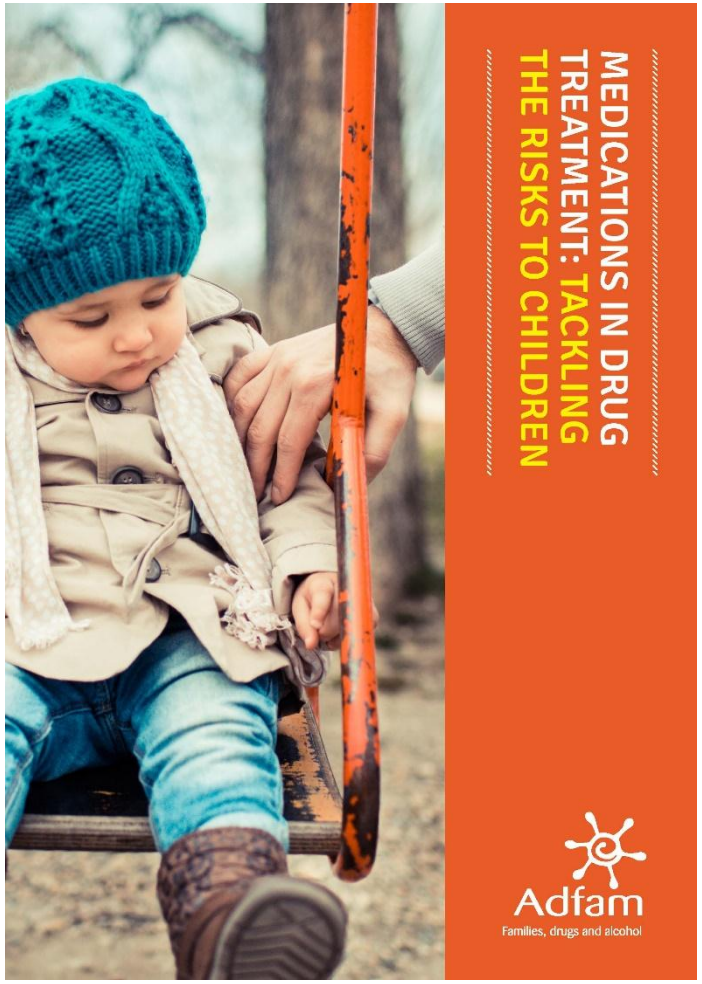

Medications in Drug Treatment: Tackling the Risks to Children

Aims

To assess how the dangers to children can be minimised during the provision of Opioid Substitution Treatment (OST) to their parents and carers, through:

- analysis of policy, practice and clinical guidelines, and academic research
- media coverage of child ingestion cases
- Serious Case Reviews in the last decade
- interviews, focus groups and roundtable discussions with practitioners, managers and experts in the fields of families, drugs and alcohol

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Literature and guidance

- 250 – 350,000 children affected by parental drug use in UK
- 61,928 adults in drug treatment with parental responsibility and a prescribing intervention
- 55% of people in treatment either parents or have children living with them
- Methadone: 414 adult drug deaths (15.9%). Buprenorphine: eight recorded deaths

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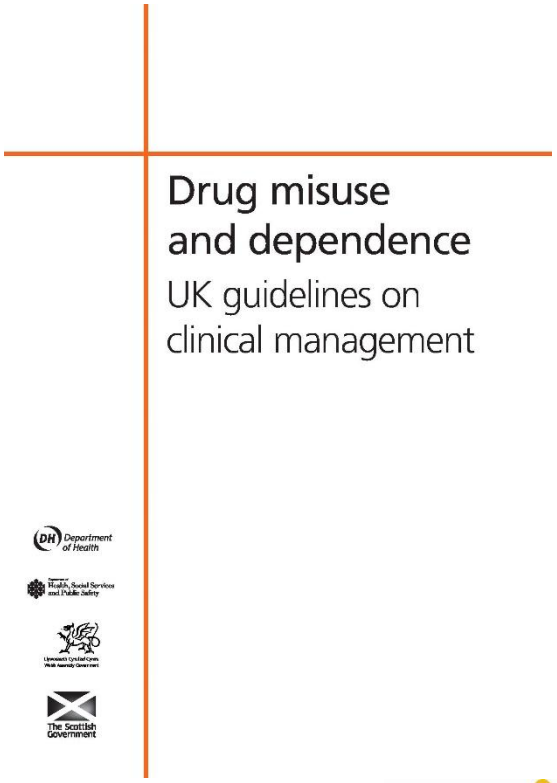
Department of Health

