected death. In this instance the ambulance staff will contact the Gardaí. If there is any doubt as to the status of the individual, staff who are appropriately trained will perform CPR until the ambulance arrives. The on-call manager will be called. The on-call will undertake the following steps:

- Will complete an incident report on the event
- Will arrange with Gardaí regarding contacting next of kin
- Provide the informal debrief with staff (note a formal debrief will be provided the next day)

6B: SUPPORT FOR RESIDENTS FOLLOWING DEATH BY SUSPECTED OVERDOSE

Additional supports should be put in place for residents in McGarry House following the death of a fellow resident. These will ideally involve voluntary groups and individual supports. The death of a peer should also be viewed as traumatic experience for residents and therefore a potential overdose risk factor. The following supports will be extended to residents as appropriate:

- Staff will provide on-going informal opportunities to talk about the death and how residents are feeling about this, and will record interventions in the client's file or logbook as appropriate.
- All residents will be provided with the opportunity to attend the removal and funeral (if appropriate, i.e. acceptable to the family and not too far away from Limerick).
- A small ceremony will be held in McGarry House within one week of the person's death for those who wish to attend, this will be facilitated by a resident / staff member or appropriate external person.
- Key workers will check-in with their key clients as soon as possible
- Other

Note that these supports may equally be relevant to the death of resident by cause other than overdose or to an ex-resident who has recently left the project.

6C: SUPPORTS FOR STAFF FOLLOWING DEATH BY SUSPECTED OVERDOSE

It is acknowledged that staff may be affected by the death of service user. Research shows that everyone responds differently and that the effect of a death on a staff member cannot always be predicted or easily understood. In order to support staff to contextualise death with the service, some or all of the following supports will be offered and pursued in line with organisational and individual need:

- Individual formal debrief with management which will explore organisational learning following the death.
- Formal group debrief for all staff, in a number of small groups as shifts allow, following a clear structure.
- Formal team review of the case to support learning; this will be supportive and non-judgemental but honest and self-reflective on the part of the organisation to ensure learning from such traumatic experience informs practice and improves service provision for other residents and future residents. This can be done in conjunction with or separate to the team debrief.
- The opportunity to attend the removal or funeral
- External supervision to discuss any particular issues arising for individual staff members
- The chance to write condolences in a book / card

SECTION 7: ORGANISATIONAL LEARNING

- A number of small informal staff meetings/gatherings which facilitate people to remember, among other things; the resident, the organisations contribution to the residents life and lessons learnt from their interactions with the resident. Attendance at such meetings is voluntary.

7A: STAFF MEETINGS

Overdose will be a topic on the two-weekly client meeting as a standard agenda item. If any issues arise at these meetings that may provide learning for the organisation and other staff then this will also be discussed at the full team meeting. The policy will be updated with any changes to procedures or practice.

7B: MONITORING

Managers will undertake systematic checks on processes to prevent and respond to overdose to ensure consistent application of policy (note that this may be done as part of a general review or systems audit). This will include a six monthly / annual review of documents including, but not limited to:

- Booking In Records
- Risk of Harm Assessments and Reviews
- Case Files: support plans, case notes, incident reports, overdose prevention plans, harm reduction checklists etc.
- Log books: handover notes, records of informal debrief, follow through on tasks etc.
- Incident reports
- Other

7C: POLICY REVIEW

This policy will be formally reviewed by the team and management 6 months after implementation, and every two years thereafter.

