National Forum on Drug Related Deaths in Scotland

Annual Report 2009-10

safer scotland
SCOTTISH GOVERNMENT

National Forum on Drug Related Deaths in Scotland

Annual Report 2009-10

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1. Introduction

1.1 The importance of understanding and taking action to reduce drug-related deaths has never been greater. Rising numbers of cases, especially in the older age groups, and a renewed interest in the longer term prospects for drug users have highlighted the risks and prospects for those who have been drug users for long periods of their lives. The lack of adequate information about numbers involved, the dangers for those who have been in treatment for many years and the range of possible prevention measures make further investigation and action on this issue essential.

1.2 Exploration of figures and statistics from other parts of the UK, Europe and the USA reveals comparisons which are unfavourable. The explanation for the high death rate among drug users in Scotland may relate simply to the higher number of people using illegal drugs in a damaging way, or there may be a lack of compatibility between national datasets. In some instances, definitions of drug-related deaths (DRD) from elsewhere in the world include deaths from causes which we would not include in Scottish DRD data (the definition of drug-related deaths used by GROS is provided at Annex A). These variations in definitions and the associated variations in systems for recording figures make direct comparisons difficult. What is apparent, however, is the need for increased specificity in our statistics and more detail related to the nature of drug-related deaths in Scotland.

1.3 The *Road to Recovery* strategy document highlighted the need for information and an evidence-based approach to treatment, as well as the importance of broadening our policy objectives beyond simple containment of drug use into improving lives.

1.4 Reducing the number of drug related deaths is a key requirement of this strategy and the Forum has spent this year making a concerted effort to find out more about drug related deaths, to be clear about the benefits of various interventions and to consider all possible available prevention measures. With these objectives in mind, a combination of consultation

with local, national and international experts and discussion around prevention measures has highlighted some important ways forward and informed recommendations for action.

1.5 Clearly understanding the events leading to a drug-related death is one major objective for the Forum and this is being addressed with the evolution of a new stream of information from all front-line agencies on each drug-related death. A further objective is to formulate a strategy for improving access to, and quality of, treatment for those most at risk and this is outlined in the conclusions on treatment services.

1.6 Most of the deaths included in the current statistics are limited to accidental overdose of one, or a combination of, drugs. Therefore, a major strand in the deliberations of the group has been to begin to understand and quantify the larger numbers of drug-related deaths which, at present, go unnoticed. Discussions have begun and steps set in place to gather information from a range of agencies to include those deaths not normally included in the annual totals. These deaths occur from a range of diseases which would, in all probability, not have occurred if the person had never used drugs. Obvious examples are blood borne viruses, Hepatitis C in particular, and also HIV/AIDS.

1.7 Based on data from surveys conducted at needle exchange services, it is estimated that the adjusted overall prevalence of Hepatitis C amongst injecting drug users in Scotland in 2008-2009 was 53%[1]. Given the potential damage caused by this virus, this could have a significant impact on the mortality rates of injecting drug users. It is noted that the number of deaths in Scotland related to Hepatitis C has increased over recent years (a graph showing deaths caused by this virus since 1996 is provided at Annex B). While not all of these individuals will have contracted the virus as a result of drug injecting behaviours, it is estimated that around 90% of those with Hepatitis C have been infected through behaviour relating to injecting drug use. Gathering further information on

[1] Hepatitis C in the UK Annual Report 2009:
http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1259152221168

this and the impact it could have on drug related deaths is essential.

1.8 In addition to blood borne infections, greater scrutiny should also be given to deaths caused by a range of respiratory and cardiovascular conditions, as well as those deaths resulting from trauma, violence and road traffic accidents in order to investigate the proportion of these which may be caused by, or related to, drug use. The ongoing epidemic of deaths from injection of anthrax bacteria in contaminated heroin further highlights the ever-expanding collection of causes of drug-related deaths.

1.9 Unfortunately, Scotland already remains ahead of other comparable countries in numbers of drug-related deaths and increased ascertainment of cases and enlargement of the case definition will further increase this position. However, this should not stop us from highlighting these deaths in the hope that their recognition will lead to efforts to reduce them.

1.10 The National Forum on Drug-related Deaths is a multi-disciplinary committee made up of participants from a range of medical, social, community, prison, police, legal and non-statutory agencies. Full membership of the Forum and its related sub-groups can be found at Annexes C and D.

1.11 Drug-related Deaths have a wide impact and any prospect for reducing fatal incidents relies upon sharing responsibility for the provision of suitable interventions.

ROY ROBERTSON

Chair,
National Forum on Drug-related Deaths in Scotland
July 2010

2. GROS Report on Drug-Related Deaths in 2008.

2.1 The General Register Office of Scotland (GROS) published their report, *Drug-related Deaths in Scotland in 2008* on 12 August 2009[2].

2.2 It should be noted that the data contained in the 2008 GROS report relating to the numbers of deaths in that year involving particular drugs are not directly comparable with those from earlier years. This is due to the revision, with effect from 2008, of the questionnaire which collected this information. It should be noted that the total number of drug related deaths will be unaffected by this reclassification.

2.3 In future reports, GROS will provide information on 'drugs implicated in or which potentially contributed to' each death. GROS are currently reprocessing the 2008 data to enable them to report figures on that basis. The Forum will review this additional set of figures on publication and this information will help to inform the Forum's programme of work going forwards.

2.4 The main points within the 2008 GROS report included:

- Drug deaths rose to **574** compared to **455 deaths in 2007**. This is the highest ever annual recorded figure and early indications are that this increase will continue into 2009. There were **119 more deaths** than in 2007 and **325 more than in 1998**. These figures confirm that, although drug death numbers do fluctuate over time, there has been a steady upward trend over the last ten years.

- 80% of the deaths were men (461), with percentage increases rising more rapidly in men compared with women (113).

- In comparison to 2007, the percentage increase of drug related deaths recorded in 2008 was highest in those aged 45 years and over (54% increase), followed by those aged

[2] .http://www.gro-scotland.gov.uk/statistics/publications-and-data/drug-related-deaths/drug-related-deaths-in-scotland-2008/index.html

between 25-34 years (42% increase) and then those aged between 34-44 years (17% increase). There was a very slight fall in the number of drug-related deaths for people aged under 25 years (2%). Given fluctuations in the number of drug-related deaths year to year, it is advisable to compare 5 year rolling averages. Please see the GROS Drug Related Deaths in Scotland in 2008 report for more information.

- Based on the number of deaths in each area, the largest increases have been in Greater Glasgow and Clyde (an increase of 40 cases), Lothian (an increase of 40 cases) and Tayside (an increase of 24 cases).

- Very few drug-related deaths are caused by one drug alone. Multiple drug use continues to be a problem particularly in conjunction with alcohol.

The Forum's Response to the GROS report into Drug-Related Deaths in Scotland in 2008

2.5 With the continuing rise in drug deaths the Forum felt that they should provide some useful recommendations to services and service commissioners. The following is the Forum's response to the GROS paper which was circulated to prescribing and other agencies involved with the care of people with drug misuse problems:

<u>The Forum's main observations from the GROS report:</u>

- Increase in deaths was not surprising but scale of rise is a concern.
- Older men seem most vulnerable.
- Underlying co-morbidities, i.e. physical (hepatitis C, alcohol-related liver disease) and mental health problems (suicide risk) seem most likely explanations for increase, along with social isolation and entrenched drug using lifestyles.
- The report suggests that poly-substance misuse and problematic drinking (probably co-dependency with

alcohol in many cases) contributes to drug-related death risks.

- Figures don't tell us if individuals were in treatment or not. The National Drug Death Database will help but local intelligence from some areas suggests most drug-related deaths are individuals not linked to services or in treatment.
- It is important to note that relatively few deaths are from any one drug alone. It is the combination of drugs (and alcohol) that is the greatest danger.

The Forum's key recommendations:

1. Increase access to services:

- ***Treatment is protective***, particularly substitute replacement therapy for opiate dependant individuals.
- ***Reduce waiting times*** to treatment and target resources to achieve this.
- ***Ease of access*** **to services**, e.g. through primary care and community based services.
- ***Target hard to reach groups -*** this will require local research/intelligence into barriers to existing services.
- ***Prioritise retention*** in services to reduce risks of treatment interruption and unplanned discharges.

2. Continue to Develop/Improve Services:

Prescribing:

- Emphasis should focus on evidence-based treatments, e.g. **not** short detoxification regimes for chronic drug users;
- Promote adherence to UK Guidelines on Clinical Management 2007 to improve prescribing standards, e.g. optimal dosing, safe initiation, supervision arrangements to minimise diversion;
- Offer other treatment options such as buprenorphine as alternative to methadone, if appropriate.

Assessment:

- Focussing particularly on high risk groups, i.e. ageing, male, isolated, co-dependant with alcohol, and with physical and mental health co-morbidities.

Interventions:

- Particularly in high risk groups as described above, support with better coordinated/less fragmented care, e.g. Hepatitis C testing, co-dependency treatments, access to mental health teams. A one stop-shop approach would be ideal.
- Detoxification should be planned with good quality recovery based after-care as the norm.

Innovative services:

- Take home naloxone and overdose awareness training provided as norm.
- Take into account outcome of heroin prescribing (RIOTT) trials in England, particularly for long-term chronic drug users who have had multiple treatment episodes.

3. Improved Partnership Working:

- With Scottish Ambulance Service and police to promote the preservation of life as their first priority and to support non-fatal overdose clients.
- With Scottish Prison Service to ensure treatment and continuity of care for prisoners on admission and release; and harm reduction and overdose awareness measures are in place.
- With Emergency Departments/Acute Health Services to create links with treatment services to ensure continuity of care and to identify and link high risk individuals with service response.
- With Homelessness, Criminal Justice and other appropriate services to promote overdose awareness and training, naloxone use and referral to services.
- With Employment/Benefit services, where those not in touch with services may be located.

3. PRIORITIES AND PROGRESS IN 2009-10

3.1. The following list summarises the areas of priority interest and investigation this year:

Spread of Anthrax bacteria in contaminated heroin

3.2. As set out in the introduction, there are a growing number of causes of drug-related deaths in Scotland, many of which are not included in the formal definitions. As of the end of last year, this sadly now includes anthrax infection contracted from injecting contaminated heroin.

3.3. On the 17th December 2009, NHS Greater Glasgow and Clyde's Public Health Protection Unit confirmed two cases of anthrax contamination and a further suspect case. At that time all three cases were potentially linked as they presented with serious soft tissue infections in areas of the body where heroin had been injected. As of 2 July there have been 46 confirmed cases in Scotland resulting in 13 deaths. While the majority of cases (19) were located in Greater Glasgow and Clyde area, there have been a number of confirmations across Scotland (Ayrshire & Arran, Dumfries & Galloway, Fife, Forth Valley, Lanarkshire, Lothian and Tayside) with 3 confirmed case in England and 1 in Aachen, Germany.

