



Report of the Association of Drug Action Teams

Drug-related Deaths short-life Information Sharing sub-group

January 2005

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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

Section 1

Purpose and Scope of Report

The importance of co-ordinated action on reducing drug-related deaths is a primary concern of all Drug and Alcohol Action Teams. At the forefront of implementing the national drugs strategy, they have been tasked (through national targets) to reverse the upward trend in drug-related deaths and to ensure a reduction of the total number of deaths by at least 25% by 2005.

Following a prolonged rise in drug-related deaths, the reduction by 17% of overall deaths between 2002 and 2003 (as identified by the General Register Office for Scotland; weblink at Appendix B) is seen as a move in the right direction. However, such figures disguise significant local variation, and Action Teams are the first to acknowledge the need not be complacent, and to continue working to ensure that this prolonged upward trend has now been reversed.

In order to support continued action and thinking on the best mechanisms to reduce drug-related deaths, a short life sub-group was convened as a priority area arising out of the Association's 2003 – 04 annual work plan. During 2004 the sub-group met on four occasions, and invites to participate in the sub-group were extended to all twenty-two Scottish Drug Action Teams. With the support of the Scottish Executive, the sub-group was able to offer video conferencing facilities to increase participation opportunities.

At the initial meeting of the sub-group, the importance of providing mechanisms for information sharing was considered paramount. Therefore a new section on Drug-Related Deaths was incorporated into the Sub-Groups section of the DAT Association website, running parallel with group meetings. All associated minutes, papers and local Action Team reports considered by the sub-group are now accessible through the Association's website (details at Appendix B).

From the outset it has not been the intention of the group to duplicate the extensive amount of work that has already been undertaken (or is in the process of being undertaken) on aspects of identifying either risk factors leading to deaths, or terminology of what constitutes a drug-related death. Equally, the group, whilst recognising the large amount of 'delayed deaths' that may occur as a result of HIV, Hepatitis B (HBV) or Hepatitis C (HCV), has not addressed these issues in any depth. Instead, the group has focused its energy towards identifying current Action Team initiatives, future information sharing needs, and key areas that should be considered for advancement under local Action Teams reducing drug-related deaths strategies.

The short-life nature of the sub-group was intended to ensure that any future consideration and continuation of the sub-group will draw on related areas of work, primarily the outcomes of the current national investigation that is due to report in early 2005. Against this back-drop, the remit of the short-life group was to:

- support the sharing of information across local DAATs on strategies to prevent drug-related deaths
- identify relevant local initiatives currently being advanced by DAATs and to explore common themes and issues
- make recommendations on future information sharing arrangements across DAATs
- make recommendations on key initiatives that DAATs and other partner bodies might wish to consider advancing

Membership of the group is outlined in Appendix A.

Structure of the Report

Following this introductory chapter the report is structured in the following way:

Section 2: This section lists the known risk factors identified from national and international research and reports.

Section 3: This section draws on the experience of group members to identify local Action Teams' initiatives that have been implemented across varying settings. The aim of this section is not to provide a comprehensive list of all Action Team initiatives, but rather to provide a flavour of the scope and range of initiatives that have been advanced by those areas represented within the sub-group.

Section 4: Throughout the duration of the sub-group, key themes emerged for discussion. This aspect to the report details those areas most discussed, and presents relevant information associated with those discussions.

Section 5: In this final section the group have drawn together their thinking to make a number of recommendations on key priorities for advancement, and areas requiring further consideration.

Appendix A: List of members of the sub-group.

Appendix B: Although not included within the main body of the report, the members of the sub-group view this section as of particular importance for supporting information sharing. Where possible, all relevant web links have been provided to all the material considered by the group and referred to in this Report.

Appendix C: Report from Ayrshire & Arran ADAT Drug Death Review Group, August 2004.