- *'Patients must be made fully aware of the risks of their medication and of the importance of protecting children from accidental ingestion. Prescribing arrangements should also aim to reduce risks to children'*



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Public Health England

- *'Are clinical decisions to relax, drop or reinstate supervised consumption regularly reviewed and based on individual users' present circumstances, taking into account their level of stability, work commitments and level of risk (especially to children)?'*

Public Health England

TURNING EVIDENCE INTO PRACTICE

Optimising opioid substitution treatment

Although opioid substitution treatment (OST) is the most effective intervention for heroin use and dependence, the medication itself, and accompanying psychosocial/recovery interventions, need to be optimised to give the user the best chance of recovery and sustained abstinence. This briefing focuses on elements that can be optimised and provides key messages to help achieve this. The content is drawn from authoritative guidance, published evidence and service provider feedback.

What is the issue?

While more service users are completing treatment drug-free and are showing evidence of sustaining their recovery, others find such change difficult. We know that various treatment factors can help to encourage positive change and promote recovery (such as using recommended 'high' doses of OST; providing flexible and responsive services; and engaging service users in psychosocial and recovery-support interventions). Older, more severely affected and complex users who have been in treatment for many years are likely to need particularly careful care planning if they are to make significant gains.

A comprehensive recovery framework for optimising OST

Individuals whose treatment has been optimised in line with the evidence base will have their care competently and regularly reviewed.[1] Agreement will be reached with users on the most appropriate combination and intensity of pharmacological, co-morbid, psychosocial and recovery support interventions for their treatment and recovery goals. Care will continue to be optimised throughout their treatment journeys, along with personalised needs assessments and regular progress reviews. Treatment will be adapted where evidence shows it is not meeting need. It is not possible to predict exactly what support options, or their order and combination, a particular service user will need. Providing a menu of options, carefully discussed with users within a positive, flexible, therapeutic and motivational framework of care is likely to be most effective, including targeted incentivisation (contingency management) when appropriate. OST may be most effective in supporting recovery within a broad evidence-based framework of care. "Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community."[2]

Prompts

1. Is there a clear vision and framework for recovery within the local system?
2. Is there an established process of initial and ongoing need assessments within the service?

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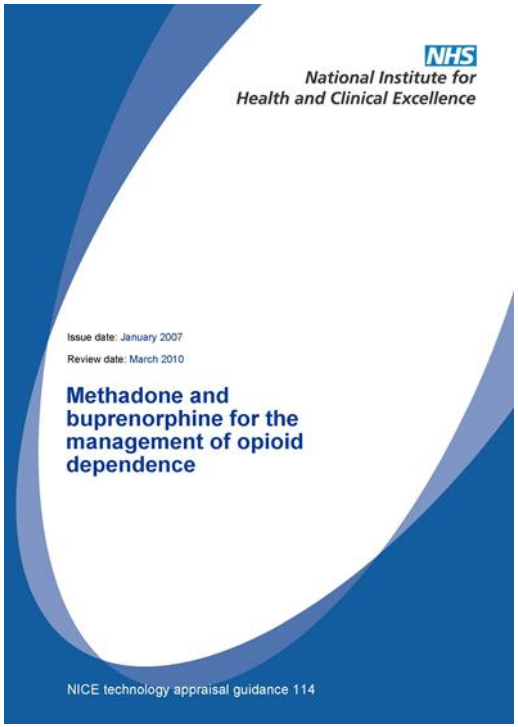
NICE

- *'High mortality risk associated with methadone in opioid-naïve people'; clinicians should 'estimate the benefits of prescribing methadone or buprenorphine, taking account of the person's lifestyle and family situation (for example, whether they are considered chaotic and might put children and other opioid-naïve individuals living with them at risk'*
- It is a statutory obligation for commissioners to make funding available for NICE-recommended medicines



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Literature review

- The issue is covered quite well in guidance, but there is a lack of clarity in terms of what practice – and 'good practice' – look like on the ground
- No large-scale studies of practice; what does exist shows it to be patchy (e.g. provision of safety information or compliance with rules)
- Evidence base for OST as a medical intervention is clear and strong
- Vast majority of patients use OST safely, but those who *do* pose a risk pose a *very high* risk