3.4. On 15 January 2010, the Chair of the National Forum on Drug-related Deaths in Scotland was invited to join the Outbreak Control Team (OCT), convened by Health Protection Scotland (HPS). The OCT then moved to:

- co-ordinate expert epidemiological advice on responding to the outbreak and providing robust surveillance, and the reporting of cases, in conjunction with affected NHS Boards;

- oversee the administration of a small stock of anthrax anti-toxin (purchased from the sole supplier in Canada by Scottish Government) to help treat those affected;

- co-ordinate national communications on the outbreak, posting daily updates on the HPS website and issuing press releases to report on significant developments;

- work closely with the Police in support of the active Police operation seeking to identify the source of the contaminated heroin and remove it from the streets;

- liaise with relevant agencies in the UK and overseas (such as the Centre for Disease Control in Atlanta and the European Centre for Disease Prevention and Control) on the outbreak;

- co-ordinate the provision of information to at-risk individuals and to services working with drug users, to ensure they are alerted to the risks and can respond appropriately;

3.5. On the last point, the Volunteers sub-group were invited by the OCT to provide advice on how to best get information and advice to those at greatest risk. The OCT also reviewed the information materials that the Scottish Drugs Forum (SDF) had been commissioned to prepare and distribute to all services across Scotland, including needle exchanges, homeless hostels, Accident and Emergency departments etc. The advice and comments from the Volunteers group were fed back directly to Scottish Ministers and to the OCT and were invaluable in informing how information was provided to those at greatest risk from infection.

3.6. The Scottish Government have approached the Chair of the National Forum to ask for the Forum's input when it comes to reviewing the effectiveness of the interventions and possible lessons for the future.

National Drug-Related Deaths Database:

3.7. Since early 2009, National Drug Related Deaths (NDRD) Data Collection Coordinators have been assigned to each area of Scotland. These Coordinators are tasked with collecting and

collating DRD data from different agencies (e.g. drug treatment services, police, GPs and pathologists) and sending completed NDRD datasets to Information Services Division (ISD).

3.8. The collection of all NDRD data is expected to be completed by summer 2010. Scotland's '2009 National Drug-related Deaths Report' is scheduled to be published by ISD before the end of 2010. The National Drug Related Deaths database is explored in more detail in Chapter 4.

Recommendation 1

In recognition of the expanding range of causes of drug related deaths, and in keeping with the aims of the Advisory Committee on Misuse of Drugs report on Drug Related Deaths (published in 2000) to include a wider view of mortality caused by drug misuse, the forum recommends:

- ♦ that GROS include a table within their annual drug related deaths report that reflects deaths from 'some causes which may be associated with present or past drug misuse';
- ♦ that in the coming year, this includes detail on deaths caused by Hepatitis C and HIV; and
- ♦ that the forum and GROS explore the possibility of including violence, trauma and road traffic accidents in future reports.

Action for: GROS

National Naloxone Programme:

3.9. Naloxone is an opiate antidote which temporarily reverses the effects of opiate overdose. This medication can therefore potentially save lives by providing more time for the emergency services to arrive and administer treatment following an overdose.

3.10. Following the success of the pilots of the provision of 'take home' naloxone within NHS Greater Glasgow and Clyde,

NHS Lanarkshire and NHS Highland, the Minister for Community Safety requested that the Forum take forward the development of a national 'take home' naloxone programme in Scotland

3.11. In December 2009, the Forum established a Short Life Working Group (SLWG) to take this work forward. The SLWG have examined all elements to the development of such a scheme.

3.12. The Group's report was presented to the Forum on 12 May and raised the following key points:

- Naloxone can legally be *administered* by anyone present at the scene of an overdose who was in a position to intervene in advance of the emergency services arriving.
- However, the *supply* of naloxone, as a Prescription Only Medicine (POM), can only be made on a named patient basis, using either a prescription or a Patient Group Direction.
- The SLWG recommended the use of 'Heartstart' training as the best means of providing the basic life support component of a 'take home' naloxone scheme.
- In the absence of a specific 'take home' preparation at present, the Group recommends the use of the Naloxone Hydrochloride 1mg/1ml pre-filled 2mg syringe in this scheme. This syringe will contain 5 doses.
- The Group also identified barriers to the expansion of this scheme which are related to the product itself, and also the legal supply restrictions of a POM and made recommendations on how these barriers could be overcome.

The full report of the SLWG's findings is provided at Annex E.

3.13. The SLWG have developed a protocol and guidance for the supply of naloxone, along with a Patient Group Direction (PGD) which enables the supply of this medication to named patients by nurses and pharmacists. The Forum has approved both these documents.

3.14. In recognition that individuals are at higher risk of overdose in the first three months post liberation from custody, take home naloxone will initially be made available to all high-risk individuals at the point of liberation from Scotland's prisons. This programme will commence later this year.

3.15. The national roll-out of this programme will follow and the Forum will work closely with the Scottish Government and local partners to support the delivery of this. The Forum will carefully monitor the ongoing evaluation of this scheme to review whether it has an impact on reducing drug-related deaths in Scotland.

Transitions from community to custody and back again

3.16. Drug-related deaths after release from custody remain a concern. The Forum believes that urgent consideration is given to the periods of transition from community to prison and back again to ensure that access to opiate substance treatment is seamless during these movements.

3.17. The Forum also heard a presentation from the Glasgow Throughcare Addiction Service (further detail is provided on page 51). The Forum recognises this as a model of good practice in supporting people in the transition from custody to the community but one which is unfortunately not replicated across Scotland.

3.18. The Forum understands that the Scottish Government is currently undertaking a review of the TAS service which will allow the Reducing Reoffending Programme to identify best practice and issues encountered locally in the development of this service. It will also provide a picture of how the service is linking with local Alcohol and Drug Partnership (ADP) strategies. The Forum will wish to review the findings of this review for information and future consideration.

Recommendation 2

'Take home' naloxone should be available to all high risk individuals on release from custody later this year.

This programme should be underpinned by a detailed evaluation which builds on data already held by the Scottish Prison Service (SPS) for the three years preceding the implementation date.

This should be supported by increased availability of 'take home' naloxone though specialist and primary care services and the Forum encourages the development of local 'take home' naloxone programmes where these are not already in place.

Action for: Scottish Prison Service
Scottish Government – Drugs Policy Unit.
NHS Boards
Alcohol and Drug Partnerships

Recommendation 3

The forum has been impressed by the role of Throughcare Addiction Services (TAS) in engaging high risk prisoners with community addiction services and recommends that this service should be developed in all areas.

In addition, the Scottish Government review of the Throughcare Addictions Service (TAS) should consider how to support the development of improved information sharing processes between the TAS and the Enhanced Addiction Casework Services (EACS) in order to share vital feedback regarding client attendance at community appointments following release from custody.

Action for: Scottish Government

Pathology Standards and Protocols for Drug-Related Deaths, including toxicology testing.

3.19. Having very successfully introduced a new system of reporting of drug related deaths to the General Registrar of Scotland in previous years, the pathology sub-group was tasked by the Forum with another challenge: agreeing a standard practice for reporting drug related deaths across all areas of Scotland.

3.20. The Forum has always regarded the role of forensic pathologists as crucial to our understanding drug related deaths. Much of the information we base our responses on comes from their daily work. This year, the Forum explored some of the challenges that pathologists face in coming to a robust conclusion about suspicious deaths before concluding them as being drug related. Pathologists have to consider what was known about the individual who has died circumstantial evidence at the scene of death, their own pathology post-mortem findings and toxicology results. It is the pathologist's unenviable task not only to gather but also to interpret this often incomplete, confusing and sometimes contradictory information.

3.21. The Forum's view is that, despite these difficulties, our understanding and monitoring of drug related deaths would be greatly improved if all forensic pathologists and toxicology laboratories in Scotland worked as uniformly as possible. The sub-group has now begun exploring the complex issue of common standards and will report to the Forum in due course.

Recommendation 4

Pathology departments should arrive at common standards of sampling, laboratory testing and interpretation of results. Testing in forensic laboratories should include a standard range of substances and, in particular, buprenorphine should be routinely tested for in fatal cases.

Action for: Pathology Departments.

Treatment Services – range and efficacy.

3.22. Equity of access to drug treatment services across Scotland is seen by the Forum as a major priority. The Forum recognises that, for many, General Practice is largely considered to be the first point of access for patients to treatment services. Easy access to GPs for this group is, however, variable within and between Health Boards areas. As well as equal and timely access, the Forum firmly believes that there should be good quality, person centred drug treatment services available in all areas.

3.23. The Forum has discussed and explored treatment issues and possibilities and has, through focussed sessions with invited experts, considered various treatment options which might reduce drug related deaths. Much of the evidence gathered by the Forum this year has indicated the suitability of community and primary care settings for interventions designed to reduce drug related deaths. There is recognition, however, that General Practice in particular is finding it difficult to manage large caseloads of individuals with drug misuse problems, especially those more complex cases involving mental health as well as drug dependency causes of morbidity.

3.24. Some of the Forum's discussions have focused on substance replacement therapy. Expansion of the use of Suboxone (buprenorphine and naloxone) is considered by the Forum to be a useful addition to the more traditional methadone maintenance substitution for opiate dependent patients. At present, Suboxone is under-used by specialists and general practitioner services and, for some reason, is associated more with reduction towards abstinence treatment, rather than maintenance treatment (which was shown in the 2007 NICE appraisal and endorsed in the National Departments of Health Guidelines as being equally effective to methadone).

3.25. The Forum has also taken an active interest in the possibility of establishing drug consumption rooms as a mechanism for reducing the harm and possibly the mortality from drug injecting. More work needs to be done before a formal recommendation can be made. In considering this issue,

the Forum have reviewed the 2006 Joseph Rowntree Foundation report on drug consumption rooms[3] and intends to hear detailed evidence from some of the authors of this report in the near future.

3.26. The recent publication of the Randomised Injectable Opiate Treatment Trial (RIOTT) in the Lancet[4] has drawn attention again to the use of this therapy for the most intractable cases. The Forum will focus on this in more detail in the coming year.

Recommendation 5
The Forum feels that, in light of the review of the Orange Guidelines and the launch of the Road to Recovery, there should be an urgent review of the capacity and suitability of the Enhanced Service Contract as the main mechanism for supporting GPs in taking drug treatment work forward. In particular, there is a need to encourage all GPs to consider treatment of drug users as essential, rather than optional, work.

Providing access to treatments for drug related problems (of all types) is an essential service and negotiations between Scottish Government Health Directorates and the GP representative agencies should work towards including drug services in the framework of core GMS services.

Action for: Scottish Government
Primary Care Services

[3] http://www.jrf.org.uk/publications/drug-consumption-rooms-summary-report-independent-working-group
[4] http://www.kingshealthpartners.org/khp/2010/05/28/supervised-adminstration-of-injectable-%E2%80%98medical%E2%80%99-heroin-leads-to-larger-reductions-in-street-heroin-use-than-injectable-or-oral-methadone-riott-trial/

Recommendation 6

Prescribing services should focus on increasing uptake of prevention interventions, including the increased use of buprenorphine maintenance prescribing in chronic opiate dependent patients. In doing this, prescribing services should also focus on engaging with hard to reach groups within the drug-using population. This could most effectively be achieved by upskilling agencies already working with these groups in drug treatment.

Action for: Prescribing Services

Recommendation 7

The Scottish Government should respond to recent publications on the subjects of heroin prescribing and the provision of consumption rooms to allow the Forum to proceed with investigating these possibilities in Scotland.