Section 2

Key Risk Factors Associated with Drug-related Deaths

Although the remit of the group, and therefore scope of this Report, is focused on current Action Team prevention strategies, members did draw on the considerable body of evidence to identify key risk factors associated with overdose. These risk factors have been well documented through reports such as that by the Advisory Council on the Misuse of Drugs.

From this body of evidence a number of general trends were noted that contributed to increasing the risk of overdose. It included, sometimes in combination, the following:

- injecting and polydrug misuse
- recent release from prison
- detoxification
- homelessness (either street or hostel dwelling)
- previous history of non-fatal overdose
- unemployment and social circumstances
- prescribing practice
- contributory effects of alcohol

We did not examine all of these factors systematically because this has been done already. It was felt to be more useful to concentrate on other areas which may be overlooked, and where there might be scope to improve outcomes by sharing good practice between regions.

Section 3

Current Action Team-Led Activities

Whilst it is evident that all Action Teams have in some way considered the issue of how to reduce drug-related deaths, the actual development of detailed local strategies (e.g. Critical Incidents Groups or similar mechanisms) has been less widespread. Of those Action Teams involved in the sub-group, and from responses to a Scotland-wide Action Team snapshot survey¹, the following examples are provided as having advanced significant local activities:

Greater Glasgow Drug Action Team

In response to the 2002 figures and the national target for all DAATs to reduce the total number of death by 25% by 2005, it was agreed that a short-life working group be set up under the auspices of the Glasgow City Drugs and Alcohol Planning and Implementation Group. The first meeting was held in the summer of 2003, and its aim was to analyse in detail the 124 deaths which had occurred in the previous year. The group met quarterly, and a range of subgroups and individuals carried out more detailed work on the deaths, in relation to:

- prisons and prison throughcare
- homelessness
- risk factors and accessibility of services
- methadone deaths and other prescribing issues
- harm reduction information – Know The Score
- previous contact with services
- previous A&E attendance and history of overdose

A report and action plan was submitted in December 2003 (see Appendix B). A smaller group continues to meet to implement the plan, to monitor local drug deaths, and to disseminate new information urgently when appropriate.

Argyll & Clyde Drug Death Action Group

The Argyll & Clyde Drug Death Action Group started in December 2003 and was set up following local police-led conferences on drug-related deaths. Building on the models used in both Ayrshire and Grampian, the group agreed an information sharing proforma based on the Department of Health's Guidelines. This 'closed' group was set up under the auspices of the NHS Caldicott Guardian in order to meet the governance and legal needs of those partners not already licensed to share relevant data. It has a wide professional membership and has, to date, carried out a comprehensive information sharing exercise on the details of 27

¹ A snap-shot survey of all 22 Scottish Drug Action Teams was conducted in February 2004. Outwith those Action Teams represented on the short-life working group, a further response was received from Orkney. As such it is accepted that wider activity than is documented in this report might currently be underway.

individuals. This involves police, prison, fiscal, NHS, local authority and voluntary sector records of the known persons who have died in circumstances where drug misuse has been suspected.

The quarterly meeting provides a review of the written data available and an opportunity for those who worked directly with the person to share information, and to consider lessons learned and implications for service design changes. The group are preparing their first annual report, which will be considered in early January 2005.

Lanarkshire Drug and Alcohol Action Team

The Lanarkshire Critical Incidents Group was convened in 2003 to pool and analyse information on drug-related deaths (DRDs) in order to identify risk factors and opportunities for intervention. Based on an analysis of DRDs in 2001 and 2002, the group suggested some early actions in terms of reducing drug-related deaths in Lanarkshire, which have been ongoing throughout 2004. These included:

- Prioritising education and awareness-raising regarding the increased risk of drug-related death for recently released prisoners, and improving links to community-based services;
- Conducting an audit of the local distribution of Know The Score materials to vulnerable groups and their families/friends;
- Continuing and expanding upon the work initiated by Lanarkshire's Harm Reduction Team regarding the provision of resuscitation training for agency staff, service users and their families/friends;
- Investigating opportunities for the provision of Naloxone (the overdose-reversing opioid antagonist) to appropriate groups in the community;
- Engaging with families and service-user groups.