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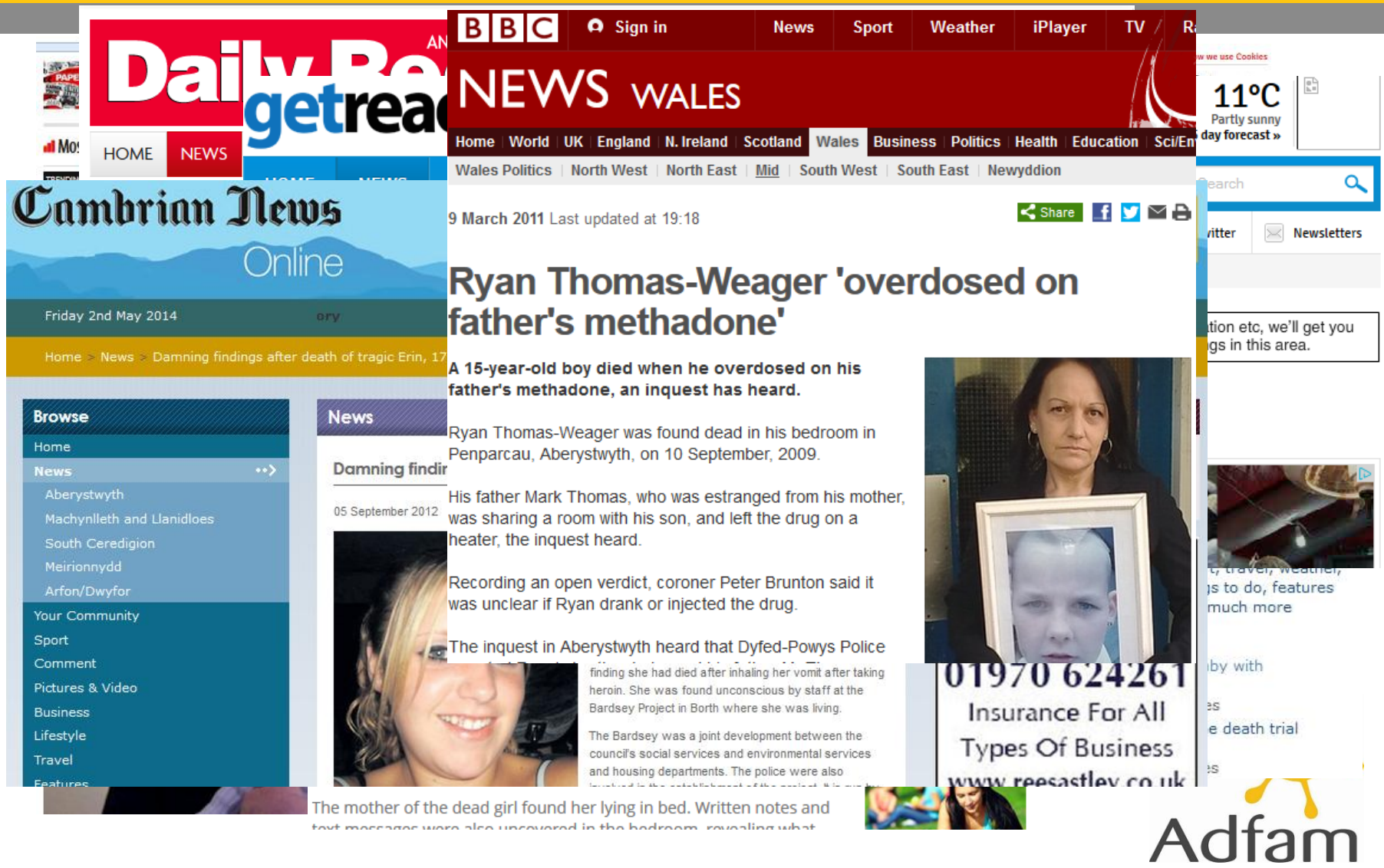
Media analysis



Media analysis

- Coverage of individual cases, but often focused on criminal trials
- No deeper analysis of practice
- No overview or comparison to be found
- No take-up of the issue from drug treatment organisations, children's charities etc

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Safeguarding

'Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care'

In this context, safeguarding refers to professionals' responsibility to consider the welfare of children when making assessments or decisions about work with adults.

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Serious Case Reviews

Child dies or comes to significant harm

Abuse or neglect are suspected factors

Serious Case Review undertaken

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Serious Case Reviews

- Responsibility of Local Safeguarding Children Boards
- Interviews/reports from agencies involved with the family, and sometimes family themselves
- Gives ‘lessons learned’ and makes recommendations to prevent future incidents
- Concludes whether the incident was predictable or preventable
- Not criminal enquiries, and don’t aim to apportion blame: analyse the history of professional engagement with the family, with an eye on partnership work