16

REFERENCES

1. Grigsby, D., and McKnew, M. Work-stress burnout among paramedics. *Psychological Reports*, 1998: 63(1); 55-64.
2. Ganster, Daniel C., and John Schaubroeck. Work stress and employee health. *Journal of Management*, 1999: 17.2; 235-271.
3. Cooper C and Payne R (eds). *Causes Coping and Consequences of Stress at Work*. Wiley: New Jersey; 1988.
4. Cooper, Cary L. and Cartwright, S. Healthy mind; healthy organization—A proactive approach to occupational stress. *Human relations*, 1994: 47.4; 455-471.
5. Ursano, Robert J., Carol S. Fullerton, Tzu-Cheg Kao, and Vivek R. Bhartiya. Longitudinal assessment of posttraumatic stress disorder and depression after exposure to traumatic death. *The Journal of Nervous and Mental Disease*, 1995: 183 (1): 36-42.
6. Hare, J., Pratt C. and Andrews, D. Predictors of burnout in professional and paraprofessional nurses working in hospitals and nursing homes. *International Journal of Nursing Studies*, 1998: 25 (2) 105-115.
7. Revicki, D and May, H. Organizational characteristics, occupational stress, and mental health in nurses. *Behavioral Medicine*, 1989: 15 (1): 30-36.
8. Fox M., Dwyer, D. and Ganster, D. Effects of stressful job demands and control on physiological and attitudinal outcomes in a hospital setting. *Academy of Management Journal* 1993: 36 (2): 289-318.
9. Saunders, B., Wilkinson, C. and Phillips M. The impact of a brief motivational intervention with opiate users attending a methadone programme. *Addiction*, 1995: 90(3): 415-424.
10. Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., and McGovern, J. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry*, 2001: 158(10), 1706-1713.
11. Toumbourou, J. W., Stockwell, T., Neighbors, C., Marlatt, G. A., Sturge, J., and Rehm, J. Interventions to reduce harm associated with adolescent substance use. *The Lancet*, 2007: 369(9570); 1391-1401.
12. McCambridge, J., and Strang, J. The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomized trial. *Addiction*, 2004: 99; 39-52.
13. McCambridge, J., and Strang, J. Deterioration over time in effect of motivational interviewing in reducing drug consumption and related risk among young people. *Addiction*, 2005:100 (4); 470-478.
14. Rollnick, S. and Miller, W. What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 1995: 23; 325-334.
15. Sporer, K. Acute Heroin Overdose. *Annals of Internal Medicine*, 1999: 130(7); 584-590.
16. Davidson P., Ochoa K., Hahn J., Evans J. and Moss A. Witnessing heroin-related overdoses: The experiences of young injectors in San Francisco. *Addiction*, 2002: 97;1511–1516.
17. The EU Action Plan on Drugs 2013 – 2016. Available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2013:351:0001:0023:EN:PDF> Accessed on 26/03/2014
18. Mcgregor C, Darke S, Ali R and Christie P. Experience of non-fatal overdose among heroin users in Adelaide, Australia: circumstances and risk perceptions. *Addiction*, 1998: 93 (5); 701-711.
19. Markham P., Rudenstine S., Stancliff S., Sherman S., Nandi V., Clear A. and Galea S. Overdose prevention for injection drug users: lessons learned from naloxone training and distribution programs in New York City. *Harm Reduction Journal*, 2007: 4(1).

20. Tobin K., Sherman S., Beilenson P., Welsh C. and Latkin, C. Evaluation of the staying alive programme: training injection drug users to properly administer naloxone and save lives. *International Journal of Drug Policy*, 2009: 20; 131-136.
21. Seal K., Thawley R., Gee L., Bamberger J., Kral A., Ciccarone, D., Downing, M. and Edlin, BR. Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot Intervention Study. *Journal of Urban Health*, 2005: 82(2): 303-311.
22. Galea, S., Worthington, N., Markham Piper, T., Nandi, V. V., Curtis, M., and Rosenthal, D. Provision of naloxone to injection drug users as an overdose prevention strategy: Early evidence from a pilot study in New York City. *Addictive Behavior*, 2006: 31(5); 907-912.
23. Scottish Government. Effective Interventions Unit: Measuring staff attitudes to people with drug problems: The development of a tool. Available at: <http://www.scotland.gov.uk/Publications/2003/08/17735/23443> Accessed on 07/10/2013
24. Shaw S., Cartwright A., Spratley T. and Harwin J. *Responding to Drinking Problems*. London: Croom Helm; 1978.
25. Gossop M., Griffiths P., Powis B., Williamson S. and Strang J.. Frequency of non-fatal heroin overdose: survey of heroin users recruited in non-clinical settings. *BMJ*, 1996: (313).
26. Darke S. and Ross J. Overdose Risk Perceptions and Behaviours among Heroin Users in Sydney, Australia. *European Addiction Research*, 1997: (3): 87-92.
27. Weinstein, N. and Lyon, J. Mindset, optimistic bias about personal risk and health-protective behaviour. *British Journal of Health Psychology*, 1999: (4); 289-300.
28. Weinstein, N. Testing four competing theories of health-protective behavior. *Health psychology*, 1993: 12(4); 324.
29. Scott D., Valery P., Boyle F., and Bain C. Does Research into Sensitive Areas do Harm? *Medical Journal of Australia*, 2002: 177 (9).
30. Russell, D. *Rape in Marriage*. New York: Macmillan;1982.
31. McGee H., Garavan R., deBarra M., Byrne J., and Conroy R. *The SAVI Report. Sexual Abuse and Violence in Ireland*. Dublin: Liffey Press/DRCC; 2002.
32. Advisory Council on the Misuse of Drugs. *Consideration of Naloxone*. London; 2012. Available at <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/consideration-of-naloxone>. Accessed on 13/10/13
33. World Health Organisation. *Model List of Essential Medicines 2012*. Available at http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf Accessed on 13/10/13
34. Kelly A., Carvalho, M. and Tejeur, C. *Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study*. Dublin: National Advisory Committee on Drugs: 2009.
35. EMCDDA. *Annual Report 2012*: Available at: <http://www.emcdda.europa.eu/publications/annual-report/2012> . Accessed on: 13/10/13
36. Bellerose D., Carew A., and Lyons S. *HRB Trend Series. Treated Problem Drug Use in Ireland 2005 – 2010*. Dublin: Health Research Board: 2011.
37. EMCDDA. *Drug Treatment Overview for Ireland*. Available at: <http://www.emcdda.europa.eu/data/treatment-overviews/Ireland#provision> Accessed on: 13/10/13
38. Health Research Board. *Drug Related Deaths and Deaths Among Drug Users in Ireland. 2010 Figures from the National Drug Related Death Index*. HRB: Dublin;2012
39. EMCDDA. *Statistical Bulletin 2012. Mortality due to drug-induced deaths among all adults (15 to 64 years) in European countries for the most recent year reported*. Available at <http://www.emcdda.europa.eu/stats12#display:stats12/drdfig7a> Accessed on 14/10/13
40. Road Safety Authority. *Deaths on Irish Roads, 2010*. RSA: Dublin; 2011. Available at http://www.rsa.ie/Documents/Road%20Safety/Crash%20Stats/death_injuries_irish_roads_2010.pdf Accessed on 14/10/13
41. Government of Ireland. *Revised Estimates for Public Services 2013*. Available at <http://per.gov.ie/wp-content/uploads/REVISED-ESTIMATES-VOLUME-2013-final.pdf> Accessed on

