

# **Drug Death Review Group** **Ayrshire and Arran Alcohol and Drug Action Team**

**Submitted to DAT Association Drug Related Death Sub Group 31/08/04**

## **Participants names**

- 1. Detective Superintendent Stephen Heath Strathclyde Police(Chair)**
- 2. Dr Charles Lind Associate Medical Director NHS Ayrshire and Arran**
- 3. Mr Terry Kane DTTO Co-ordinator Criminal Justice Services**
- 4. Ms Janet Cameron Area Procurator Fiscal Procurator Fiscal Services**
- 5. Ms Marnie Hodge Regional Manager Cranstoun Drug Services**
- 6. Ms Maria McLaren Addiction Co-ordinator HMP Kilmarnock**
- 7. Ms Ruth Shepherd Co-ordinator Alcohol and Drug Action Team**
- 8. Ms Lesley Robb Support officer Alcohol and Drug Action Team**

Over the past five years drug use has become an increasing cause of death for fifteen to thirty five year olds in Ayrshire and Arran. Most have been due to fatal overdose of a cocktail of drugs, usually involving Diamorphine (heroin) with either a tranquilliser and/or alcohol.

At the Ayrshire and Arran Alcohol and Drug Action Team (ADAT) meeting held in January of 2002, the worrying increase in drug related deaths was highlighted. After discussion it was decided that a multi agency approach was required to address the gaps in provision to this client group. Accordingly the Drug Death Review Group was formally adopted by the ADAT in March 2002.

As there were no examples of similar work or groups in other ADAT areas in Scotland, it was decided to structure the group based on the Child Protection Case Conference Model. The group was to meet timeously but in any case within 3 weeks of a relevant death.

The remit of the group was to examine each drug-related death in the area of responsibility and: -

- Consider the individuals circumstances prior to death, including, place of death, employment and accommodation status, family support and the nature of the individuals drug use.
- Analyse information available from Police, toxicology, addiction services, and Criminal justice services relating to the clinical and social circumstances surrounding the death.
- Identify patterns in social and clinical circumstances surrounding the deaths, and consider the associations between them.
- Make recommendations to ADAT partners and key stakeholders for policy and practice changes, impacting on a future reduction in drug related deaths.

All information processed by the group is stored on a confidential database which is used to identify patterns and trends as they emerge. Sanitised information and action points from the group are then circulated to all the other sub groups within the ADAT structure, as well as being uploaded onto the ADAT website.

The group initially identified two main categories of person at risk from fatal drug overdose.

1. Persons recently released from prison
2. Hostel dwellers.

An examination of addiction services available to drug dependant persons who had been taken into custody revealed that there was no provision for through care. That is to say once in custody, the individual was no longer under the remit of the community based drug treatment services, and any treatment they were receiving ceased. This was a particular problem for short term prisoners as, once they were released from custody they were not entitled to rejoin the treatment programme they had been on, but instead went to the bottom of the waiting list.

This was identified by the Drug Death Review Group as an issue which should be addressed. Therefore in December 2002 the ADAT, via NHS monies, funded the appointment of two addiction nurses, for one year, to work within HMP Kilmarnock. The focus of their work was on reception management and through care issues, in order to reduce drug related deaths soon after release from custody.

Put simply the two addiction nurses were to provide support for drug abusers prior to and after release from custody and to ensure access to health care services as an essential element of successful and safe integration back into the community.

This was achieved at a cost of £51,000. Importantly no new funding was required. The money was secured from existing budgets.

In order to target the second identified group, hostel dwellers, the Drug Death Review Group established an education programme. The programme was to take the form of a leaflet campaign. All homelessness service providers in the Ayrshire and Arran health board area were written to, and provided with "Know the score" overdose leaflets to circulate to all of their clients. This ensured that not only hostel dwellers, but people who live in supported B&B accommodation were reached. All of the partner organisations were involved in the formulation and delivery of the campaign.

The programme utilised leaflets available free of charge from "know the score", therefore the only costs incurred were those of ADAT support staff, which are contained within existing budgets.

These are only two examples of actions emanating from the drug death review group and along with other actions are currently being evaluated.

Initial statistics indicate a significant reduction in drug deaths within the Ayrshire and Arran Health Board area since the group's formation. Whilst this cannot solely be attributed to the group, there are encouraging reductions in prison release and hostel based deaths.