Following initiation of action in these areas and subsequent analysis of DRDs in 2003 and 2004, the group have also identified:

- A marked variation in local (LHCC area) DRD rates unrelated to problem drug use prevalence;
- An increase in DRDs involving methadone (from 1 per year in 2001-03 to at least 3 in 2004);
- A continuing problem regarding recently-released prisoners;
- The need to reconsider the targeting, delivery and format of educational materials; and Procedures for conducting in-depth case-by-case reviews of subsequent fatalities.

Ayrshire and Arran

As noted in Appendix C (ADAT Drug Death Review Group)

Forth Valley Substance Action Team

Forth Valley set up a drug-related Critical Incidents Group (ongoing), whose first meeting was held in February 2004. This group produced a flow diagram to describe possible points of intervention, and consider various risk factors (see Appendix B). Overall they take a preventative approach, which involves some work looking at the needs of clients. This goes beyond a consideration of need in terms of services, but considers clients' beliefs and attitudes as well. FVSAT identified tolerance - or rather, a reduction in tolerance to opiates - as a significant risk factor; they want to make sure any message aimed at changing the behaviour of clients will take account of the fact that most clients are aware of the risks, but that it is perhaps other factors which prevents this awareness leading to a change in behaviour. They are therefore focussing on the training of people who are involved with providing support and advice, to try to ensure that this is given in a way which is most likely to lead to a change in behaviour of clients.

All of the above-identified developments were seen as highly valuable and of relevance to co-ordinating prevention strategies across Action Teams. However, in considering that other Action Team areas might be in the process of establishing local Critical Incidents Groups, the sub-group particularly wished to draw attention to the approach and remit adopted by Ayrshire and Arran ADAT. The Ayrshire and Arran model (Appendix C) was considered as a good working example that other areas might wish to adopt in the establishment of similar local working groups.

Section 4

Themes Addressed by the Sub-Group

In the course of the four meetings, the sub-group took the opportunity to identify key themes for further exploration. This section of the report provides a summary of those deliberations.

A&E as a point of non-fatal overdose

Following work undertaken by the three Action Teams in Grampian during 2001, a relationship between non-fatal overdose and admission into Accident and Emergency Departments was identified. As a result of further studies, it has been established that for the Grampian area a relationship exists between drug-related deaths and previous Accident & Emergency overdose treatments. As a result of these findings, the following preventative interventions were identified for implementation across Grampian:

- Provision of safer drug use information at Accident & Emergency centres throughout NHS Grampian area;
- Referral protocols and clinical pathways between Accident & Emergency centres and specialist drug treatment services/GPs;
- Improved data collection within Accident & Emergency centres;
- Referral protocols for under-17s who have been treated for a drug overdose between Accident & Emergency and Social Work child protection services, to improve the health, welfare and safety of children;
- Motivational interviewing of individuals admitted to Accident & Emergency in-patient care, and referrals to community services.

It was the view of the sub-group that this trend between drug-related deaths and previous Accident & Emergency overdose treatments should be considered by all Action Team areas. Members viewed as a high priority the need for all Action Team areas to determine what prevention measures should be considered within their local Accident & Emergency Departments.

The Use of Naloxone In Response To Overdose

Throughout the duration of meetings, the use of Naloxone was considered on a number of occasions. To help inform group thinking on this subject, Kay Roberts (Specialist Pharmacist in Drug Misuse) was invited to present on key issues surrounding the use and provision of Naloxone (a web link to the presentation can be found at Appendix B).

Several summary points emerged on the thinking of Naloxone, including:

- The use of Naloxone is not without side effects or risk but if used in the correct situations can save lives;

- Naloxone is not currently on the list of approved medicines that can be administered by anyone in an emergency to save life, and therefore a change in legislation would be required to enable its wider use by non-medical staff in the advent of an emergency;
- Advice to potential victims/friends/carers must be aimed at a) avoiding overdose b) First Aid (recovery position etc.); therefore Naloxone should only be considered for use *after* standard First Aid procedures have been attempted (Patient Group Direction (PGD) was highlighted as a useful tool which areas might wish to consider, as had been advanced locally in Glasgow).