Action for: Scottish Government – Drugs Policy Unit

Drug Treatment Services Waiting Time Initiative

3.27. The forum has also considered the Health Efficiency Access and Treatment (HEAT) target:

> 'By 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery'
>
> 'Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by 2011. '

3.28. The Forum welcomes initiatives which improve access to drug treatment services. However, it is recognised that in order to meet this target, Boards will undoubtedly be required to increase throughput in treatment services. The Forum has

concerns that this could lead to an increased reliance on short term detoxification programmes which can be harmful for those with chronic drug problems. The Forum are clear about the need to balance retention on treatment programmes with recovery and have concerns that an increased use of short-term detoxification services may disrupt this balance. The Forum will continue to monitor the use of short term detoxification services to evaluate whether this target is leading to an increase in this provision.

Drugs Strategy Delivery Commission – overlap areas of interest.

3.29. The Drugs Strategy Delivery Commission (DSDC) was established with the aim of ensuring a more effective and sustainable implementation of Scotland's National Drug Strategy, *The Road to Recovery*. The role of the Commission is to independently assess the Scottish Government's progress in delivering this Strategy.

3.30. The DSDC met for the first time in December 2009. The work of the Commission is in the very early stages and the Forum recognises that there will be several areas of shared interest going forward. The Forum is committed to working collaboratively with the Commission, and indeed the Chair of the Forum and two other Forum members sit on the Commission.

Older drug users, wider range of problems and issues for non specialist services such as social work and medical specialties.

3.31. There are now an estimated 15,000 problem drug users who are over 35 years of age. Given the overall age profile of problem drug users in Scotland it is predicted that the proportion of older drug users will continue to rise, in line with most other EU countries. The health problems of this older group are likely to be significantly greater than younger users and they are also often socially very isolated. Both these factors are likely to have an impact on the high level of drug related deaths among this population.

3.32. Primary care is in an ideal position to engage this group who may be unwilling to access specialist treatment services or to not consider their problem to be primarily one of opiate or other drug dependency. They may for example have alcohol related problems, be using illegal drugs in a relatively controlled pattern or to have chronic viral or cardio-respiratory conditions which make them more vulnerable to overdose, suicide or mental health problems. Holistic treatment is important for this group and multiple agencies may have to be involved with care packages.

Recommendation 8

Health Boards, Social work services and the voluntary sector should collaborate to develop comprehensive care packages for older drug users coming into contact with services, taking specific account of issues of isolation when planning and delivering services for this group. Primary care and general practitioners in particular should be alerted to the chronic health and social needs of older drug users.

Consideration should also be given to the support and training required by General Practitioners and other primary care services providing support to homeless or other marginalised groups to enable them to best meet the needs of older drug users.

Action for: General Practitioners
Primary Care services
Local Alcohol and Drug Partnerships.

Overlap with alcohol strategy and the importance of alcohol treatment services in preventing DRDs.

3.33. The Forum has noted with alarm the increasing role that alcohol seems to play in drug related deaths. This is despite the limited definition we currently employ - a wider definition of drug-related deaths would undoubtedly make the figures even more alarming. This is perhaps a reflection of the wider social

and health problems that exist in Scotland in relation to alcohol and particularly the fact that the worst outcomes are in the most deprived communities. However, from a more pragmatic service delivery perspective, it seems that concurrent use of alcohol with other respiratory depressants, often heroin, must be addressed by drug and alcohol services.

3.34. Polysubstance use and co-dependency have long been recognised in drug services as a risk factor for drug related deaths, but the Forum has discussed whether drug services could be more pro-active in providing alcohol services for drug misusing service users. Equally, the Forum feels alcohol services need to be vigilant for concurrent opiate use, especially heroin and illicit methadone, in service users with primary alcohol problems. Unfortunately, it seems that a significant number of drug related deaths occur in people considered to have a predominant alcohol problem who also dabble dangerously with drugs, unknown to the professionals involved in their care. The Forum, therefore, strongly feels that the traditional divisions that still occur in some areas between drug and alcohol services are unhelpful. A large number of vulnerable individuals seem to require a joined up approach from both services.

Recommendation 9

Co-operation, liaison and joint working between drug and alcohol services should be enhanced. Alcohol and Drug Partnerships should lead the development of appropriate multiagency interventions, including strategies for joint working and joint funding of projects. These should involve all key partners including Health Boards, social work services, emergency services and the voluntary sector.

Action for:

Alcohol and Drug Partnerships.

Liaison meetings with English and Wales DRDs committee

3.35. The Forum continues to have representation at the equivalent meetings in England. These meetings have provided the opportunity to share information with representatives from the other three UK nations. Representatives of the Forum have also taken part in a specially convened meeting with those responsible for the Welsh Naloxone project.

3.36. Similar interests and approaches to this issue were apparent as well as the structural differences which make data gathering, for example, variable between countries.

Family/Carer support following bereavement from a Drug Related Death.

3.37. The Forum recognises the devastating effect that a drug related death can have on the family and friends of the person who died. Improving the support and information available to families during this difficult time has long been a priority for the Forum and the group benefits from representation from the Scottish Network of Families Affected by Drugs and the Perry Fowler Trust.

3.38. Further work is needed in this area to ensure that families and friends are supported following a drug related death and are aware of the service they can expect to receive from the various agencies who may be involved.

Recommendation 10

All services in contact with people with substance misuse problems should consider how best they can support the families and carers of people with substance misuse problems. Special consideration should be given to supporting the families and carers following a bereavement from a drug related death. Support should be provided, in a coordinated way, proactively by all agencies and may be required for prolonged periods. A variety of technical advice should be available to allow families to negotiate the complex legal and organisational issues as easily as possible. A national protocol or guidance document would help in this area of service provision.

Action for:

All agencies in contact with people with substance misuse problems and their families/carers;
The police
The Procurator Fiscal's office

Future Work

3.39. The Forum has begun to scope out priorities for the coming year. This will include:

- a review of the outcomes of the Randomised Injectable Opioid Treatment Trial (RIOTT);
- engaging with the Scottish Drug Recovery Consortium and exploring the links between the recovery agenda and the work of the Forum;
- establishing clear links with the Drugs Strategy Delivery Commission;
- supporting the roll out of the national 'take home' naloxone programme and monitoring it's impact on drug related deaths in Scotland;
- A focus on how families and carers can be better supported following a drug related death;
- A review of progress on previous work around suicide prevention and engaging with mental health networks to

explore how developments in this area can help reduce drug related deaths.

- A focus on the dataset gathered around drug related deaths, exploring the potential to include information about non-overdose drug related deaths.

4. DATA COLLECTION SUB-GROUP

New National Drug-Related Deaths Database

4.1. Scotland's new National Drug-related Deaths Database (NDRDD) was developed by the Information Services Division (ISD) of NHS National Services Scotland in 2009.

4.2. The database gathers information about every drug-related death that occurs in Scotland on or after 1st January 2009. For every deceased drug user collected information includes personal circumstances, drug use history, contact with drug treatment services and GPs, medical history, substitute prescriptions, contact with the criminal justice system, scene of death, and toxicology results.

4.3. From late 2010, ISD will use the database to provide national and regional analysis on a regular basis. The Forum and the Scottish Government will also be able to use any national trends and patterns that are identified during analysis to help inform policy decisions designed at reducing the Scottish drug-related death rate.

4.4. Alcohol and Drug Partnerships and drug treatment services can use both national and local indicators to inform the introduction of interventions aimed at reducing the drug-related death rate in their area.

4.5. Analysis will also help identify which groups of drug users are most at risk which will help interventions to be targeted effectively.

4.6. From 2011 the NDRD dataset will be linked to other datasets e.g. SMR01 (acute hospital discharges), SMR04 (psychiatric inpatients) and the Scottish Drug Misuse Database. This linkage will enable as complete a picture as possible to be built up of deceased drug users and will also improve the process of identifying which groups are most at risk.

5. VOLUNTEERS FORUM

5.1. The volunteer forum met seven times during April ‘09 and March 2010, with one of these dates being a training and development day. The volunteer forum also attended a two day ‘overdose prevention/intervention’ train the trainer course.

5.2. Two members, chosen on a rotational basis, have continued to attend the National Drug Related Death Forum to offer contributions and comments that are representative of the volunteers’ views. As expected, some experienced forum members have moved on and left the group, and new members have been recruited. To support this, earlier in the year, the volunteer forum developed a membership and attendance process and induction pack for new members. The forum currently has 9 active members, with an average of 7 in attendance at meetings.

5.3. Throughout the year, the volunteer forum has sought to consider and review key issues pertinent to drug related deaths in Scotland. This has included: heroin prescribing; community based Naloxone training/prescribing; availability and access to abstinence based treatment and support; methadone and buprenorphine maintenance/detoxification programmes; public injecting and drug consumption rooms; and waiting times for access to drug treatment.

5.4. An overview of the Forum’s discussions on some of these issues are set out below:

TAKE HOME NALOXONE	CONSENSUS- The NVFDRD welcomes the national roll out of ‘Take home Naloxone (THN)’ Schemes across Scotland. The Volunteer Forum consider this to be excellent addition to the range of interventions aimed at reducing Scotland’s growing numbers of drug related

	deaths. The volunteer forum fully supports the development of flexible and locally tailored approaches to the delivery of the training, thereby increasing the likelihood of those who are most at risk of overdose death, their families, friends and carers being afforded access to this training.
ACCESS TO/PROVISION OF ABSTINENCE BASED SERVICE IN SCOTLAND	CONSENSUS- The NVFDRD does not feel that there is adequate provision of abstinence based services across Scotland. The forum recognises that substitute prescribing can act as a protective factor, however the forum feels that greater access to these services with adequate psychosocial support should be a priority.
POLICE ATTENDANCE AT OVERDOSE SCENES	CONSENSUS- The Volunteer forum believes Scotland should look to adopt a similar approach to that of various states in America, where individuals who telephone emergency services are afforded temporary immunity from prosecution for minor offences in light of their life saving actions. Referred to as ‘the good Samaritan act’, in these places, the introduction of this has seen a greater willingness among the drug using community to call for an

	ambulance early, thereby increasing the likelihood of survival by the overdose casualty.

5.5. The reviewing of some of these issues was helped considerably by the attendance of guest presenters who were involved in the specific areas to be reviewed. Many of these subjects will be explored further, and invitations to key figures have been offered to provide a different perspective.

5.6. The volunteer forum has also consulted on, developed and designed overdose prevention resources which will be disseminated later in 2010, and contributed to front line worker information briefings that were necessary as a result of the Anthrax bacterium outbreak that emerged in late 2009.

6. PATHOLOGIST SUB-GROUP

6.1. The forum benefits from having a forensic pathologist, Dr Julie McAdam from Glasgow University, at its meetings but was keen to keep the pathology sub-group active. The sub-group's key members are the forensic pathologists. All four University Departments- Aberdeen, Dundee, Edinburgh and Glasgow- are invited although not all have been represented at recent meetings. However, the sub-group has had the benefit of NHS pathologists involved in drug deaths and the recent addition of a toxicologist. It has proved to be a valuable resource to colleagues from GROS and ISD who are collating the National Drug Death Database, and to others. It is also a useful forum to discuss issues affecting the pathologists and the Crown Office, who also have membership on this group.