14/10/13

42. Health Service Executive. Performance Report May 2009. Available at http://www.hse.ie/eng/services/Publications/corporate/performance-reports/May_2009_Performance_Report.pdf Accessed on 14/10/13
43. Bellerose D., Lyons S., Carew A., Walsh S. and Long J. Problem benzodiazepine use in Ireland: treatment (2003-2008) and deaths (1998-2007). HRB Trends Series, HRB: Dublin; 2010.
44. Ashton, H.C. (1994): The Treatment of Benzodiazepine Dependence. *Addiction*, 89: 1535-1541.
45. Saris, J.A. and O'Reilly, F. A Dizzying Array of Substances: an ethnographic study of drug use in the canal communities area. Dublin: Canal Communities LDTF; 2010
46. Department of Health and Children. Report of the Benzodiazepine Committee. Dublin: DOHC; 2002.
47. Smith, D.E. and Landry, M.J: Benzodiazepine Dependency Discontinuation: Focus on the chemical dependency detoxification setting and benzodiazepine poly-drug abuse. *Journal of Psychiatric Research*, 1990: 24 (Suppl 2); 1145-156.
48. Central Statistics Office. Homeless Persons in Ireland: a special census report. CSO: Dublin; 2012
49. Simon Community. How Many People are Homeless in Ireland. 2012. Available at: <http://www.simon.ie/Portals/0/Docs/How%20many%20people%20are%20homeless%20in%20Ireland%20-%20Sept%202012.pdf> Accessed on 14/10/13
50. Cleary, A., Corbett, M., Galvin, M. and Wall, J. Young men on the margins. Dublin: Katharine Howard Foundation. 2004.
51. Lawless M. and Corr C. Drug Use among the Homeless Population in Ireland. Dublin: Stationery Office; 2005.
52. Cox, G. and Lawless, M. Where-ever I Lay My Hat ... A Study of Out of Home Drug Users. Dublin: Merchants Quay Project; 1999.
53. Mayock, P. and Carr N. Not Just Homeless... A Study of Out of Home Young People in Cork City. HSE South / TCD Childrens Research Centre. 2008
54. Flemen K. Smoke and whispers: drugs and youth homelessness in central London. London: Turning Point/The Hungerford Drug Project; 1997. Available at: <http://www.kfx.org.uk/resources/Smoke%20and%20Whispers%202002.pdf> Accessed on 06/03/2013
55. O'Driscoll, P., McGough, J., Hagan, H., Thiede, H., Critchlow, C., and Alexander, E. Predictors of accidental fatal drug overdose among a cohort of injection drug users. *American Journal of Public Health*, 2001: 91(6); 984-987.
56. Darke, S. and Ross, J. Overdose among heroin users in Sydney, Australia: Prevalence and correlates of non-fatal overdose. *Addiction*, 1996: 91 (3); 405-411.
57. National Suicide Research Foundation. Drugs used in intentional overdoses in Ireland. Briefing. Cork: National Suicide Research Foundation; 2011.
58. EMCDDA. EMCDDA trend report for the evaluation of the 2005-12 EU drugs strategy. EMCDDA: Lisbon; 2011.
59. Galea, S., Ahern, J., Tardiff, K., Leon, A., Coffin, P.O., Derr, K. and Vlahov, D. Racial/ethnic disparities in overdose mortality trends in New York City, 1990-1998. *Journal of Urban Health*, 2003: 80(2); 201- 211.
60. McAuley, A. Lanarkshire naloxone pilot [conference presentation]. National Drug Treatment Conference; 14th March 2008 ; Glasgow. Available at: http://www.exchangesupplies.org/conferences/NDTC/2008_NDTC/speakers/andrew_mcauley.html . Accessed on: 04/05/2012.
61. Cullen W., Bury G., Langton D. Experience of heroin overdose among drug users attending general practice. *British Journal of General Practice* 2000;50:546-9.
62. Cullen W., Griffin S., Bury G., Plunkett P. Opiate overdose in Dublin. *Irish Journal of Medical Science* 2003;172:46.
63. Sporer, K.A. 'Strategies for preventing heroin overdose', *British Medical Journal*, 2003: 326;