It was established that administration and protocol on the use of Naloxone varied significantly across Action Team areas. Variations ranged from no policy or usage, to administration only in Accident & Emergency hospitals, and to the development of small-scale pilots and exploration of use via non-medical staff.

The status of Naloxone use (outwith Accident & Emergency Departments) by those Action Teams represented on the sub-group was reported as follows:

- Consideration of potential use has been discussed but not pursued as an option (Ayrshire & Arran);
- Consideration given to implementing a small-scale pilot on the use of Naloxone via the Harm Reduction Service. However, due to issues around legitimacy of prescribing Naloxone, a final decision was made that it would be more appropriate for a national research project to be conducted instead (Forth Valley);
- Discussion undertaken through Action Team Critical Incidents Group resulted in an application early 2004 for a Letter of Comfort from the Lord Advocate, to allow its use by non-medical staff; this request was declined (Lanarkshire).

Across sub-group members there was a variation in opinion on the usage and benefits of Naloxone; however, the sub-group considered that in certain instances (i.e. "hot spot" areas) there remains scope to expand its use outwith the traditional setting of Accident & Emergency departments. Such an expansion of use would clearly require an amendment to the Medicines Act, and therefore the full DAT Association should consider recommending that Naloxone be put onto the 'safe' list for general administration.

In the meantime, and until such legalisation is advanced, further consideration on the use of Naloxone should be examined by local-level Critical Incidents Groups. These groups should continue to liaise and be tasked with a) identifying best practice, and b) developing the wider evidence base on Naloxone usage.

The Medicines and Healthcare Regulatory Agency (MHRA) have recently consulted, in accordance with Section 129 (6) of the Medicines Act, to add Naloxone to the range of prescription-only medicines which can be administered parenterally by anyone for the purpose of saving life in an emergency. This would

be achieved by an amendment to Article 7 of the Prescription Only Medicines Order, 1997. Consultation closed on 17th January 2005. The proposal is aimed specifically at allowing ambulance technicians to administer Naloxone in an emergency, in circumstances where a registered paramedic may not be available. The MHRA's website can be found via the weblink at Appendix B.

Terms of Reference of Local Critical Incidents Groups

Through the workings of the sub-group, members took the opportunity to share (for wider dissemination) the remit and membership of established local groups.

Electronic links to the information provided by members is outlined at Appendix B.

Local Methadone Prescribing Practices

A consistent theme raised throughout group meetings was the need to ensure good practice in relation to methadone prescribing. Although part of wider Action Team prescribing strategies, members emphasised the need to ensure implementation of standard guidelines and related training strategies as vital components in helping to prevent overdose.

Mechanisms for delivering Education and Training

The topic of education and training (including peer education) was discussed and recognised as highly important by all areas represented on the sub-group. However, few Action Teams reported having put in place specific initiatives that focused on either overdose prevention or responding to overdose situations. Those initiatives that were identified across Action Teams included:

Ayrshire & Arran: "Heart Start", a local organisation who are prepared to deliver First Aid training to local drug users;

Lanarkshire: The establishment of two groups which have been identified as potential *recipients* of specific First Aid/overdose training: key social network members and family members;

Forth Valley: Planning a series of workshops aimed at improving skills at delivering harm reduction advice to clients;

Argyll and Clyde: Currently looking at expanding First Aid training to family support groups.

Since the majority of overdoses are either observed and/or take place in a home setting, the sub-group felt that these two groups of people known to a drug user would be most likely to benefit from the training provided to help prevent death from overdose. One such strategy considered as having great potential was the expanded use of peer education and social support networks.