6.2. There have been two meetings of the sub-group in the last year. These have provided opportunities to review previous work- namely the ME4 and the F49b forms currently used to report deaths. On the whole, both forms seem to be working well. More challenging matters discussed during the year include the delays in obtaining toxicology results in some areas of Scotland. This often holds up the process of fully reporting a drug death. The forum has heard that this is not only posing difficulties in terms of collating the information needed for the national database, but more significantly, affects family members who have to wait many weeks to discover the cause of death of a relative. The sub-group and the Forum have highlighted the urgent need for this problem to be addressed.

6.3. Over the course of the year, it has emerged that the science of forensic pathology may not be practised in a standard manner across the country. To investigate this further Dr McAdam was asked to present her own practice to the sub-group as basis for further discussion. What has emerged is that although the professionals present agreed on most matters, there may well be significant variations between pathology reporting in different parts of Scotland. This includes whether post-mortems are performed in all suspected drug related death cases or not, how or what samples are taken for toxicology and the lack of standardisation of what drugs are

looked for and the limits of detection. Any significant variation in practice will have serious implications for our reporting and analysis of such deaths. Therefore, the sub-group's next task will be to explore the possibility of developing a more standardised practice. All forensic pathologists in Scotland will be invited to participate in achieving this goal. The Forum hopes that with representation from all four forensic medicine departments, this should be achievable.

7. PRESENTATIONS – WHAT HAVE WE LEARNED?

7.1. Throughout the year, the Forum invited guest speakers who could provide information, reflect upon and stimulate discussion on key issues. This chapter provides an overview of these presentations and what the Forum has learned as a result.

Lessons from the Edinburgh Addiction Cohort (EAC) - Jo Kimber, Research Fellow, Centre for Research on Drugs and Health Behaviour, National Centre in HIV Epidemiology & Clinical Research, University of New South Wales

7.2. On the 9 June 2009, Jo Kimber provided a presentation to the Forum on a longitudinal study which examined survival and long-term injecting cessation (LTC) in a cohort of drug users recruited in a primary care setting. This study was carried out in a large general practice surgery in Muirhouse, Edinburgh.

7.3. **Design:** Open cohort with a mean of 10.2 years (SD 6.8, range <1-25) follow-up. Data sources were primary care notes, participant interviews and linkage to the national mortality register.

7.4. **Participants:** 794 patients with a history of injecting drug use (mostly opiates) recruited between 1980 and 2007. Their mean age at first injection was 19.9 years (SD 5.1, range 11-41). At the study endpoint, 228 (29%) were dead and 75% of survivors were followed up.

7.5. **Main outcome measures:** Time from first injection to death; and last injection beginning a period of LTC ≥5 year's duration.

7.6. **Key findings:** The leading causes of death in the cohort were HIV (44%), drug overdose (26%) and liver disease (11%). Based on a competing risks multinomial logistic regression model (n=566), 35% of survivors did not achieve LTC, 16% died before achieving LTC, and 49% achieved LTC. The analysis suggests that the relative hazard of death before achieving LTC compared to surviving without achieving LTC

decreased for those with a history of opiate substitution therapy (OST) and increased for HIV positive participants, those who started injecting after 1985, those aged over 18 years at first injection, and those with a history of overdose. The relative hazard of achieving LTC compared to surviving without achieving LTC decreased for those with a history of OST, those who started injecting after 1985 and those with a prison history; and increased for those aged over 18 years at first injection.

7.7. **Conclusions:** The EAC study suggests that exposure to more than a year of OST is protective; reducing the risk of death before long term cessation while more than a year of prison increases the hazard of death. For those who achieve long term cessation, exposure to both OST and prison increases the duration of injecting drug use - reducing the likelihood of long term cessation.

7.8. These findings suggest that for those who do not achieve long term cessation from injecting the hazard of death is greatest among those who have had none or little time in OST, are HIV positive, and have a history of overdose. Efforts to prevent drug related deaths should target these groups.

What did we learn from this presentation?

Drug dependence is a longstanding problem for individuals, characterised by relapse and remission.

Opiate substitute treatment reduces deaths in injecting drug users.

Treatment for many cases is lifelong.

In this study, after 20 years, half of all injecting drug users were dead.

Blood borne viruses account for a large number of deaths.

The findings from this project were published in the British Medical Journal online earlier this month (BMJ 2010; 340: c3172).

A Pathologist's Perspective - Dr Julie McAdam, Forensic Pathologist, Glasgow University

7.9. Dr McAdam provided a presentation on 9 September 2009 to the Forum on a pathologist's perspective of drug-related deaths. Along with four colleagues, Dr McAdam performs post mortem examinations in a large proportion of Scotland's drug-related deaths.

7.10. In this presentation, the legal procedure in suspected drug-related death was outlined and the need for full post mortem examination (with toxicology and histology), in order to ascertain an accurate cause of death, was demonstrated.

7.11. Dr McAdam discussed factors which are taken into consideration when ascertaining cause of death, such as drug abuse habits, potential drug interactions, the role of tolerance and abstinence and the importance of accurate information regarding the circumstances surrounding death and the mode of death e.g. sudden collapse (such as in cocaine-related deaths) or a period of unconsciousness (as is often the case in opiate deaths).

7.12. Common post mortem findings were discussed and some of the difficulties in interpretation of toxicology results highlighted. It was also demonstrated that forensic pathologist's encounter many "drug-related" deaths which are not included in the official statistics, in the form of drug-related chronic disease and the increased number of suicides and accidental deaths in the drug abusing population.

What did we learn from this presentation?

Pathological examination of cases involving drugs is common.

Arriving at a definitive diagnosis is often difficult and is a clinical conclusion based on a variety of factors including post mortem examination, forensic toxicology, circumstantial information from police and observers reports and clinical judgement.

Standards vary between departments in samples taken, tests employed, histology carried out and interpretations of findings.

Death certification is variable across Scotland.

Mortality and Treatment of Opiate Dependence - Dr James Bell, Consultant in Addiction at South London & Maudsley NHS Trust

7.13. On 9 September James Bell presented the findings to the Forum on the relationship between methadone and buprenorphine treatment and drug overdose deaths, in relation to studies carried out in Australia

7.14. Opiod substitution treatment reduces the risk of fatal overdose among regular heroin users. Data linkage studies investigating death rates in people seeking Opiod Substitution Treatment (OST) have demonstrated that risk of death is lower among those who enter treatment than those who are placed on a waiting list.

7.15. The first two weeks of entry to methadone treatment are a time of slightly increased risk of overdose, but thereafter death rates during treatment are low, although occasional overdose fatalities still occur (usually in a setting of polydrug use, particularly benzodiazepines and antidepressants).

7.16. People are at sharply increased risk of death in the month after leaving treatment, and this risk gradually falls, such that 12 months after leaving treatment, the risk of death falls is back to approximately the same as during treatment.

7.17. About 2/3 of methadone overdose deaths occur in people who are not in treatment, and are the result of diversion from treatment programs. In contrast to methadone, the risk of deaths due to diversion of buprenorphine appears very low.

7.18. The critical factor in most overdose deaths – whether involving methadone or heroin – is that other drugs, usually prescription drugs, are also present, often in high concentrations. One valuable step in minimizing drug related deaths is to minimize prescribing of benzodiazepines to people known to be injecting drug users.

7.19. General practitioners are encouraged to look for evidence of injecting drug use – such as vein damage – and to avoid prescribing benzodiazepines to injecting drug users.

What did we learn from this presentation?

Methadone protects drug users from dying from overdose of illegal heroin.

The risk of death from methadone is mainly in the induction period which needs to be managed with care and supervision

Stopping methadone increases the risk of death, at least for the first 12 months after stopping.

Most overdose deaths are caused by combinations of drug

Buprenorphine may have a safer profile in causing drug related deaths from overdose.

Use of Buprenorphine and Methadone in France, Marc Auriacombe, Professor of Psychiatry and Addiction Medicine at the Medical School of the University of Bordeaux

7.20. In November 2009 Marc Auriacombe provided a presentation to the Forum on methadone and buprenorphine use in France.

7.21. In France, clinicians have been allowed to prescribe buprenorphine without any special education or licensing since 1995 and methadone treatments have been restricted to Center-based treatment. This has led to a rapidly increasing number of opiate-dependent users under buprenorphine treatment in primary care in comparison to methadone in Specialized Opiate Treatment Centers. Today at least 2/3 of the estimated 180,000 problem heroin users are in either methadone or buprenorphine assisted treatment.

7.22. Diversions and intravenous use of buprenorphine and methadone have been reported and some cases of possible overdoses in combination with sedatives have also been reported although total opiate overdose deaths have declined by over 80%.

7.23. Buprenorphine diversion and induced morbidity is more visible then that of methadone, however, when total number of subjects exposed is taken into account, methadone related problems appear more frequent. Clinicians recognise the dangers of diversion and inappropriate use of prescribed opiates but also understand the inevitability of this sort of trading. Some of the public health benefits seen during the time of buprenorphine expansion in France might be contingent upon characteristics of the French health care and social services systems and may not necessarily be generalisable to other areas of the world. The French model is unparalleled in its rapid growth, and even though there was some level of diversion and continued intravenous use, it also is fair to report that there were very significant societal and individual benefits.

7.24. Implications of the French experience were discussed. The relatively low death rate in France was considered to be

surprising but important and worth further clarification and, if possible, further explanation. Some warnings were expressed about extrapolating the French model too freely to the Scottish situation when it comes to expanding buprenorphine prescribing but the essential message and successes of Prof Auriacombe's information were recognised.

What did we learn from this presentation?

In France, the introduction of buprenorphine for opiate substitute treatment in general practice has revolutionised drug treatment.

General practice is the most suitable situation for prescribing for drug users in France.

Opiate-related deaths in France have decreased by 80%.

The death rate in France among opiate users is very low compared to Scotland.

Diversion of buprenorphine is common in France (French Buprenorphine has been found to be on sale on the street in Helsinki).

A Case-Control Study of Drug-Related Deaths in Homeless Patients Registered with the Edinburgh Access Practice – Dr John Budd, General Practitioner, Edinburgh Access Practice

7.25. On 3 February 2010 John Budd provided a presentation to the Forum on an observational study of drug-related deaths in homeless patients.

Background

7.26. It is known that periods of homelessness increase an individual's risk of drug-related death; however, little data exists examining the relationship between homelessness and drug-related deaths specifically. This study examined data from the Edinburgh Access Practice (formerly Edinburgh Homeless Practice) to try to identify particular risk and protective factors in a homeless population.

Methods

7.27. There were 32 drug-related deaths identified at the EAP between January 2004 and January 2010. Their patient records were investigated against a template questionnaire. 20 randomised living drug using controls from the Practice records were investigated using the same template, who were all homeless and enrolled on the Substance Misuse Team's programme.

Findings

7.28. The questionnaire assessed markers of a chaotic lifestyle, interaction with health services, drug and alcohol history, and medical and mental health history. The data from the patient records was often incomplete, making comparisons difficult. Of note were some unexpected findings, including a lower proportion amongst the cases who had been released from jail within the last year (compared to controls). Over 90% presentation to the GP or Practice Nurse within the last 6 months in both groups, however, 59% (19/32) of cases had presented to A&E within the last 6 months, while only 20% (4/20) of controls had done so. There were high numbers of

co-morbidities amongst the drug-related deaths – particularly alcohol misuse. The results also show a greater proportion of the control group were in current treatment with methadone than amongst the drug-related deaths (55% in the control group against 28% in the drug-deaths group).