442–444.

64. Rome, A., Shaw, A. and Boyle, K. Reducing Drug Users' Risk of Overdose, Edinburgh: Scottish Government Social Research; 2008
65. Frisher, M., Baldacchino, A., Crome, L. and Bloor, R. Preventing opioid overdoses in Europe: A critical assessment of known risk factors and preventative measures. EMCDDA, 2012.
66. Lenton, S.R. and Hargreaves, K.M. Should we conduct a trial of distributing Naloxone to heroin users for peer administration to prevent fatal overdose? *Medical Journal of Australia*, 2000; 173: 260–263.
67. Neale, J. Suicidal intent in non-fatal illicit drug overdose', *Addiction*, 2000; 95: 85–93.
68. Zador, D. Reducing non-fatal overdoses among heroin users as an all-of-society challenge. *Addiction*, 2005; 100; 141–142.
69. United Nations Office of Drugs and Crime. Peer to Peer: Using peer to peer strategies for drug abuse prevention. New York: UN; 2003.
70. Keane, M. Peer drugs education programme in Kilkenny wins major European award. *Drugnet Ireland*, 2006; 19;10.
71. Ballyfermot Youth Service. Peer Education Drugs Education Project. Available at <http://www.ballyfermotyouthservice.ie/peer-education-drugs-awareness-project/> Accessed on 14/10/13
72. Darke, S., Ross, J. and Hall, W. Overdose among heroin users in Sydney, Australia: I. Prevalence and correlates of non-fatal overdose. *Addiction*, 1996; 91; 405-11.
73. Sporer, K. Acute heroin overdose. *Annals of Internal Medicine*, 199; 130; 584-590.
74. Zador, D., Sunjic, S., Darke, S. Heroin-related deaths in New South Wales, 1992: toxicological findings and circumstances. *Medical Journal of Australia*, 1996; 164; 204-7.
75. Darke, S. and Zador, D. Fatal heroin 'overdose': a review. *Addiction*, 1996; 91(6); 1765 - 1772.
76. Green, T., McGowan, S., Yokell, M., Pougé,† E., Rich, J. HIV infection and risk of overdose: a systematic review and meta-analysis. *AIDS*, 2012; 26(4); 403–417.
77. Darke, S., Kaye, S. and Duflou, J. Systemic disease among cases of fatal opioid toxicity. *Addiction*, 2006; 101; 1299–1305.
78. Rao, R. and Mittal, A. Opioid Overdose Prevention and Management for Injecting Drug Users. United Nations Office for Drugs and Crime. 2012. Available at: <http://www.unodc.org/documents/southasia/publications/sops/opioid-overdose-prevention-and-management-among-injecting-drug-users.pdf> . Accessed on 06/03/2013
79. Kerr, T., Fairbairn, N., Tyndall, M., Marsh, D., Li, K., Montaner, J. and Wood, E. Predictors of non-fatal overdose among a cohort of polysubstance-using injection drug users. *Drug and Alcohol Dependence*, 2007; 87; 39–45.
80. Jones J., Roux P., Stancliff S., Matthews W. and Comer S. Evaluation of the effectiveness of overdose response training in New York City. NIDA. 2012. Available at: <http://international.drugabuse.gov/meetings/abstract-database/result/fn%3D%2526amp%3Bid%3D3713> Accessed on 06/03/2013
81. Sporer, K. and Kral, A. Prescription Naloxone: A Novel Approach to Heroin Overdose Prevention. *Annals of Emergency Medicine*, 2007; 49(2); 172 – 177.
82. Dettmer, K., Saunders, B., Strang, J. Take home naloxone and the prevention of deaths from opiate overdose: two pilot schemes. *British Medical Journal*, 2001; 7291; 895-896.
83. US National Library of Medicines. Use [of naloxone] in Pregnancy: Teratogenic Effects: Pregnancy Category C. Available at: <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=8535cc84-ad4a-4d67-8480-fb5a2e3406f8> Accessed on 22/10/13
84. EMCDDA. An overview of the drug related deaths and mortality among drug users (DRD) key indicator. 2009. Available at: <http://www.emcdda.europa.eu/themes/key-indicators/drd>
85. Morrison, D. S. Homelessness as an independent risk factor for mortality: Results from a retrospective cohort study. *International Journal of Epidemiology*, 2009; 38; 877–883.