The one-year award by the Scottish Executive to the Scottish Drugs Forum (SDF) to provide First Aid training to service users and family members was considered by the sub-group as an important step in the development and implementation of local fatal overdose prevention strategies. The SDF initiative is a welcome addition to the national provision of training, although individual Action Teams should still consider what strategy they could employ locally to offer comprehensive First Aid training for service users.

“Know The Score” and Additional Resources for Local Use

Communication tools for use in various locations was considered an area that Action Teams should be more actively promoting with local service providers. One such communication tool is the ‘Know The Score’ website (www.knowthescore.info), which provides a range of information and advice on drugs in Scotland; it also has resources (such as publications) available for use by Action Teams.

Joint Police and Ambulance Protocols

On a number of occasions group members considered the current ACPOS and Scottish Ambulance protocol on responding to drug-related overdoses, or suspected overdoses. Members noted that a legal dilemma might exist in some instances in calling for medical assistance. Given that the Lord Advocate’s guidelines state that all drugs deaths are to be treated as a potential culpable homicide, and the police are duty-bound to investigate, the joint protocol between ACPOS and the Scottish Ambulance Service automatically requires police attendance at an overdose. Consideration was given to whether automatic involvement of the police might, in some instances, delay witnesses calling for an ambulance.

Whilst no clear conclusion was reached, members recommended that individual Critical Incidents Groups be tasked with considering the issue further.

Additional Issues

Within the limited time available to the group, members considered (although were not in a position to form any clear views) wider initiatives that might help to form part of a strategy for preventing drug-related deaths. These included the use of safer injecting rooms targeted at high-risk homeless individuals; heroin prescribing; and the provision of greater outreach to older and more vulnerable drug users.

Section 5

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.

Appendix A

Membership

A total of four meetings of the Drug-Related Deaths sub-group were held throughout 2004 (in February, May, August and December). Details of attendees are as follows:

<u>Name</u>	<u>Representing</u>	<u>Attended</u>
Dr. Jane Jay (Chair)	Glasgow Drug Problem Service	all
Leona Paget	Forth Valley SAT	all
Justine Walker	DAT Association	all
Jackie Davies	Dumfries & Galloway ADAT	February, May, August
Stevie Lydon	Argyll & Clyde ADAT	February, May, December
Ian Smillie	Perth & Kinross DAAT	February, May, August
Sandra Wallace	Substance Misuse Division, Scottish Executive	May, August, December
Det. Supt. Gill Wood	Scottish Drug Enforcement Agency	May, August, December
Mark Connelly	Lanarkshire ADAT	May, August
Grahame Cronkshaw	Aberdeen City, Aberdeenshire, Moray DAATs	February, August
Insp. John Duffy	Strathclyde Police	May, December
Dr. Oliver Harding	Forth Valley Health Board	May, December
Ruth Shepherd	Ayrshire & Arran ADAT	August, December
Elaine Fetherston	Highland DAAT	August
Caird Forsyth	Forth Valley SAT	February
Brian Gardner	Highland DAAT	August
Sharon Hackney	Ayrshire & Arran ADAT	February
Stephen Heath	Ayrshire & Arran ADAT	August
Insp. Les Johnson	Grampian Police	May
Mike McCarron	Glasgow DAT	February
Alistair McKie	Strathclyde Police	August
Dougie Montgomery	NHS Highland	August
Kay Roberts	Specialist Pharmacist in Substance Misuse	August
Hilary Smith	West Lothian DAAT	May
Jim Stephen	Substance Misuse Division, Scottish Executive	August
Liam Wells	Forth Valley SAT	February
Linda Bates	DAT Association (minutes)	May, August, December
Sharon Mahood	DAT Association (minutes)	February

Appendix B

Key Reports and Useful Documents

The following is not a comprehensive list of all relevant documents but it is a useful resource for Action Teams and relevant partners to consult as they develop their local strategies to reduce drug-related deaths.