Interpretation

7.29. The data from this study was limited, in both the size of the samples and the data available in the records. The results also merit further statistical analysis, before the significance of many of the apparent differences can be ascertained. However, traditionally perceived risk factors, such as inexperience using drugs and recent major life events, may not be as important as chronic drug-use over many years, multiple co-morbidities, and ambivalence towards the consequences of such actions. This would fit with findings from other reports that the risk of drug-related deaths is highest in older, male injecting drug users. The data also suggests that current methadone treatment is a protective factor against overdose death.

Recommendations

- **Drug liaison worker for patients in hospital/A+E**
- **Alert system for patients at high-risk of OD**
- **Assertive outreach service**
- **OD awareness training for Methadone Maintenance patients**
- **Community link MMx service for liberated offenders**
- **Supported hostels for high risk**
- **Standardizing exclusion prevention criteria for local authority funded accommodation**
- **Supervised injecting rooms**

What did we learn from this presentation?

People who are homeless are a very high risk group for opiate and alcohol problems

Most patients in the category examined are in touch with some medical and social service and are not, as suspected, out with the reach of caring agencies.

Of those who died, less than one third were receiving methadone treatment at the time of death suggesting under-treatment of the group, rather than over-treatment.

Homelessness Addiction Team - Kennedy Roberts, Formerly Senior Medical Officer, Glasgow Addiction Services

7.30. Kennedy Roberts provided a presentation to the Forum on 3 February on work undertaken by the homeless addiction team in Glasgow. This presentation focused in particular, on engagement with homeless who experience substance misuse issues including chronic rough sleepers.

7.31. An important approach in engaging with this group is to take the service to the user – e.g. visit sleeping 'sites' in order to building relationships. This enables workers to assess the individual's needs while providing practical support such as sleeping bags, food parcels/voucher, and harm reduction information.

7.32. Treatment is provided through outreach clinics targeting service users in hostels and voluntary agencies. This is characterised by flexible system of engagement and provision of low threshold methadone.

7.33. Service users value flexible one-stop access to services. For example, a combination of medical care and food vouchers. These services should be accessible (no appointment required) and have flexible rules of engagement ('challenging behaviour' tolerated in early stages of engagement, no exclusions to service).

7.34. Service users were characterized as experiencing a high proportion of drug use and/or hazardous drinking including age related effects. There are a greater proportion of those in the younger age groups with both drug dependency and hazardous drinking compared with older age group (32% of 25-34 year olds compared with 5% of 35-54 year olds).

7.35. It is important to focus on assessment and treatment of drug and alcohol dependence as dynamic process. There should be a minimal time requirement at the start to keep users engaged. An important additional role of healthcare services is to assess and treat psychiatric co-morbidity. Treatment

includes alcohol detox, methadone maintenance, therapeutic interventions and harm reduction.

7.36. There is an aspiration/need amongst some users for sustainable drug free housing.

What did we learn from this presentation?

The needs of this group of individuals extends beyond heath and addiction into housing and social care issue
The outreach service was able to provide a range of treatments and interventions.

An outreach service like the one described requires commitment and support and must be able to work with a range of agencies.

HEAT A11 Target: Drug & Alcohol Waiting Times – Hilary Smith, Policy Manager, Essential Services & Alcohol HEAT Target, Scottish Government

7.37. A presentation to the Forum on 3 February 2010 focussed on the HEAT targets for drug and alcohol waiting times.

What is HEAT?

7.38. HEAT stands for **H**ealth Improvement, **E**fficiency, **A**ccess to Services and **T**reatment. It is an internal NHS performance management system that includes targets that support National Outcomes. NHS Boards are accountable to the Scottish Government for achieving HEAT targets.

What is the A11 HEAT target?

7.39. In 2008, the Scottish Government announced a new HEAT target 'to offer drug misusers faster access to appropriate treatment to support their recovery'. During the Spring of 2009, Scottish Government officials within the A11 HEAT Project Team consulted with NHS Boards and a range of stakeholders on a target that was achievable, on what was best for people with drug problems and on the possibility of the target being expanded to alcohol treatment services. This resulted in the following target being approved by Ministers in November 2009:

- *By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery*

- *Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by April 2011*

As a milestone to deliver 3 weeks from referral to drug or alcohol treatment by 2013/14, by December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received; and 90% of clients will receive a date for treatment that falls within 4 weeks of their recovery plan being agreed

What does this mean for people with drug problems in Scotland?

7.40. In some parts of Scotland, people with drug and alcohol problems are waiting too long for specialist treatment. This HEAT target is based on the principle that people with drug and alcohol problems are entitled to the same level of care as other clients within the NHS. Reducing waiting times for drug and alcohol treatment services will mean that people with drug and alcohol problems will be able to access services, at the point of need, to support their recovery.

Does the HEAT target only apply to the NHS or does it also apply to local authority and voluntary sector services?

7.41. The HEAT target applies to NHS services and the services NHS Boards fund to act on their behalf. However, since 2004, waiting times data has been collated for all drug treatment services, including those within the voluntary sector services and local authorities. This will continue and expand to include alcohol services, as the principle is to ensure that a wide range of drug and alcohol treatment services are available, at the point of need, to support individual's recovery. It is the Scottish Government's aim that all drug and alcohol treatment services, no matter who they are funded by, will all work to ensure that people with drug problems get access to the treatment they need within 3 weeks of referral.

Will the HEAT target help people recover from their drug and/or alcohol problem?

7.42. To achieve the HEAT target in a meaningful way, NHS Boards will need to work closely with their partners in local authorities and the voluntary sector to ensure that their local pathway of care addresses the needs of people with drug and/ or alcohol problems in their area. This means ensuring that a full range of high quality, recovery focused services are available at point of need to enable people to move on, when they ready to do so.

Are alcohol services included in the target?

7.43. At present waiting times information is not as robust for alcohol services as it is for drug services. Therefore 2010 – 2011 is a developmental year for alcohol treatment services and the proposal of a measurable target for alcohol treatment services will be based on the outcome of a detailed audit of alcohol waiting times during April –June 2010. This means that an alcohol treatment services waiting times target will be introduced from April 2011.

Guidance and Improvement Support

7.44. To support drug and alcohol services to achieve the HEAT target we have consulted widely with a range of stakeholders and developed Guidance on Referral Pathways that embeds the reduction of waiting times in Scotland's strategy to help individuals move on from their problem drug use, towards a drug free life as an active and contributing member of society. The guidance also outlines what services the HEAT target applies to, how waiting times will be monitored and reporting mechanisms.

7.45. Scottish Government officials are currently embarking on work to identify essential core services for alcohol treatment and support through an Alcohol Essential Services Group. Guidance on the reduction of waiting times for alcohol treatment will follow on conclusion of this work.

7.46. An Improvement Support programme is also being developed to share best practice amongst ADPs and NHS Boards. This will promote the benefits of service re-design and contribute to ensuring that clients not only receive timely, but also quality, support and treatment.

What did we learn from this presentation?

Reducing waiting times in a Government priority.

Targets are ambitious but still limited in expectation.

Unintended consequences of pressure to reduce waiting times could include provision of shorter and maybe inappropriate treatments, such as short term detoxification.

The HEAT target is explicit that treatment should support a person's recovery.

Pathology practice in drug-related death – Julie McAdam, Forensic Pathologist, Glasgow University.
Presentation provided to Pathology Sub-group.

7.47. The purpose of this presentation provided in March 2010 to the pathologist sub-group of the Forum was to consider the possibility of standardisation of pathological practice in drug-related death.

7.48. The Royal College of Pathologist's Guidelines indicate that a full post mortem with toxicology and histology should be carried out, with microbiology and serology added if appropriate to the case. A full post mortem report should be issued, including the results of all ancillary investigations and including a clinicopathological correlation.

7.49. Perceived differences in practice within the 9 pathology departments in Scotland who currently perform post mortems in suspected drug related deaths were discussed, with a view to ensuring "best practice" in all areas.

What did we learn from this presentation?

Post mortem examination is essential for all suspected Drug Related Deaths.

Pathologist have a difficult task in interpreting and collating clinical, pathological and laboratory findings.

Work needs to be done to develop common standards which should be adopted by all pathology departments.

Glasgow Throughcare Addiction Services (TAS) – A Safety Net –Allison Lawson, Senior officer, Glasgow Addiction Service

7.50. Allison Lawson provided a presentation on Glasgow Throughcare Addiction Services (TAS) – A Safety Net at the National Forum on 12 May 2010.

Introduction

7.51. Glasgow Throughcare Addiction Service (TAS) has been delivered by Glasgow Addiction Services since April 2007 (prior to that date, it was provided by Glasgow Criminal Justice Social Work Services).

7.52. The Glasgow TAS workers are located within the Community Addiction Teams (CATs) and deliver the TAS service from that point. The referrals are received from Scottish Prison Service Enhanced Addiction Casework Service (EACS) provided by Phoenix Futures and come in to one central point in Glasgow Addiction Services (Claremont), the referral is then analysed and directed to the offender's local area for service delivery.

7.53. TAS is a service for prisoners with alcohol and/or drug problems. TAS workers will work with individuals for 6 weeks pre-release and 6 weeks post release from prison. In addition to the 6 weeks mandatory post-release follow-up, Glasgow Addiction Service provided a total of 6 months post-release follow-up to ensure that TAS offenders are encouraged into addiction services and supported to remain in treatment and care.

7.54. Glasgow Addiction Services work hard to ensure that individuals receive continuity of care between prison and the community and that offenders are linked in to robust treatment and care packages at point of release.

Support Provided

Pre release:

7.55. Before an offender is released from prison, TAS workers assess the offender's needs and identify how those needs will be met. All TAS offenders are linked in to a Community Addiction Team for treatment and care. A Community Integrated Plan (CIP) meeting takes place which will include a mandatory referral into a Community Rehabilitation Service. If an offender needs a GP or a CAT Medic, the TAS worker will co-ordinate this and ensure that the necessary links are made before the offender is released.

7.56. Links are also made to a local pharmacy if a prescription requires to be dispensed.

7.57. If an offender needs a residential rehabilitation placement then they will be assessed and referred into the unit identified as the most suitable by the TAS worker and the offender.

7.58. All TAS female offenders are referred in to 218 service and 218 and the TAS workers jointly manage a service user's care pathway and package of care.

Post release:

7.59. Every TAS offender is linked in to a CAT /HAT. Additional services include:

- Community Rehabilitation Services;
- Residential Rehabilitation Services;
- Employability services including training, education, voluntary work;
- Secondary Services;
- Partial Hospitalisation;
- Range of Day Programmes;
- Crisis Care.

7.60. In addition, for the most vulnerable homeless, TAS supports informal work with Clyde Place (Homeless Service) for 6 weeks post release.

7.61. TAS workers also provide informal links in to Wise Group Life Coaches for gate meetings for the most vulnerable individuals on the day of their release.

Number and presentation of referrals to TAS in 2009/10.

7.62. In 2009/10, TAS received 215 referrals, 167 (78%) were male, 34 (16%) were female and 14 (6%) were young offenders.

7.63. 158 (73%) referrals were received from HMP Barlinnie. 101 (47%) of referrals were classed as homeless.

