



**What are the views of drug users when there is an
'overdose situation' that requires contacting
emergency services?**

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April Shaw, SDF Research Officer

Introduction

In conjunction with the Scottish Executive the Scottish Drugs Forum (SDF) held a conference on Drug Deaths in August 2005. Prior to the conference SDF User Involvement and Research section held three focus groups in Inverness, Hamilton and Glasgow on the subject of witness actions in an overdose event. The findings from the focus groups were presented at the conference and are detailed here in this report.

The focus groups were organised by the User Involvement Development Officers and facilitated by SDF's research officer. The group discussions were transcribed by the UIDOs. The transcripts were validated by members of the focus group discussions and the report was written by the research officer. The report has been read and commented on by UI group members to ensure the findings are a genuine reflection of the focus groups and users' views.

In total the focus groups consisted of 21 people (ten females: eleven males) some of whom were ex-drug users whilst others were current drug users. The focus groups lasted between 40 minutes and one hour and explored the actions of people who had been witness to an overdose event and the barriers they considered prevented drug users calling emergency services as soon as an overdose was identified.

Background

In 2002 the highest ever annual number of drug related deaths, 382, were recorded [GROS]. In response the Deputy Justice Minister commissioned a national investigation into all drug related deaths for the year January to December 2003 and charged that DAATs reduce the number of drug related deaths by 25% by 2005. In 2003 the recorded number of drug related deaths was 317.

The Scottish Advisory Committee on Drugs Misuse [SACDM] has recently undertaken a great deal of work examining the background to Scotland's reported drug deaths. The conclusions from the National Investigation and the DAT Association Drug Deaths Report reported similar conclusions.

It is known from both international research and the national reports mentioned above that many deaths are preventable due to missed opportunities to intervene in an overdose situation. For example the National Working Group paper found that in 48% of cases witnesses were present 'in the vicinity' of an overdose event whilst 68% of deaths occurred in a home environment. They also reported that in 50% of drug deaths in 2003 there was a

time lapse of several hours between overdose and death; only in 14% did death occur within an hour of overdose. The questions that are raised from these findings are:

- What criteria do witnesses use to identify an overdose?
- What happens in the intervening period between overdose and death?
- What actions do witnesses take in this intervening period?

It is known that the most common actions undertaken by witnesses are inappropriate forms of intervention such as applying cold water/ice and/or physical pain such as slapping/punching the overdose victim. However the national investigation showed that no intervention was attempted in almost 40% of cases. Despite the perceived fear of involving the police in an overdose situation the ambulance services were called in 82% of cases although death on arrival was recorded in 81% of cases. Therefore it is important that the intervening period between overdose and the calling of emergency services is more rigorously examined with particular emphasis placed on exploring the actions of witnesses in overdose events.

Findings

The opening questions examined the focus group participants' experiences of dealing with an overdose event. The aim was to look at the actions they took at the time of the overdose.

Question 1:

'What do you think is the best course of action to take when someone overdoses?'

Eight people had undertaken the Critical Incidents Training (CIT) provided by SDF and their answers reflected the training and advice they had received:

- Call an ambulance straight away
- Check pulse
- Put in recovery position
- Check airways and if heart/pulse slows call ambulance

In contrast, among those participants who had not attended the CIT the following responses were given:

- Slap/pinch overdose victim (OV)
- Move OV around (“get them on their feet and walk them about”)
- Talk to OV and try to get response
- Put water on OV
- Tell someone else
- Get OV out of house

There are then two main procedures that the participants suggested; the first was to employ some sort of physical contact in order to rouse the OV whilst the second was to diffuse responsibility to someone else. The second procedure was highlighted by one male respondent who said that he had (and would in the future) contacted his family “to take the wife to hospital. We just keep it in the family.”

A number of people stated that they had in the past removed the OV from the house in which the overdose occurred and then called an ambulance. Five people stated that they had rung ambulance services during an overdose event but left the scene before the paramedics arrived.

One person said that if the OV’s response did not “dip” he would not call an ambulance. The participant was asked what he meant by ‘dip’ and he explained this was when someone’s “lips and ears turn blue”.

Question 2:

‘Have you ever successfully managed an overdose without contacting an ambulance?’

Five people said they had successfully managed an overdose without calling an ambulance. They had used physical contact to bring the person around; i.e. slapping, applying ice and water to the OV.