National

- Reducing Drug-related Deaths, Report of the Advisory Council on the Misuse of Drugs, HMSO, 2000
www.drugs.gov.uk/ReportsandPublications/Treatment/1033489222
- Drug-Related Deaths In Scotland In 2003: General Register Office for Scotland (and for previous years)
http://www.gro-scotland.gov.uk/search_results.html
- National Treatment Agency Report on Reducing Drug-related Deaths
www.nta.nhs.uk/publications/drugdeath.htm
- Scottish Police Forces' specialist drug co-ordinators
<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/policecoord.pdf>
- Medicines and Healthcare products Regulatory Authority
www.mhra.gov.uk
- Scottish Executive's Review of Drug Treatment & Rehabilitation Services: Summary and Actions (published 27 October 2004)
<http://www.scotland.gov.uk/library5/health/drugrehabreview.pdf>

Action Team Reports

- **Ayrshire and Arran Alcohol and Drug Action Team**

Ayrshire and Arran Drug Death Review Group: Membership, Remit and Priorities areas of Work

<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/AAdrugdeathgrp.pdf>

- **Forth Valley Substance Action Team**

Critical Incidents Group: Membership and Terms of Reference (07/09/04)

<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/FVcriticalincidencegrp.pdf>

Association of Drug Action Teams
Drug-Related Deaths sub-group: Final Report
January 2005

Critical Incidents Group Flow Chart:

<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/FVcriticalincidence.pdf>

- **Grampian (Aberdeenshire, Aberdeen City and Moray Action Teams)**

Drug-related Deaths and Accident and Emergency Services in Grampian: Report to Working Group (19/05/04)

http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/Drug_Deaths_190504.pdf

- **Greater Glasgow Drug Action Team**

Drug Death Action Plan Working Group: Final Report to Glasgow City Drug and Alcohol PIG

http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/drd_final_PIG.pdf

Executive Summary - Drug Death Action Plan Working Group: Final Report to Glasgow City Drug and Alcohol PIG

http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/drd_exec_sum.pdf

- **Lanarkshire Alcohol and Drug Action Team**

Social network correlates of self-reported non-fatal overdose – Article Summary for DAT Association Drug-related Deaths sub group

<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/SocialNetwork.pdf>

- **Association of Drug Action Teams: Drug-related Deaths Sub Group Minutes and Presentations**

Main Page: Provides links to sub group reports, minutes, papers and presentations considered by the short life group:

<http://www.drugmisuse.isdscotland.org/dat/datassoc/subgroup.htm>

Presentation: Dr Jane Jay, The Glasgow Experience (04 Feb 2004)

http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/drd_pp.pdf

Presentation: Mark Connelly, Lanarkshire ADAT Critical Incidents Group (10 Dec 2004)

http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/Critical_Incident_Group.pdf

Presentation: Kay Roberts, The Use of Naloxone (31 Aug 2004)

<http://www.drugmisuse.isdscotland.org/dat/datassoc/pdfs/Naloxone.pdf>

Appendix C

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

Submitted to DAT Association Drug-Related Death sub-group, 31/08/04

Participants' names:

- **Detective Superintendent Stephen Heath, Strathclyde Police (Chair)**
- **Dr Charles Lind, Associate Medical Director NHS Ayrshire and Arran**
- **Mr Terry Kane, DTTO Co-ordinator Criminal Justice Services**
- **Ms Janet Cameron, Area Procurator Fiscal, Procurator Fiscal Services**
- **Ms Marnie Hodge, Regional Manager, Cranstoun Drug Services**
- **Ms Maria McLaren, Addiction Co-ordinator, HMP Kilmarnock**
- **Ms Ruth Shepherd, Co-ordinator, Alcohol and Drug Action Team**
- **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 a 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 three 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 individual's circumstances prior to death, including place of death, employment and accommodation status, family support, and the nature of the individual's 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 (www.adat.org.uk).

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 their clients. This ensured that not only hostel dwellers but also 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 were 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.

Drug Death Review Group
Ayrshire & Arran Alcohol & Drug Action Team
31 August 2004