What did we learn from this presentation?

The role of TAS is vital in helping to engage offenders with treatment and support services post liberation from prison.

The support TAS offers is hugely variable and personalised to the individual. Examples of support provided include engagement with drug treatment services, support to access employability and training services etc.

Methaemoglobinaemia amongst cocaine users – Tasmin Sommerfield, Consultant in Public Health at NHS Lanarkshire

7.64. Tasmin Sommerfield provided the national Forum with a presentation on 12 May 2010 on Methaemoglobinaemia amongst cocaine users

Background

7.65. Methaemoglobinaemia is a rare condition in which the iron in haemoglobin is oxidised from the ferrous to the ferric state, subsequently reducing the oxygen-carrying capacity of the blood. Symptoms include cyanosis, headache, dizziness, shortness of breath, loss of consciousness and, in some instances, death. The condition is most commonly acquired following exposure to oxidising drugs or chemicals such as:

- Nitrates/nitrites (including 'poppers')
- Local anaesthetic agents (including those commonly used to cut cocaine);
- Anti-malarials
- Sulphonamides.

It is not caused by cocaine it its pure form.

Recent cases in UK

7.66. In February 2009, NHS Greater Glasgow and Clyde's Public Health Protection Unit was informed of two cases of methaemoglobinaemia occurring amongst cocaine-users within a five week period. Over the next few months a further four cocaine-associated Scottish cases and one English case emerged.

Investigation into UK Cases

7.67. Initial research indicated that whilst cocaine in its pure form cannot cause methaemoglobinaemia, it can be associated with benzocaine – a local anaesthetic agent sometimes used in the cocaine "cutting" process. Cases were interviewed regarding their cocaine use and supply. Toxicology

investigations carried out on the urine of one of the Glasgow cases detected benzocaine. Alert letters were issued to hospitals and general practitioners across NHS Greater Glasgow and Clyde, and cascaded to public health teams in other health boards. A press statement was issued and media interviews took place. Liaison took place with Health Protection Scotland and the Scottish Poisons Information Bureau.

Future considerations

7.68. The falling price of street cocaine combined with a significant reduction in its purity makes it likely that further cases of methaemoglobinaemia will occur. The initial public health response raised awareness of the condition and led to the detection of further cases. Further work is required to determine how best to maintain awareness amongst clinicians and also deliver effective risk communication to cocaine users.

What did we learn from this presentation?

Methaemoglobinaemia is an extremely rare condition which reduces the oxygen-carrying capacity of the blood and can result in death if not recognised and treated promptly.

Since February 2009, there have been 6 cases in Scotland and one in England.

Cocaine in its pure form cannot cause Methaemoglobinaemia, however this condition can be caused by benzocaine which is commonly used as a cutting agent for cocaine.

As this is such a rare condition, there is a risk that there have been additional deaths from Methaemoglobinaemia which have not been identified as toxicology results do not usually include screens for cutting agents.

It was recognised that it would not be practical to test for all cutting agents, but there may be further discussions to be had about whether it would be possible to test for the more common ones which are associated with this condition.

8. SUMMARY OF RECOMMENDATIONS

Recommendation 1

GROS include a table in the annual drug related deaths figures that reflects deaths from 'some causes which may be associated with present or past drug misuse';
that in the coming year, this includes detail on deaths caused by Hepatitis C and HIV; and
that the Forum and GROS explore the possibility of including violence, trauma and road traffic accidents.

Recommendation 2

'Take home' naloxone should be available to all high risk individuals on release from custody later this year. This programme should be underpinned by a detailed evaluation which builds on data already held by SPS for the three years preceding the implementation date.

This should be supported by increased availability of 'take home' naloxone though specialist and primary care services and the Forum encourages the development of local 'take home' naloxone programmes where this is not already in place.

Recommendation 3

Throughcare Addiction Service (TAS) should be developed in all areas. The Scottish Government review of TAS should consider how to support the development of information sharing processes between the TAS and the Enhanced Addiction Casework Services (EACS) in order to share vital feedback regarding client attendance at community appointments following release from custody.

Recommendation 4

Pathology departments should arrive at common standards of sampling, laboratory testing and interpretation of results. Testing in forensic laboratories should include a standard range of substances and, in particular, buprenorphine should be routinely tested for in fatal cases.

Recommendation 5

There should be an urgent review of the capacity and suitability of the Enhanced Service Contract as the main mechanism for supporting GPs in taking drug treatment work forwards. Providing access to treatments for drug related problems (of all types) is an essential service and negotiations between Scottish Government Health Directorates and GP representatives should work towards including drug services in the framework of core GMS services.

Recommendation 6

Prescribing services should focus on increasing uptake of prevention interventions, including the increased use of buprenorphine maintenance prescribing in chronic opiate dependent patients. Prescribing services should also focus on engaging with hard to reach groups within the drug using population. This could most effectively be achieved by upskilling agencies already working with these groups in drug treatment.

Recommendation 7

The Scottish Government should respond to recent publications on the subjects of heroin prescribing and the provision of consumption rooms to allow the forum to proceed with investigating these possibilities in Scotland.

Recommendation 8

Health Boards and Social work services and voluntary sector agencies should collaborate to develop comprehensive care packages for older drug users coming into contact with services, taking specific account of issues of isolation when planning and delivering services for this group. Services for older drug users should place greater emphasis on forming meaningful therapeutic relationships as these are particularly important for this age group.

Consideration should also be given to the support required by General Practitioners and primary care services providing

support to homeless or other marginalised groups to enable them to best meet the needs of older drug users.

Recommendation 9

Co-operation, liaison and joint working between drug and alcohol services should be enhanced. Alcohol and Drug Partnerships should lead the development of appropriate multiagency interventions, including strategies for joint working and joint funding of projects. These should involve all key partners including Health Boards, social work services, emergency services and the voluntary sector.

Recommendation 10

All services in contact with people with substance misuse problems should consider how best they can support the families and carers of people with substance misuse problems. Special consideration should be given to supporting the families and carers following bereavement from a drug related death. Support should be provided, in a coordinated way, proactively by all agencies and may be required for prolonged periods.

A variety of technical advice should be available to allow families to negotiate the complex legal and organisational issues as easily as possible. A national protocol or guidance document would help in this area of service provision.

9. ANNEX A

GROS Definition of Drug-Related Deaths

Drug-related Deaths are defined as deaths where:

a) the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use:

(i) opiods
(ii) cannabinoids
(iii) sedatives or hypnotics
(iv) cocaine
(v) other stimulants including caffeine
(vi) hallucinogens; and
(vii) multiple drug use and use of other psychoactive substances

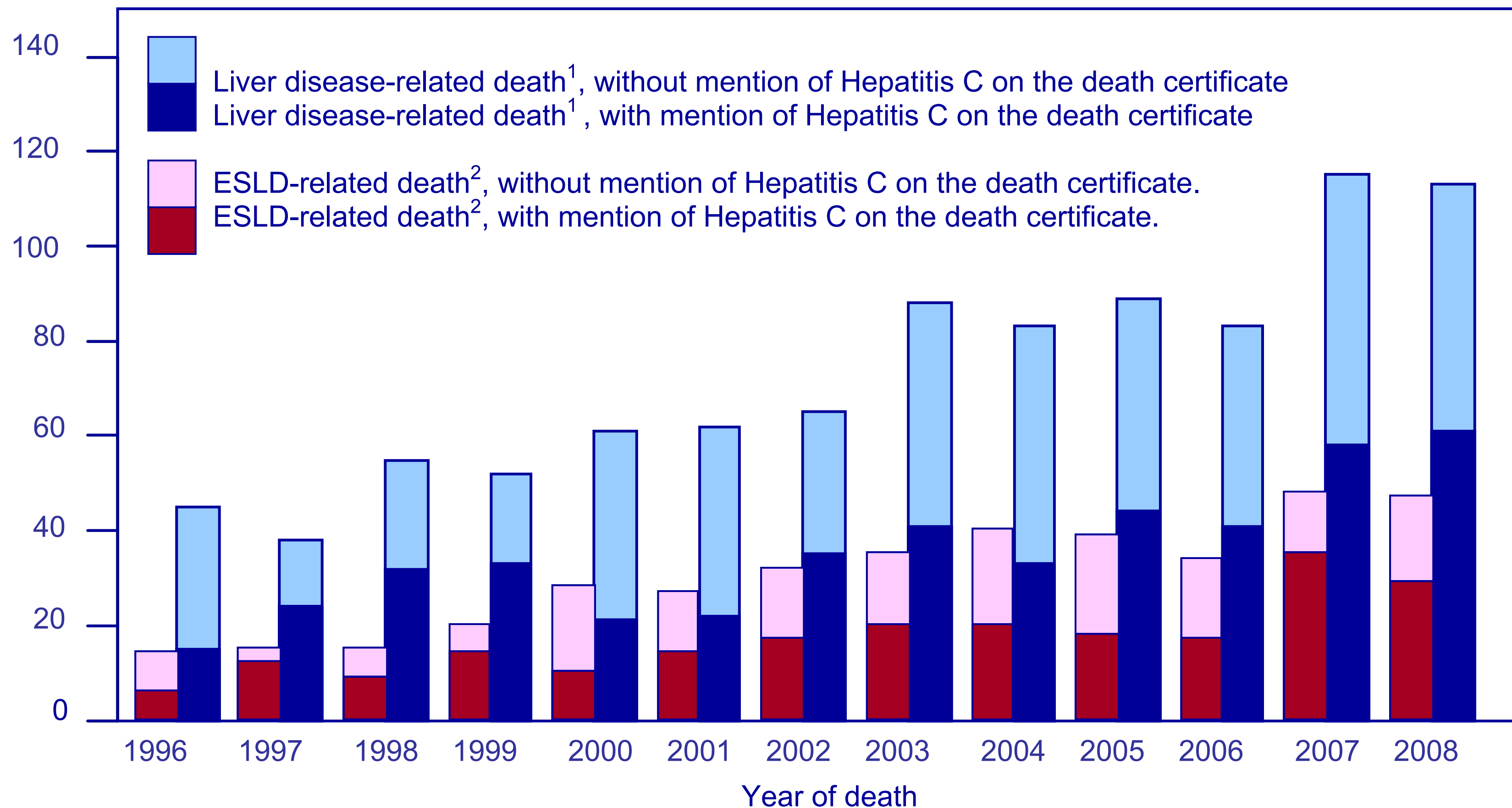
b) deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death:

(i) accidental poisoning
(ii) intentional self-poisoning by drugs, medicaments and biological substances
(iii) assault by drugs, medicaments and biological substances; and
(iv) event of undetermined intent, poisoning[5].

[5] GROS 2008 report on Drug Related Deaths: http://www.gro-scotland.gov.uk/statistics/publications-and-data/drug-related-deaths/drug-related-deaths-in-scotland-2008/index.html

10. ANNEX B

Annual number of deaths related to (i) liver disease[1] and (ii) end-stage liver disease (ESLD)[2] among persons diagnosed with Hepatitis C in Scotland, during 1996-2008.



1 Deaths were defined as related to liver disease if the underlying cause of death was either (a) viral hepatitis, (b) liver cancer, (c) alcoholic liver disease or (d) non-alcoholic liver disease, and the contributing cause of death was either (b), (c) or (d).