Interestingly, during this question the words ‘panic’, ‘fear’, ‘scared’ were mentioned in all the focus groups. One male participant who had received CIT said:

“Sometimes people are in a heavy gouch – now [*after CIT*] I would get someone in the recovery position. It’s totally different now I have had the training – I would phone an ambulance right away – previously I was fearful, didn’t know what to do and scared of the consequences with the police showing up.”

One female who had successfully managed three overdose events (two of the events did not require an ambulance) through the application of physical contact and water said:

“I would do the same again if I had to. I wouldn’t be confident though and would like more information to assist in dealing with the same circumstances.”

Another male participant said he would “try one way then another way”. The techniques used by the participants to manage an overdose were picked up from other drug users.

One male participant who had received CIT stated that although a witness may perceive their actions in a non-fatal overdose event to be ‘successful’ i.e. their actions have ‘brought someone out of an overdose’; it may be the overdose would have been non-fatal anyway and no death would have occurred if no intervention had taken place. The perceived success of managing a non-fatal overdose will in many cases reinforce witness action in future overdose events.

Question 3:

If you suspected someone had overdosed would you contact emergency services first or do something else first?

A number of people said their first course of action would “depend” on the situation. A number of social, legal and observational factors were cited:

- 1) The presence of other witnesses
- 2) Relationship of witness to OV
- 3) Disposal of illicit goods
- 4) Identification of explicit overdose signs

In terms of other witnesses present at an overdose, two females said that the confusion and panic inherent in an overdose event sometimes makes it difficult for any one person to take charge; this can depend on how intoxicated other witnesses are and people “doing a runner” (leaving the scene).

Incidents of people leaving the scene of an overdose link in with the relationship of the witness to the OV and legal factors such as outstanding warrants.

“It can depend on who’s in the house – once when it happened everyone in the house had warrants and were well-known and high up in the pecking order so one person took responsibility while people were packing up stuff and getting out of the house.”

“It’s a panic situation – you have to calm people down while the OD lies there”

The first course of action for some witnesses would be to find and dispose of drugs, stolen goods etc.

It was suggested by four participants in two focus groups that the stronger the relationship to the OV the quicker a call will be made.

“There might be no relationship, you might have met person a couple of hours before.”

“Is the relationship to the person important?”

“Users are selfish.”

“If you’re having a charge with your pal you’re more into helping them than somebody you’ve just met at Central station. It’s not your shit. They’re nothing to you.”

“You’re more interested in your next charge.”

“If he can’t handle it it’s not my fault. It’s an accepted risk of using.”

“An unwritten rule?”

“Yes, it’s sad but that’s the reality.”

In terms of identifying an overdose the participants were asked what signs they recognised as symptoms of an overdose. The following symptoms were cited:

- Change colour
- Clammy skin
- Face goes blue
- Eyes at back of head
- Snoring/gurgling
- Shallow breathing
- Faint pulse

A few people said it was difficult to identify when someone had overdosed:

“It can be difficult to distinguish between a heavy gouch and an overdose.”

“Takes different times to overdose – some are immediate some take hours. Depends on the person and what they’ve been taking.”

Seven people said they would phone emergency services as soon as they suspected someone had overdosed. The changes in helping behaviour among the focus group participants appear to be have been brought about by three factors:

- 1) Critical Incident Training
- 2) Previous experience
- 3) Low self-risk of negative repercussions

Five of the six people who would call emergency services ‘straight away’ had received training in managing an overdose event:

“In the past I would have tried anything, all the myths, injecting salt and that, but now I know different.”

A previous experience of someone dying after it appeared they had come round from an overdose was cited as one reason for calling emergency services immediately:

“I’ve had someone who died after bringing them round, then I left them and they died. I wouldn’t chance it now. I would call an ambulance right away, I wouldn’t wait.”

Another participant said that now they were drug free there would be a lower risk of arrest. This person had knowledge of an acquaintance that was charged with culpable homicide after injecting their friend with heroin (the OV was unable to inject themselves).

“I’ve no hesitation about contacting the emergency services now as I’m clean and the risk of arrest is much lower.”