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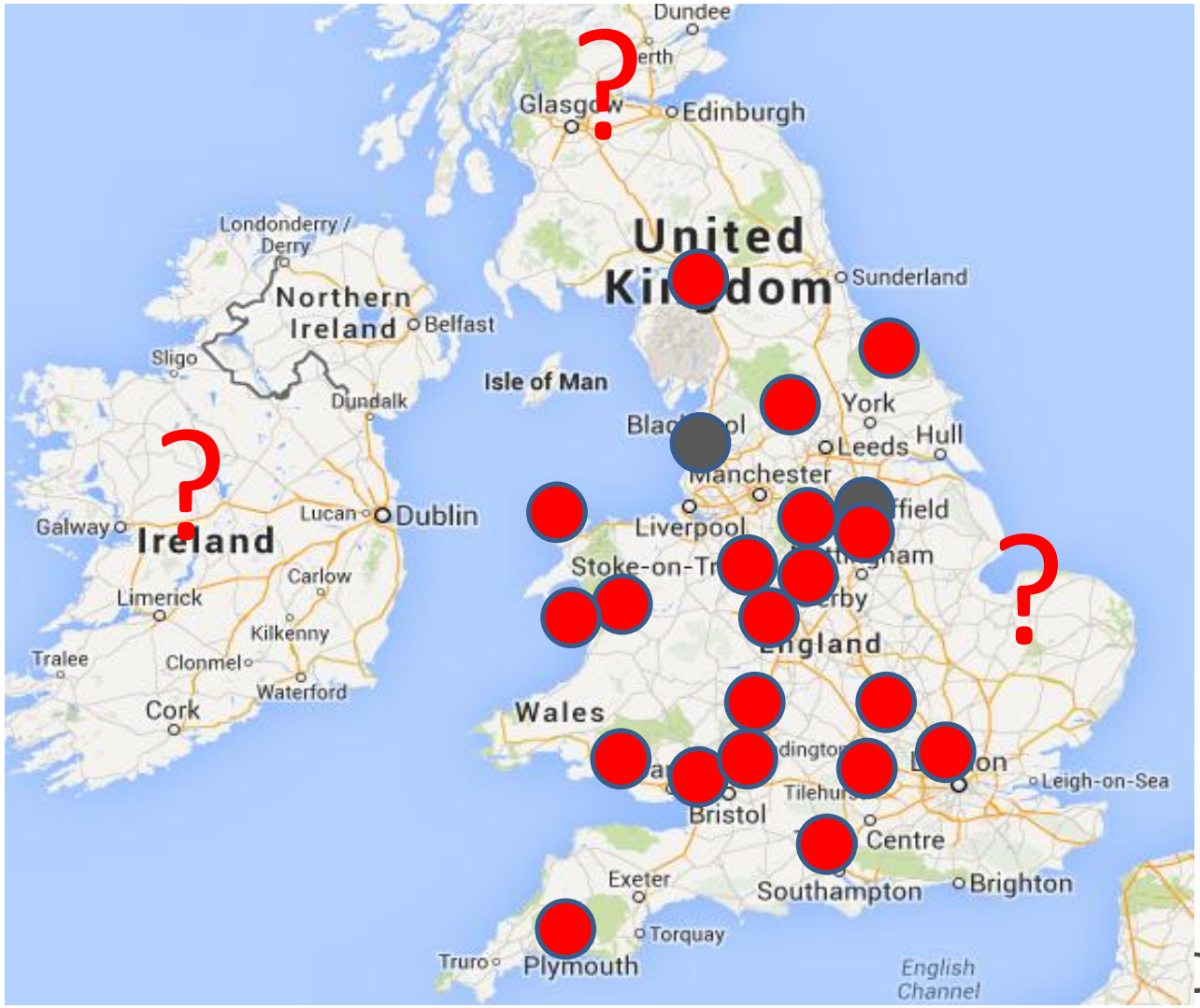
Serious Case Reviews



SCR findings

- **20 Serious Case Reviews** 2003-13 where OST drugs were ingested by a child – 17 in the last 5 years alone
- Cases involved 23 children, **17 deaths**
- **Methadone** mentioned in 19 of the 20 reviews, and caused 15 fatalities
- Median age of the children was **two**
- 6 accidents; **5 cases of intentional administration** by parents/carers; 6 unclear how it happened; 3 intentional (e.g. suicide)
- Most commonly prescribed to the **child's mother** (eight cases)

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SCR Recommendations: summary of themes

- Providing lockable storage boxes for methadone, monitoring their use, and undertaking and recording safe storage discussions with service users
- Reviewing or restricting the availability of take-home OST for parents (but no mention of buprenorphine or NICE)
- Investigating and counteracting the practice of parents deliberately giving young children methadone as a soother
- Performing toxicology tests on the children of substance users, either when admitted to hospital or as a routine practice
- Training for practitioners including pharmacists, midwives and health visitors on OST, safe storage and signs of ingestion in children
- Requesting further research on the extent and nature of these cases by central Government

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Lack of learning?