86. Nordentoft, M., and Wandall-Holm, N. 10 year follow up study of mortality among users of hostels for homeless people in Copenhagen. *British Medical Journal*, 2003: 327; 81–83. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Directorate of Strategy and Clinical Care, HSE. *Clinical Practice Guideline: Methadone Prescribing and Administration in Pregnancy*. Dublin: HSE; 2013.
87. Dunne, E. and Duggan, M. and O'Mahony, J. Mental health services for homeless: patient profile and factors associated with suicide and homicide. *Irish Medical Journal*, 2012: 105 (3); 71-74.
88. Comiskey, C., O'Sullivan, K. and Milnes, J. A Roadmap for the Future. A Rapid Assessment Response (RAR) on the Needs and Service Evaluation of the South-East Regional Drugs Task Force. South Eastern Regional Drugs Task Force: 2010.
89. Cahill N. Linking Prison and Community Addiction Treatment. *Irish Medical News* 30/08/13. Available at <http://www.drugsandalcohol.ie/20498/> Accessed on 22/10/13
90. Long J. Multi-dimensional approach required to prevent overdose. *Drugnet Ireland*. 2004. 10 pp. 12-13. Available at <http://www.drugsandalcohol.ie/11365/> Accessed on 22/10/13
91. Branagan, O. and Grogan, L. Providing health education on accidental drug overdose. *Nursing Times*, 2006: 102 (6); 32-3.
92. Coleman, L. and Lynn, E. (2007) Drug users' experiences of overdose. *Drugnet Ireland*, 2007: 23; 14.
93. The Availability of Naloxone in a Homeless Primary Healthcare Service:. Youtube Video Published April 2012. Available at <http://www.youtube.com/watch?v=t4kOcl6M-tU> Accessed on 22/10/2013
94. Ana Liffey Drug Project. Naloxone, The Welsh Experience. Presentation and Project Overview. Available at: http://www.drugs.ie/features/feature/naloxone_the_welsh_experience Accessed on 22/10/2013
95. Doe-Simkins, M., Walley, AY., Epstein, A. and Moyer, P. Saved by the Nose: Bystander-Administered Intranasal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health*, 2009: 99(5); 788–791.
96. Baggett, T., Hwang, S., O'Connell, J., Porneala, B., Stringfellow, E. Orav, E., Singer, D. and Rigotti, N. Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-Year Period. *JAMA Intern Med*, 2013;173(3);189-195.
97. Darke, S., Williamson, A., Ross, J., Mills, K. L., Havard, A., and Teesson, M. Patterns of nonfatal heroin overdose over a 3-year period: findings from the Australian treatment outcome study. *Journal of Urban Health*, 2007: 84(2); 283-291.
98. PDR Network: www.pdr.net [homepage on the internet]. New Jersey, USA: PDR Network LLC 2012; Accessed on 03/05/2012. Available at www.pdr.net.
99. EMCDDA. EMCDDA trend report for the evaluation of the 2005–12 EU drugs strategy. EMCDDA: Lisbon; 2011.
100. Hickman, M., Carrivick, S., Paterson, S., Hunt, N., Zador, D., Cusick, L. and Henry, J. London audit of drug-related overdose deaths: characteristics and typology, and implications for prevention and monitoring. *Addiction*, 2007: 102 (2); 317-323.
101. Cartwright, A. and Gorman, D. Processes Involved in Changing the Therapeutic Attitudes of Clinicians toward Working with Drinking Clients. *Psychotherapy Research*, 1993: 3(2); 95-104.
102. Watson, H., Maclaren, W., and Kerr, S. Staff attitudes towards working with drug users: development of the Drug Problems Perceptions Questionnaire. *Addiction*, 2007: 102(2); 206-215.
103. Skinner, N., Roche, A., Freeman, T. and Addy D., Responding to alcohol and other drug issues: The effect of role adequacy and role legitimacy on motivation and satisfaction. *Drugs: education, prevention and policy*, 2005: 12(6); 449-463.
104. Shaw, S., Cartwright, A., Spratley, T. and Harwin, J. Responding to Drinking Problems. London: Croom-Helm; 1978.
105. Loughran, H., Hohman, M., and Finnegan, D. Predictors of role legitimacy and role adequacy of social workers working with substance-using clients. *British Journal of Social Work*, 2010: 40(1); 239-256.