The National Investigation found that the time between overdose and death varied between within one hour (14%) and several hours (50%) thus an opportunity to intervene is present in the majority of overdose events. The participants were asked why there might be some delay in contacting emergency services of an hour or more. The reasons given for delay were:

- Witness might be intoxicated and unaware
- Spend time hoping person comes round
- Panic – overload of thoughts
- Nobody present - person just found

Question 4

What are the barriers for witnesses phoning emergency services?

The barriers for witnesses calling emergency services are varied. They have been categorised into the following barriers:

- Legal
- Practical
- Social
- Location
- Past experience

Legal

The most frequently cited barrier is police presence at an overdose event. The experience of witnesses with regard to the police was relatively negative with actual experience or hearsay of intrusive questioning of witnesses and/or the OV but there was also the risk of being caught with drugs and other illicit goods in the house.

“Police ask questions while you’re “out of it” and gear being in the house.”

“Aye police wanting to know more about where the drugs had been bought from, who the supplier was.”

“If you’re a witness and they die you have to sit through it all with the police and high court. When you are feeding a habit you don’t have time for that or space in your head for it.”

The risk of arrest either because of illegal contraband or outstanding warrants is the main barrier for people to overcome hence the delay in calling emergency services to allow witnesses time to get rid of anything that might incriminate them. Furthermore there is also the witness fear of a possible arrest for culpable homicide should it be a fatal overdose.

There is though a recognition that the police are not always attending an overdose to make an arrest: Three people stated that police attend overdose events for the “security” of the ambulance staff; e.g. if someone at the scene becomes violent or if the scene of the overdose is in a “rough area”.

Practical

There are a number of practical issues that people consider a barrier to calling emergency services and these are:

- Possible eviction if the overdose takes place in the witness’s house
- Children present possibly leading to social work involvement
- Effect on witness probation/criminal record
- Withdrawal of prescription for OV
- Panic
- No phone
- Robbery: i.e. witness robbing OV will not call an ambulance. This ties in with the relationship between a witness and the OV as described earlier.

Social

The social barriers that exist for witnesses include:

- Stigma
- Peer pressure
- Repercussions

Stigmatisation and “embarrassment” as perceived by the participants included the presence of emergency services attracting the attention of neighbours. This was one reason why the participant mentioned earlier in this report contacted his family in the event of his wife’s overdose and had them drive to the hospital.

One person mentioned peer pressure. The relationship between the witness and OV if close could lead to a split in the friendship if emergency services are called and the overdose is not fatal. The participant who stated peer pressure as a barrier had been witness at a friend’s overdose and described the pressure they felt in calling an ambulance with the knowledge that the police would also be present. They feared their friend would resent the presence of emergency services particularly if this led to a loss of their prescription. Another participant noted that “losing the hit and being strung out in hospital” would be a barrier to calling an ambulance and that the OV would resent the witnesses actions in the event of this scenario; whilst another participant noted that sometimes you may be getting a response from the OV and the OV may not want an ambulance called even if the witness fears they may slip into unconsciousness. In this event the witness will invariably follow the wishes of the OV.

Repercussions from the OV or family and friends of the OV were cited at two focus groups. One person had knowledge of someone murdered by the family of an OV because he had helped the OV obtain the heroin which he overdosed on. At a second focus group one participant stated that:

“If you’re up a dealer’s close you can’t bring the police to the close in case they get busted.”

The factor of panic, fear and confusion has already been described and can act as a barrier to calling the emergency services.

Location

Location is important in that the calling of emergency services will be dependant on where the overdose has taken place. As in the example above an overdose within the vicinity of a dealer's house will be prohibitive in that witnesses will not want to attract attention to the particular location. In other cases the location of the overdose may be outside where access to a telephone is not immediately available; alternatively,

One participant mentioned that people may be on private property and trespassing when an overdose occurs.

Past experience

As noted earlier, information passed on through drug user networks has a large influence on how people may react in an overdose situation and information may be based on one's own or someone else's experiences. Again as noted earlier, experience (either self or someone else) of arrest at an overdose event may have some influence on whether an ambulance is called. Two women from the Hamilton focus group stated that the hospital experience can be a barrier to calling emergency services.

"If you get to the hospital you might get sectioned. If you have a bad experience in the past this affects the way you will act in the future. Hospital staff can be unfriendly."

"Hospital doctors humiliate people who have an overdose. They stand at the bed and make a point of identifying you as an overdose."

Question 5

Manchester Protocol – Would this make a difference to how you would act in an overdose situation if this policy was adopted in Scotland?