- In each case, messages about OST dangers either weren't transmitted, didn't get through, or were ignored
- 'Lessons learned' and recommendations mirrored across different areas: are they really being learned from?
- Some areas referenced more than one incident, or referred to safety measures in place
- Limited contribution of drug services/experts, and lack of OST-specific content in several SCR reports

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Practitioner interviews/focus groups

Interviews with pharmacists, doctors, drug workers, family workers, service user reps, service managers, LSCB members, policy experts…

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Practitioner interviews/focus groups

Variety of practices: safe storage boxes, home visits, strict supervised consumption for some parents, agreed safety plans…

“there’s a form that [service users] sign, so they agree that they understand what we’re talking about”

Solution: safe storage?

No simple answers: policy/protocol shouldn't remove clinical responsibility

"when we focus on a storage box, we tick a box that makes us feel better but it doesn't necessarily improve safety for a child"

"many service users are known to have chaotic lifestyles. They are probably not going to be the most reliable when storing drugs in a locked box"

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Solution: Supervised consumption?

- *“may risk the engagement of the client”*
- *“the people who would drop out of treatment and stopped picking up [methadone] would be the ones we are most worried about”*
- *“could be seen as punitive from a parent’s point of view”*
- *“a very simplistic, reactive way of doing something”*
- *“we might assess a man at a point in treatment when he’s single, with no connection to women or children, a very quickly he can be in a situation we would class as a risk”*
- Practical considerations of daily pharmacy attendance

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Intentional administration

Addressing the issue of intentional administration would be very challenging for practitioners:

- *"As a GP, in 30 years I have been working with drug users, I have never thought about a client using methadone as a soother"*
- *"when it comes to saying 'would you deliberately give your child methadone?' – the idea would be abominable to staff"*
- *'Positive regard' for clients – wanting to be supportive – can mean they "rule out the unthinkable"*
- *"Safe storage information doesn't specifically inform or educate the parents or remind them that [administration] is a very dangerous thing to do"*

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Learning and development

Scepticism about sustainable, long-term changes to practice:

- *“there was a load of activity after the SCR and then it dropped off, and then staff changed and it was almost like the lessons had to be learned all over again”*
- *“The [SCR] recommendations are there and nobody would disagree with them, but it’s the ‘how do we do that?’”*
- *“why has nobody nationally rounded up the SCRs, said ‘OK, methadone ingestion does seem to be a predictable thing, all these other cases have happened in similar circumstances, let’s write them up and make them accessible”*

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Practitioners' recommendations

- More prominent role for pharmacists, health visitors, social workers, police in OST safeguarding
- Educating treatment staff on physical welfare checks for children, including signs of drug ingestion
- Including messages about safe *disposal* and intentional administrations alongside existing safe storage information
- Incorporation of OST-specific elements in training for substance misuse workers
- Improved joint working e.g. home visits
- No mention of buprenorphine as a safer alternative; methadone as the default

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Conclusions and recommendations

Lack of national, and even local, learning	• Government to republish full SCR reports and analyse biennially • Drug treatment agencies to be represented on all LSCBs
Limited knowledge and awareness of OST dangers	• Central data collection on hospital admissions, child ingestions/deaths (A&E), drugs prescribed and on which supervision regimes • Training for drug services, pharmacies, GPs (inc. intentional administration), social workers, health visitors
Safeguarding not prioritised in OST decision-making	• Guidance on implementation of NICE Technology Appraisal 114 • Safe storage boxes for anyone who ever takes any of their medication home, with agreement of safety plans and sharing between agencies working with the family
Majority of cases involve methadone	

Discussion

- Unacceptable number of child deaths: one would be too many
- Frequency and similarity of cases merits more open and honest discussion of risk, especially relating to intentional administration
- Highlighting cases and raising awareness without endangering the rightful place of medications in recovery

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How can you help?

- Is this issue familiar to you? What is your experience of it?
- How is it addressed in your practice:

- prescribing/dispensing decisions
- conversations with service users
- posters/leaflets
- storage arrangements/checks
- information sharing
- training/development?

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Contact details

Adfam

25 Corsham Street

London

N1 6DR

Tel: 020 7553 7640

Oliver French - o.french@adfam.org.uk

www.adfam.org.uk

twitter @AdfamUK

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