2 Deaths were defined as related to ESLD if the underlying/contributing cause of death was either ascites, hepatic encephalopathy/failure, hepatocellular carcinoma or varices.

Source: Hepatitis C in the UK 2009. London: Health Protection Agency Centre for Infections, December 2009.

11. ANNEX C

NATIONAL FORUM REMIT AND MEMBERSHIP

Remit

The main aims of the National Forum on Drug Related Deaths are:

- To make recommendations to Scottish Government Ministers, Alcohol and Drug Action Teams (now Alcohol and Drug Partnerships) and other joint planning groups as appropriate on action and policy changes;

- To consider any new research findings from the national and international medical literature and consider policy issues as expressed elsewhere. Appropriate experts are asked to contribute to discussions;

- To identify areas where examples of good practice are recognised and disseminated to others through the newsletter *Drug Death Matters,* published on the Drug Misuse Information Scotland (DMIS) website; and

- To report annually to Scottish Ministers with recommendations for further action as required.

Membership

Name	Title
Dr Roy Robertson (Chair)	Reader, Department of Community Health Sciences, Edinburgh University and Muirhouse Medical Group, Edinburgh
Dr Saket Priyadarshi. (Vice Chair)	Lead Clinician, Glasgow Addiction Services
Dr David Best	Reader in Criminal Justice, University of West of Scotland

Dr Malcolm Bruce	Consultant Psychiatrist in Addiction, NHS Lothian.
Marina Clayton	Re-Solv Scotland
Linda Cockburn	Crown Office
Frank Dixon	General Register Office for Scotland
Keith Fowler	Perry Fowler Trust
Marnie Hodge	Development Manager, Turning Point Scotland
Carole Hunter	Lead Pharmacist, Glasgow Addiction Service
Lorna Jackson	NHS Services Scotland, Information Services Division
Dave Liddell	Director, Scottish Drugs Forum
Sion Matthews	NHS Services Scotland – Information Services Division
Dr Julie McAdam	Consultant Forensic Pathologist – University of Glasgow
Willie MacColl	Superintendent, National Drugs Co-ordinator, Scottish Crime and Drugs Enforcement Agency
Bill Mason	Scottish Ambulance Service
John O'Sullivan	(until Feb 2010) Emergency Services Manager, Glasgow Homeless Partnership
Ruth Parker	Scottish Prison Service
Dougie Paterson	Director, Scottish Drugs Recovery Consortium (from Jan 2010; Programme Manager, Choose Life (to Dec '09)
Dr Samantha Perry	A&E Consultant, Western Infirmary, Glasgow
Eleanor Robertson	Scottish Network for Families Affected by Drugs
Dr Maria Rossi	Consultant in Public Health Medicine, NHS Grampian

Dr Jim Sherval	Drug Policy and Research Co-ordinator, NHS Lothian
Ian Smillie	Scottish Association of Drug and Alcohol Action Teams

Scottish Government Official Support and Secretariat

Roisin Ash	Scottish Government, Justice Analytical Service
Catherine Church (Minutes)	Scottish Government, Drugs Policy Unit
Sandra Wallace (Secretary)	Scottish Government Drugs Policy Unit

12. ANNEX D

MEMBERSHIP OF NATIONAL FORUM SUB-GROUPS

DATA COLLECTION SUB-GROUP MEMBERSHIP

Name	Title
Dr Roy Roberstson (Chair)	Reader, Department of Community Health Studies, Edinburgh University and Muirhouse Medical Group, Edinburgh
Dr Malcolm Bruce	Consultant Psychiatrist in Addiction, NHS Lothian
Lee Davis	NHS Services Scotland, Information Services Division
Lorna Jackson	NHS Services Scotland, Information Services Division
Lynne Jarvis	NHS Services Scotland, Information Services Division
Dr Jane Jay	
Sion Matthews	NHS Services Scotland, Information Services Division
Dr Jim Sherval	Drug and Policy Research Co-Ordinator, Lothian NHS Board
Ian Smillie	Scottish Association of Drug and Alcohol Action Teams.

Scottish Government Official Support and Secretariat

Roisin Ash	Scottish Government, Justice Analytical Service
Catherine Church (Minutes)	Scottish Government, Drugs Policy Unit
Sandra Wallace (Secretary)	Scottish Government Drugs Policy Unit

PATHOLOGIST SUB-GROUP MEMBERSHIP

Name	Title
Dr Saket Priyadarshi (Chair)	Lead Clinician, Glasgow Addiction Service
Margaret Balstitis	NHS Ayrshire and Arran
Dr Marjorie Black	Consultant – University of Glasgow
Dr Ralph Bouhaidar	University of Edinburgh
Frank Dixon	General Register Office for Scotland
Linda Cockburn	Crown Office.
Dr James Grieve	Consultant – University of Aberdeen
Dr Julie McAdam	Consultant Forensic Pathologist– University of Glasgow
Rosslyn Rankin	Pathologist - NHS Highland
Cameron Ritchie	Crown Office Procurator Fiscal, Area Procurator Fiscal, Fife.

Thanks to the following who also attended meetings of this sub-group throughout the year:

Name	Title
Sion Matthews	ISD
Hazel Torrance	University of Glasgow

Scottish Government Official Support and Secretariat

Roisin Ash	Scottish Government, Justice Analytical Service
Catherine Church (Minutes)	Scottish Government, Drugs Policy Unit
Sandra Wallace (Secretary)	Scottish Government Drugs Policy Unit

VOLUNTEER FORUM

Name	Location
Stephen Malloy (Facilitator)	Scottish Drugs Forum
Brian	Aberdeen
Warren	Aberdeen
Alistair	Edinburgh
David	Edinburgh
Yanni	Edinburgh
Neil	Edinburgh
Lesley	Edinburgh
Karen	Edinburgh
Patrick	Edinburgh
Charlene	Edinburgh
Michael	Edinburgh
Colin	Edinburgh
Gillian	Edinburgh
Katrina	Greater Glasgow
Angie	Perth
Sarah	Perth
Sandi	Perth
Jennifer	Perth
Brian	Renfrewshire
Mark	Renfrewshire
John	Renfrewshire

13. ANNEX E

Report from Short Life Working Group on Naloxone Supply

1. Purpose of Report

1.1. To advise the National Drug Related Deaths Forum (NDRDF) on the development of a national standardised supply scheme for "take-home" naloxone in Scotland. To develop an agreed national PGD for "take-home" naloxone supply.

1.2. The work of the SLWG has involved a full review and assessment of the numerous different UK schemes and PGDs (including the existing Scottish examples in NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Highland) that have evolved and to propose a national scheme that will provide consistency and equitable access for all "at risk" individuals in Scotland.

2. Background Legal Information

2.1 Naloxone is a parenteral Prescription Only Medicine (POM).

2.2 Under the Medicines Act (1968), no-one, except individual patients in receipt of a prescription and appropriate medical practitioners (or those acting under medical instructions, including nurses), is allowed to administer parenteral (injectable) POMs.

2.3 There is a limited list of exceptions to the restrictions of Section 7 of the Act. These include a number of injectable preparations that can be administered by anyone in an emergency situation to save lives. The list includes adrenaline, atropine, glucagon, glucose and snake-venom antiserum. In 2005, naloxone was added to the list of exceptions (MHRA, 2005).

2.4 The 2005 amendment allowed the development of "take-home" naloxone schemes, as this potentially life saving antidote to opiate overdoses could now legally be administered by anyone present at the scene of an overdose

that was in a position to intervene in advance of the emergency services attending.

2.5 It should be noted that this exemption to the requirements of the Medicines Act applies to "administration" only. The "supply" status was not altered under this exemption and under the Medicines Act, therefore naloxone remains a POM. **This means that the supply of naloxone, as a POM, can only be made on a named patient basis using either a prescription or a Patient Group Direction (PGD).** A PGD is a legal device that allows suitably qualified nurses or pharmacists to supply POMs in specific defined circumstances.

2.6 This has inevitably caused some confusion between the legal differences relating to "administration" and "supply". The proposal developed by the SLWG is for a national naloxone PGD supply / training scheme. The barriers to any further expansion of the groups who can legally be supplied and suggestions for possible solutions were addressed by the group and these are detailed below in point 6.

<u>3. PGD for supply.</u>

3.1 The SLWG have developed a draft PGD for the supply of "take-home" naloxone to named patients (attached as a separate document). It is proposed that this should be submitted for ratification to enable all services across Scotland to make supplies using a nationally agreed PGD. This will also provide national consistency and equitable access for patients through the current existing and proposed new naloxone supply schemes.

3.2 Access to supplies using a PGD is not restricted to patients who are in contact with treatment services. This is for unplanned care and is available to anyone that the nurse or pharmacist identifies as being at risk of opiate overdose irrespective of any current or previous contact with treatment services.

3.3 Once a PGD has been nationally agreed the standard procedures are followed. **It should be noted that health boards are able to tailor nationally approved PGDs to**

suit local needs. This allows flexibility to take account of different local population needs and varying staffing structures.

4. Training in Emergency Basic Life Support in Overdose.

4.1 After consideration of the range of available training programmes the SLWG recommend the use of the 'Heartstart' training programme as the basic life support component of the naloxone PGD. This has been discussed with Heartstart UK who have agreed in principle to accredit an agreed Scottish national programme. This will require the production of a standardised training manual.

4.2 The group are of the view that this proposal provides the best means of incorporating the basic life support component of a naloxone supply scheme. After reviewing the evidence and the evaluations of current programmes, the group consider that it is essential that any initial naloxone supply is made in conjunction with a tailored programme that includes information on the risk factors and symptoms of overdose along with a practical basic life support training programme.

4.3 There is recognition that not all areas may have the capacity to adopt this programme. It should be noted that when a national PGD is agreed it is then submitted to individual health boards where it can be tailored to suit local needs. As a minimum, any locally developed schemes should ensure that all patients can demonstrate an awareness and understanding of overdose risks and prevention, signs and symptoms, emergency basic life support procedures at the scene of an overdose, the need to contact the emergency services, the full details of the drug, including the pharmacological action, dosage, storage, resupplies and safe disposal of naloxone.

4.4 The Heartstart training programme has the advantage that it can be delivered by staff from existing treatment services, harm reduction teams and voluntary agencies and enables peers, family members and other volunteer groups to participate in a naloxone supply scheme as they can also be trained and accredited as Heartstart trainers. The delivery

is therefore not confined solely to medical or other healthcare professionals. It also has the advantage that it circumvents the problems of nurses being unable to provide practical life support training to patients without additional qualifications. The incorporation of the Heartstart scheme overcomes this problem and ensures the necessary indemnities are in place.

4.5 As harm reduction and overdose awareness are part of the existing core work of all staff engaged in work with drug users the associated training needs to be embedded within this existing role. **The supply of naloxone and training in overdose awareness and prevention needs to be embedded in local services and become a core element of all services as recommended in the NDRDF annual report (2008).** Each Alcohol and Drug Partnership (ADP) should identify a lead person to co-ordinate local naloxone implementation.

4.6 The Scottish Government currently fund a post to provide national overdose awareness training. This post is hosted within the Scottish Drugs Forum (SDF). The SLWG recommend that the Government should consider the extension of the remit and role of this post to incorporate trainers training and other support in promoting the expansion of naloxone supplies nationally.