The focus group participants were shown a leaflet that was produced by Greater Manchester Ambulance Service (see Appendix 1). The leaflet explains that from January 2002 the Manchester ambulance service will not call police to an overdose event unless there is a death, a child at risk or threat of violence to the paramedics. The leaflet also illustrates the recovery position.

The focus group participants were asked if the Manchester policy was adopted in Scotland would this make a difference to the actions they would take if witness to an overdose event.

The Manchester policy was deemed to be a "good idea" by the majority of participants however there were some caveats. A number of participants said a similar policy in Scotland

would not make a difference to their actions because there would be a lack of “trust” in the veracity of police non-attendance.

“No it wouldn’t make a difference. Would think it was a lie. Don’t trust them. When you’re using you’re negative about authority, you don’t trust anybody.”

“Police would just use everything as exceptional circumstances.”

In order for a similar policy to gain credibility among the drug using community the policy would have to be experienced by drug users and the outcomes disseminated by “word of mouth”.

“We would have to hear through other people’s experiences. Hear from people who are using.”

“Word of mouth may also spread the information. However, issues remain like trusting the information and it may well need to be tried and tested to prove – users need to know the reality.”

The focus group participants suggested a number of ways through which a change in policy could be disseminated:

- Needle exchanges
- Drug Services
- Methadone clinics
- GP clinics
- Leaflet drops
- Local media campaigns

Dissemination through the local media was suggested in the Hamilton and Inverness groups but in Glasgow the focus group participants thought this would be a waste of financial resources.

“Too much money having an advert like that on TV, it would cause too much trouble for users as well. There’s no need for everyone else to know anyway as it doesn’t affect them.”

“The media reaches normal people like grannies. They phone the police anyway they don’t need those adverts. They would be concerned why police aren’t attending. People not involved in the drugs scene would phone for help anyway.”

The layout of the leaflet was thought to be good and gave the right amount of information however if a similar policy was to be adopted in Scotland the participants felt that the information regarding the police should be highlighted; for instance the border containing police policy should be the top border on the leaflet.

On the whole the Greater Manchester Ambulance Service’s overdose policy was deemed to be appropriate and would remove the primary barrier that currently delay witnesses phoning emergency services in the event of an overdose.

Conclusion

The focus groups have raised some interesting findings concerning witness actions in an overdose event.

Although most of the overdose witnesses who took part in the focus groups were able to recognise the signs of an overdose there are legal, practical and social factors that will be considered by some witnesses and may delay an appropriate response or act as a barrier to calling emergency services.

Inherent among witnesses in most overdose events are feelings of *“panic”*, *“fear”* and *“confusion”*. These feelings should not be underestimated and in regard to this it is important that people at risk of a drug overdose should be well-informed of the best measures to pursue in the event of an overdose in order to minimise such feelings. The focus group members who had received Critical Incidents Training reported feeling more confident in their ability to manage such a situation and were able to suggest appropriate actions.

Past experience - either the witnesses own or through hearsay - plays an important role in the actions of witnesses. This can relate to how the overdose victim is managed physically and/or the rapidity to which emergency services will be called and will in many cases reinforce future actions in similar circumstances. The relationship of the witness to the OV should also not be underrated; the closer the relationship the more likely an ambulance will

be called but as has been noted where there is an absence of a significant relationship witnesses may be less inclined to involve emergency services.

