

## Appendix 2

### Drug-Related Deaths sub-group Final Report

#### Chairman's Introduction

In 2002 drug-related deaths in Scotland showed a substantial rise to 382, 50 (15%) more than in 2001. Of these, the number of deaths of persons previously known or suspected to be drug dependent rose, from 227 in 2001 to 280 in 2002 (figures from the General Register Office for Scotland).

In response, the Scottish Executive commissioned a national investigation to analyse all drug-related deaths which had occurred in 2003, and charged DAATs with reducing the upward trend in drug-related deaths by 25% by 2005. An important influence was a report from the Advisory Committee on the Misuse of Drugs (Stationery Office, 2000), which provided details about risk factors and made recommendations for the prevention of many of the deaths.

In the autumn of 2003 the National DAT Association invited me to chair a short-life working group with representatives from DAATs, drug agencies, the police, and public health medicine. Its purpose was not to duplicate work already in progress, but to produce a report as a vehicle for dissemination of shared experience and ideas in order to raise awareness in a wider audience.

Encouragingly, there was a significant nationwide reduction in drug-related deaths in 2003 but it would appear from preliminary data for 2004 that numbers are rising again. There is therefore no room for complacency.

We must continue to emphasise the known risk factors such as injecting, recent prison release, recent detoxification, a previous history of non-fatal overdose, homelessness and waiting lists for treatment. We must also ensure that all substitute prescribing is of the highest standard, in line with national guidelines and subject to audit and clinical governance. In addition, all practitioners must have appropriate training and support.

These untimely yet often preventable deaths wreak untold misery on families and communities. We must use our shared knowledge to keep them to a minimum.

Jane Jay, FRCP.

January, 2005

## Drug-Related Deaths sub-group Final Report

### Recommendations

#### Action Team and Local Services Recommendations:

**Development of Local Action Team Critical Incidents Groups:** Continued improvement in liaison between agencies over drug deaths, e.g. setting up a standing drug deaths monitoring and prevention group, involving key agencies to ensure rapid sharing of information on deaths/street drug trends, and to report on progress in implementing proposals to reduce deaths.

**Database development:** Local services should develop a database containing known details and service contacts of those who died, to be used to improve risk assessment and inform service improvements that avoid breakdowns in care pathways.

**Linkages with Accident & Emergency:** All Action Teams should consider the experience of the three Grampian Action Teams and review their current relationship with Accident & Emergency Departments.

**Improving Witness / Emergency Intervention:** All Action Teams should consider as a priority ways of decreasing delays at the scene of an overdose, and methods for raising the level of resuscitation skills among drug users, family members, service providers and social networks.

Key to this recommendation is the expanded delivery of local First Aid training, with a particular focus on dealing with overdose. Efforts should be directed towards peer education, emergency services, and family support groups. Action Teams should therefore identify local structures and resources required for advancing training that utilises both peer and social support networks. A valuable resource for Action Teams in advancing this area will be the new SDF initiative.

Homelessness services staff and homeless people should be considered as high priority for emergency intervention training. For staff this should include improved recording and investigation of non-fatal overdoses, rapid access to addiction services, and development of appropriate accommodation options (with support).

**Best Practice in the use of Naloxone:** Local Critical Incidents Groups or other similar structures should consider the benefits, particularly within 'hot spots', of the extended use of Naloxone.

**Staff Training:** A resource pack (including 'Know The Score' materials and wider training presentations) should be developed to assist local addiction managers in

familiarising staff with good overdose prevention practice. Such training should form part of a rolling programme. Coupled with this, steps should be taken to emphasise overdose prevention training as part of local training strategies.

## **Association of Drug Action Teams Recommendations:**

### **Amendment to the Medicines Act:**

The Association of Drug Action Teams should consider recommending an amendment to the use of the Medicines Act that would place Naloxone on the 'safe' list for general administration. Such a change would create the opportunity, for those areas that wish to do so, to proceed with local fatal overdose prevention pilots to include the use of Naloxone.

## **National Strategy, Co-ordination and Communications:**

### **National "Preventing Drug-Related Deaths" Forum:**

A national steering group to be developed, with a remit to look at how recommendations from the ACMD 'Reducing Drug-Related Deaths' report and findings of National Investigation can be best implemented across Scotland. Representation should include police, prison, Scottish Ambulance Service, Accident & Emergency departments, Action Teams, and relevant service sectors. This group should look at wider initiatives such as safer injecting rooms and heroin prescription, and how such initiatives might reduce drug-related deaths.

### **National Communications / "Know The Score":**

It is recommended that an updated overdose related publication of 'Know The Score' is published and addresses the issue of 'scene of crime' versus 'medical emergency'.

### **National Conference**

Members recommend that during 2005 a multi-disciplinary conference on reducing drug-related deaths be hosted by the Scottish Executive. Such an event should draw on the experiences of this working group together with the findings from the national investigation.