106. Weinstein, N. Unrealistic optimism about susceptibility to health problems. *Journal of Behavioral Medicine*, 1982: 5 (4); 441-460.
107. Weinstein, N. Testing four competing theories of health-protective behavior. *Health Psychology*, 1993: 12(4); 324
108. National Institute for Drug Abuse. Overdose Deaths Among Homeless People 2013. Available at: <http://www.drugabuse.gov/about-nida/directors-page/messages-director/2013/01/overdose-deaths-among-homeless-persons> Accessed on 31/10/2013
109. Massachusetts Department of Public Health Bureau of Substance Abuse Services. Opioid Overdose Prevention Strategies in Massachusetts. 2012. Available at: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid-overdose-prevention-strategies.pdf> Accessed on: 31/10/13
110. Harm Reduction Coalition. DOPE Project Case Study. Available at: <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/naloxone-program-case-studies/dope-project/> Accessed on 31/10/13
111. Harm Reduction Coalition. New York SKOOP Project. Available at: <http://harmreduction.org/our-work/overdose-prevention/new-york-skoop/> Accessed on 31/10/13
112. Reinås, K, Waal, H., Buster, M., Harbo, M., Noller, P., Schardt, S., Müller O., and Wolfgang J. Strategic Choices for Reducing Overdose Deaths in Four European Cities. Oslo: Alcohol and Drug Services; 2002
113. Lakeman, R. How Homeless Sector Workers Deal with the Death of Service Users: A Grounded Theory Study, *Death Studies*, 2011: 35 (10); 925-948.
114. Lehmann U. and Sanders D. Community Health Workers: what do we know about them? Geneva: World Health Organisation; 2007
115. Burke, S. Tackling Poverty: Tackling Health Inequalities. Dublin: Combat Poverty Agency; 2009
116. McNiff J., McNamara G. & Leonard D. Action Research in Ireland. Dorset: September Books; 2000.
117. Uebersax JS. Likert scales: dispelling the confusion. *Statistical Methods for Rater Agreement website*. 2006. Available at: <http://john-uebersax.com/stat/likert.htm>. Accessed 15/11/2013
118. Gaster, L. Quality in Public Services. Bristol, Pa.: Open University Press, 1995
119. Ellis R & Whittington D: Quality Assurance in Healthcare: A Handbook. London: E Arnold; 1993.
120. National Economic & Social Council. Achieving Quality in Ireland's Human Services - A Synthesis Report. Dublin: NESCC; 2012.
121. Mazutis, D. Slawinski, N. Leading Organizational Learning Through Authentic Dialogue *Management Learning*, 2008 39: 437
122. Pérez López, S. Manuel Montes Peón, J, and Vazquez Ordás, C. Human Resource Management as a Determining Factor in Organizational Learning. *Management Learning* 2006 37: 215
123. Talib F, Rahman, Z Azam, M. Best Practices in Total Quality Management Implementation in Health Care Settings. *Health Marketing Quarterly*. 28:3



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