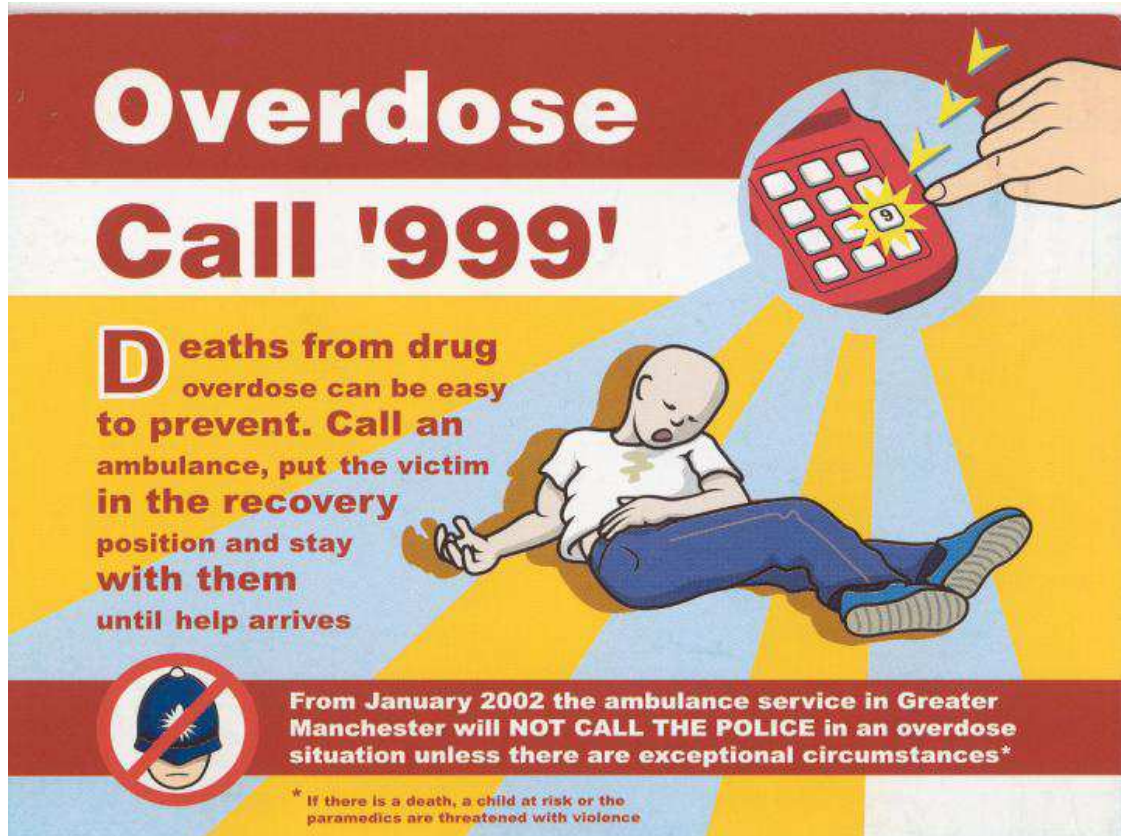
The presence of police at an overdose event has been identified as the foremost barrier to calling an ambulance and the consequences of police involvement may be based on actual experience or through word of mouth. The possibility of legal action taken against witnesses can prove a deterrent for some witnesses. Clearly drug user networks play an extremely important role in disseminating information and where a 'heavy-handed' approach may have been taken by the police this will be relayed to other drug users within that community. Although it is recognised that police involvement is not always avoidable and that their presence is required in certain situations, police involvement remains the most important barrier to calling an ambulance among those people who took part in the focus groups.

The importance of providing potential overdose witnesses, particularly drug users and family members/carers with appropriate training cannot be underestimated if the Scottish Executive's aim of reducing drug deaths is to be achieved. Peer networks are meaningful channels of communication and this study has demonstrated the importance of these networks with regard to overdose knowledge, intervention and police involvement. It is crucial that CIT continues to be rolled out to all potential witnesses of an overdose event and that the effective dissemination of relevant information and the appropriate actions to be taken in response to an overdose are pursued through the use of peer networks. Furthermore in light of the barriers inherent in potential police attendance at every overdose event (fatal and non-fatal) it is suggested that the present policy is reviewed on a multi-agency basis.

Acknowledgements:-

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Appendix 1



**Overdose
Call '999'**

Deaths from drug overdose can be easy to prevent. Call an ambulance, put the victim in the recovery position and stay with them until help arrives

From January 2002 the ambulance service in Greater Manchester will **NOT CALL THE POLICE** in an overdose situation unless there are exceptional circumstances*

* If there is a death, a child at risk or the paramedics are threatened with violence

The poster features a red mobile phone being pressed by a hand, with yellow lightning bolts emanating from it. Below, a person is shown lying on their side in the recovery position. A red circle with a diagonal slash over a blue helmet icon is positioned to the left of the bottom text.

Use the Recovery Position

Lay the victim on their side to stop them from choking on their own vomit



1 Put their right hand by their head (as if they were waving)



2 Put their left arm across the chest, so that the back of the hand rests against the cheek



3 Hold the hand in place and lift up the left knee



4 Turn the victim on their side by pushing down on the knee