5. Product.

5.1 The group reviewed all of the available UK products. The advantages and disadvantages of all currently available products were investigated and it is the unanimous recommendation of the group that the Naloxone Hydrochloride 1mg/1ml (2ml) pre-filled syringe provides the best current option until an alternative specific "take-home" preparation is produced. The advantages of this product are that it contains more than one dose, which may be needed before emergency services arrive at the scene of an overdose, it is contained within a hard plastic case which provides a degree of protection, and the assembly process requires only one step to attach the needle. This is also the most cost effective product currently available.

5.2 The main disadvantage of this product is that no needles are contained in the sealed unit and it therefore has to be opened and 2 needles added. This means that there needs to be a reliable consistent means of resealing the container. The use of "tamper evident" tape is recommended and it is essential that local police are involved in the early stages of development of local schemes to ensure that sealed products are not routinely confiscated from patients.

5.3 There is an urgent need for the development and manufacture of an alternative formulation of naloxone. Ideally the product should be simple to administer, have robust packaging and be easy and discreet to carry. It should require a minimum number of steps to assemble and administer, have a prefilled syringe with needles attached and include relevant patient information literature. This would overcome a number of problems with all current UK schemes where prior assembly of packs is required. Although individual representatives from the existing naloxone supply schemes have made numerous representations to a number of pharmaceutical manufacturing companies, it is the view of the SLWG that this approach may be more effective if made with the support of the NDRDF and the Scottish Government.

6. Barriers to Expansion

6.1 There are two main barriers to the extension of a national "take-home" naloxone scheme. These are the product itself and the legal supply restrictions of a POM. The difficulties with the existing product range have been outlined above (see section 5.2) The legal barriers to expansion are outlined below.

6.2 The legal background has been outlined above (see section 2.) The current legal position means that only named patients can be supplied, despite the amendment to the Medicines Act that allows anyone to administer naloxone to save lives. This means that although other groups can participate in the training programme, they cannot have a personal supply of naloxone unless there is permission from a named patient. As the PGD is for unplanned care the patient must be present for authorisation as the nurse or pharmacist has no access to records or other means of

confirming patient consent. For this reason, it is recommended that if possible, patients attend training sessions with a "buddy" (family or friend). This will increase the pool of people trained to administer naloxone and increase the availability of naloxone in overdose situations.

6.3 It is the view of the SLWG that ideally, supplies of take-home naloxone should be made available to non health staff in services such as homeless hostels / supported accommodation / outreach services and other non-NHS sites and agencies where staff routinely have contact with large groups of individuals at high risk of overdose. At the moment, unless these premises have qualified nursing staff on site and a Home Office licence to order and store POMs, then stock supplies of naloxone cannot be stored in advance for use in an emergency. The only stocks that are available are those that have been prescribed to individual patients (using a medical prescription or a PGD). These stocks remain the personal property of the individual patient and there is no guarantee that these are easily accessible for emergency use.

6.4 This supply difficulty was previously identified by the Advisory Committee on the Misuse of Drugs (ACMD) and a letter was sent to the Medicines and Healthcare Products Regulatory Authority (MHRA) requesting an amendment that would allow additional groups of staff who had undergone appropriate training to hold stocks of naloxone for emergency use. To date there has been no response and no changes in the legal status of naloxone (ACMD, 2009).

6.5 The group formed the view that this anomaly should be actively addressed by the NDRDF. It is legal for anyone to administer naloxone in an emergency and in order to enable staff likely to encounter this situation to respond immediately they should be trained to provide emergency basic life support and be provided with stocks of naloxone for immediate use before the ambulance services arrive.

6.6 The restrictions relating to the supply of drugs is controlled by UK legislation and is not a devolved issue. However the SLWG propose that a letter is sent to the Lord Advocate outlining the current problem and seeking an

assurance that there would be no prosecution of individual staff. If successful, this proposal would allow staff in specified sites and services who have undergone the recognised training programme to hold stocks of naloxone. This would help to target supplies at some of the hard to reach groups who are known to be most at risk of a drug related death, including the homeless population.

6.7 There is a precedent for this in Scotland where a "letter of comfort" was issued that permitted supplies of citric acid to be made in advance of a change in the Misuse of Drugs Act (1971). During this research it was considered not in the public interest to prosecute staff for supplies of citric acid sachets that were in technical contravention of Section 9A of the Misuse of Drugs Act. In preparation for the citric research *"the regional Procurator Fiscals (RPFs) approached the Lord Advocate's department about the supply of citric acid to IDUs. They were advised that under no circumstances would pharmacists supplying citric acid as part of an approved needle exchange programme be prosecuted"* (EIU, 2003:4).

7. Costs

7.1 The availability and the amount of any additional funds to support the implementation of this scheme are not known to the SLWG. To date a number of health boards have developed schemes within existing resources. **It would be informative and helpful to support the case for additional funds if each health board had information on the details of expenditure so far and estimates for expansion of supplies of "take- home" naloxone.** The costs associated with the Heartstart training are minimal. These are shown below along with the current drug costs. These are shown below along with the current drug costs. Replacement costs for disposable items such as faces/lungs will have to be calculated on an individual basis based on activity.

"Little Annie", 4 pack inc 8 faces, airways	£598.66
Individual "Annies" with 2 faces	£161.21
lungs for use with the above	£65.45

Pack of 6 faces	£42.77
Naloxone 1mg/1ml , 2ml prefilled syringe	£8.36

7.2 As mentioned in Section 4.4 the role of the Government funded Overdose Awareness Trainer should be extended to provide support to health boards in developing take-home naloxone schemes. If funds are available nationally it would be cost effective to strengthen this role to maximise support to health boards and for the associated admin support to be consolidated within the existing Overdose Awareness post and structures.

8. Child Protection.

8.1 This issue was considered by the group. The supply of naloxone using this PGD is restricted to those aged 16 and over. However it was recognised that child protection issues may arise in the operation of this scheme. In these instances, the health care professionals, approved to make supplies under the PGD, will continue to address any issues of child protection that may arise in line with their existing responsibilities and professional codes of conduct.

9. Information Recording

9.1 Details of the information recording procedures, recommended data collection fields and consent forms will be contained in the National Guidelines Training Manual. Areas developing take-home naloxone programmes are encouraged to use these to help contribute to the evidence base in this area.

10. Recommendations

The NFDRD is asked to:-

a) Note the contents of this report.

b) Approve submission of the PGD for national ratification.

c) Actively support the development of a new "off the shelf" product..

d) Recommend that each ADP assign a lead person who is responsible for local implementation and monitoring of the national "take-home " Naloxone programme.

e) Request a "Letter of Comfort" from the Lord Advocate to enable supplies to be made to identified groups of staff working with "at risk" drug users who have completed the naloxone and basic life support training programmes to hold stocks of Naloxone for use in emergencies.

f) Develop a national training manual and other required resources.

g) Request that the Government reviews the role and remit of the existing Overdose Awareness Trainer, hosted within SDF, with a view to enabling this post to support the rollout of a national scheme.

h) Liaise with the Association of Chief Police Officers in Scotland (ACPOS) to develop a communication strategy to inform police officers of the relevant background and implementation of a national "take-home" naloxone scheme.

Appendix 1

Short Life Working Group Membership:

Carole Hunter, Lead Pharmacist, Glasgow Addiction Services (Chair)

1.1.1 Stephen Heller-Murphy, Addiction Policy Development Manager, Scottish Prison Service

Andrew McAuley, Public Health Adviser, (Substance Misuse / Alcohol) NHS Health Scotland

Dr Sam Perry, Emergency Medicine Consultant, Western Infirmary, Glasgow

Lisa Ross, Clinical Harm Reduction Nurse Specialist, NHS Highland

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14. ANNEX F

GLOSSARY OF TERMS

Term	Meaning
A & E	Accident and Emergency
ADAT	Alcohol and Drug Action Team
ASIST	Applied Suicide Intervention Skills Training
AUDIT	Alcohol Use Disorders Identification Test - developed by the World Health Organisation as a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence.
BAT	Buprenorphine Assisted Treatment
Bi-polar Disorder	A mood disorder sometimes called manic-depressive illness or manic-depression that characteristically involves cycles of depression and elation or mania.
BMJ	British Medical Journal
Caldicott Recommendations	In 1997 a committee was established under Dame Fiona Caldicott to review patient identifiable information. Her subsequent report made a series of recommendations with regard to confidentiality that all healthcare organisations should take on board within local information governance. A key recommendation of the 1997 Caldicott report was the establishment of the Caldicott Guardian across the NHS to safeguard access to patient-identifiable information. The Caldicott Guardian is responsible for agreeing and reviewing policies governing the protection of patient-identifiable information The Caldicott principles include: _ justify the purpose _ do not use patient identifiable information unless it is absolutely necessary _ use the minimum necessary patient identifiable information _ access to patient identifiable information

	should be on a strict need to know basis _ everyone should be aware of their responsibilities _ understand and comply with the law.
CARES	Centre for Addiction Research and Education Scotland
Chi-Square test/analysis	A statistical test to determine the probability that an observed deviation from the expected event or outcome occurs solely by chance.
Term	**Meaning**
Choose Life	Choose Life is the Scottish Government's 10 year national strategy and action plan aimed at reducing suicides in Scotland by 20% by 2013
CMO	Chief Medical Officer
CoSLA	Convention of Scottish Local Authorities
CVS	Council for Voluntary Service
DORIS	Drug Outcome Research in Scotland
ePRF	Electronic Patient Report Form
ESCR	Emergency Service Control Room
EU	European Union
GP	General Practitioner
GPwSI	General Practitioners with Special Interest
GROS	General Register Office for Scotland
HCV	Hepatitis C Virus
HEAT	Health, Efficiency, Access and Treatment
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
HRAS	Harm Reduction Awareness Sessions
ICD Codes	International Statistical Classification of Diseases and Related Health Problems
IDU	Injecting Drug User
ISD	Information Services Division
JRF	Joseph Rowntree Foundation
MAT	Methadone Assisted Treatment
MOU	Memorandum of Understanding
N-ALIVE	Naloxone Investigation

Naloxone	a drug used to counteract the effects of narcotic overdoses
NHS	National Health Service
NTORS	National Treatment Outcomes Research Study
Orange Guidelines (or Book)	Drug Misuse and Dependence – UK Guidelines on Clinical Management
ONS	Office of National Statistics
PGD	Patient Group Directive
POM	Prescription Only Medicine
PRF	Patient Report Form
RCGP	Royal College of General Practitioners
SAADAT	Scottish Association of Alcohol and Drug Action Teams
SACDM	Scottish Advisory Committee on Drug Misuse
SAS	Scottish Ambulance Service
SCDEA	Scottish Crime and Drugs Enforcement Agency
SDDCare	Senior Drug Dependents and Care Structures
SDF	Scottish Drugs Forum
Term	**Meaning**
SMACAP	Scottish Ministerial Advisory Committee on Alcohol Problems
SMR01	Data source for Hospital Discharges
SMR04	Data source for Psychiatric Discharges
SMR25	Data source for Scottish Drug Misuse Database
SNFAD	Scottish Network for Families Affected by Drugs
SPS	Scottish Prison Service
STRADA	Scottish Training on Drugs and Alcohol
UK	United Kingdom
WHO	World Health Organisation

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